

BALTIMORE CITY HEALTH DEPARTMENT

RYAN WHITE OFFICE

CLINICAL QUALITY MANAGEMENT PROGRAM (CQM)

Service Category: Outreach Services

June, 2011



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SECTION 1. INTRODUCTION

The Clinical Quality Management (CQM) program's purpose is to ensure that persons living with HIV/AIDS (PLWHA) in the Greater Baltimore/Towson Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White HIV/AIDS Treatment Extension Act of 2009. The Baltimore City Health Department (BCHD) Ryan White CQM program began in 2001, looking at data on services provided during calendar year (CY) 2001. In 2010, CQM reviewed fiscal year (FY) 2009 records for outreach services.

As defined in the Greater Baltimore HIV Health Services Planning Council Standards of Care (Standards of Care), outreach services are, "those activities that promote the access to, and continuation of, appropriate services at the earliest possible stage of HIV disease by addressing the multitude of issues and service barriers that impact upon the individual. Services may be provided on the streets in areas where there is a demonstrably high incidence of HIV infection, in non-traditional HIV service settings and facilities, and within the traditional HIV health-care system."¹

To assess the degree to which services adhered to the standards of care across the EMA, data was gathered and analyzed from all Part A- and Minority AIDS Initiative (MAI)-funded outreach programs in the EMA. In addition to providing the results for the data collected, this report provides details of the methodology, a summary of the findings, as well as recommendations for improving the quality of outreach services. The appendix contains the standards of care used throughout the review. *Section 2* of the report contains a description of the methodology, *Section 3-7* contain results of the chart reviews, *Section 8* contains consumer insights on outreach services received, *Section 9* contains an organizational assessment of providers' quality management activities, and *Sections 10* and *11* summarize the findings and recommendations.

¹ Greater Baltimore HIV Health Services Planning Council, Minority AIDS Initiative: Outreach/Linkage to Care. Origination June 2000.

SECTION 2. METHODOLOGY

Clinical Quality Management reviews were conducted at **9** agencies providing outreach services in fiscal year 2009. Data was collected through client chart abstractions, consumer surveys, and QI organizational assessments. The data collected may not reflect all Ryan White clients receiving outreach services throughout the Baltimore/Towson EMA.

Outreach Record Abstraction: The chart abstraction tool was designed to assess the vendor’s adherence to the EMA’s local standards of care. The review period focused on services provided in fiscal year 2009 (March 1, 2009 – February 28, 2010) for Part A clients and (August 1, 2009 – July 31, 2010) for MAI clients. Vendors were directed to provide a random sample of charts and CQM provided two methodologies for how to pull records. CQM did not verify that the charts provided by the agencies represented a random sample. The number of charts requested from an agency was based on the total number of Ryan White clients receiving outreach services from that agency and guided by the 2008 HIVQUAL sampling methodology developed by the New York State Department of Health, AIDS Institute.²

For each chart reviewed, one survey instrument was completed. A total of **307** outreach charts were reviewed at the **9** agencies funded to provide outreach services. Data collected via client chart abstraction is presented in *Sections 3-7*. The number of charts reviewed at each agency ranged from **21** to **50**, with an average of **34** charts reviewed per site.

Based on service utilization data reported to BCHD by agencies receiving MAI and/or Part A funding, a total of **576** persons received outreach services during 2009.³ Half (**53%**) of all outreach charts were reviewed during the CQM process, *Table 1*.

Table 1. Outreach Charts Reviewed, N=307

Program	Charts Reviewed	% CQM Sample	Clients Seen	% Agency Sample
Ann Arundel County Health Department	30	10%	35	86%
Baltimore County Health Department	33	11%	47	70%
Baltimore City Health Department, Prevention Program	43	14%	179	24%
Baltimore City Health Department, STD Program	36	12%	39	92%
Johns Hopkins Women’s Program (MAI)	32	10%	46	70%
Park West Medical Center (MAI)	22	7%	39	56%
People’s Community Health	21	7%	60	35%
Sisters Together and Reaching	40	13%	64	63%
Total Health Care (MAI)	50	16%	67	75%
Total	307	100%	576	53%

² New York State Department of Health, AIDS Institute. The 2008 HIVQUAL Project Sampling Methodology, August, 2009.

³ This data was obtained from the monthly Form 8s submitted to the Baltimore City Health Department (BCHD) as the administrative agency. This total is unduplicated at the vendor level, and then aggregated to give a duplicated EMA-wide count.

Consumer Survey: The consumer survey assesses quality from the client’s perspective. The tool captured demographics, specific outreach services received, and client satisfaction with services. Vendors were instructed to provide a sample of consumers for interviews during the scheduled visit. An independent consultant administered the consumer interviews while on site. When on-site interviews were not possible, telephone interviews were conducted after obtaining client consent by the agency.

Organizational Assessment: CQM utilized a quality improvement organizational assessment checklist to measure quality improvement indicators in multiple domains including quality structure, quality planning, quality performance measurement, quality improvement activities, staff involvement, consumer involvement, evaluation of the quality program, and clinical information systems. CQM staff interviewed each agency and completed the organizational assessment based on vendor responses and substantiating documentation where available. The assessment was developed by the HIVQUAL-US program at the New York State Department of Health AIDS Institute.

⁴

The client chart abstraction tool and QI organizational assessment were distributed to vendors and the Greater Baltimore HIV Health Services Planning Council (Planning Council) for comment prior to utilization during the reviews. CQM also conducted conference calls with all outreach programs in advance of their reviews to confirm dates, locations, any additional logistics, and to answer any questions specific to the tools and/or review process.

⁴ <http://www.hivguidelines.org/wp-content/uploads/HIVQUAL-OA.pdf>

SECTION 3. DEMOGRAPHICS

AGE

More than half of clients were between 40 and 59 years of age. For Part A clients, **35%** were in their 40s and **26%** in their 50s, *Figure 1*. Similarly for MAI clients, **41%** were in their 40s and **29%** in their 50s. The mean age for Part A clients was **42** years old while that of MAI clients was **44** years old. As shown in *Figure 2*, the 2010 review included only adult clients while the 2003 outreach review included some youth outreach clients. The outreach sample is similar in age to the HIV population within the EMA overall. Further, the current sample showed a **20%** increase of clients in their 50s compared to the 2003 outreach review. Note, percentage totals may be slightly above or below 100% due to rounding.

Figure 1. Age, N=307

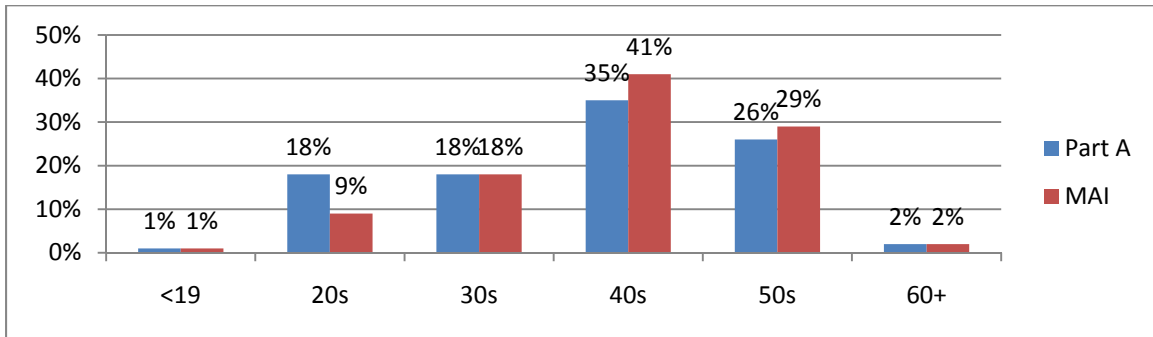
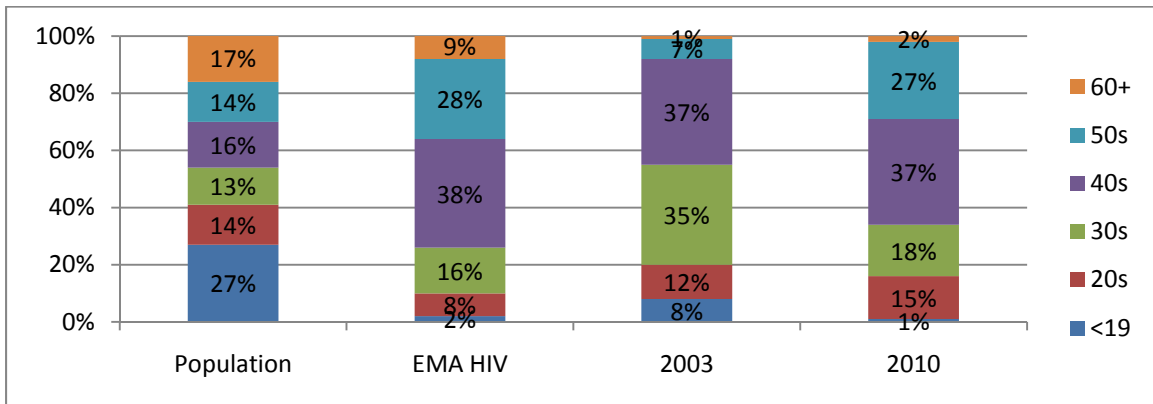


Figure 2. Age Comparisons, N=307



GENDER

In 2010, there were twice as many males as females receiving Part A funded outreach services and three times as many males as females receiving MAI outreach services, *Figure 3*. This is similar to the proportion of males to females seen within the EMA as seen in *Figure 4*. However in comparison

to the general population, males are disproportionately affected by HIV. In 2003, the ratio of males to females was similar to the current sample.

Figure 3. Gender, N=307

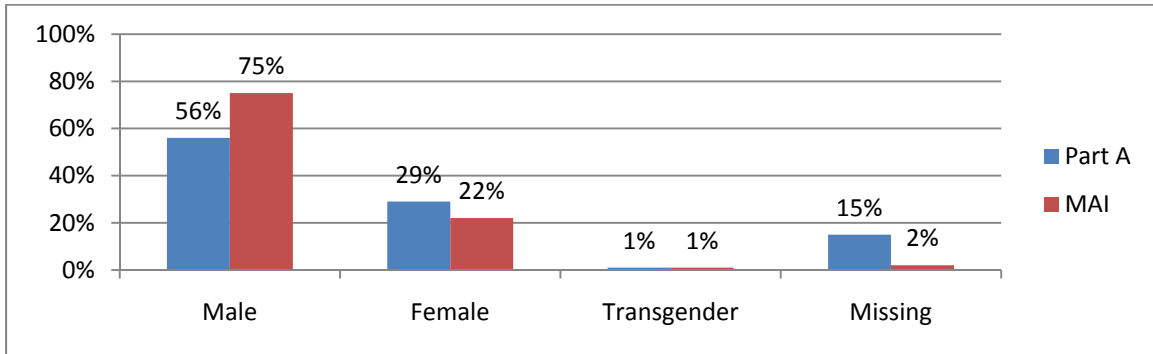
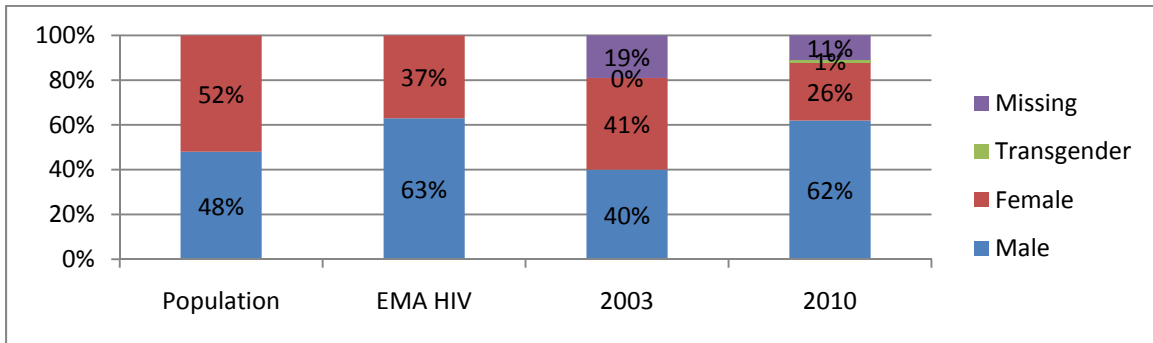


Figure 4. Gender Comparisons, N=307



RACE/ETHNICITY

Figure 5 shows race/ethnicity by funding. As seen throughout the EMA, African Americans make up the majority of the outreach sample. A slight increase in Caucasians was seen compared with the 2003 outreach sample, Figure 6. A small proportion of Hispanic males with HIV, as well as Transgender clients were seen in the 2010 outreach sample.

