

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

FY13 Medical Case Management

Baltimore – Towson EMA

April, 2014



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INTRODUCTION

The Baltimore City Health Department (BCHD) Part A Clinical Quality Management Program (CQM) began in Calendar Year (CY) 2001. The purpose of the CQM program is to ensure that people living with HIV/AIDS (PLWHA) in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White CARE Act, with HIV/AIDS Bureau (HAB) performance measures, with Public Health standards, and with the local Standards of Care developed by the Greater Baltimore HIV Health Services Planning Council (PC). The FY2013 CQM initiatives focused on five service categories: Outpatient Ambulatory Primary Medical Care, Medical Case Management (including Treatment Adherence), Medical Nutrition Therapy, Food Bank (including Emergency Financial Assistance), and Legal Services. This report summarizes EMA wide findings of Medical Case Management (MCM) services based on chart abstraction and consumer interviews.

As defined in the Greater Baltimore HIV Health Services Planning Council Standards of Care, "Medical case management (MCM) services (including treatment adherence) are a range of client- centered services that links [*sic*] a client with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. MCM services ensure timely and coordinated access to medically appropriate health and support services and continuity of care, through ongoing assessment of the client and other key family members' needs and personal support systems.

Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management including face-to-face, phone contact, and other forms of communication."

One survey instrument was completed for each chart reviewed. A total of 430 charts of clients receiving MCM services between March 1, 2012 and February 28, 2013 were reviewed (*Table 1*).

Table 1. Medical Case Management Charts Reviewed by Provider, FY2013

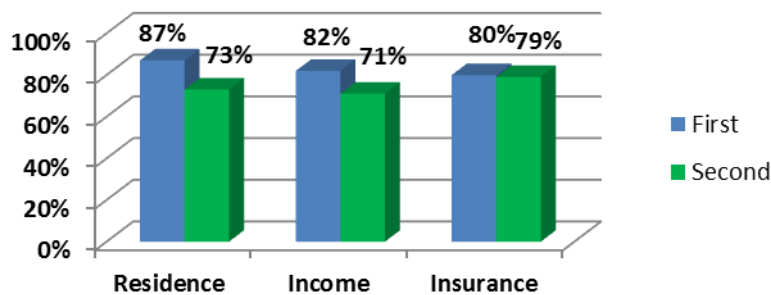
| Provider Name | # (% of total) |
|----------------------------------|-----------------------|
| Anne Arundel County | 25(5.8%) |
| Baltimore County | 26(6.0%) |
| Carroll County | 20(4.7%) |
| Chase Brexton Health Services | 25(5.8%) |
| Harford County | 24 (5.6%) |
| Health Care for the Homeless | 25(5.8%) |
| JHU Bayview | 25(5.8%) |
| Queen Anne's County | 18(4.2%) |
| Sisters Together and Reaching | 25(5.8%) |
| UMD STAR Track | 25(5.8%) |
| JHU Pediatrics | 12(2.8%) |
| Family Health Centers | 20(4.7%) |
| UMD Pace Clinic | 25(5.8%) |
| JHU Moore Clinic | 37(8.6%) |
| UMB Institute for Human Virology | 25(5.8%) |
| Peoples Community Health Centers | 25(5.8%) |
| Park West Health System | 25(5.8%) |
| Sinai Hospital | 23(5.3%) |
| Total | 430 (100%) |

RYAN WHITE ELIGIBILITY

Before Ryan White funds can be used, providers must establish that the client is eligible for care. This includes one-time documentation of HIV status, and semi-annual documentation of residence in the Baltimore-Towson EMA, income and third party payer capacity.

Documentation that the client was HIV positive was found in all but one chart (99%). Semi-annual documentations are illustrated in *Figure 1*.

**Figure 1: Percent of Charts Containing Eligibility Documentation:
N = 430 for first verification**



Residence

Three hundred seventy-four (87%) of the 430 MCM charts reviewed documented residence in the EMA once between March 1, 2012 and February 28, 2013. Of the 374 charts having residence documented once, second documentation was not required for 69 charts because the client was not in care for the full year. Residence was documented a second time in 222 (73%) of the remaining 305 charts.

Income

Three hundred fifty-four (82%) of the 430 MCM charts reviewed documented income once between March 1, 2012 and February 28, 2013. Of the 354 charts where income was documented once, second documentation was not required for 68 charts because the client was not in care for the full year. Residence was documented a second time in 204 (71%) of the remaining 286 charts.

Insurance

Three hundred forty-four (80%) of the 430 MCM charts reviewed documented insurance eligibility verification once between March 1, 2012 and February 28, 2013. Of the 344 charts where insurance was documented once, second documentation was not required for 73 charts because the client was not in care for the full year. Insurance was documented a second time in 214 (79%) of the remaining 271 charts.

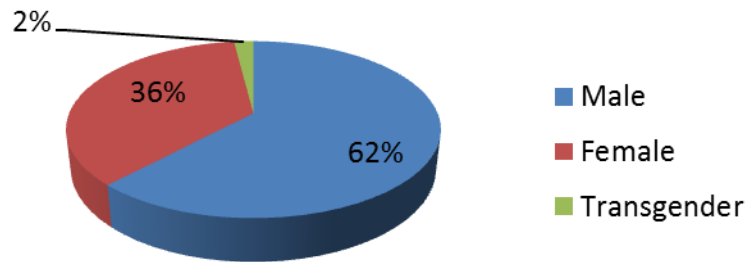
DEMOGRAPHICS

This section presents demographic data for the 430 clients sampled receiving Medical Case Management services between March 1, 2012 and February 28, 2013.

Gender

As shown in Figure 2, 267 (62%) charts in the MCM sample documented male gender, 155 (36%) female gender, and 8 (2%) documented gender as transgender. The sample's gender distribution is reasonably consistent with data for the past several years, and with data of all Ryan White clients served in the EMA.

