

BALTIMORE CITY HEALTH DEPARTMENT
RYAN WHITE OFFICE
CLINICAL QUALITY MANAGEMENT PROGRAM (CQM)

FY12 Medical Transportation Services

Baltimore – Towson EMA

May, 2013



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SECTION 1. INTRODUCTION

The Baltimore City Health Department (BCHD) Part A Clinical Quality Management Program (CQM) began in Calendar Year (CY) 2001. CQM's purpose is to ensure that people living with HIV/AIDS (PLWHA) in the Baltimore-Towson Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White Treatment Modernization Act. The FY2012 CQM initiatives focused on Outpatient Ambulatory Health Services, Medical Transportation, Housing Services, Child Care Services, and Health Insurance Premiums & Cost-sharing.

This review pertains to both "Medical Transportation: Indirect" and "Medical Transportation: Direct" as defined in the Greater Baltimore HIV Health Services Planning Council Standards of Care (Standards) Ratified October, 2010, which offer the following definitions:

*"Medical transportation services are conveyance services provided, directly or through a voucher, to a client so that he or she may access health care services...Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical services and support services."*¹

Both direct and indirect medical transportation are included in the service category.

Direct transportation is provided via:

- *"Taxi, sedan or van by an agency approved by the Maryland Public Service Commission,"* or
- *"Allocation of funding to support purchase or lease of organized vehicles used solely for the provision of allowable transportation services."* *ibid*

Indirect transportation is provided via:

- *"Monthly mass transit passes*
- *Daily mass transit passes or single-use tokens,*
- *Taxi vouchers."* *ibid*

Throughout the year reviewed in this report (FY11), the Planning Council restricted funding of Medical Transportation services to single mass transit trips (tokens), taxi or van vouchers, and Direct Transportation vans.

This category was first assessed in 2004 and, in order to reassess adherence with the Standards of Care, re-measurement data were gathered and analyzed in 2008 and 2012 from all Part A and MAI-funded transportation vendors in the EMA. In addition to providing results for the data collected, this report provides details of the methodology and a summary of the findings, as well as recommendations for improving the quality of transportation services. The Appendices contain the Standards of Care used during the review, and Medicaid transportation contact information for each jurisdiction in the EMA.

¹ InterGroup Services, Inc. for the Greater Baltimore HIV Health Services Planning Council. (2010, 11). *Service category standards of care: Medical transportation*. Retrieved from http://balpc.intergroupinfo.com/doc/doc/158/FINAL_2010_

Wherever possible, FY12 adherence to the Standards of Care is compared with FY08 findings, with the understanding that data variance can be attributed to: 1) Different reviewers, 2) Different agencies being reviewed, 3) Different records being reviewed, 4) Revisions of the Standards of Care, 5) Variations in the abstraction tool, and 6) Actual differences in performance. Occasionally, where there have been dramatic changes, FY04 data are also shown.

SECTION 2: METHODOLOGY

CQM reviews were conducted at all **11** agencies providing Part A-funded medical transportation services during FY2011 and all **3** agencies providing MAI-funded transportation services. Data were collected through three avenues: 1) agency organizational quality assessments, 2) client chart abstraction, and 3) consumer interviews. The data collected through the CQM review and presented in this report are not intended to reflect all Ryan White Part A clients receiving transportation services in the Baltimore-Towson EMA.

Client Chart Abstraction: The chart abstraction tool was designed to assess adherence to the Standards of Care. The review period focused on services provided in FY2011: 3/1/2011 – 2/29/2012. Reviews were conducted in the fall and winter of 2012, which is used as the report's reference date. Vendors were directed to provide a random sample of the charts of clients who received transportation services during FY11, and CQM provided guidance for doing so. CQM staff 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 number of Ryan White Part A clients receiving transportation services from that agency, as reported by providers on Form 8 documents. Sampling was guided by the 2008 HIVQUAL sampling methodology developed by the New York State Department of Health².

For each chart reviewed, one survey instrument was completed. Charts were assessed based on the first transportation service provided during the fiscal year. A total of 621 Part A charts and 155 MAI charts were reviewed, representing 26% and 33% of clients receiving transportation services, respectively. As shown in Table 1, the number of Part A charts reviewed per site ranged from 8 to 90 with an average of 57 charts reviewed. As shown in Table 2, the number of MAI charts reviewed per site ranged from 51 to 54, with an average of 52. Information gathered from the client chart abstraction is presented in *Section 3*. *Section 6* contains a summary of findings, and *Section 7* recommendations based on the review.

Consumer Survey: The Consumer Instrument was completed by CQM staff while posing the questions to clients. The tool focused on two primary areas: 1) transportation services received; and 2) satisfaction with services. Questions emphasized the type of services provided and frequency of use. Results of the consumer interviews are presented in *Section 4*.

QI Organizational Assessment: CQM utilized a quality improvement organizational assessment tool to measure quality improvement activities within each agency along multiple quality domains including quality management, workforce engagement in quality programs, measurement and use of data, quality improvement initiatives, consumer involvement, quality program evaluation and

² New York State Department of Health AIDS Institute, *The 2008 HIVQUAL Sampling Methodology*, 8/10/2009.

achievement of outcomes. CQM staff interviewed contact staff at each agency and completed the organizational assessment based on vendor responses and substantiating documentation where available. The assessment was developed in 2012 by the HIVQUAL-US program at the New York State Department of Health AIDS Institute.³

Copies of 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 piloting them with several agencies. CQM also conducted conference calls with all agencies prior to the visits to confirm review dates, locations, additional logistics, and to answer any questions related to the tools and review process. Results of organizational assessments are presented in *Section 5*.

Table 1: Part A-Funded Transportation Services Agencies Reviewed in FY12

Agency Name	Number of Part A records reviewed	% of Sample
Anne Arundel County Health Department	51	8.2%
Baltimore County Health Department	49	7.9%
Chase Brexton Health Services	75	12.1%
Harford County Health Department	52	8.4%
Johns Hopkins University Moore Clinic	47	7.6%
Moveable Feast	48	7.7%
Queen Anne's Health Department	8	1.3%
University of Maryland - Evelyn Jordan Center	90	14.5%
UMB Maryland General Hospital	69	11.1%
Baltimore City Health Department	56	9.0%
UMB Institute of Human Virology Clinic	76	12.2%
Total	621	100.0%

Table 2: MAI-Funded Transportation Service Agencies Reviewed In FY08

Agency Name	Number of MAI records reviewed	% of MAI total
Johns Hopkins University Moore Clinic - MAI	50	32.2%
Moveable Feast - MAI	51	32.9%
Baltimore County Health Department - MAI	54	34.8%
Total	155	99.9%

³ <http://www.hivqualus.org/index.php?q=organizational-assessment-tool>

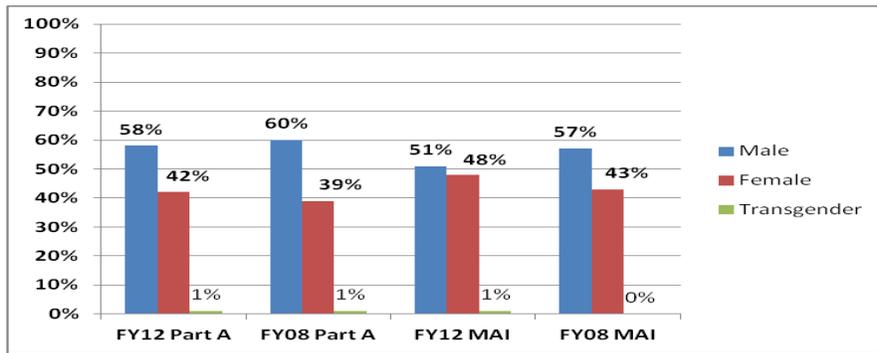
SECTION 3: CHART ABSTRACTION

Gender

Of the sample of 621 Part A clients, **58%** were male and **42%** female (*Figure 1*). Fewer than **1%** (**5**) were transgender and gender was missing from 2 tools. The MAI sample was **51%** male, and **48%** female with **1%** (**2**) charts of transgender clients sampled. The proportion of women to men has increased over time.