Figure 5. Race/Ethnicity, N=307

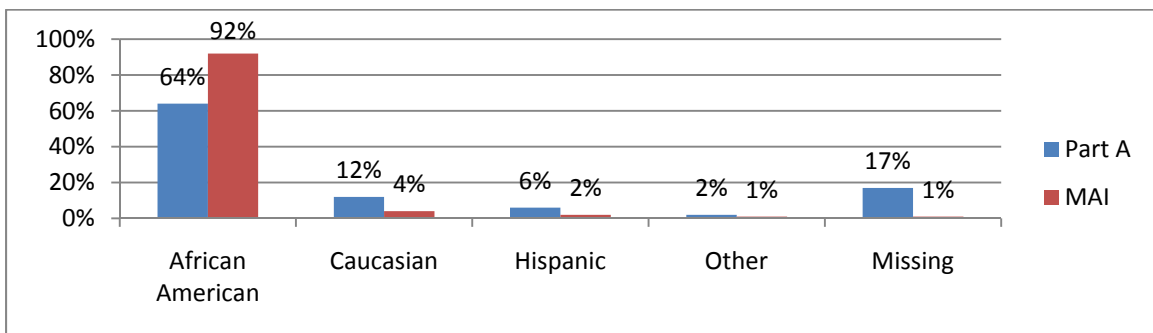
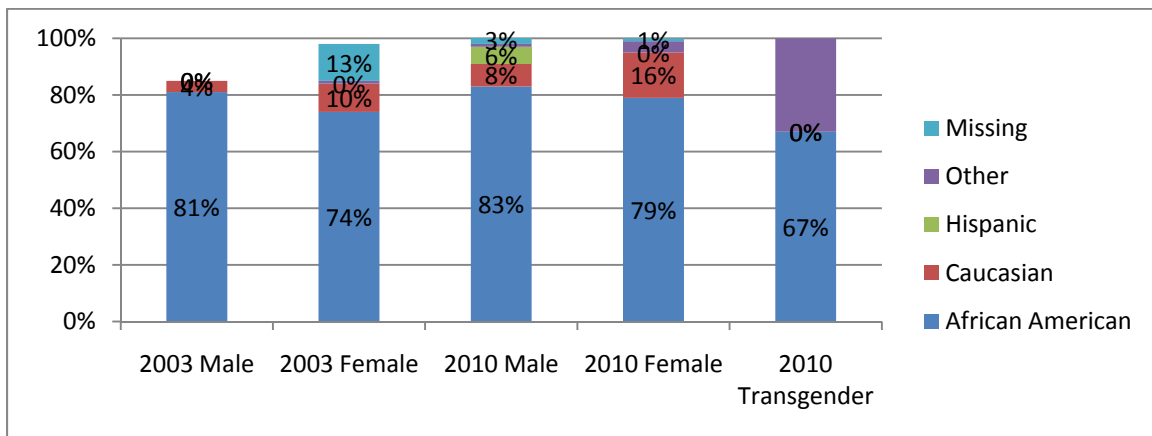


Figure 6. Race/Ethnicity by Gender, N=307



RESIDENCY

Zip codes were abstracted from client charts to determine residency in Baltimore City or surrounding counties as shown in *Table 2*. The majority of clients were from Baltimore City and Baltimore County for both Part A and MAI records, with a few additional clients from other surrounding counties. More Part A records (**22%**) were missing residency than MAI records (**5%**).

Table 2. Residency, N=307

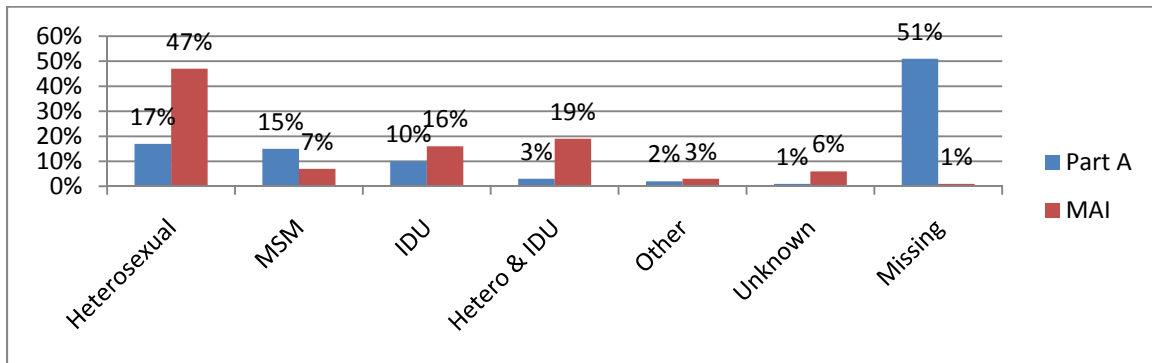
Residency	Part A, N=203	MAI, N=104
Baltimore City	46%	75%
Baltimore County	19%	14%
Ann Arundel County	13%	1%
Howard County	0%	1%
Montgomery County	0.1%	0%
Caroline County	0%	1%
Washington County	0%	2%
Prince George's County	0%	1%
Missing	22%	5%
Total:	100%	100%

RISK FACTOR

Figure 7 shows the distribution of risk factor for the outreach records. MAI charts had better documentation of HIV risk than Part A records where half were missing risk factor. Heterosexual transmission was the most frequent mode of HIV transmission in both Part A and MAI charts. Other modes of transmission included injection drug use (IDU) and Men who have Sex with Men (MSM) in Part A records and also a combination of heterosexual and IDU transmission in MAI records. Risk factors categorized as “other” included perinatal transmission, hemophilia, occupational exposure, and MSM combined with IDU, each of which represented less than **1%** of records. IDU has

decreased since the 2003 outreach review, however sexual transmissions have increased proportionally, *data not shown*.

Figure 7. Risk Factor, N=307



INSURANCE

Table 3 shows a higher portion of uninsured consumers among MAI consumers compared with Part A clients; **37%** versus **16%** respectively. Likewise, three times as many MAI clients had Medicaid (**33%** vs. **10%**). For Part A clients, the most common types of insurance coverage were Medicaid and private insurance (**10%** and **5%**), while for MAI clients, the most common forms of insurance were Medicaid and PAC (**33%** and **9%**) respectively. However, keep in mind insurance coverage was missing from over **60%** of Part A charts versus only **4%** of MAI records.

Table 3. Insurance, N=307

Insurance	Part A (%)	MAI (%)
Medicaid	10%	33%
Medicare	3%	7%
MHIP	0%	1%
Veteran's Administration	1%	0%
Corrections	2%	1%
CHIP	0%	0%
PAC	3%	9%
Private	5%	7%
MADAP	2%	0%
Unknown	0%	5%
None	16%	37%
Missing	61%	4%

CLINICAL INDICATORS

Primary care enrollment was defined as a consumer having two or more medical visits with a prescribing provider occurring at least three months apart within fiscal year 2009. Of all the outreach records reviewed, **30%** of Part A and **56%** of MAI clients met this criteria.

HIV status was documented in nearly all Part A (**99.5%**) and MAI (**98%**) records. Treatment status with highly active antiretroviral treatment (HAART) medications was documented in **18%** of Part A and **64%** of MAI records. Of those, **13%** and **46%** of Part A and MAI clients respectively were prescribed HAART. *Figure 8* shows the mean CD4 counts across gender, race, and funding stream. Only cases with a CD4 count present in the record were included (**N=141**). The average CD4 count across the entire outreach sample was **393** cells/mm³.

Table 4. Mean CD4 Count by Gender, Race, and Funding, N=141

Sample	Mean CD4 Count
Male (N=96)	341
Female (N=40)	505
African American (N=115)	402
Caucasian (N=12)	419
Hispanic (N=10)	267
Part A (N=57)	350
MAI (N=84)	422
Total Sample With a CD4 (N=141)	393

Females had a higher mean CD4 count than males. Hispanics had the lowest mean CD4 count, however the sample size was very small. Part A clients had an average CD4 count lower than MAI clients as well. *Figure 8* shows the CD4 distribution across the Part A and MAI samples. A total of **28%** of clients had CDC-defined AIDS with a CD4 count below 200. When stratified by funding stream, **37%** of Part A and **23%** of MAI clients were AIDS defined with a CD4 count below 200. Viral load counts were present in **26%** of Part A and **80%** of MAI charts respectively. *Figure 9* shows **6%** of Part A and **32%** of MAI clients achieved viral load suppression and were undetectable.

Figure 8. CD4 Range, N=141

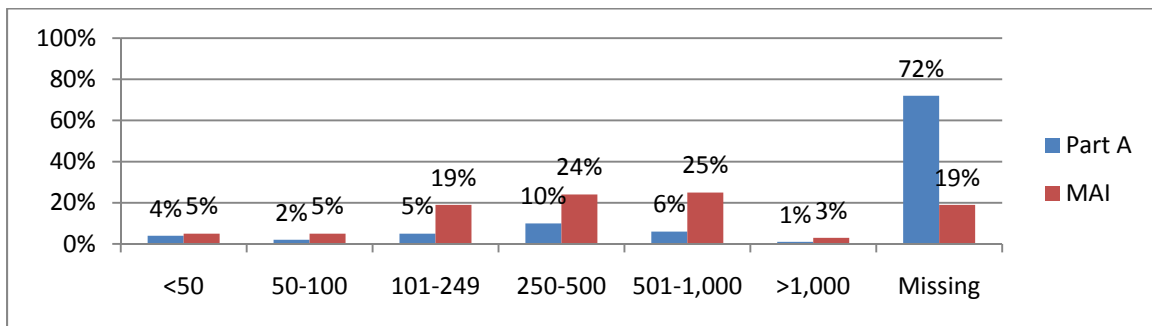
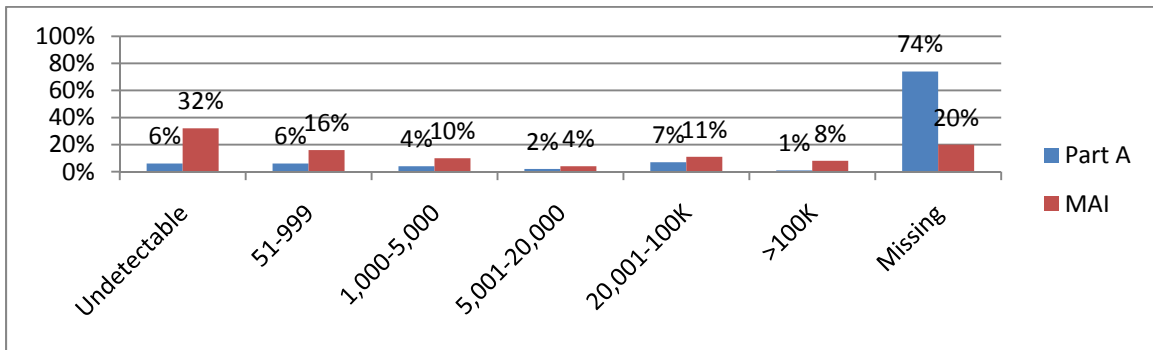