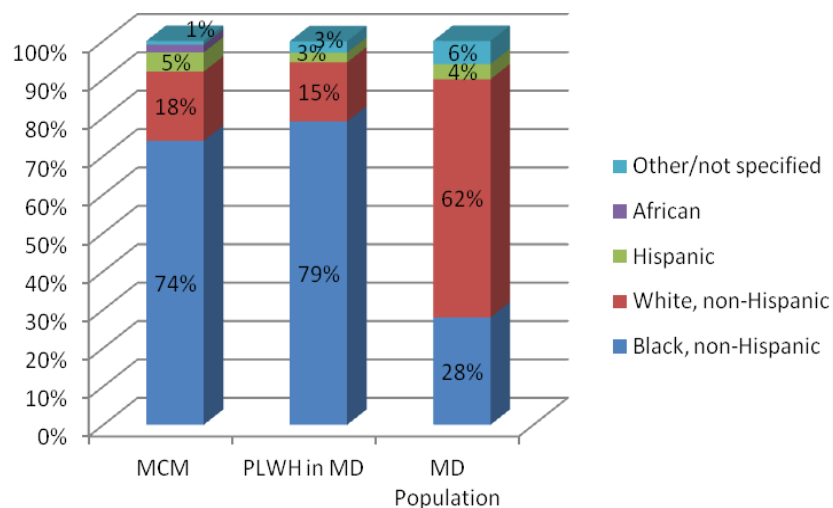
Figure 2: MCM Sample Gender Distribution N=430



Race/Ethnicity

As shown in Figure 3, excluding the 5% not documented, the MCM sample was 74% Black, 18% White, 5% Hispanic, and 2% African, with 1 person self-identifying as bi-racial. The fact that Black Marylanders are disproportionately represented among PLWH is reflected in the MCM sample.

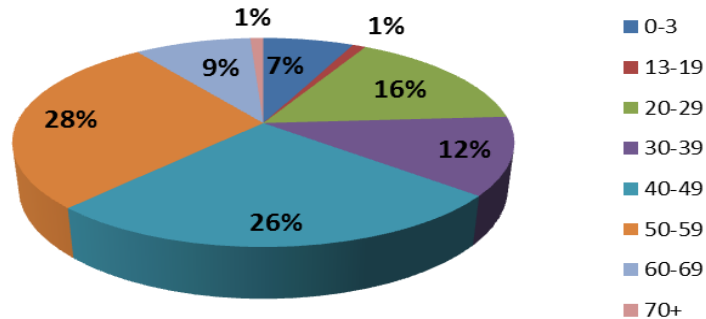
Figure 3: MCM Sample Race Distribution N=430



Age

Figure 4 shows the age distribution of clients whose charts were selected for review. The median age was 46. The population served is aging. There were 28 children under age 3, born to HIV positive mothers, who received MCM services. A Ryan White MCM visits them at birth, assures that they receive HIV testing and treatment, and that they are referred to the State’s Rare and Expensive Case Management program (REM). REM covers HIV service until newborns are determined to be HIV negative, or grow into adolescents.

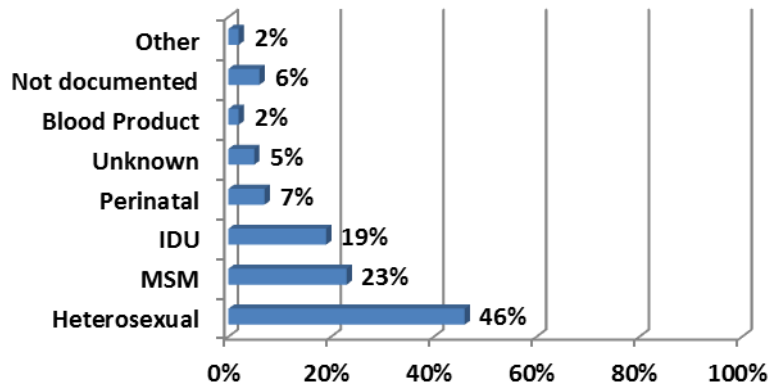
Figure 4: Age Distribution of MCM Sample N=429



Risk Factor

As shown in Figure 5, the most frequently cited risk factor for contracting HIV was heterosexual contact, which was cited in almost half of the charts reviewed. Men who have Sex with Men (MSM) was cited in almost a quarter of charts, and Injection Drug Use (IDU) in almost a fifth of charts. Where “other” risk factor is cited, the risk in the chart was not one of the Centers for Disease Control and Prevention’s (CDC) defined risk factors (e.g., “commercial sex worker,” “exposed,” or “someone’s blood got in his eye”). The total percentages for risk factors exceeded 100% as some charts documented more than one risk factor.