Figure 1: Medical Transportation Sample Gender Distribution

FY12 Part A n=621, FY12 MAI n=155
FY08 Part A n=691, FY08 MAI n=90

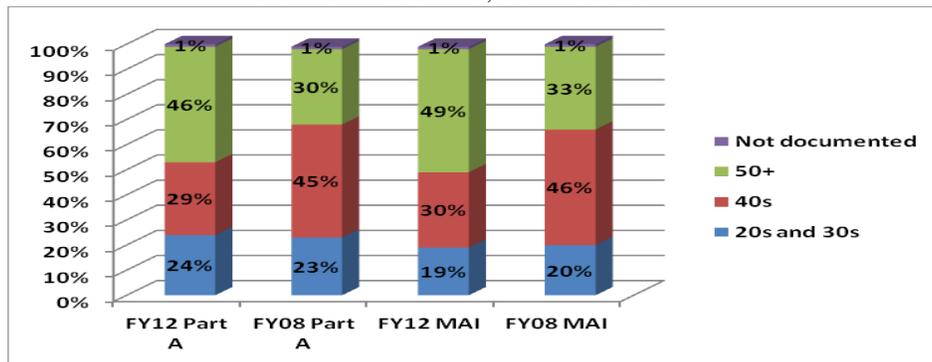


Age

Twenty-four percent of Part A clients whose records were sampled were in their twenties and thirties, **29%** were aged in their forties, **46%** were in their fifties and above, and **1%** (**5**) undocumented (*Figure 2*). MAI figures are similar. The proportion of those sampled above age 50 has increased, while the proportion of those in their forties is lower.

Figure 2. Medical Transportation Sample Age Distribution

FY12 Part A n=621, FY12 MAI n=155
FY08 Part A n=691, FY08 MAI n=90



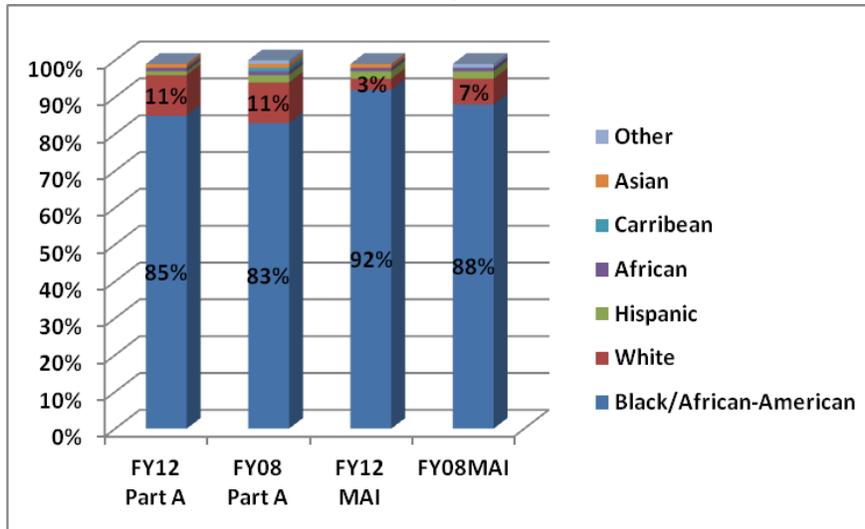
Race/ethnicity

In the 2012 review, African-American clients were **85%** of the Part A sample, and **92%** of the MAI sample as illustrated in *Figure 3*. Fewer whites were included in the MAI sample in FY12 than in FY08 (**3% down from 7%**). Hispanics were **2% (3)** of the MAI sample and **1% (9)** of the Part A sample. No other ethnic group represented more than **1%** of either sample.

Figure 3: Medical Transportation Sample Race/Ethnicity Distribution

FY12 Part A n=621, FY12 MAI n=155

FY08 Part A n=691, FY08 MAI n=90



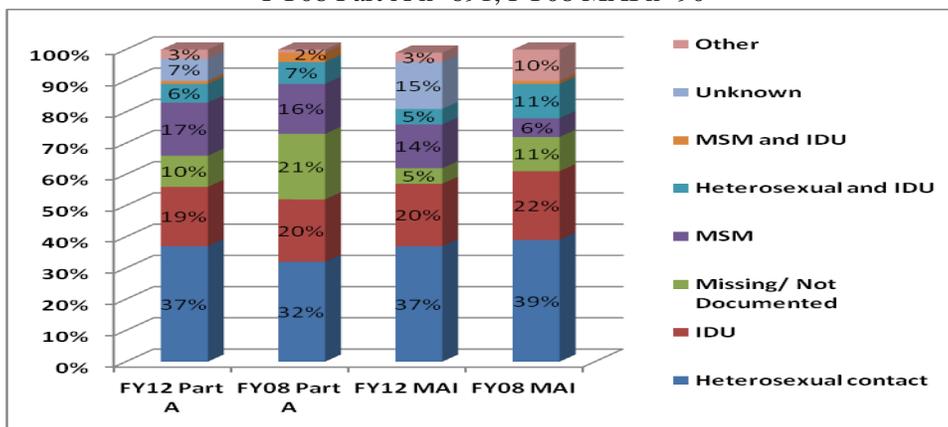
Risk factor

Figure 4 shows that heterosexual transmission continues to be the most frequently documented risk factor. In 2012, Heterosexual contact was reported as the risk factor in **37%** of both Part A and MAI charts. IDU was cited as the risk factor for **19%** of the Part A sample, and **20%** of the MAI sample. Men who have sex with men (MSM) was cited in **17%** of Part A charts, and **14%** of MAI charts. Both IDU and heterosexual contact was cited as a risk factor in **6%** of Part A charts, and **5%** of MAI charts.

Figure 4: Medical Transportation Sample Risk Factors

FY12 Part A n=621, FY12 MAI n=155

FY08 Part A n=691, FY08 MAI n=90



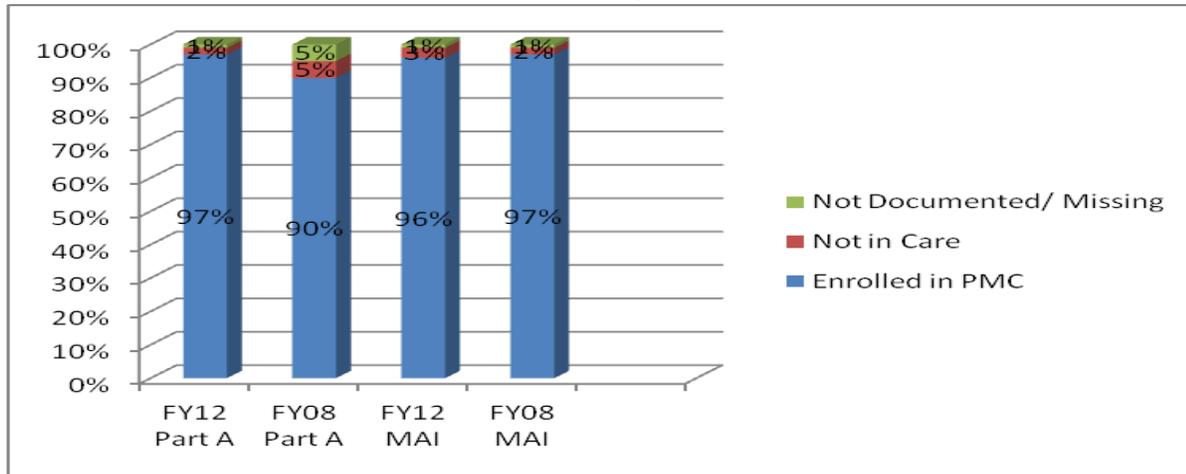
Enrollment in Primary Medical Care

As shown in *Figure 5*, charts documented enrollment in primary medical care (PMC) for **97%** of sampled Part A clients in FY12, and **96%** of MAI clients. Documentation of enrollment by transportation clients in primary medical care has increased steadily over the years.