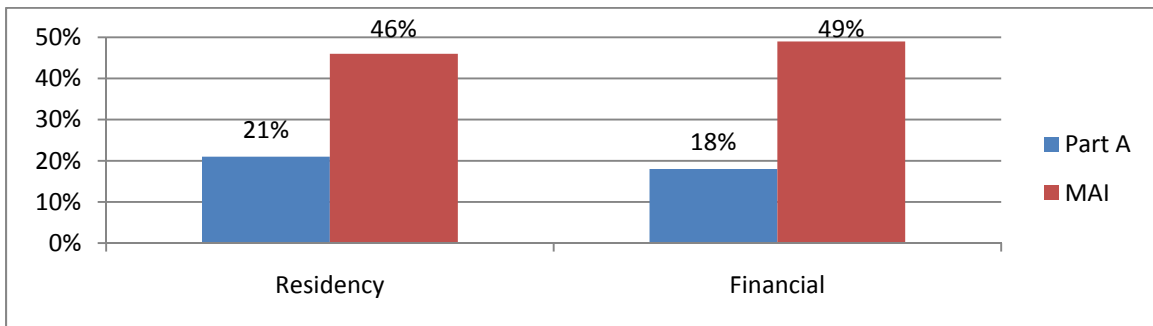
Figure 9. Viral Load Range, N=136



ELIGIBILITY

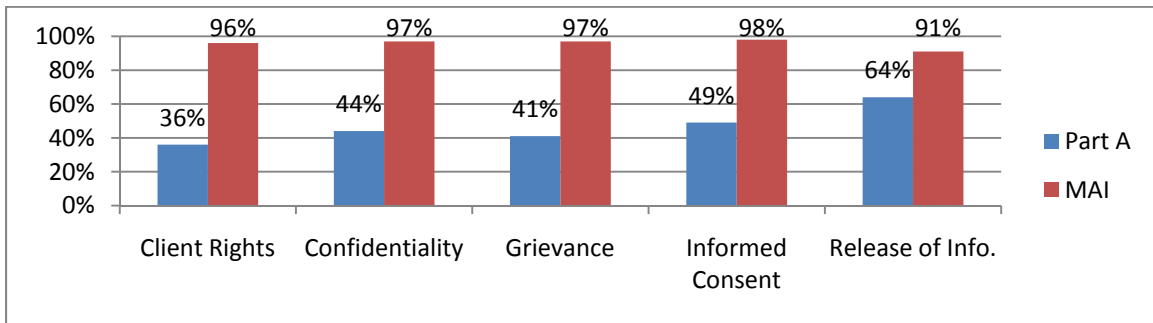
Upon intake and bi-annually thereafter, agencies are required to document proof that the client resides in the Baltimore/Towson EMA and that their income is no more than **300%** of the federal poverty level. *Figure 10* shows residency eligibility was present in **21%** of Part A records and **46%** of MAI charts. Similarly, financial eligibility was documented in **18%** of Part A charts and **49%** of MAI records. Bi-annual recertification of residency and financial eligibility were found in less than **10%** of both Part A and MAI records.

Figure 10. Eligibility, N=307



MAI charts also documented distribution of agency policies at higher rates than Part A records. Part A charts had less than **50%** documentation for all policies except release of information which was documented in **64%** of the charts, *Figure 11*.

Figure 11. Policies, N=307



SECTION 4. NATIONAL HIV/AIDS STRATEGY

The National HIV/AIDS Strategy outlines several target outcomes tracked by the BCHD Ryan White office. *Table 5* highlights data from the 2010 outreach sample on three indicators related to access to care and reducing health disparity.

Table 5. National HIV/AIDS Strategy Outreach Indicators, N=307

National HIV/AIDS Strategy Indicator	Outreach (%)
Increasing Access to Care and Improving Health Outcomes for People Living with HIV	
Increase the % of RW HIV/AIDS clients who are in continuous care (at least 2 visits) for routine HIV medical care in 12 months at least 3 months apart from 73% to 80%	39%
Reducing HIV-Related Health Disparities	
Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%	11%
Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%	18%
Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%	14%

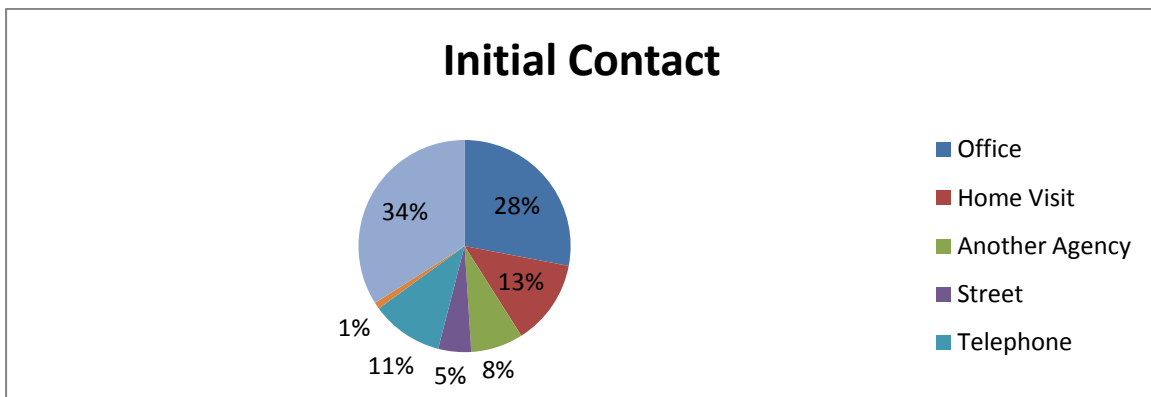
As expected, the outreach sample performed low on the HIV/AIDS Strategy indicators as clients are in the process of re-engaging in care. As the EMA implements the strategy, these rates will serve as a baseline for the category.

SECTION 5. STREET OUTREACH

A total of **307** client records were reviewed. More than half (**57%**) were for street outreach services, **35%** were for site-based outreach (at non-Ryan White-funded locations), and **8%** were for traditional outreach services that targeted a Ryan White program's own client base. Of the nine agencies reviewed, **3** provided street outreach only, **2** provided site-based outreach only, **2** provided both street and site-based outreach, **1** traditional outreach provider also conducted site-based outreach, and the remaining **1** site provided all three outreach modalities.

As defined in the standards of care, "Street outreach services are performed in areas where there is a high documented incidence of HIV, and or a discrete population that has a high rate of HIV population." A total of **175** clients were engaged in Part A street outreach services. Of the **66%** for which a location of initial contact was documented, the most common locations were at the agency's office or clinic (**28%**), home visits by the outreach worker (**13%**), and telephone contact (**11%**). Only **5%** of clients were encountered on the street. *Figure 12* shows the locations of initial contact for street outreach services.

Figure 12. Street Outreach Initial Contact, N=175



Of the **175** records reviewed, client assessments were documented in **125 (71%)** of them. The assessments included information on a wide array of services with the most frequently assessed areas of need being primary care (**98%**) and case management (**25%**). *Table 6* shows the needs assessed by the outreach worker and subsequent referral rates for services.

Table 6. Street Outreach Needs Assessment, N=125

Element	Assessed (%)	Referred (%)
Primary Care	98%	87%
Case Management	25%	23%
Medication	1%	1%
Counseling and Testing	0%	0%
Housing	5%	4%
Oral Health	5%	4%
Mental Health	2%	2%
Substance Abuse	5%	2%
Food	3%	3%
Transportation	6%	6%
Partner Notification	8%	4%
Support Group	3%	2%

Subsequently, a plan for assistance was documented in **79%** of records. Of the records with a documented assistance plan, the most common areas within the plan were provided needed referrals (**82%**) and transporting clients immediately for services (**15%**). *Table 7* shows the areas included in the assistance plans.

Table 7. Street Outreach Assistance Plan Strategies, N=124

Strategy	%
Providing referrals for needed services	82%
Assisting client in making future appointments	11%
Transporting client immediately for services	15%
Planning to transport client for future appointments	13%
Planning to follow-up on referrals	6%
Accompanying client to appointments	2%
Partner notification	2%

Follow-up with the client was documented in **68%** of the records reviewed. Under half (**43%**) of follow-ups was through a face-to-face contact, while three quarters (**75%**) followed up by telephone. *Table 8* shows the types of contact used to follow-up with clients after their initial outreach contact. The most common areas addressed during follow-ups were discussions regarding the referrals that were provided (**24%**), primary care services (**22%**), providing transportation (**22%**), and appointment reminders (**21%**), *Table 8*. Most client records documented a total of 2-5 follow-up contacts, *Table 10*. The most commonly documented frequency of follow-up contacts was “a few times a month” (**31%**) and “more than once a week” (**29%**), *Table 11*.

Table 8. Types of Follow-Up Contact, N=120

Contact Type	%
Face-To-Face: Home/Street	43%
Face-To-Face: Office	18%
Letter	6%
Telephone	75%
Other	8%

Table 9. Follow-Up Strategies, N=120

Strategy	%
Discussion with client regarding referrals provided	24%
New assessment of needs and/or barriers	7%
Providing additional referrals	5%
Reminder about appointments	21%
Providing transportation	22%
Accompanying client to appointment	13%
Discussion regarding availability of HIV-related services	10%
Discussion regarding primary care services	22%
Discussion regarding non-HIV-related services	2%
Reminder about medication adherence	1%
Plan to re-contact client for follow-up	4%
Trying to reach client to take HIV confirmation test	4%
Trying to locate client	9%
Areas addressed not documented	3%

Table 10. Number of Follow-Up Contacts, N=120

Contacts	%
1	8%
2-5	49%
6-10	36%
11-20	8%

Table 11. Frequency of Follow-Up, N=120

Contact Frequency	%
Daily	10%
More than once a week	29%
Once a week	13%
A few times a month	31%
Monthly	8%
Less than monthly	2%

Follow-up with referral sites was provided in **37%** of cases. The areas addressed by the outreach worker during follow-up were mostly contacting the client’s primary care provider (**43%**), contacting the client’s identified case manager (**37%**), and contacting the agency regarding the referrals provided (**37%**). *Table 12* summarizes the areas addressed by the outreach worker following up on referrals.

Table 12. Referral Follow-Up, N=65

Strategy	%
Contact with agency regarding referrals provided	37%
Contact with client’s identified case manager/client advocate	37%
Contact with client’s primary care provider	43%
Arranging transportation for client for future date	6%
Contact to verify partner’s HIV status	2%

In terms of re-connection to care, only **6%** of street outreach clients were documented as being engaged in primary care at initial contact. An additional **75%** documented a need to be connected to primary care. No documentation of primary care engagement was available in **18%** of records at initial contact. *Table 13* shows the methods used to address re-connection with primary care services by the outreach worker.