Figure 5: MCM Sample Risk Factor Distribution: N=430



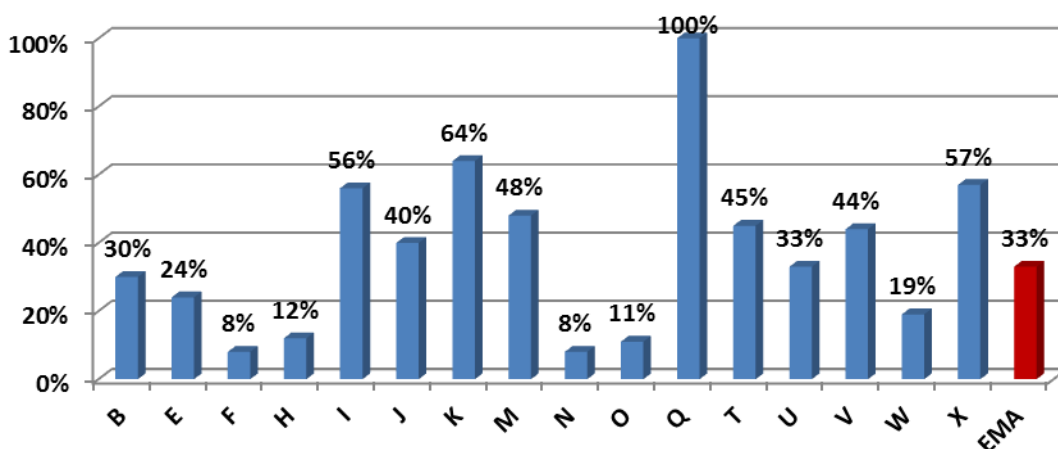
RECORD ABSTRACTION

Note that in the Record Abstraction section, some graphs show agency-specific performance, compared with the EMA average compliance with the Standards of Care. EMA performance is shown in the right-most, red bar. Individual agencies' compliance is shown in blue bars. Agencies have been provided with the letter that corresponds with their agency.

New MCM Clients

Reviews of 430 MCM charts in the EMA revealed that about a third of clients 142 (33%) began MCM care at the reviewed agency between March 1, 2012 and February 28, 2013. As shown in Figure 6, the proportion of new client charts reviewed varied from agency to agency between 8% and 100%. Because agencies L and R did not have any new client charts reviewed, they are excluded from further analysis of new clients.

Figure 6: Percent of new clients during the fiscal year by agency: EMA N=430



Section 2.1 of the Standards of Care addresses baseline evaluation of new clients in four phases: identification, intake, psychosocial needs assessment, and care plan development.

Phase 1 (2.1.1): Identification: “the process used to determine if an individual is eligible for services.”

- **Screening for appropriateness of service including verification of HIV status:** Section 1.2 of the Standards requires either eligibility assessment or a signed referral on agency letterhead. No referrals from external agencies were reported, and eligibility of both new and continuing clients is reported in the previous section.
- **Referral for those who are not appropriate for agency case management, but in need of services:** All clients in the charts were treated by the reviewed agency. No charts reported clients needing referral to other agencies for MCM.
- **Assessment of individuals in crisis:** One hundred and twenty-four (87%) new clients did not have any emergency needs on intake. The treatment of those with emergency needs is addressed in Phase 2, Intake.

- **Assignment of a case manager within 5 days:** 97% of new clients in the EMA had case managers assigned within 5 days; four clients did not.

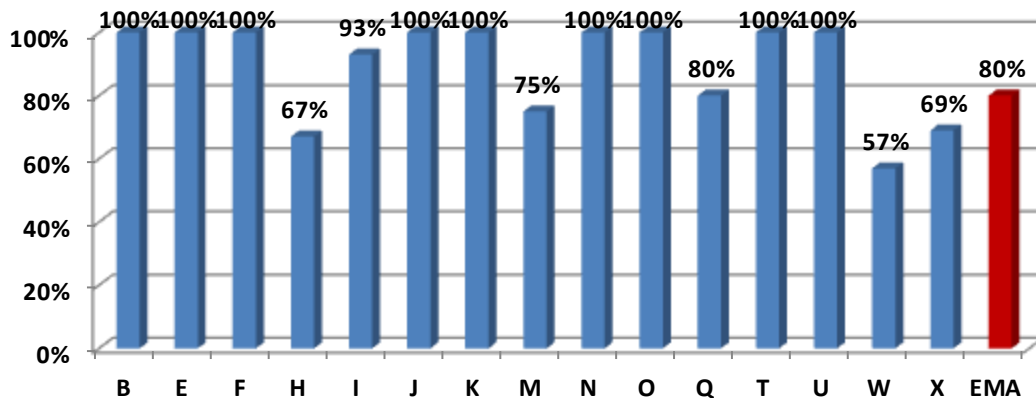
Phase 2 (2.1.2) Intake: “the process to formally enroll an eligible client into the system...”

- **Initial assessment within two business days:** Most agencies provide an initial assessment the same day clients present for case management services. In fact, 99% of new clients had a rapid initial assessment. An initial assessment was missing from one chart.
- **Emergency needs addressed by the conclusion of the intake appointment:** For the 18 clients who had emergency needs, 17 (94%) had their emergency needs addressed.
- **First case management appointment within five days:** 92% of clients had their first MCM appointment in a timely manner.
- **Appointment with primary care provider:** Retention in care is reported in the *All MCM Clients* section, below.

Phase 3: (2.1.3) Bio-Psycho-Social (BPS) Assessment:

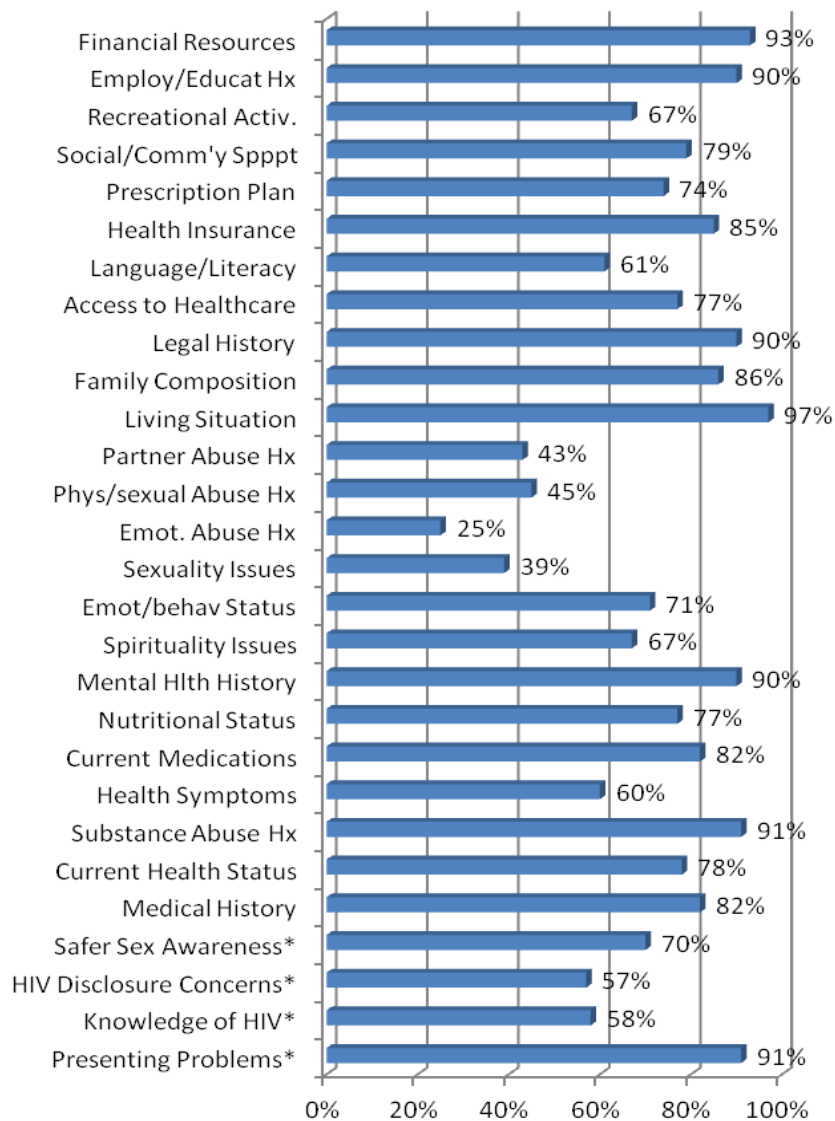
- Of the 142 new clients whose charts were reviewed, 114 (80%) had a BPS assessment completed within 30 days or by the third MCM visit. Agency performance on timely BPS completion for new clients is shown in Figure 7.

Figure 7: Timely Completion of BPS Assessment for New MCM Clients—EMA N=142



- **Section 2.1.3.2 specifies areas to be covered in the BPS assessment.** For 28 new clients, specific items are not assessed because a BPS assessment was not done (13), or was not applicable (15) because either, 1) the client was an infant referred to the REM program or 2) the client was not seen for sufficient time for a BPS assessment to be completed. For the remaining 114 new clients, Figure 8 shows the percent of BPS items assessed, EMA wide. Partner abuse history is not required in the Standards of Care.

Figure 8: Percent of New Clients' BPS Where Item Was Completed: N=114



- Section 2.1.3 requires written indication that current needs have been discussed and/or identified at the time of the BPS assessment.** 103 (90%) of the 114 charts with a BPS assessment completed documented that current needs were discussed with the client.

Phase 4 (2.1.4) The standards require development of a Plan of Care for new clients following development of the BPS assessment. 129 (90%) new clients had a care plan, and 104 (81%) of these were completed in a timely manner: by the third appointment or within 30 days. Not all care plans were based on the BPS assessment, as only 114 clients had a BPS assessment.

All MCM Clients

Analysis of all clients receiving MCM services during the review year, both new and continuing, begins with the HAB MCM performance measures:

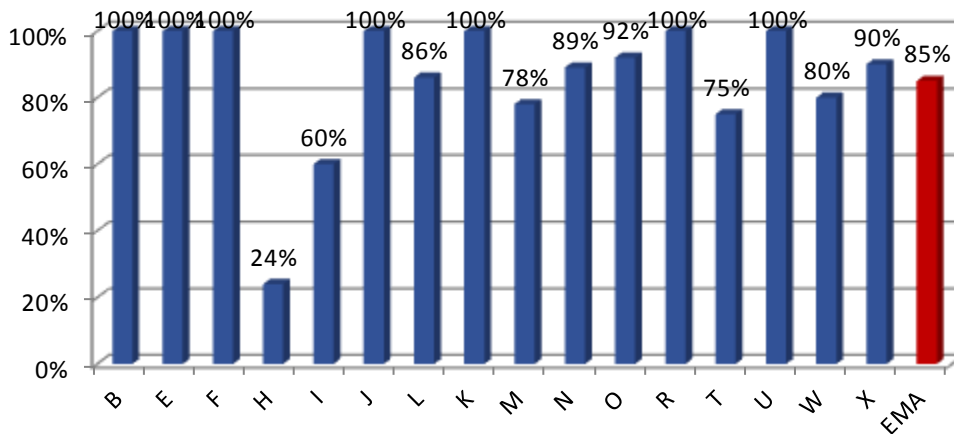
- HIV medical visit frequency and gaps in HIV medical visits (retention in care)
- Creation and update of the MCM care plan

Retention in Care

HIV medical visit frequency is a HAB performance measure defined as the “percentage of MCM patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.” CQM used a 12 month measurement period rather than the 24 month period issued by HAB. For purposes of analysis, the 177 clients in the sample with less than a full year of MCM service were excluded from the analysis; those who started care or whose charts were closed during the review year, were not included, leaving 253 full-year clients.

As shown in Figure 9, EMA-wide, 216 (85%) of the 253 clients with MCM charts open for the full year had at least one medical visit documented in each of the two six-month periods. Eleven of the 18 agencies receiving MCM funding documented retention in care for at least 85% of their full-year clients. Three agencies (H, I, and T) documented retention in care that was at least 10% less than that the EMA average. For these agencies this is an area for improvement. Two agencies, Q and V (not shown), had all or almost all clients who were new or discharged during the review year, yielding numbers of full-year clients too small for analysis of retention in care.