Figure 5: Percent of Medical Transportation Clients Enrolled in PMC

FY12 Part A n=621, FY12 MAI n=155

FY08 Part A n=691, FY08 MAI n=90



Residence

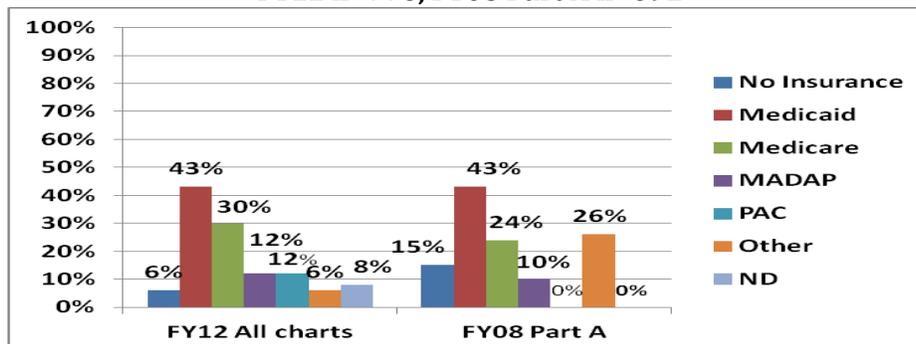
Eleven percent of charts documented zip code 21217. Seven other Zip codes had **4-6%** of the sample: 21218, 21219, 21223, 21213, 21207 and 21216. Other zip codes had less than **4%** of the sample, and less than **1%** of the sample lacked a documented residence.

Insurance Coverage

CQM reviewers abstracted the types of insurance a client had at any point in the review period, *Figure 6*. The proportion of clients without any type of insurance has not changed a great deal. Medicaid continues to be the most frequently cited insurance followed by Medicare. While Medicaid provides transportation for medical visits, those receiving Ryan White transportation may have gone to a supportive service visit, or may not have been covered by Medicaid at the time of transport. Note also that clients may have dual insurance coverage.

Figure 6. Insurance Coverage Distribution for Transportation Clients

FY12 n=776, FY08 Part A n=691



Eligibility Documentation

Before Ryan White funds can be used, providers must establish that the client is eligible for care. This includes documentation of HIV status, residency and income. HIV-positive status was documented in **90%** of Part A charts and **68%** of MAI charts reviewed. Documentation of HIV status has decreased from the FY08 review where it was documented in 98% of both Part A and MAI charts.

As *Figure 7* illustrates, financial eligibility documentation (at least once during the year) was **66%** in FY12 for Part A clients. A second update was documented in **half** the charts in FY12. Note that, in all analyses of second eligibility assessment, the denominator was decreased by the number of clients for whom a second eligibility assessment was not appropriate: those whose files were open less than 6 months. Financial eligibility was documented at least once in **47%** of FY12 MAI charts. This represents a decrease from FY08 when **64%** of charts documented financial eligibility, not shown. Eligibility was documented twice in **38%** of FY12 MAI charts.

Figure 7: Financial Eligibility Documentation

FY12 Part A n=621, FY12 MAI n=155

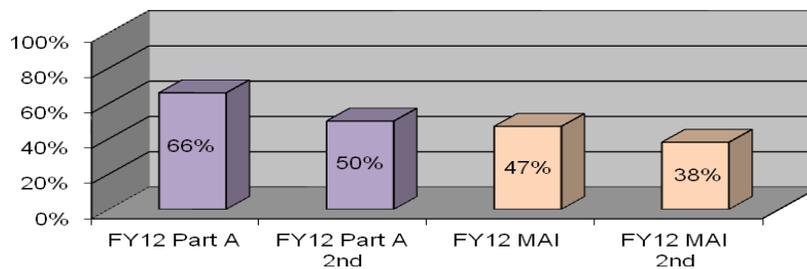
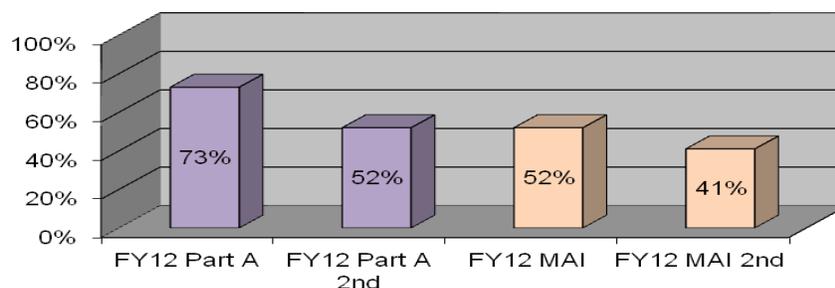


Figure 8 shows that Part A documentation of residence eligibility (at least once during the year) was **73%** in FY12. A second update was documented in **52%** of charts in FY2012. FY12 MAI residence eligibility was documented at least once in **52%** of reviewed charts, which is a decline from FY08 when 73% of MAI clients documented residence, not shown. Residence was documented twice in **41%** of MAI charts.

Figure 8: Residence Eligibility Documentation

FY12 Part A n=621, FY12 MAI n=155



Policy Documentation

In general, more charts in FY12 documented that clients had received information about confidentiality (HIPPA), the agencies' grievance policies, and client rights and responsibilities than in FY08. *Figure 9* shows that the only area showing a decrease was provision of MAI HIPPA data.

Figure 9: Medical Transportation Charts: Information Provided to Clients

FY12 Part A n=621, FY12 MAI n=155

FY08 Part A n=691, FY08 MAI n=90

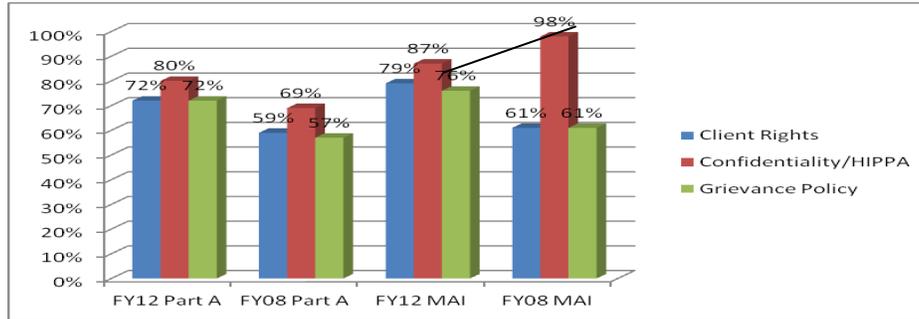
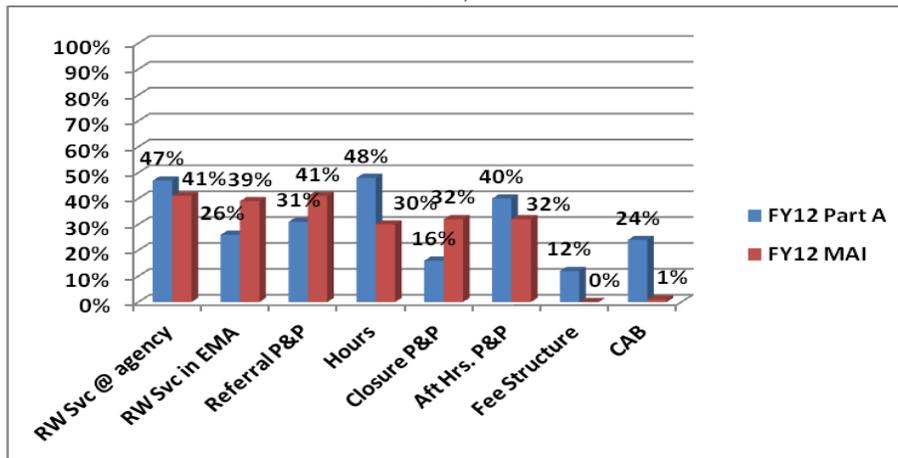


Figure 10 shows the new requirements outlined in the Standards of Care regarding information provided to clients. For these items, there is no comparison data available from the prior review as they were not assessed in FY08. None of these items are documented as provided to patients in even half of reviewed charts

- Agency hours and after-hours procedures, and services Ryan White provided are strongest.
- Agency fee structure and closure policies & procedures were provided to the fewest clients.