Table 13. Re-Connection to PMC Strategies, N=132

Strategy	%
Discussion with client regarding need to re-connect with PMC	47%
Re-connection with previous primary care provider	1%
Referral to another primary care provider	67%
Client indicates not wanting primary care at this time	2%
Client could not be located	6%
Attempts to connect client to primary care not documented	5%

By the end of the review period, **69%** of clients were re-connected with primary medical care services.

SECTION 6. SITE-BASED OUTREACH SERVICES NON-RYAN WHITE SITES

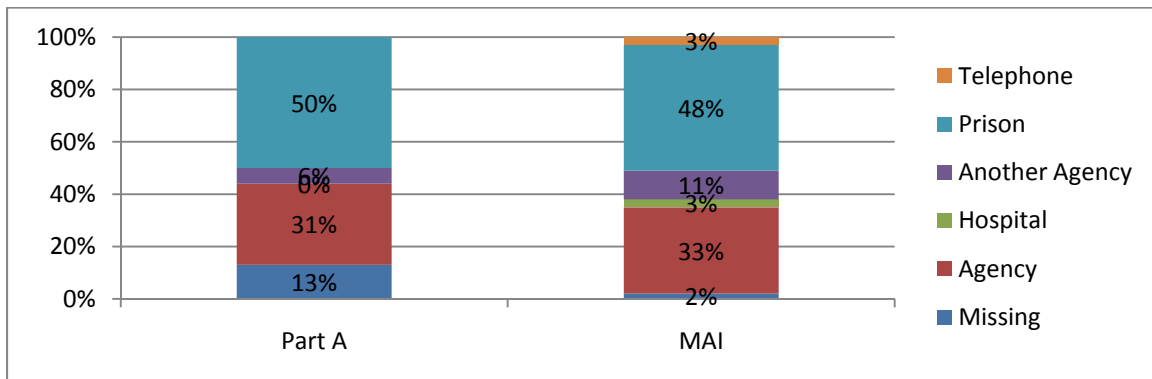
As described in the standards of care, outreach workers providing site-based outreach are an integral part of the structure of the host agency or facility offering non-traditional services. The review of site-based outreach services focused on the referral for outreach, client assessment, establishment of client goals, documentation of assistance provided, and outcomes. Of the **107** records reviewed, **16 (15%)** were funded by Part A, while most (**91, 85%**) were funded through the MAI program. Most of the clients were referred from prisons or other corrections centers. Most records did not document who referred the client for outreach services, however **32%** showed either a case manager or social worker making the referral, *Table 14*. The most common reason for referral for both Part A (**88%**) and MAI clients (**87%**) was identified HIV positive clients in need of services. The remaining clients were referred from the legal system either due to a recent release or a need for care as a condition of probation. The referrals contained documentation of HIV status in **63%** of Part A charts and **31%** of MAI charts.

Table 14. Referring Staff for Site-Based Outreach Services, N=107

Staff	Part A, N=16 (%)	MAI, N=91 (%)
Social Worker	0%	19%
Case Manager	0%	13%
Administrative Staff	0%	6%
Client	0%	3%
Primary Care Provider	0%	2%
Other	6%	7%
Not Documented	94%	51%

Figure 13 shows the majority of initial client meetings were conducted in prison settings followed by an agency clinic for both Part A and MAI outreach clients.

Figure 13. Initial Site-Based Meeting Location, N=107



An assessment of needs and barriers was documented in **94%** of Part A and **99%** of MAI charts. The most common areas of need assessed were primary care, case management, and substance

abuse treatment for both Part A and MAI clients. *Table 15* shows the needs assessed and subsequent referrals made.

Table 15. Site-Based Outreach Needs Assessment, N=105

Element	Part A (N=15)		MAI (N=90)	
	Assessed (%)	Referred (%)	Assessed (%)	Referred (%)
Primary Care	100%	87%	98%	86%
Case Management	33%	33%	68%	58%
Medication	--	--	9%	3%
Housing	7%	7%	42%	20%
Oral Health	7%	7%	21%	3%
Mental Health	--	--	32%	19%
Substance Abuse	27%	27%	52%	22%
Food	7%	7%	22%	--
Transportation	7%	7%	21%	11%
Insurance	--	--	26%	8%

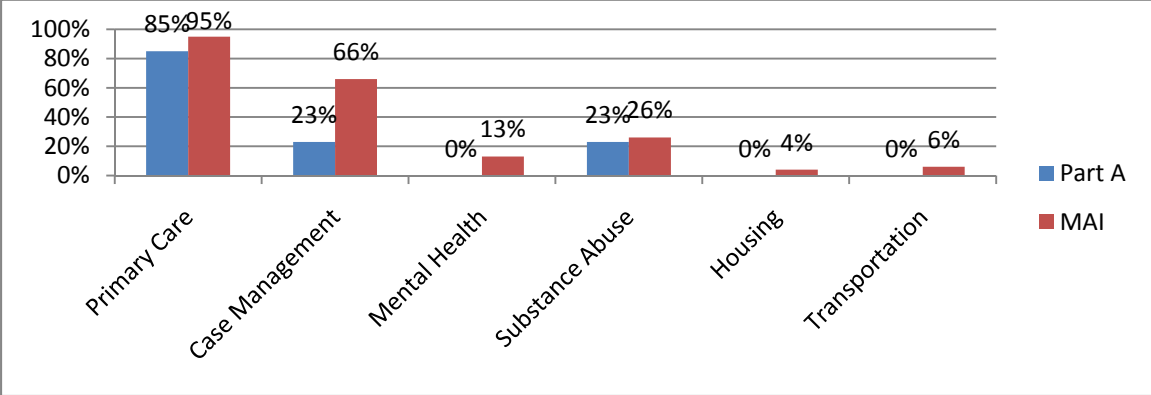
Mutual goal setting was documented in **81%** of Part A and **91%** of MAI charts. The records documented assessment of the level of assistance that the client needed to implement their goals in **88%** of Part A and **91%** of MAI charts. All Part A (**100%**) clients and most (**96%**) MAI clients reported they needed assistance in achieving their goals. Completion of intake and assessment forms by outreach workers and subsequently opening a client folder was documented for **100%** of Part A and **99%** of MAI clients. Additionally, completion of referral documents was found in **44%** of Part A and **84%** of MAI records. Most follow-up activities by outreach workers were with the clients directly, followed by the primary care providers, and referrals to the outreach worker's agency. *Table 16* shows the follow-up rates for site-based outreach providers.

Table 16. Site-Based Outreach Follow-Up, N=107

Follow-Up With:	Part A, N=16 (%)	MAI, N=91 (%)
Client	94%	91%
Referral to Outreach Agency	6%	55%
Other Referrals	19%	15%
Host Agency	25%	24%
Primary Care Provider	50%	63%

By the end of the review period, **81%** of Part A and **60%** of MAI clients were receiving HIV-related services. The most common service received by both Part A and MAI clients was primary medical care, *Figure 14*.

Figure 14. Connection to HIV-Related Services, N=68



SECTION 7. TRADITIONAL OUTREACH SERVICES RYAN WHITE SITES

According to the standards of care, “This service is primarily focused upon re-engaging clients into a provider agency’s own services; such services being other HIV services provided by the agency in question. This may be a stand-alone service performed by outreach workers or a function incorporated into existing case-management systems.”

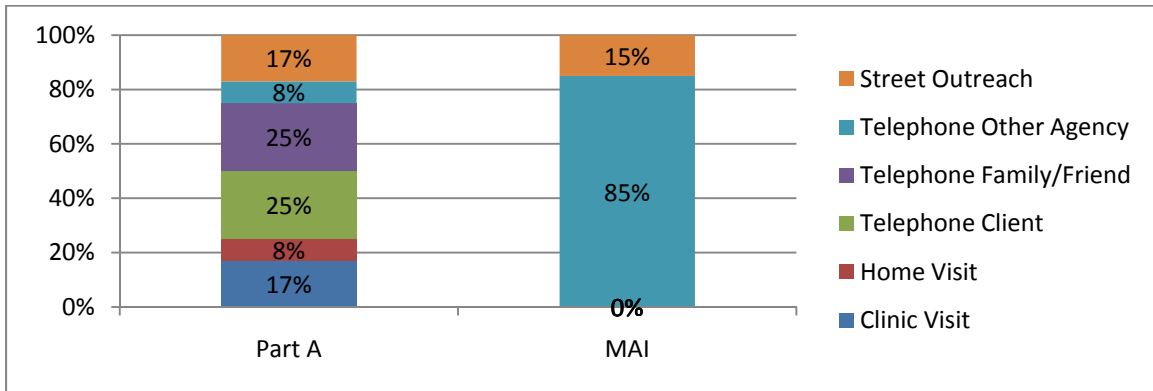
Only **2** of the agencies reviewed provided traditional outreach services. A total of **25** traditional outreach records were reviewed. *Table 17* shows the most frequently documented reason for referral for Part A clients was missed appointments while for MAI clients, it was newly diagnosed post-partum women needing to be linked to care.

Table 17. Traditional Outreach Referrals, N=25

Reason for Referral	Part A, N=12 (%)	MAI, N=13 (%)
Missed Appointments	75%	--
Medical	8%	31%
New Diagnosis	--	23%
New Diagnosis Post-Partum	--	39%
Reason Not Documented	17%	8%

The most frequently documented method of first outreach effort for Part A clients was a telephone call to the client or to the client’s family or friends (**25% each**), while for MAI clients calling other agencies working with the client accounted for **85%** of initial efforts to reach the client. *Figure 15* shows the initial outreach approaches for traditional outreach programs.

Figure 15. Traditional Outreach Initial Effort, N=25



The first outreach effort was shown to be successful in **17%** of Part A and **92%** of MAI clients. Additional outreach efforts were documented in all cases where the initial effort was unsuccessful in engaging the client in care. Among the **10** Part A clients with subsequent outreach efforts, the most common method was home visits (**40%**), telephone calls to the client (**20%**), and telephone calls to the client’s family or friends (**20%**). Only **1** MAI client required additional outreach who

was subsequently reached by telephone. All **(100%)** MAI clients and **90%** of Part A clients were successfully reached with 2-5 outreach efforts, while **10%** of Part A clients required 6-10 outreach efforts to establish contact. All efforts were successful in contacting clients.

Assessments of the client’s needs and barriers were documented in **42%** of Part A and all **(100%)** MAI records. Of the clients with a needs assessment conducted, primary care and case management were the most frequent needs assessed. *Table 18* shows the needs assessed and subsequent referral rates for Part A and MAI clients.

Table 18. Traditional Outreach Needs Assessment, N=18

Element	Part A (N=5)		MAI (N=13)	
	Assessed (%)	Referred (%)	Assessed (%)	Referred (%)
Primary Care	100%	100%	100%	100%
Case Management	20%	20%	31%	31%
Housing	20%	20%	8%	8%
Mental Health	--	--	8%	8%
Transportation	20%	0%	--	--

Documentation of a plan to address the identified barriers was found in **33%** of Part A and **92%** of MAI charts. Of those records with a plan, the most frequent method for addressing client barriers was assisting the client in making an appointment, **100%** of Part A and **83%** of MAI charts respectively. Following up on the client’s appointments was documented in **25%** of Part A and **100%** of MAI charts. The most frequent method of follow-up was a telephone reminder (**33%** Part A, **85%** MAI). *Table 19* shows the follow-up strategies utilized by the outreach workers to monitor the client’s appointments.