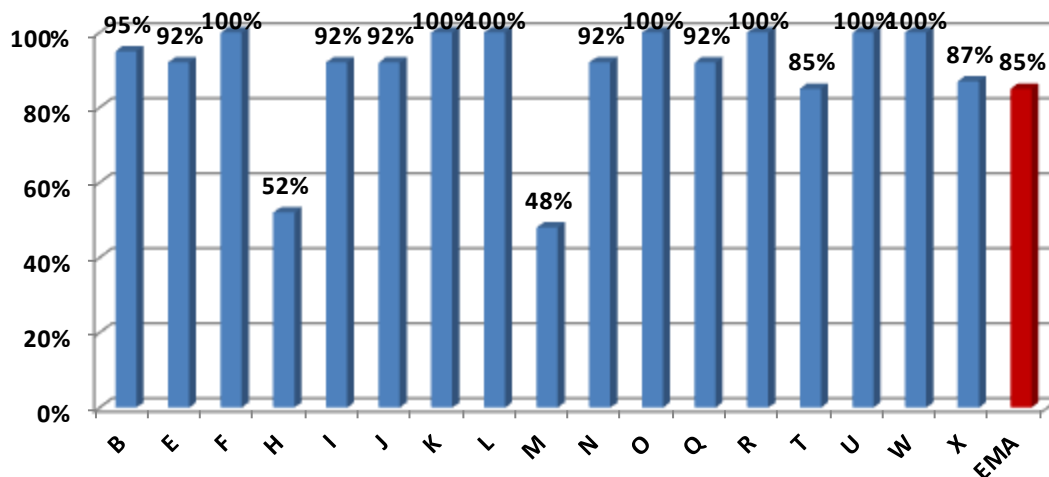
Figure 9: Retention in Care for Full-Year Clients—EMA N=253



Care Plan Development and Update

As shown in Figure 10, of the 430 clients whose charts were reviewed, 367 (85%) had care plans. For 13 of the 18 agencies reviewed, more than 90% of charts contained a care plan. For two agencies (H and M), including care plans in the chart is an area for improvement.

Figure 10: Clients With Care Plans—EMA N=430

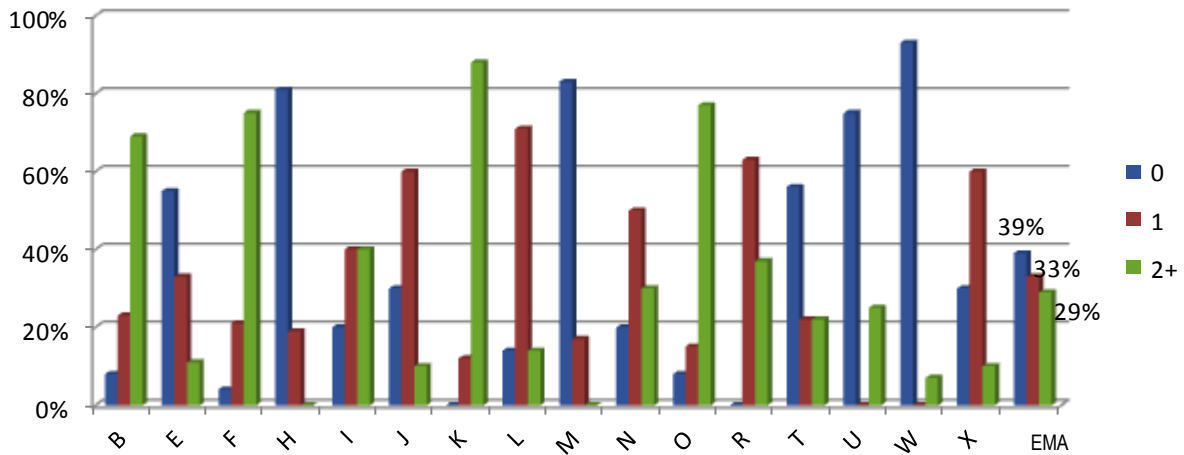


Clients whose charts were not open for the full year are not included in the analysis of care plan review and update. 177 new or closed charts are excluded, leaving 253 charts of full-year clients. Two agencies, Q and V are not included in the analysis as they had all or almost all new client or charts had been closed.

As shown in Figure 11, EMA-wide almost 40% of full-year clients had no updates to their care plan during the FY. This is an area for improvement in the EMA. Agencies varied considerably on their performance on this variable with, for example agencies B, F, K, and O documenting two or more updates to the care plan for most of their full-year clients (longer green bars), while agencies E, H, M, T, U and W documented no care plan updates for the majority of full-year clients (longer blue bars).

Note that agencies with fewer full-year clients, those with a substantial proportion of new clients, may be under-represented in the graphs illustrating care plan findings.

**Figure 11: Full-Year-Clients—EMA N=253
Were Care Plans Updated**

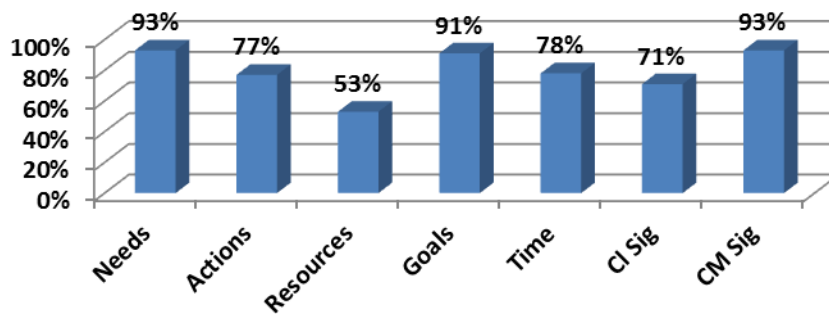


Care Plan Details and Follow-up

The following items were assessed to determine, for the 367 (85%) clients who had care plans, whether or not 1) care plans contained the level of detail required by the Standards of Care, and 2) the needs identified in care plans were met.