Figure10: Medical Transportation Charts: New Information Provided to Clients

FY12 Part A n=621, FY12 MAI n=155

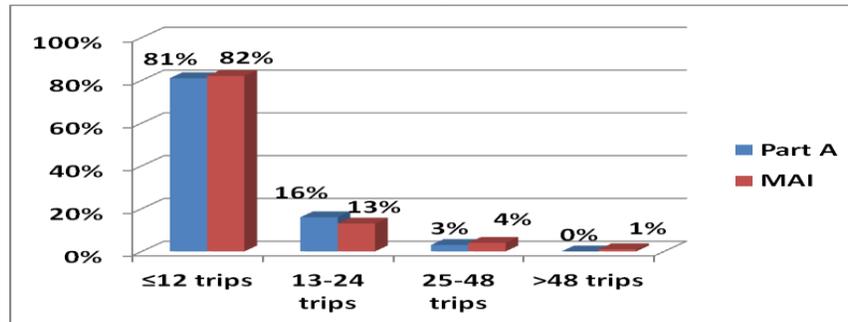


Frequency of Use: Ryan White-Funded Transportation Services

Reviewers counted the number of times each chart documented use of RW transportation service. Transportation services are recorded as a one-way ride or tokens for a one way ride, although the transportation may include stops for several services. In the charts reviewed only one client was issued a monthly bus pass. Frequency of use data were not collected during the FY08 review, so comparative information is not available. As shown in *Figure 11*, the vast majority of clients used Ryan White transportation services fewer than a dozen times a year, and the proportion using more

than 12 trips per year was virtually the same between Part A and MAI clients. Since destination was only collected for the first trip in the fiscal year, reviewers could not compare destinations based on frequency of trips. However, reviewers observed that those using more transportation were likely to receive recurring services such as substance abuse treatment.

Figure 11: Number of Trips Taken
FY12 Part A n=621, FY12 MAI n=155



Referral source: First Transportation Use

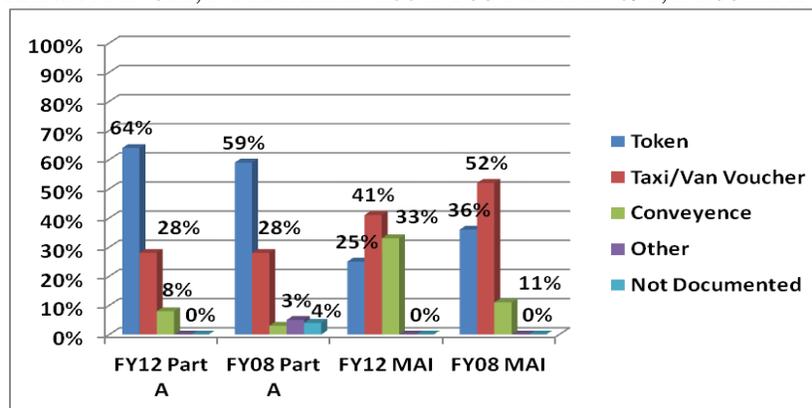
Transportation requests almost universally came from internal referrals, with staff at the agency referring the client to the staff member who coordinates transportation. The exception was that transportation requests came from outside agencies to the agency providing conveyance transportation: travel in a van owned by the agency.

Mode of Transportation: First Transportation Use

In each chart, reviewers looked for the mode of transportation used for the first visit during the review year. *Figure 12* shows that, in FY12 as in FY08, the most frequently reported Part A mode of transportation was mass transit token (64%) followed by taxi or van voucher (28%). Agency-owned conveyance increased to 8%. In FY08, a small proportion of Part A transportation had been provided via daily bus pass or volunteer, but these modes were no longer allowed under Ryan White funding in the EMA in FY11. Part A documentation was also better, with all charts indicating mode of transportation.

MAI shows more dramatic changes in the mode of transportation used. Although taxi/van vouchers continue to be the most commonly used mode (41%), this has decreased, while use of agency-owned conveyance has increased threefold to 33%, and now exceeds use of public transit (25%).

Figure 12: Mode of Medical Transportation
FY12 Part A n=621, FY12 MAI n=155 FY08 Part A n=691, FY08 MAI n=90



Use of Medicaid Transportation

Ryan White funds are funds of last resort, so clients who are enrolled in Medicaid should use Medicaid services if they travel to receive services that are 1) covered by Medicaid transportation such as primary medical care and specialty medical care, and 2) provided by a provider who accepts Medicaid clients. Medicaid requires advanced scheduling. There are Medicaid transportation offices serving each jurisdiction in the EMA.

For **102** of the charts reviewed, there was documentation showing Medicaid EVS check at some point during the year for clients whose first transportation destination was either a primary or specialty medical care visit. Of these, **three-quarters (76%)** took public transportation, which is not a service offered by Medicaid, but is cheaper than a taxi or van. For the **24** clients who traveled by taxi or van, **four** had an urgent appointment which justified use of Ryan White funds. Charts do not document whether or not destination providers accept Medicaid.

Transportation Destination

Reviewers examined the destination(s) of the first transportation arrangement recorded in each chart reviewed.

While Medical Transportation is a supportive service category, it removes a barrier to clients obtaining other Ryan White services, in particular core services such as primary medical care and medical case management. As shown in *Figure 13*, the vast majority of trips in the FY12 review were to core services (**88%** of Part A trips and **89%** of MAI trips), while fewer trips were provided to support services (**6%** of both Part A trips and MAI trips.) Figure 13 is capped at 100% to show relative frequency of use for each category. Detail is provided below concerning FY12 “other” destinations.

Documentation of destination increased dramatically between FY04 and FY08. Destination has continued to be well-documented. In FY04 the majority of transportation charts reviewed (**85%**) did not specify a destination, but were “not documented” or “other,” and no additional information is available for FY04 “other” destinations.

Figure 13: Transportation Destination

FY12 Part A n=812 FY12 MAI n=155
FY08 Part A n=870, FY08 MAI n=116, FY04 n=788

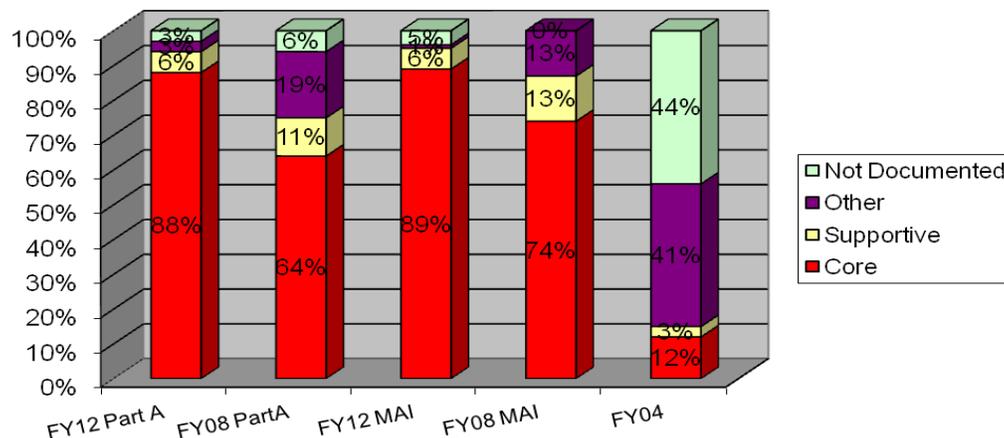


Table 3 provides details concerning transportation destinations. Note that emergency financial assistance (EFA) was counted as a Core service although it may be Supportive service depending on its parent category (outpatient ambulatory health services, housing, or food bank). Since transportation arrangements may have more than one destination, the basis for the analysis (n) is greater than the number of charts sampled.