Table 19. Traditional Outreach Follow-Up, N=16

Follow-Up Strategy	Part A, N=3 (%)	MAI, N=13 (%)
Appointment Reminder	33%	92%
Appointment Rescheduled	33%	23%
Contact Case Manager	--	8%
Make Additional Referrals	33%	23%
Accompany Client to Appointment	--	23%

By the end of the review period, **3** Part A clients (**25%**) and **8** MAI clients (**62%**) re-engaged with the agency’s services. All **(100%)** of these clients were re-connected to primary medical care services, while **67%** of Part A and **38%** of MAI clients were re-connected to case management services as well.

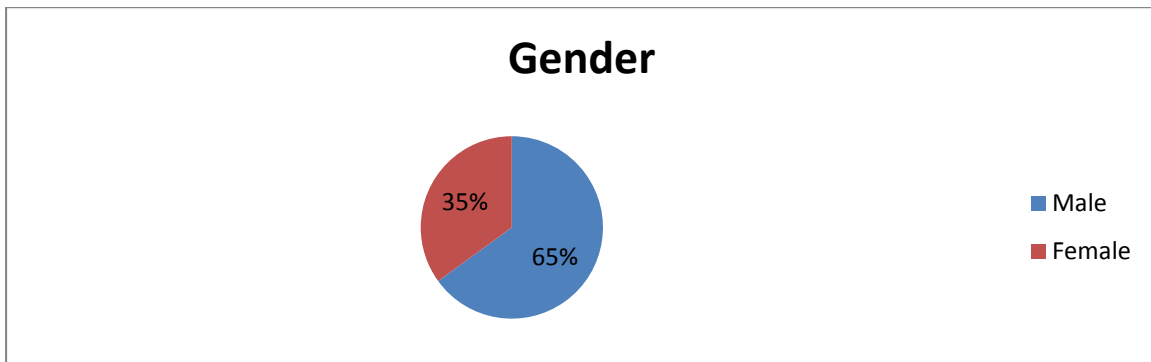
SECTION 8. CONSUMER SURVEY

Consumers for the outreach survey were directly recruited from the Ryan White agencies. Consumers were surveyed about their outreach service experiences during the past twelve months. A total of **69** outreach consumers were interviewed across the nine sites. Survey questions were administered by a consultant interviewer either in-person or by telephone. The consumers represent a convenience sample and consent for permission to contact clients by telephone was obtained prior to calling individual clients. Note, results may total above or below **100%** due to rounding and all survey participants were 18 years of age or older.

DEMOGRAPHICS

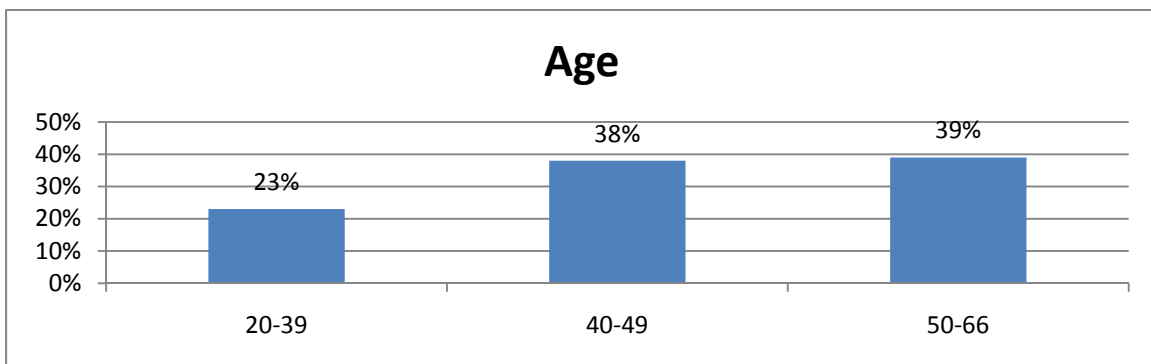
Gender: Two thirds (**65%**) of the outreach clients interviewed were male and **35%** were female, *Figure 16.*

Figure 16. Gender, N=69



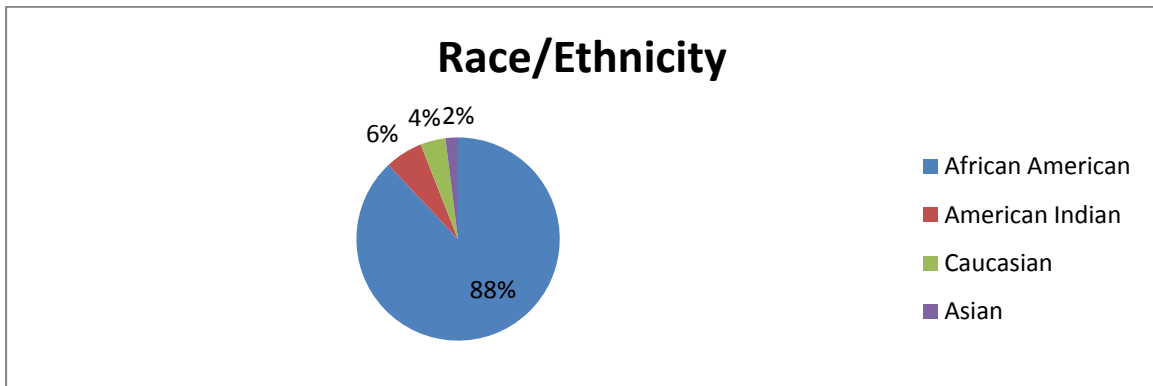
Age: The majority of outreach consumers interviewed were over forty years of age, *Figure 17.*

Figure 17. Age, N=69



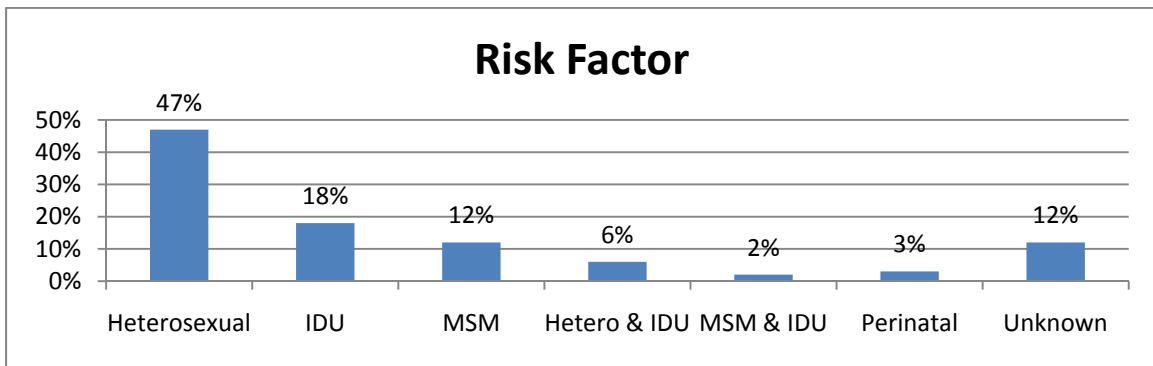
Race/Ethnicity: Most (**88%**) consumers interviewed were African-American, **6%** Native American, **4%** Caucasian, and **2%** Asian/Pacific Islander, *Figure 18.*

Figure 18. Race/Ethnicity, N=69



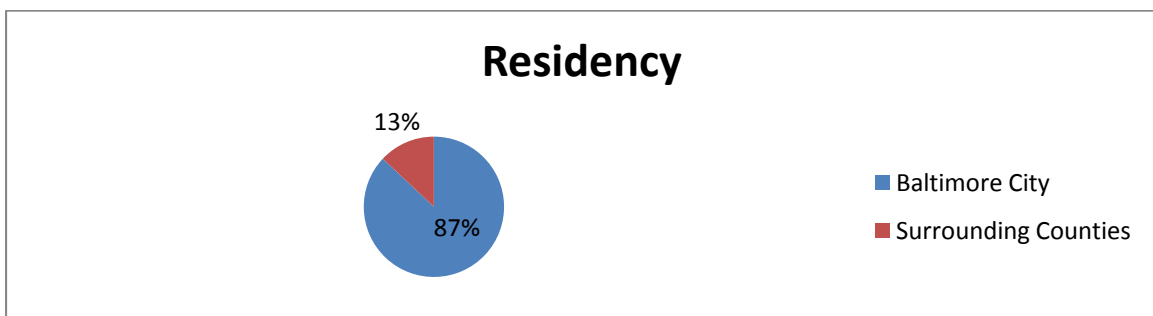
Risk Factor: Heterosexual transmission was the most frequent risk factor (**47%**) followed by injection drug use (IDU) at **18%**. Additionally, **12%** reported Men who have Sex with Men (MSM) as their risk factor for acquiring HIV, and **12%** reported they did not know how they got the virus, Figure 19.

Figure 19. Risk Factor, N=69



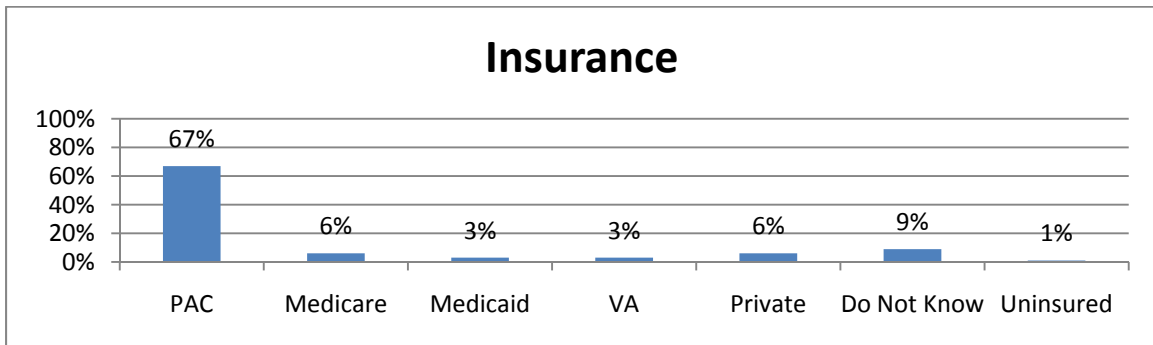
Residency: The majority (**87%**) of consumers interviewed reported Baltimore City as their residency, Figure 20.

Figure 20. Residency, N=69



Insurance: Two thirds (**67%**) of clients had Primary Adult Care (PAC) and **9%** did not know their insurance status, *Figure 21*.