Care Plan Details—MCM Standard of Care section 2.1.4.2 specifies required contents for the care plan, including identifying client needs, goals and objectives, time frames, and resources, and signatures of both the client and the case manager. 340 (93%) care plans identified client needs, and of these 241 (71%) prioritized client’s needs. 282 (77%) care plans identified actions to be taken to address client needs. 194 (53%) plans identified resources required to meet needs. 335 (91%) identified goals/objectives, and 287 (78%) specified time frames for achieving goals. 259 (71%) care plans contained client signatures, and 342 (91%) contained the Medical Case Manager’s signature. A graphic representation of care plan details is included as Figure 12.

Figure 12: Care Plan Details—EMA N with care plans=367



Treatment Adherence Services

Section 4 of the MCM Standards of Care identifies clients as needing treatment adherence services if they have difficulty 1) keeping their medical care appointments, 2) following their medication regimen, or 3) following through on their care plans.

Assessment of treatment adherence services is complicated by variations in treatment adherence modalities. Some agencies have separate treatment adherence programs and clients with difficulty adhering to visits, medications, or care plans are referred to these programs. For other agencies, treatment adherence is addressed as part of routine MCM visits. For still other agencies, medical visit and medication adherence are considered the responsibility of the medical provider rather than the case manager.

Section 5 of the MCM standards addresses treatment adherence standards of care. Treatment adherence baseline assessment standards include completion of demographic and eligibility information and assessment of barriers. Reporting on demographic and eligibility assessments for the fiscal year is included at the beginning of the report, and assessment of barriers for new patients is reported in the *New MCM Clients* section.

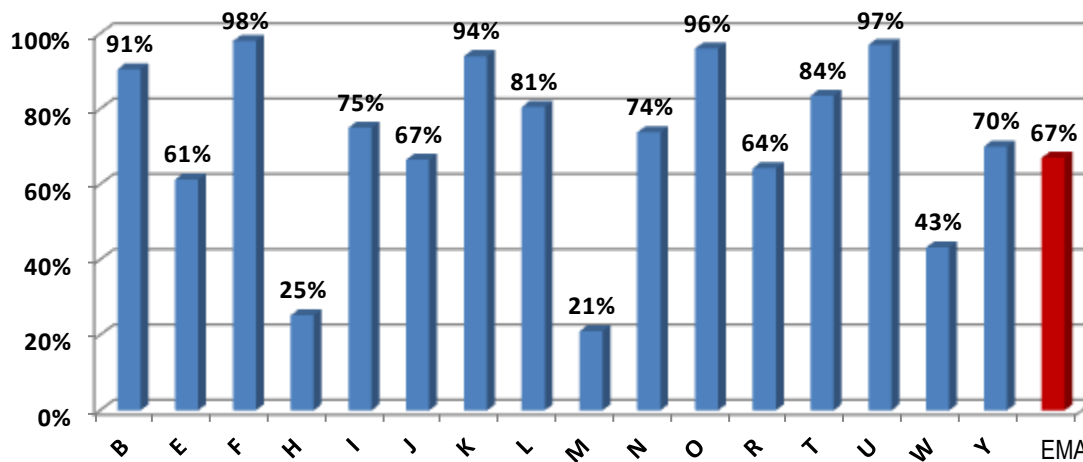
Infants were excluded from treatment adherence analysis. EMA-wide, 35 (10%) clients were referred to treatment adherence; 5 agencies referred more than 10% of their clients to treatment adherence, and 7 agencies referred no clients. However, this does not reflect all treatment adherence provided to clients, as only referrals are addressed: treatment adherence provided by case managers or providers is not included.

Six clients were referred to treatment adherence because of missed medical appointments, 26 for medication adherence issues, two because of difficulty adhering to the care plan, and eight because they were new to medical regimens. One client had multiple reasons for referral.

MCM Visits

Standard 2.2.2.1 states that monitoring is performed “to routinely review the success in achieving services...to monitor progress...intervene as appropriate, and to revise the plan as necessary.” CQM staff documented whether the MCM contacted the client in each of the four quarters of the review year. For each agency, and for the EMA, Figure 13 shows an overview of the average percent of clients contacted in each of the review year’s four quarters.

Figure 13: Average percent of clients contacted quarterly—EMA N=253



Agencies B, F, K, O and U exceeded 90%, while Agencies H, M, and W were substantially under the EMA average on frequency of MCM visits.

Further or Continued Service—Standards of care Section 2.2

Support to Clients—Reviewers assessed whether the case manager provided support, advocacy, consultation and crisis intervention in accordance with the care plan. 95% of clients having a care plan received case manager support in accordance with the care plan. For the handful of clients (18/355) who did not receive support, reasons included an absence of case notes documenting follow-up, client missed appointments, and client engaged in care too late in the year to determine follow-up.

Referrals—230 clients, or 63% of clients with care plans needed referrals. For clients needing referrals, 63 charts (27%) documented that the MCM advised the client on obtaining the service. In 181 charts (78%), the client needed assistance accessing referral services, and in 176 of these (97%), assistance accessing services was provided.

Progress Notes—348 (95%) of the 367 charts with care plans had progress notes. 144 (41%) charts with progress notes showed that there were difficulties achieving care plan goals and objectives, and 138 (96%) of these documented strategies for resolving those difficulties.

Care Plan Evaluation by a Supervisor or Peer—325 clients with care plans received MCM services for at least six months. Care plans for 93 (29%) of these documented evaluation of the care plan by a supervisor or peer. 284 of charts with care plans documented MCM services for the full year. Care plans for 42 (15%) of these documented a second evaluation by a supervisor or peer during the last six months of the review year. Most agencies did not make review of the care plan part of the client’s record.