Table 3: Transportation Destinations

FY12 Part A N= 812 FY12 MAI N=155

FY08 Part A N= 870 FY08 MAI N= 116

FY04 N=788

		FY12Part A	FY08 Part A	FY12MAI	FY08 MAI	FY04
Core	Primary Medical	54% (442)	40% (351)	77% (119)	42% (49)	11% (86)
	Specialty Care	5% (39)	3% (24)	3% (5)	4% (5)	0%
	Medical Case Mgt	11% (91)	12% (108)	5% (7)	22% (26)	0%
	Substance Abuse	2% (14)	2% (17)	3% (4)	2% (2)	1% (11)
	Oral Health	3% (22)	2% (15)	2% (3)	1% (1)	0%
	Mental Health	2% (20)	2% (15)	-	1% (1)	0%
	Pharmacy	10% (82)	2% (20)	-	1% (1)	0% (4)
	Med. Nutrition	1% (5)	1% (5)	-	1% (1)	0%
	EFA	1% (9)	4% (32)	-	4% (5)	0%
Support	Psychosocial	2% (20)	4% (33)	3% (5)	6% (7)	2% (16)
	Housing	1% (7)	2% (16)	1% (1)	0% (0)	1% (7)
	Transportation	-	1% (9)	1% (2)	3% (3)	0%
	Health Ed	1% (9)				
	Other	3% (27)	19% (170)	5% (7)	13% (15)	41% (320)
	Not Doc.	3% (25)	6% (55)	1% (2)	0%	44% (344)
	Total	99% (812)	100% (870)	101% (155)	100% (116)	100% (788)
Sample size/ number of destinations		621/812	691/870	155/155	90/116	

SECTION 4: CONSUMER SURVEY

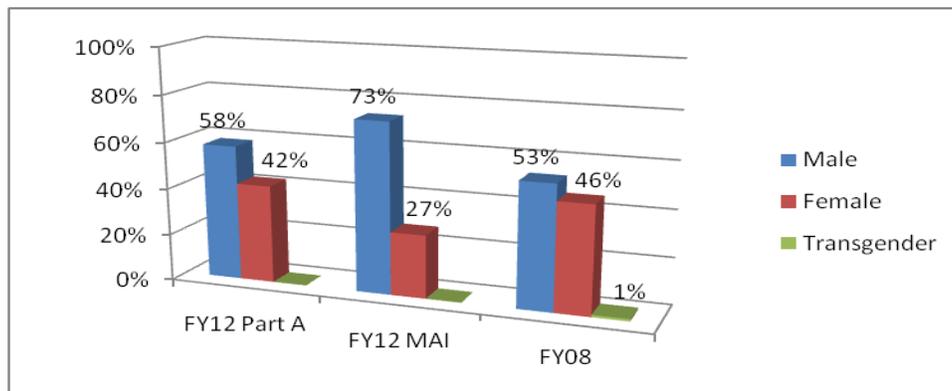
Consumer Survey Sampling Methodology

A total of 138 consumer surveys were completed during the site review period. Transportation survey participants were directly recruited from agencies funded by Ryan White Part A to provide the service. A convenience sample was provided by each site which consisted of either (a) clients who received the service and were present at the clinic on the day of the survey elicitation, or (b) clients who were contacted by the site before the scheduled site visit, and instructed to come in to complete the survey. The average survey took **8** minutes to complete. Consumers were provided gift card incentives for survey completion.

Surveyed Consumers' Demographics

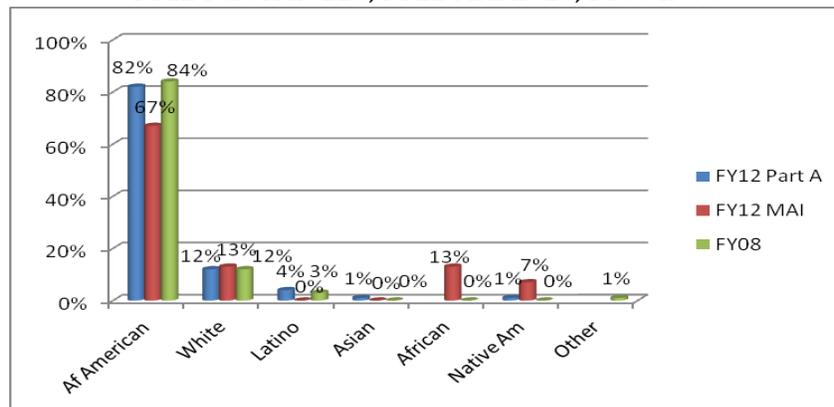
Fifty-eight percent of Part A and **(73%)** of MAI consumers surveyed were male, *Figure 14*. During FY08, **(53%)** indicated their gender to be male, **(47%)** female and **(1%)** transgender.

Figure 14: Consumer Survey Gender Breakdown
FY12 Part A n=123, FY12 MAI n= 15, FY08 n=76



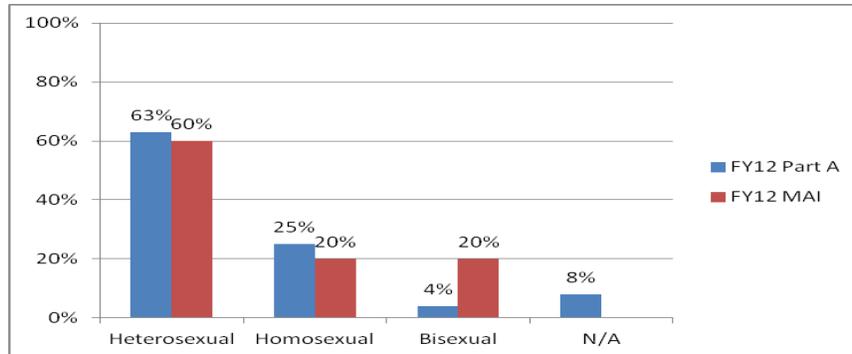
As shown in *Figure 15*, **(84%)** of FY12 Part A respondents identified their race as African American, while **(12%)** individuals indicated their race was White. The remainder noted their race/ethnicity as Latino, Asian or Native American which was very similar to FY08 findings.

Figure 15: Consumer Survey Race/Ethnicity
FY12 Part A n=123, FY12 MAI n=15, FY08 n=76



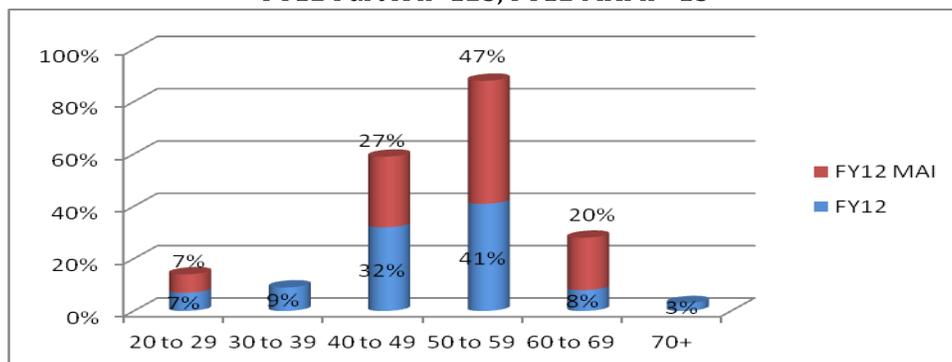
Sexual orientation is shown in *Figure 16*. Most (**63%**) respondents were heterosexual, one quarter (**25%**) homosexual, (**4%**) bisexual and (**8%**) were either asexual or chose not to respond.

Figure 16: Consumer Survey Sexual Orientation
FY12 Part A n=123, FY12 MAI n=15



As shown in *Figure 17*, the largest percentage (**41%**) and (**47%**) of FY12 Part A and MAI respondents respectively, were aged 50 to 59, followed by participants in their 40s, (**32%**) and (**27%**). **Three percent** of the Part A sample was aged 70 years or older.