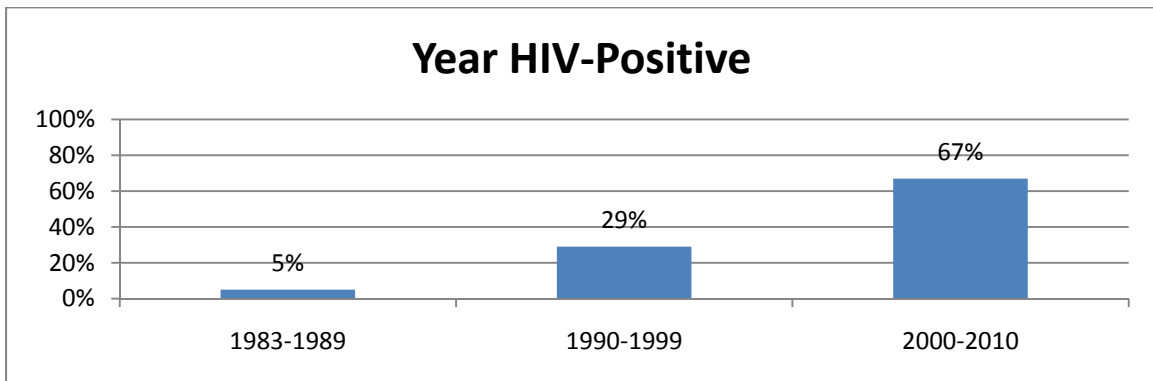
Figure 21. Insurance, N=69



CLINICAL INDICATORS

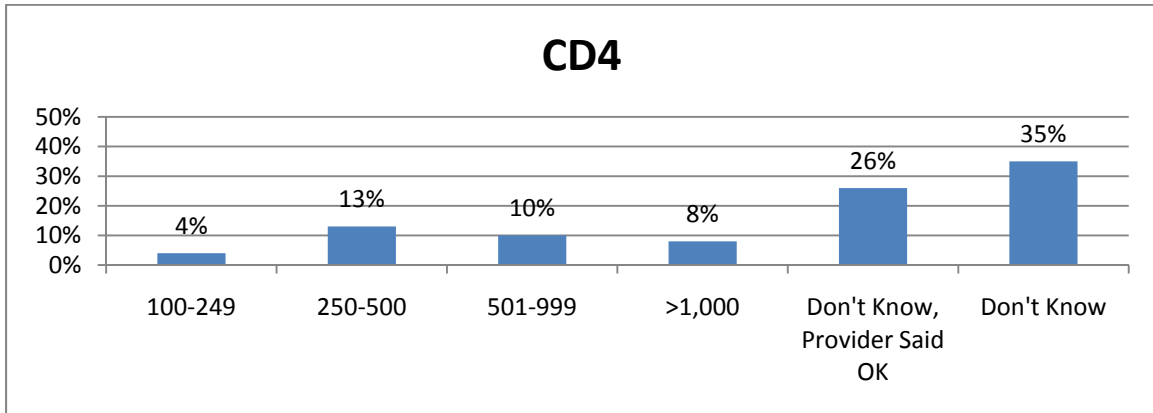
Nearly three-quarters (**73%**) of consumers reported they knew their HIV-status before receiving outreach services. *Figure 22* shows two thirds (**67%**) of consumers reported first testing positive for HIV between 2000-2010.

Figure 22. Year HIV-Positive, N=69



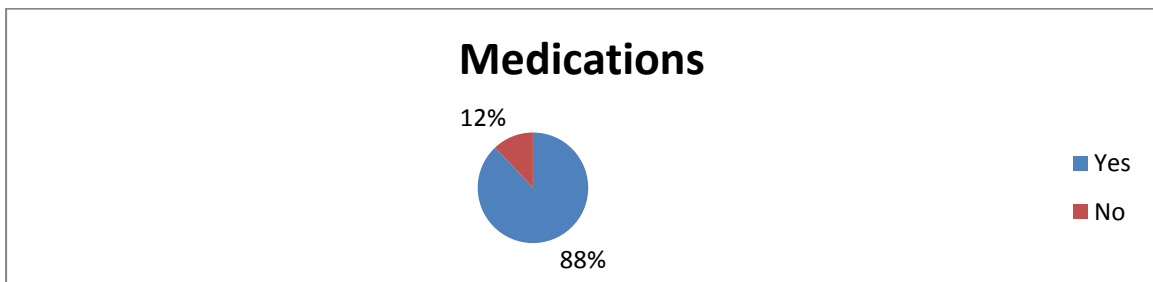
When consumers were asked what their last CD4 count was, **61%** did not know or could not remember, *Figure 23*.

Figure 23. Last CD4 Count, N=69



As shown in *Figure 24*, most (**88%**) clients stated they were taking HIV medications.

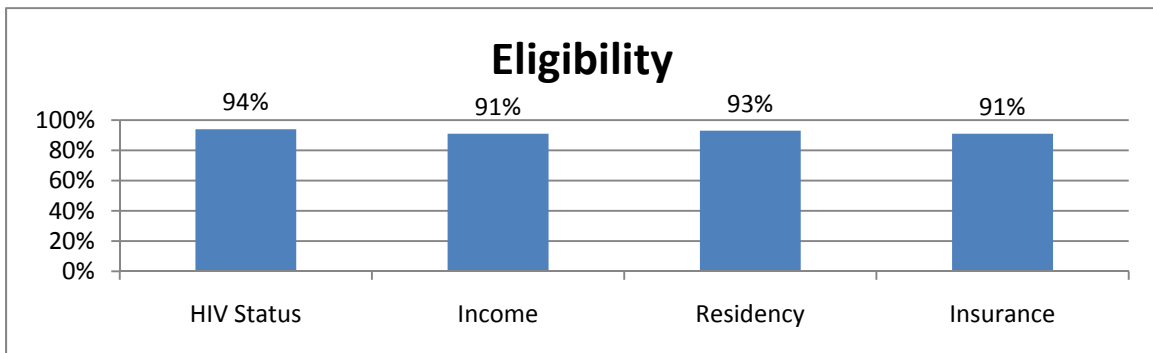
Figure 24. HIV Medications, N=69



ELIGIBILITY

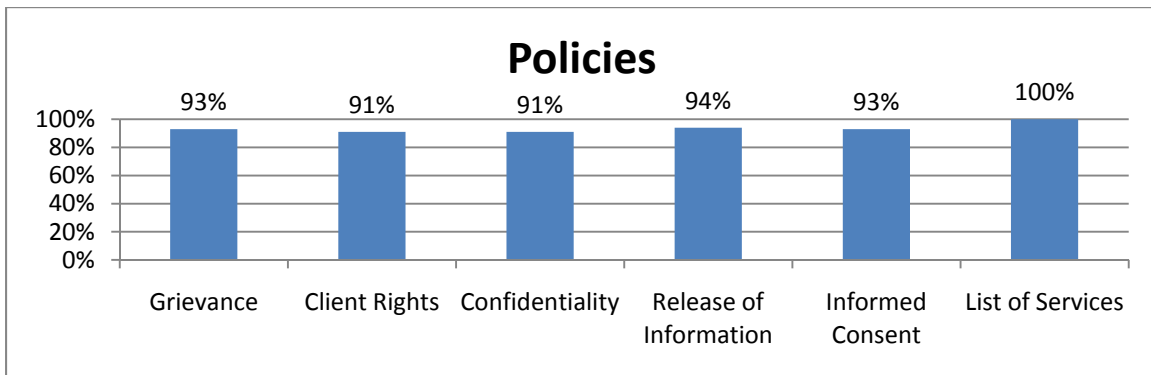
Figure 25 shows that more than **90%** of consumers interviewed stated they were asked to provide proof of their HIV status, income, residency, and health insurance coverage by their agency.

Figure 25. Eligibility, N=69



Most (**93%**) clients reported being told how to file a grievance at the agency or were given a copy of the agency’s grievance policy. When asked if they were informed of client rights and responsibilities and HIPPA/Confidentiality regulations, **91%** responded they were informed. Again, most (**94%**) consumers reported signing a release of information, **93%** said they provided informed consent to receive outreach services, and all (**100%**) clients stated they received a listing of Ryan White services offered at the agency, *Figure 26*.

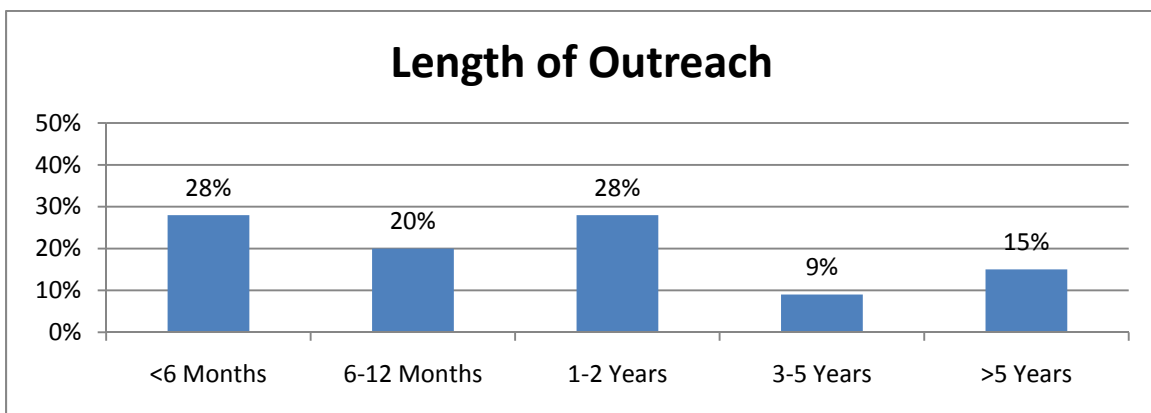
Figure 26. Policies, N=69



OUTREACH SERVICES

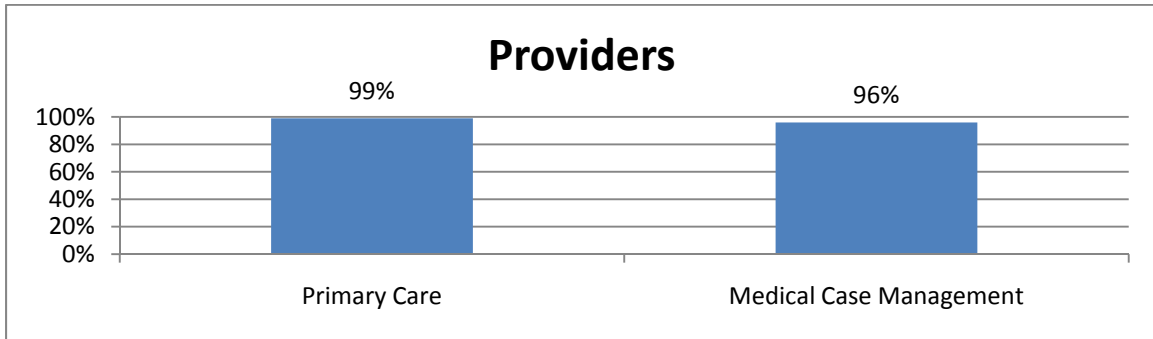
More than a quarter (**28%**) of consumers interviewed reported receiving outreach services from their agency for less than six months. However, nearly half (**48%**) reported receiving outreach services for six months to two years. Less than a tenth (**9%**) received outreach services for three to five years, but **15%** reported receiving outreach services for more than five years, *Figure 27*.

Figure 27. Length of Outreach Services, N=69



As seen in *Figure 28*, almost all consumers (**99%**) indicated they had a primary medical care provider and **96%** also reported having a medical case manager.

Figure 28. PMC and MCM Providers, N=69



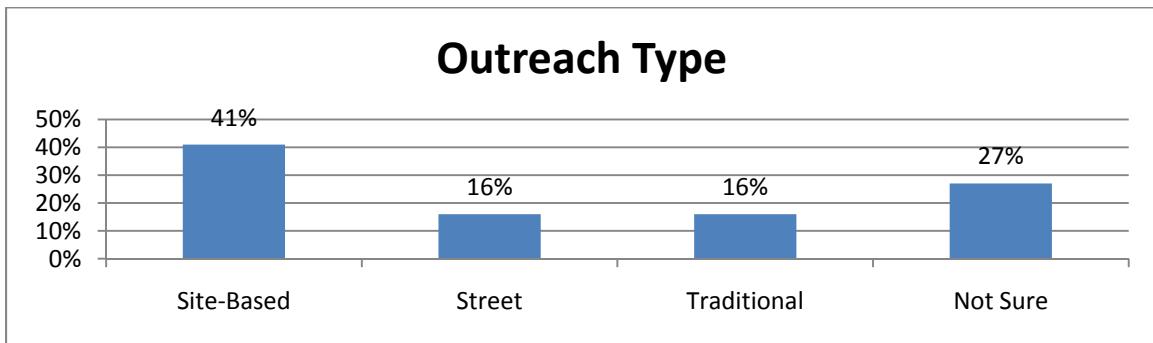
As shown in *Table 20*, **68%** of clients reported they participated in developing an action plan. However, only **44%** signed their action plans and **30%** said they re-evaluated their plans.