Information to Clients

Information must be provided to clients at least once; it need not be provided each year. MCM Standard of Care 3.2.2.1 requires that agencies have 7 written policies in place. They are shown along with the average documentation across the EMA (N=430).

- Eligibility, 65%
- Confidentiality, 90%
- Grievance procedures, 97%
- Rights and responsibilities, 89%
- Referral and linkage, 48%
- Agency expectations of clients, 89%
- Termination policies, 71%, and
- Consent for treatment, 99%.

Case Closures:

EMA-wide, 40 (9%) charts documented that cases were closed during the fiscal year. Of these, 4 (10%) closures were due to client death, 35 (88%) were a result of agency or client preference, and for 1 (2%) chart the reason for chart closure was missing.

CONSUMER SURVEYS

Utilization of Medical Case Management Services

Data were collected measuring consumer knowledge of MCM services received. 157 consumers were interviewed at 16 of the 18 agencies providing MCM services. Consumer interviews were not conducted at pediatric sites. Survey questions related to MCM services delivered, communication between provider and consumer, and satisfaction with the quality of MCM services. A \$25 incentive card to a local retailer or grocer was provided for completion of the survey.

Length of time receiving MCM

45% of consumers had been receiving MCM services at their specified agency for greater than 5 years, with 19% having been in MCM at their specified agency for 3 to 5 years. Another 32% were in care for 6 months to 2 years, and 5% were in care for less than 6 months.

Currently have primary medical care provider and MCM provider

Participants were asked if they currently had a primary care provider and a medical case manager. This data showed that 97% of consumers claimed to have a primary care provider. 99% claimed to have a medical case manager.

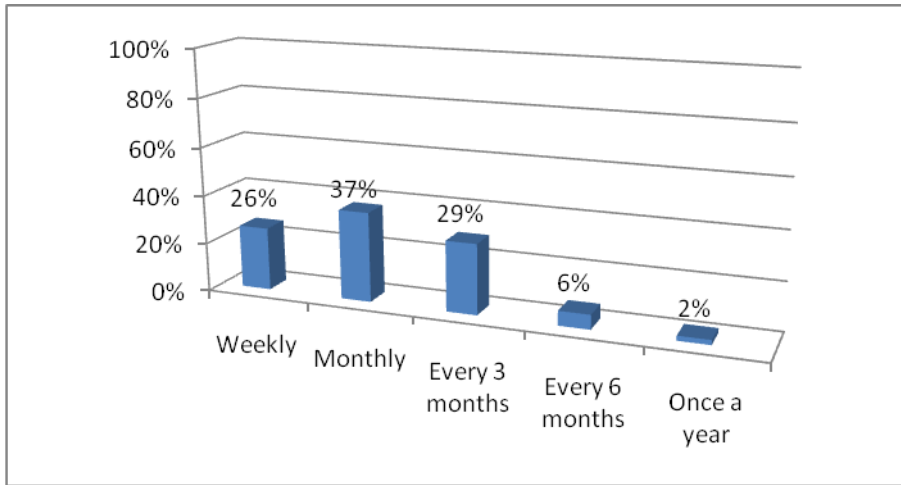
MCM care plan development

Consumers were asked whether they had participated in the development of an MCM care plan. The purpose of the care plan is to develop an appropriate course of action to access the identified resources required to meet the needs of the client and resolve problems. The majority of respondents, 82%, responded that they had developed an MCM care plan. 15% claimed they had not developed a care plan, and 2% did not remember.

Frequency of case management meetings

Figure 14 illustrates reported frequency of meetings between consumers and their case managers. Over a third of clients reported meeting with their case manager on a monthly basis and 26% indicated that met with their case manager weekly. A small portion of clients reported they met with their client on an annual basis.

Figure 14: Consumer MCM Meetings, N=157



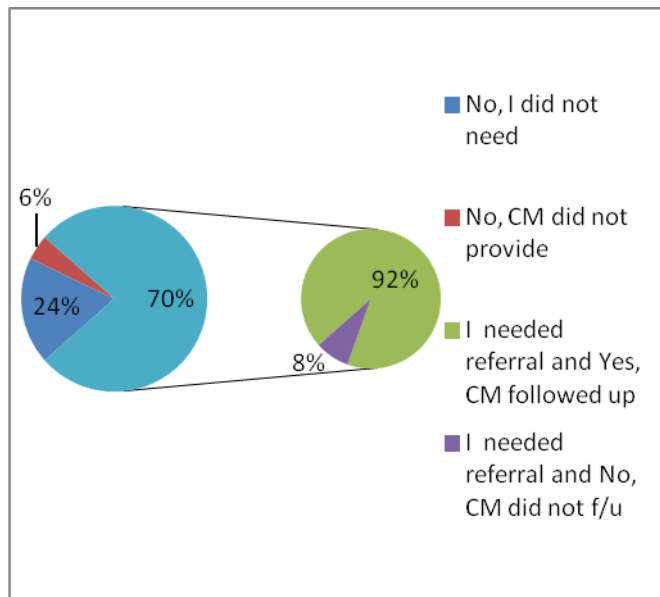
Initiation of contact between consumer and case manager

When asked about contact initiation, more than half of the consumers (64%) reported that either party, client or case manager, was just as likely to contact the other. Another 23% indicated that they usually contacted their case manager. 15% reported that the case manager was usually the one to initiate contact.

Referrals from case manager

As shown in Figure 15, 70% of consumers indicated that they had received a referral from their case manager when needed. Of those, nearly all consumers (92%) reported that the case manager followed up to make sure they received the needed service, Figure 15.

Figure 15: Consumer Referral/Follow-up, N=157



Appointment reminders

92% of those surveyed said that they received regular reminders from case managers to attend all medical appointments.