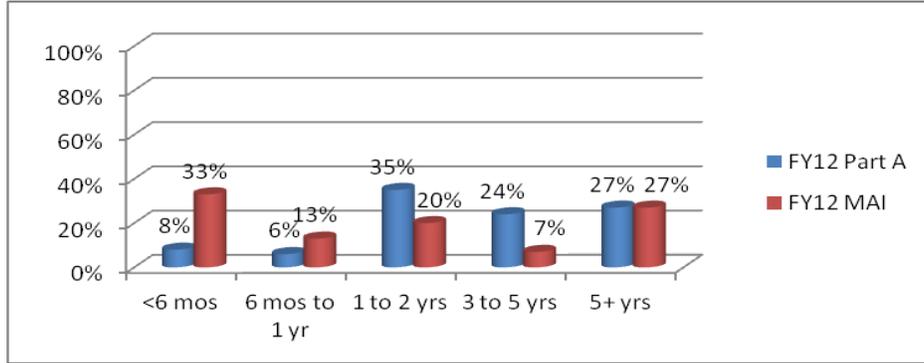
Figure 17: Consumer Age, N=123
FY12 Part A n=123, FY12 MAI n= 15



Surveyed Consumers' Transportation Experience

Consumers were asked how long they were in receipt of any Ryan White service at their individual organizations. **Twenty-seven percent** of all survey respondents had received services for 5 years or more. The second largest percentage (**35%**) FY Part A and (**20%**) MAI attended clinic for 1-2 years. Six months to 1 year was the length of time the fewest numbers (**6%**) Part A and (**13%**) MAI had received services, *Figure 18*.

Figure 18: Consumer Receipt of Service, N=123
 FY12 Part A n=123, FY12 MAI n= 15



Reported receipt of agency policies was high, at least **80%**, for all respondents, *Figure 19*. Consumers were also provided a list of possible services they may have received from their organizations. Of the list, only **three** were indicated by consumers. As shown in *Figure 20*, most Part A (**54%**), MAI (**80%**) and FY08 (**71%**) respondents indicated that transportation was used as a taxi/van service. The transportation mode least used was passes. Given that Ryan White Part A funds do not directly provide weekly and monthly bus passes, it could be that consumers were confused about the funding source. However, the few respondents who indicated use of bus passes did not indicate that they received any other transportation assistance from their agency.

Figure 19: Consumer Receipt of Agency Policy
 FY12 Part A n=123, FY12 MAI n= 15

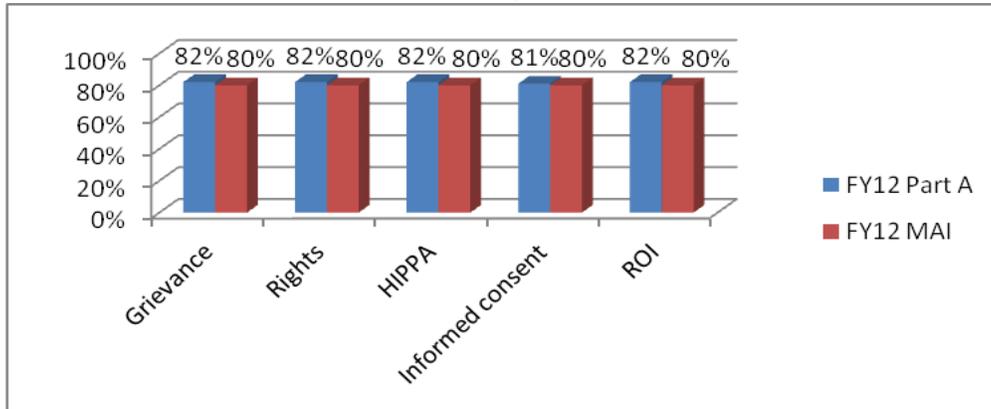
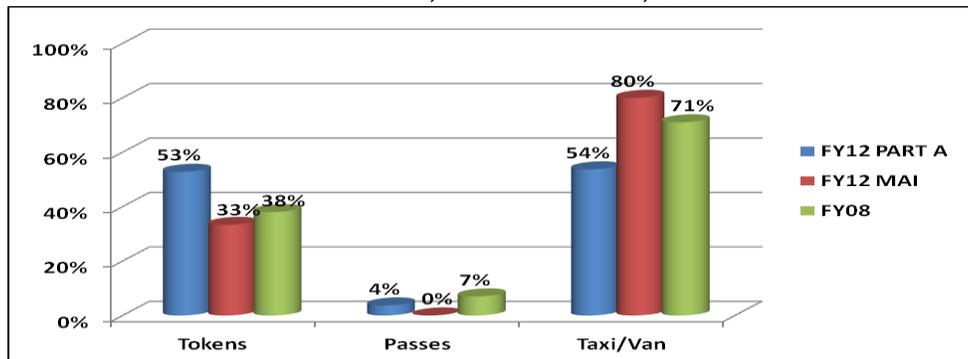


Figure 20: Consumer Survey Mode of Transportation
 FY12 Part A n=123, FY12 MAI n= 15, FY08 n=76



Consumers were provided an expansive list to identify why transportation services were used. As shown in *Figure 21*, the vast majority Part A (**94%**), MAI (**100%**), and FY08 (**82%**) stated that they used transportation services to go to a medical appointment related to their HIV care. Few Part A (**4%**), and FY08 (**1%**) consumers indicated using transportation services to go shopping, **one** Part A and **one** FY08 consumer stated that the services were used to attend Planning Council meeting.

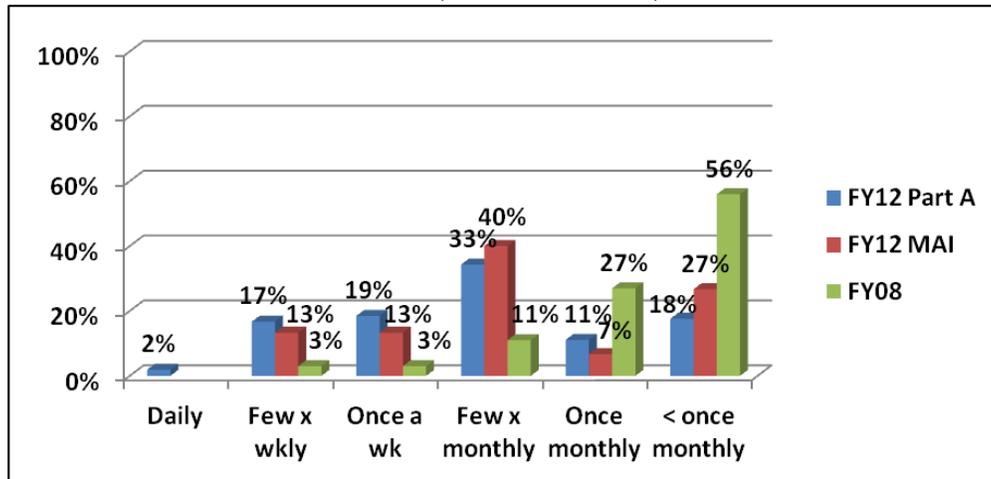
Figure 21: Consumer Survey Transportation Usage,
FY12 Part A n=123, FY12 MAI n= 15, FY08 n=76

Why Service was used		
	FY12 Part A	FY12 MAI
HIV medical appointment	94%	100%
Non HIV medical appointment	49%	27%
Mental Health appointment	32%	27%
CAB meeting	7%	7%
Substance Abuse Treatment	8%	7%
ER visit	9%	7%
Look for job	4%	0%
Shopping for Food	4%	0%
Pharmacy	37%	27%
Case Management	21%	13%
Movies	2%	0%
Social Services/Entitlement Agency	18%	0%
Dental	25%	0%
Planning council meeting	1%	0%
Other	5%	0%

When asked how often they used transportation services, the most common response by about a **third** of Part A (**33%**), and MAI (**40%**) consumers was a few times monthly, compared to more than half consumers in FY08 reporting usage as once every 2-3 months as shown in *Figure 22*.