Table 20. Consumer Action Plans, N=69

Have you participated in:	%
Developing an action plan	68%
Signing your action plan	44%
Re-evaluating your action plan	30%

Figure 29 shows **41%** of consumers received site-based outreach services. Fewer than one in five (**16%**) received street outreach and **16%** received traditional outreach services from their HIV provider.

Figure 29. Outreach Type, N=69



As seen in *Figure 30*, the most frequent consumer contact with outreach workers reported was “a couples of times a week” (**26%**). A quarter (**25%**) of consumers also reported seeing their outreach worker “twice a month.”

Figure 30. Outreach Contact Frequency, N=69

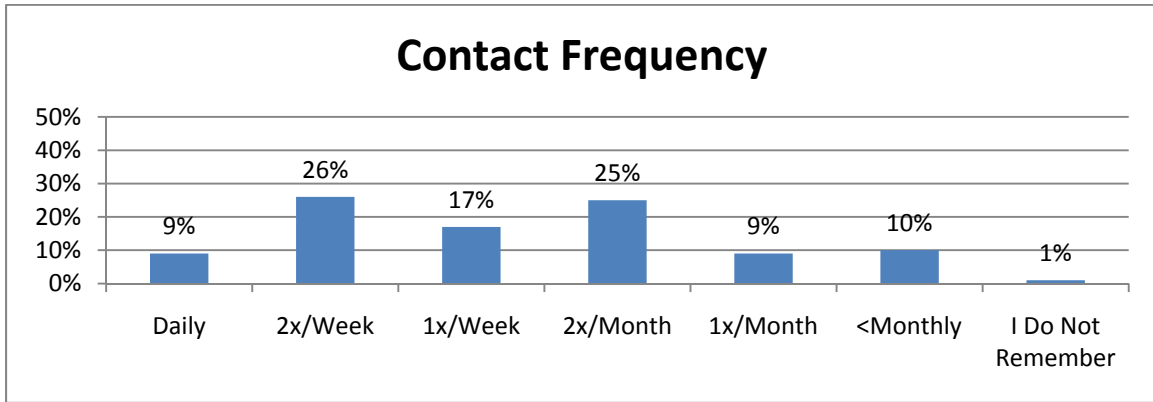
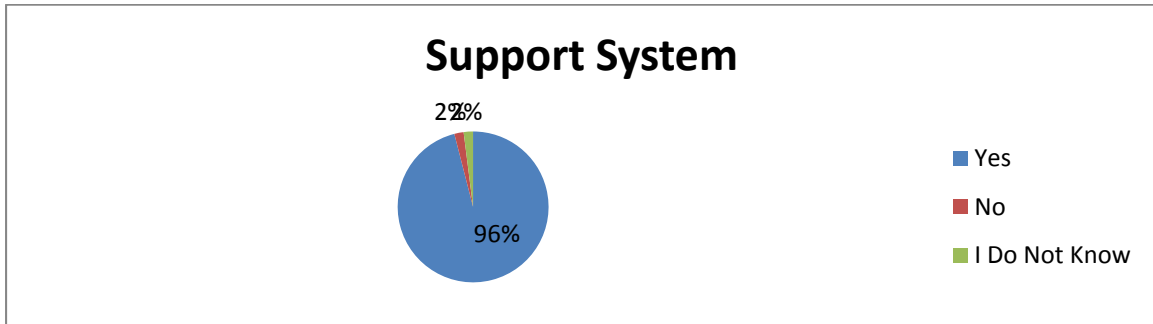


Figure 31 shows nearly all (96%) consumers reported their outreach worker discussed their support system with them.

Figure 31. Support System, N=69



As shown in Figure 32, 90% of consumers indicated their outreach worker was “extremely” or “very likely” to discuss ways to avoid passing HIV to others or how to avoid getting other sexually transmitted infections.

Figure 32. Prevention Education, N=69

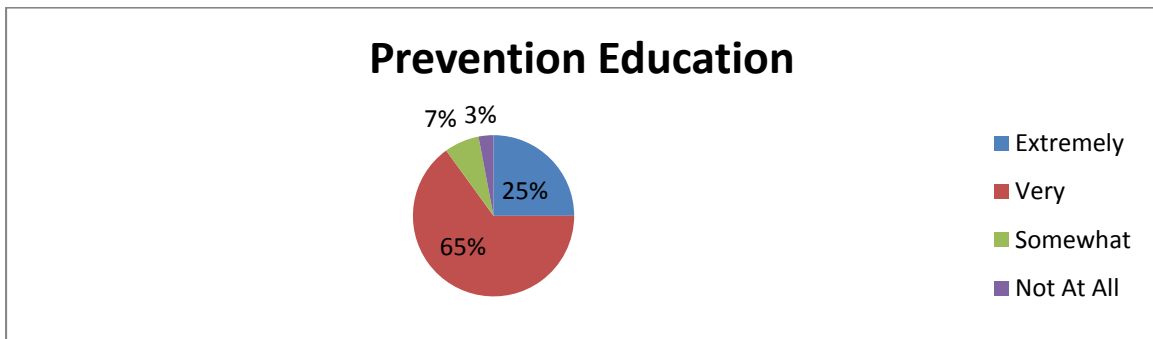
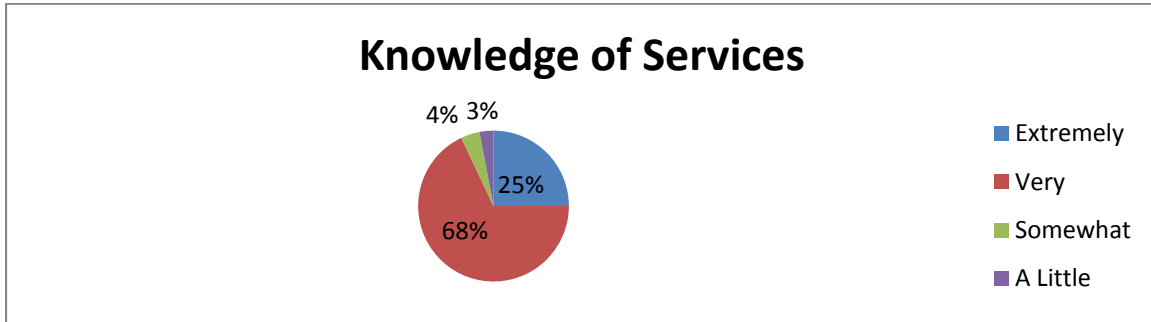


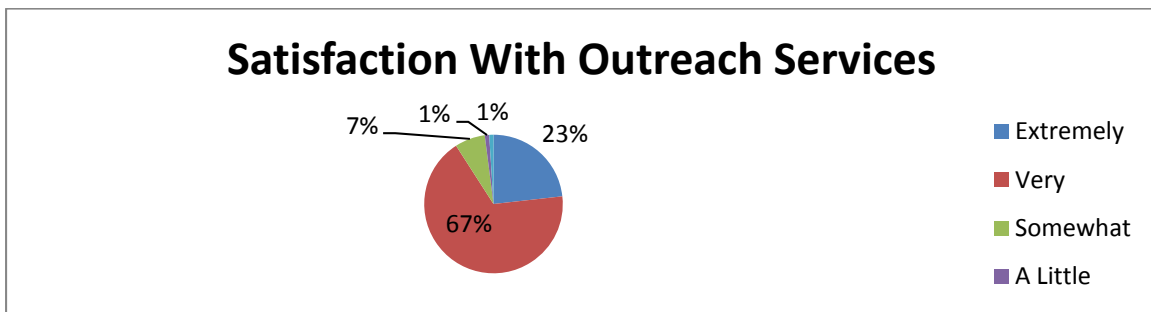
Figure 33 shows a majority (68%) of respondents were “very satisfied” with their outreach worker’s knowledge of services. Additionally, 25% were “extremely satisfied” with the outreach staff’s knowledge of services.

Figure 33. Knowledge of Services, N=69



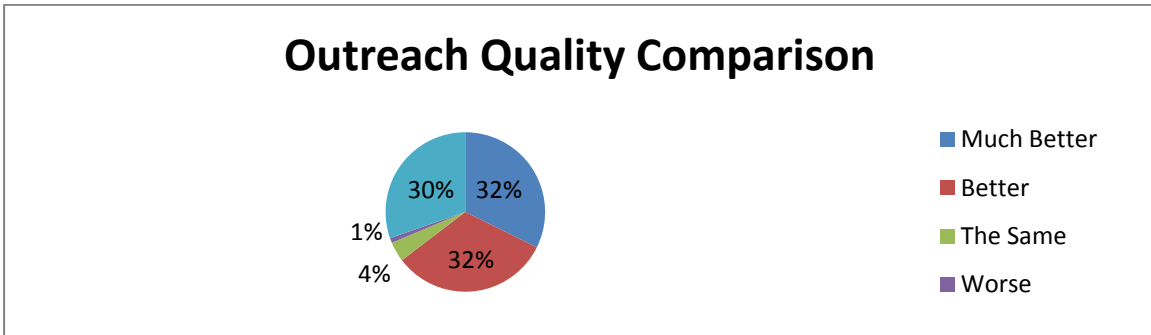
As seen in Figure 34, a majority (90%) of survey respondents indicated they were “extremely” or “very satisfied” with the agency’s outreach services.

Figure 34. Satisfaction With Outreach Services, N=69



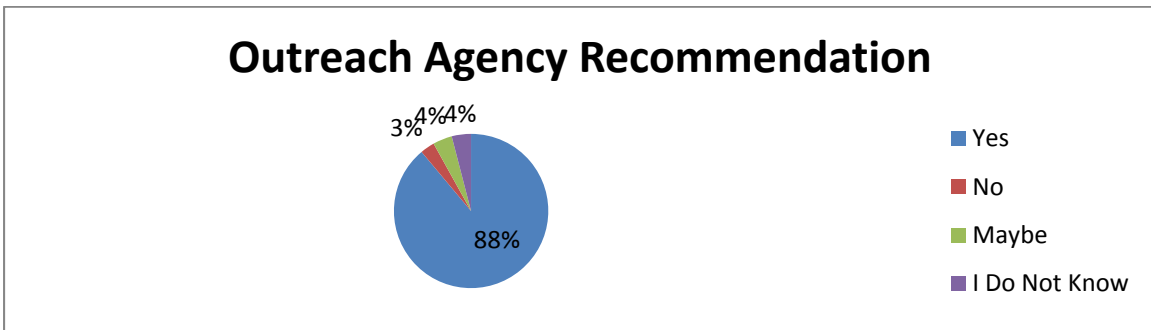
Consumers were asked to compare the quality of outreach services they received at their agency with the quality of the same services they received from another agency. Consumers indicated their current outreach services were “better” (32%) or “much better” (32%) in comparison to other outreach providers. Another 30% of consumers indicated they had not received outreach from any other agency, Figure 35.

Figure 35. Outreach Quality Comparison, N=69



As seen in *Figure 36*, most (**88%**) consumers said they would recommend their agency to friends with similar needs. Few (**8%**) consumers indicated they were uncertain if they would recommend their agency to friends. Two (**3%**) clients said they would not refer friends to their agency.