Figure 22: Consumer Survey Transportation Frequency of Use

FY12 Part A n=123, FY12 MAI n= 15, FY08 n=76



In regards to other means of conveyance, consumers were asked if they owned an automobile, or if a family member or friend ever provided them with transportation assistance, *Figure 23*. There was a slight increase (**11%**) in the number of FY12 Part A consumers who owned autos compared FY08, (**3%**). At the same time, fewer (**48%**) FY12 Part A and (**33%**) MAI consumers asked friends or family members for transportation assistance than was the case during FY08, (**64%**).

Figure 23: Consumer Survey, Other Means of Transportation Available

FY12 Part A n=123, FY12 MAI n= 15, FY08 n=76

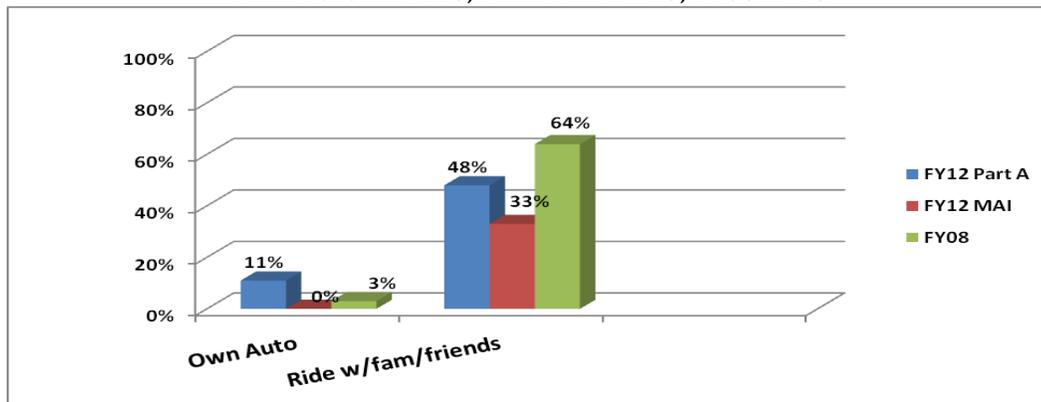
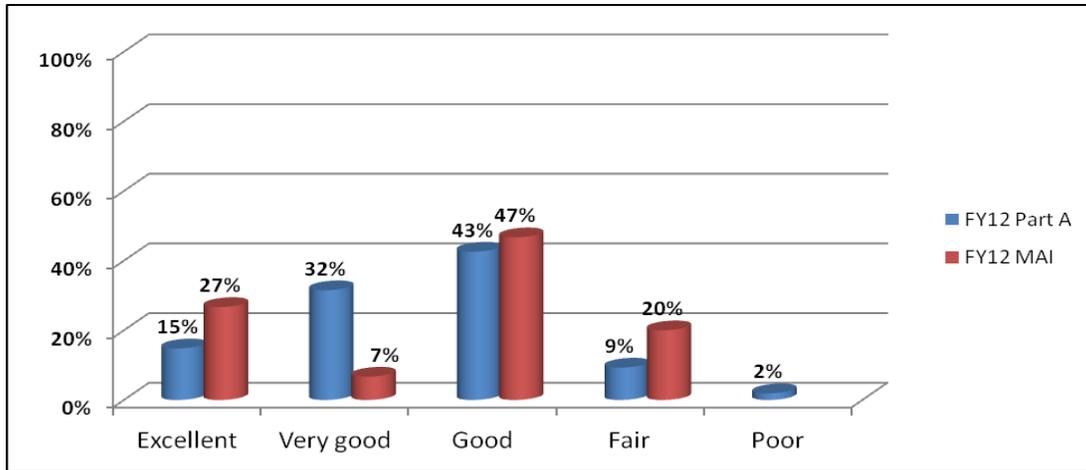


Figure 24 illustrates the response when consumers were asked to self rate their health. Nearly half, (43%) Part A, (47%) indicated they were in “good” health and only (2%) Part A answered “poor”.

Figure 24: Consumer Survey, Health Ratings
 FY12 Part A n=123, FY12 MAI n= 15,



Virtually all, (98%) were satisfied with the process for obtaining transportation services. Of the consumers using taxi or van service, (85%) reported timely pick up.

Consumer Summary

Strengths

- Nearly all clients were engaged in regular HIV care
- 98% were satisfied with this service and indicated that life ran more smoothly
- All clients agreed agency staff was responsive to concerns

Areas for Improvement

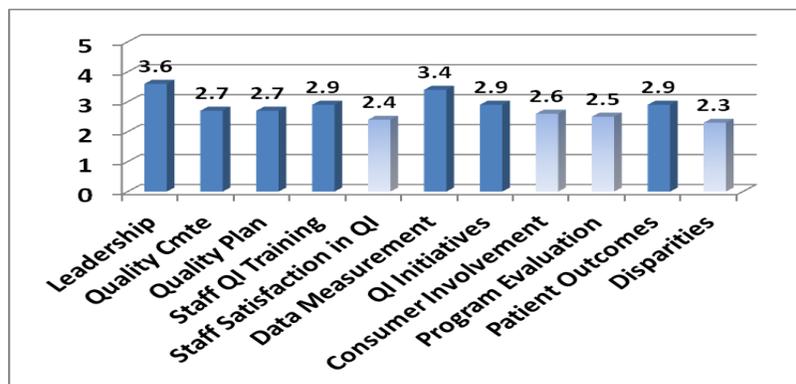
- More than half the time clients were not asked about alternative ways to appointments

SECTION 5: ORGANIZATIONAL QUALITY ASSESSMENT

During the FY12 review, the CQM team piloted use of a comprehensive organizational quality assessment tool developed by HIVQUAL-US in concert with the AIDS Institute and the State of New York Department of Health.⁴ The tool poses eleven questions along seven dimensions of quality improvement. The survey was administered by CQM staff. Agencies were read the questions and asked to rate themselves on a scale of 0 to 5, where 5 was the maximum score.

Eleven Ryan White agencies providing Medical Transportation participated in a quality improvement organizational assessment. As appropriate, the CQM team reviewed supporting documentation. Each question is presented along with the average score across all **11** agencies in *Figure 25*. As this instrument was a pilot, no comparisons with FY08 data are available.

Figure 25: Quality Improvement Organizational Assessment, N=11 agencies



A. Quality management

Question A1: To what extent does senior leadership create an environment that supports a focus on improving the quality of HIV care?

- *Average score: 3.6.*
- *Analysis:* Overall, agencies reported that leaders provided routine leadership and allocation of staff time for QI. Leaders were also actively engaged in QI planning and evaluation and used patient outcomes to inform program priorities.

Question A2: To what extent does the HIV program have an effective quality committee to oversee, guide, assess, and improve the quality of HIV services?

- *Average score: 2.7.*
- *Analysis:* Many agencies reported having a formally established multi-disciplinarian quality committee with defined roles and responsibilities for each member.

Question A3: To what degree does the HIV program have a comprehensive quality plan that is actively utilized to oversee quality improvement activities?

⁴ <http://www.hivqualus.org/index.php?q=organizational-assessment-tool>

- *Average score: 2.7.*
- *Analysis:* Quality plans at most agencies are in the implementation phase. Most agencies had written quality plans that contained all essential QI components.

B. Workforce Engagement in Quality Programs

Question B1: To what extent are physician and staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills and methodology needed to fully implement QI work on an ongoing basis?

- *Average score: 2.9.*
- *Analysis:* Core staff are reported to be generally well-engaged in quality improvement including QI training, involvement in QI projects and project development.

Question B2: To what extent is staff satisfaction included as a component of the quality management program?