Figure 36. Figure 36. Outreach Agency Recommendation, N=69



SECTION 9. QI ORGANIZATIONAL ASSESSMENT

All nine agencies completed a quality improvement organizational assessment. The **15** items covered the programs' quality structure, planning, performance measurement, improvement activities, staff involvement, consumer involvement, evaluation, and data systems. The survey was administered by CQM staff and agencies were asked to score themselves on a scale from 0-5 where 0 was the lowest score and 5 the highest. Agencies were asked to provide an explanation of each ranking and, where backup documentation was available, it was reviewed. Each question is presented along with the average score. *Figures 37A & B* show the average scores per item across outreach programs.

SECTION A. QUALITY STRUCTURE

1. Does the HIV program have an organizational structure to assess and improve the quality of care? – Average score **4.0**. Overall, most agencies had regular quarterly meetings attended by clinicians and multidisciplinary representation who were involved in the process.
2. Were appropriate resources committed to support the HIV quality program? – Average score **3.3**. Most agencies reported that key staff had allotted time for QI activities and that their programs were headed by a half-time quality manager.
3. Did the HIV leadership support the HIV quality program? – Average score **4.1**. Most agencies report that HIV program leadership set quality priorities and established a commitment to quality.
4. Does the HIV quality program have a comprehensive quality plan? – Average score **2.9**. Written quality management plans existed at most agencies. Plans were updated annually but all staff members were not involved in the plan's development or update.

SECTION B. QUALITY PLANNING

1. Were annual goals established for the HIV quality program? – Average score **3.8**. Annual goals are discussed by the HIV quality committee and were based on past performance. However, quality goals were not always communicated to all staff nor were all staff involved in the selection process for the goals.
2. Does the HIV program have clearly described roles and responsibilities for the HIV quality program? – Average score **3.0**. Many agencies report that key roles and responsibilities are described for the quality program. There is some staff involvement in the design of these roles and responsibilities.
3. Is there a document in place to specify timelines for the implementation of the HIV quality program? – Average score **3.0**. Agencies report that work plans and timelines are in place and are updated periodically. Some staff are aware of the work plan.

SECTION C. QUALITY PERFORMANCE MEASUREMENT

1. Were appropriate quality indicators selected in the HIV quality program? – Average score **3.0**. Agencies selected indicators based on results of their quality initiatives and were reflective of the standards of care. Staff were not always involved in the development of the indicators.
2. Did the HIV program routinely measure the quality of care? – Average score **3.4**. Performance measurement was completed with the input of most staff with the results reviewed by a quality committee. The process of performance measurement was described to some extent, but action may not have been taken on the results.

SECTION D. QUALITY IMPROVEMENT ACTIVITIES

1. Did the HIV program conduct quality projects to improve the quality of care? – Average score **4.0**. A score of **4** indicates that quality improvement activities focused on processes and that projects were based on data. Findings were submitted to the quality committee and at least one data-driven quality improvement project was completed.
2. Was a team approach utilized to improve specific quality aspects? – Average score **4.0**. Team approaches were common among agencies surveyed. All staff had a basic knowledge about the QI team approach and basic methodologies including PDSAs and root-cause analyses. Team approaches were used to identify and address complex quality issues.

SECTION E. STAFF INVOLVEMENT

1. Does the HIV program routinely engage staff in quality program activities? – Average score **4.0**. Nearly all staff members are involved in quality activities and some may attend annual quality trainings and participate in quality projects. Staff members are most knowledgeable about quality principles and may participate in identifying priorities and goals for the quality program.

SECTION F. CONSUMER INVOLVEMENT

1. Are consumers involved in quality related activities? – Average score **4.0**. Agencies report that patient needs are assessed and discussed in quality meetings. These findings are not always integrated into the quality program. Results of quality activities are not always shared with consumers.

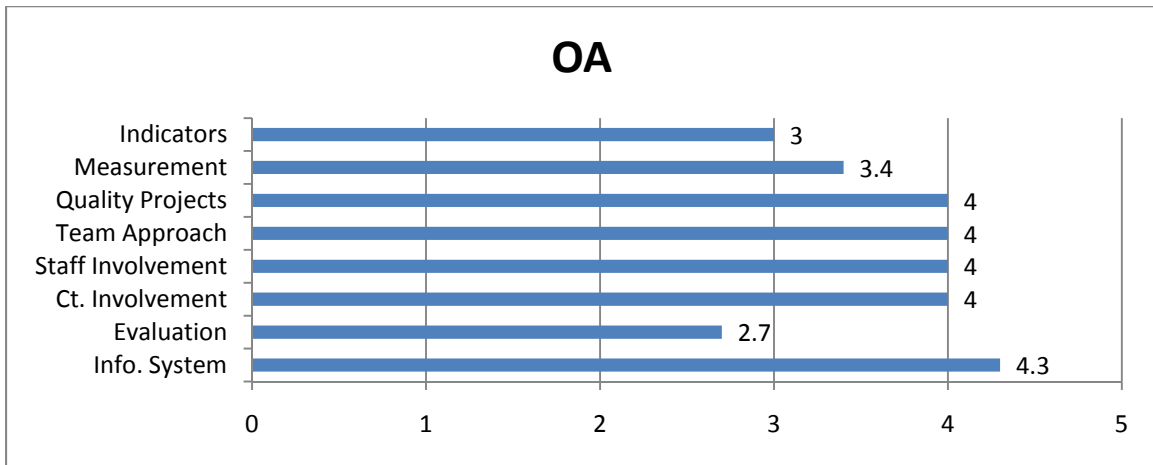
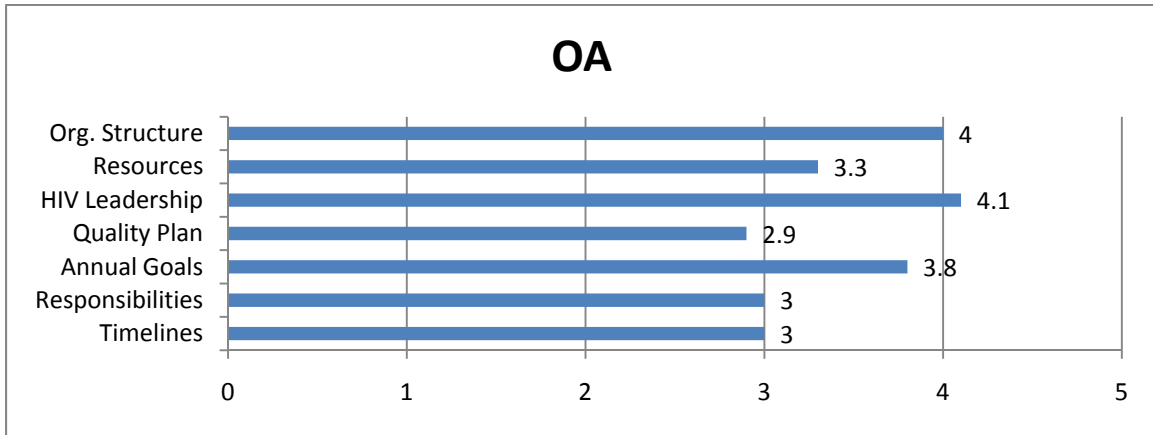
SECTION G. EVALUATION OF QUALITY PROGRAM

1. Is a process in place to evaluate the HIV quality program? – Average score **2.7**. Review of ongoing quality activities is done by group involved in leading HIV quality efforts. Some results from evaluations are used to plan ahead for future quality efforts, but not in a comprehensive approach.

SECTION H. CLINICAL INFORMATION SYSTEMS

1. Does the HIV program have an information system in place to track patient care and measure quality? – Average score **4.3**. Most agencies report having a functional information system to track patient care and produce reports. Some of the data collected are used for quality activities.

Figures 37A and 37B. QI Organizational Assessment, N=9



SECTION 10. SUMMARY OF FINDINGS

The CQM process provided a systematic review of compliance to the EMA standards of care for 9 agencies providing outreach services under Ryan White Part A and MAI during fiscal year 2009. A total of 307 outreach charts were reviewed, representing approximately 53% of outreach clients receiving services in 2009. Following are both strengths and areas for improvement from the review of outreach services.

Strengths- MAI providers documented demographics and client-level data at high rates. MAI programs were more likely to be site-based, often targeting consumers within correctional facilities about to be released. This population may have been easier to engage versus street outreach and newly diagnosed clients. Overall, most providers documented client needs assessments and noted potential barriers. High rates of mutual goal setting were documented at site-based outreach programs.

The QI organizational assessments showed strengths in leadership support for quality, collecting feedback from most staff and consumers on quality activities, and utilizing a team approach to improvement. Program also had functional information systems to track patient care and measure quality from either databases or electronic medical records. Finally, consumer feedback was largely positive and clients appear to be satisfied with outreach services and willing to refer friends with similar needs. Many clients report they are taking HIV medications, although it could not be confirmed this was specific to antiretrovirals, and most clients reported they were at least asked to provide eligibility documentation.

Areas for Improvement- Part A providers generally had lower rates of documentation for clinical indicators such as HIV labs (CD4 and viral load), treatment status with HAART, and risk factor for HIV infection. Residency, income, and insurance status were also seen less often in Part A records, as well as the provision of agency policies. For street outreach, assessment of the level of outreach assistance needed was low. Site-based outreach records were often missing referral documents in Part A charts. Ultimately, more clients need to re-engage with primary medical care after receiving outreach services. Only a quarter of Part A traditional outreach clients re-engaged with primary care, while street and site-based outreach programs re-engaged approximately two thirds of clients with medical care. Regarding the organizational assessments, programs need to develop written quality management plans or policies and update them annually.

SECTION 11. DISCUSSION AND RECOMMENDATIONS

Providers: Providers must ensure proper documentation of the client's risk factor and HIV status. Clients should be provided copies of the agency's policies and procedures before initiating services. Providers can compile a one-page signature form listing all policies distributed to the client and containing both the client's and staff member's signature and date. Eligibility documentation continues to be missing in many records. Providers should continue to request and verify financial and residency information, as well as insurance status and place documents in the client chart. All providers should complete client needs assessments and maintain referral forms in the client charts as well.

Traditional outreach providers should close outreach records or services after clients achieve two regularly scheduled medical appointments as described in the standards of care. Specific to the organizational assessment, providers should ensure there is a concrete quality management structure in place to assess and improve the quality of client care. The written quality plan should include the input of various staff and consumers, frequency of meetings, and schedule and process for reviewing and updating the plan.

Baltimore City Health Department: In addition to receiving the outreach category report, each outreach program reviewed will receive an individual vendor report assessing their individual performance on the outreach standards compared to the EMA performance overall. Each vendor report identifies specific areas for improvement and requires programs to submit an improvement project to address the issues identified.

Planning Council: The planning council recently updated the outreach services standards of care in 2010. However, outreach providers were following the 2004 standards during the fiscal year 2009 review period. Moving forward, only one type of outreach services are described in the new standards of care. This will streamline future data collection within the outreach category and allow better performance comparisons across vendors in future reviews.

The planning council should consider additional guidance for outreach charts left open after clients have been re-engaged in medical care. It remains unclear how long outreach workers should follow clients and when charts can be closed. If outreach services continue over an extended period of time, plan re-assessments and case monitoring should occur every three months. If a client is not ready to engage in care, outreach workers should document if and when they will re-contact the client at a later date.

Appendix A: Standards of Care (Origination June 2000) – Minority AIDS Initiative: Outreach Linkage to Care