- *Average score: 2.4.*
- *Analysis:* Few agencies reported using staff satisfaction to drive quality improvement efforts, although many agencies reported conducting at least one staff satisfaction survey.

C. Measurement, Analysis and Use of data

Question C1: To what extent does the HIV program routinely measure performance and use data for improvement?

- *Average score: 3.4.*
- *Analysis:* Performance measures are externally defined and used consistently. Agencies also report validating data for accuracy and using the data to identify areas for improvement.

D. Quality Improvement Initiatives

Question D1: To what extent does the HIV program identify and conduct quality improvement initiatives using robust process improvement methodology to assure high levels of performance over long periods of time?

- *Average score: 2.9.*
- *Analysis:* Agency progress toward conducting quality improvement initiatives were in the beginning implementation phase. In this phase, QI initiatives involve team leaders and begin use of specific QI methodologies to understand the causes of problems.

E. Consumer Involvement

Question E1: To what extent are consumers effectively engaged and involved in the HIV quality management program?

- *Average score: 2.6.*
- *Analysis:* While consumers are not generally involved in agency QI committees, many agencies seek consumer feedback through their consumer advisory boards (CABs). Agencies also receive feedback on consumer satisfaction through Part B survey results, and the Planning Council's periodic EMA-wide Needs Assessment.

F. Quality Program Evaluation

Question F1: Is a process in place to evaluate the HIV program's infrastructure and activities, and processes and systems to ensure attainment of quality goals, objective and outcomes?

- *Average score: 2.5.*

- *Analysis:* Some, but not all, agencies reported that quality program evaluation is part of a formal process and occurs annually, and that quality goals are revised to reflect current needs and results of the evaluation are used to plan for future quality efforts.

G. Achievement of Outcomes

Question G1: To what extent does the HIV program monitor patient outcomes and utilize data to improve patient care?

- *Average score:* **2.9.**
- *Analysis:* Programs report that patient outcome data is trended over time to show improvements. Areas of focus include viral load suppression and retention in care.

Question G2: To what extent does the HIV program measure disparities in care and patient outcomes, and use performance data to improve care to eliminate/mitigate discernible disparities?

- *Average score:* **2.3.**
- *Analysis:* Programs report that performance measures are stratified for disparities by gender, age, SES, risk factor, etc.
-

Summary of the QI Organizational Assessment: Two dimensions of quality improvement were reported above a score of 3: “leadership” and “measurement, analysis and use of data.” Leaders are perceived to be quality champions, and agencies report employing quantitative assessment of quality indicators.

The four lowest-scoring QI questions among Medical Transportation agencies (highlighted in *Figure 25*) were as follows:

- 1) Measurement of disparities in patient care and outcomes.** While CQM evaluations assess disparities in care and outcomes, internal QI assessments are not universally broken down by variables such as age, gender, and race.
- 2) Measurement of staff satisfaction.** While there are not many studies concerning whether more satisfied staff provide better HIV care, this item is included to give agencies food for thought on assessing issues that impact staff morale.
- 3) Evaluation of the QI program’s infrastructure and activities.** QI initiatives hold a mirror to HIV structures, processes and outcomes. It is also useful for the QI team to take time for self-reflection on the QI focus, processes, and results.
- 4) Consumer engagement in the QI process.** Ryan White has an active consumer engagement orientation, but consumer involvement can be extended to include engagement in quality improvement activities.

SECTION 6: SUMMARY

In 2012 CQM staff conducted a systematic review of compliance with the EMA's *Standards of Care* by **11** transportation service providers, based on **14** Part A or MAI contracts, with services provided during FY 2011. Staff reviewed **621** charts of clients with transportation funded by Part A, and **155** charts of clients funded by MAI. This represents approximately **27%** of all clients receiving transportation services funded by these programs. A total of **11** agency surveys were completed, all agencies providing transportation. A total of **138** clients were interviewed.

During exit interviews, some agencies explained that documentation (e.g. consumer-provided documentation of residence and financial eligibility) were difficult to locate due to transition to electronic medical records. It is agencies' responsibility to make these materials available to reviewers, whether scanned into EMR or contained in paper records.

Strengths:

- **Demographic documentation continues to improve.** Almost all demographics are reported for 95% or more of clients.
- **Almost all transportation clients were enrolled in primary medical care at some point during FY11.** The primary purpose of the Ryan White program is to ensure that PLWH/A receive the medical care they need.
- **Agencies have improved in the number of clients enrolled in insurance.** Since the prior review four years ago, the proportion of clients with no insurance has been reduced from 15% of the sample to 6%. Ryan White provides funds of last resort, so agency efforts to enroll clients in insurance are essential.
- **Part A agencies improved in the proportion of clients for whom residence and financial eligibility was established.** This ensures use of Ryan White funds in accordance with enabling legislation.
- **Provision of information historically required by the Standards of Care to clients has improved,** with the exception of the item noted below under Areas for Improvement.
- **The frequency with which Medical Transportation services are provided to clients is not excessive.** The vast majority of clients received transportation services less than once a month, and many less frequently than that.
- **Transportation destinations were usually specified.** 94% of trips had destinations documented.
- **An increasing majority of transportation was used to transport clients to core Ryan White services.** In FY12, 88% of Part A-funded transportation and 89% of MAI-funded transportation had a core Ryan White service as its destination.
- **Almost all Medical Transportation took clients to services funded by Ryan White.** Only 4 trips (less than half of one percent) indicated destinations that were not Ryan White categories.
- **Lowest-cost modes of transportation are used to transport clients more frequently than in the prior review.** This is largely the result of more use of conveyance transportation and less use of taxis by MAI-funded transportation
- **Reasons for using more expensive modes of transportation (taxi or van) are well documented.** The most common reason is inaccessibility of public transportation in non-urban areas.

- **Agencies quality improvement programs have evolved since the prior review.** Agencies are more involved in quality improvement as a routine and expected part of their corporate culture.

Areas for Improvement:

- **Documentation of clients' HIV status has declined.** While in FY08, HIV-positive status was documented in 98% of both Part A and MAI charts, in FY12 reviewers were only able to locate documentation of HIV-positive status in 90% of Part A charts, and 68% of MAI charts.
- **Client information requirements new to the 2010 Standards of Care (Section 3.3.1) were provided to fewer than half of clients.** These include: 1) services available through the agency, 2) categories of Ryan White Part A services available in the EMA, 3) agency referral process, 4) schedule of hours of operations, 5) procedure for notifying clients of unscheduled closings, 6) procedure for after-hours emergencies, and 7) agency fee structure.
- **Assessment of residence and financial eligibility for Ryan White Services every six months.** Although part A agencies have taken steps to improve eligibility documentation, MAI documentation of financial and residence eligibility has declined. Looking ahead, eligibility documentation will be of critical importance for all providers.

MAI-Specific Areas for Improvement: Note that only three agencies received MAI funding. Agencies should see their individual reports to determine whether the items below are applicable.

- **Documentation of financial and residence eligibility has declined.**
- **Documentation that clients received HIPPA/information confidentiality assurance has declined.**

SECTION 7: RECOMMENDATIONS

All agencies will receive vendor reports which provide comparison between each agency's performance and that of the EMA as a whole. Agencies' quality improvement initiatives should focus on areas where their performance indicators are lower than those of the EMA as a whole.

Recommendations for improvement in Medical Transportation services for the EMA are as follows:

1. **Documentation of clients' HIV status should be included in all charts.** This is a requirement of eligibility for Ryan White services.
2. **All charts should contain documentation that clients have received copies of the new information required Standards of Care: Ryan White services available in the EMA and at the agency, referral and closure policies and procedures, hours, hours, agency fee structure, and information about the Community Advisory Board.** These items can be included in patient handbooks, and keep clients fully informed and therefore better able to access care.
3. **All-Ryan White agencies should ensure that supporting documentation of clients' residence and financial eligibility is available, as well as documentation that confidentiality policies have been provided to clients.** The former are requirements of eligibility for Ryan White services.

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APPENDIX