Consumer satisfaction

Overall, consumers reported a high degree of satisfaction with case management services (94%). 93% would recommend their agency to others.

Summary

Nearly half of consumers had been receiving MCM services at their specified agency for more than 5 years. The majority had developed a MCM care plan. Most indicated that the frequency of visits with case managers was sufficient to address their needs. Nearly all consumers were reminded of medical appointments “All of the time” or “Most of the time”. Nearly 20% of consumers reported they had not established a care plan with their case manager.

Consumers were given the opportunity to provide any other comments or feedback on medical case management services. The list below details these additional comments:

- “They offer a wonderful service here”.
- “My case manager is the best!”
- Form more partnerships with housing agencies
- Offer job training on site
- Offer HIV support group for Spanish speaking people
- Offer complete listing of RW services
- Offer more films, speakers at HIV support groups
- Offer onsite N/A meetings

DISCUSSION & RECOMMENDATIONS

Overall, medical case management providers continue to deliver care in accordance with a HRSA HAB performance measures and most local standards of care. 85% of MCM charts document that clients 1) are seen at least twice a year by a medical provider (retention in care) and, 2) have care plans in place. Consumers report overall satisfaction with MCM, and report receiving needed services.

Below is an EMA-wide summary of strengths and areas for improvement for MCM services. **Refer to the cover letter of this document for your agency's strengths and areas for improvement.**

Strengths, all clients:

- Retention in care for full-year clients—85%
- Clients having care plans—85%
- Care plan details:
 - Identification of needs—93%
 - Case Manager signature—93%
 - Identification of goals—91%
- Case manager follow up to address care plan issues—95%
- Quarterly contact with case managers—67%
 - All agencies but 3 contacted 60% of their clients quarterly...for 3 agencies this is an area for improvement.
- Assistance for needed referrals—100%
- Progress notes for those with care plans—95%
- Strategies for resolving difficulties achieving care plan goals—96%

Strengths, new clients:

- Rapid initial assessment of new clients—99%
- Response to emergency needs—94%
- Timely assignment of a case manager for new clients—97%
- Timely completion of BPS assessment—80%
- Eleven items in the BPS assessments with >80% completion

Areas for Improvement

- Care plan review by supervisor or peer each 6 months—29% first review, 15% second review
- Care plan details:
 - Resources—53%
- Five required items in the BPS assessment with ≤ 60% completion

Recommendation for Change to the Standards of Care

Integrate Treatment Adherence in with general MCM Standards of Care.

Currently Treatment Adherence standards [5.1.2] identify the circumstances under which individuals are eligible for TA, but there is no direction concerning whether, when, or how often MCM should assess TA needs.

Recommended for discussion:

- At each MCM visit, require that case management progress notes document discussion of client attendance at medical visits and adherence to medication (for those on ARVs), and include MCM document whether or not treatment adherence services are needed. This will cue CQM to review treatment adherence services provided to the client.
- For continuing clients, require annual administration of an abbreviated BPS assessment to identify emerging barriers to care.
- [5.2.1] Consider ending the requirement for a separate Adherence Intervention Plan (we did not see them) but rather require including TA as a problem in the MCM Care Plan for those needing this service.
- [5.3] Because agencies TA service models vary, require each agency to have a write-up of their treatment adherence procedure, so CQM can determine whether the procedure was followed.

Ryan White Eligibility

All clients receiving Ryan White services must be screened for eligibility requirements including one-time verification of HIV status, and semi-annual verifications of residency and income. At least one of the income and residency verifications in each 12 month period must be accompanied by supporting documentation. Self-attestation is sufficient for the second verification. Please note that while self-attestation of no change is sufficient, self-attestation of change **must** be accompanied by supporting documentation. Table 2 describes the type of documentation required for each eligibility requirement.

Initial residency and income documentation were found in 87% and 82% of charts, respectively. When the client had been in care for more than 6 months, reviewers checked that residency and income had been updated. 73% of charts documented a residency update and 71% of charts documented income updates. Since Ryan White is the payer of last resort, all clients should have been screened for eligibility and all clients' eligibility should have been reassessed.

RW Eligibility and the Affordable Care Act¹

As health care reform is implemented, more PLWH will become eligible for public or private insurance. Ryan White providers are required to make efforts to secure other funds to provide services to clients. Other funding streams include Medicaid and Medicare, CHIP, or other private health insurance. Ensuring that Ryan White funds are used as a last resort helps provide services to new clients and leaves funds for other needed services.

¹ <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1303eligibilityconsiderations.pdf>

For more information please see HRSA Policy Clarification Notice #13-03.

RW Eligibility and Electronic Health Records (EHR)

With the increased use of EHRs throughout the EMA, providers will need to consider how they will document initial and semi-annual verification of Ryan White eligibility. Hard copy verification of eligibility is required once per year for every client served. When clients are seeking Ryan White services for the first time or are re-entering care, they must provide hard copy documentation of their eligibility. If after initial or annual eligibility verification the client has reported a change in residence or income, then they must also provide hard copy documentation.

Providers using EHRs will need to either maintain a paper chart containing RW eligibility or scan these documents into the EHR. Written documentation of eligibility notated in the client's record will only be accepted once per year and only if the client reports no change in their eligibility.

Table 2. Required Documentation Table²

| | Initial Eligibility Determination & Once a Year/12 Month Period Recertification | Recertification (minimum of every 6 months) |
|-------------------------|---|--|
| HIV Status | Documentation required for Initial Eligibility Determination | None required |
| Income | <p>Documentation required</p> <p><u>Examples from the Greater Baltimore HIV Health Services Planning Council (GBHHSPC)</u></p> <ol style="list-style-type: none"> 1. Copy of a signed lease with client’s name and address 2. Copy of a current or previous month’s utility bill or rent receipt with client’s name and address 3. Copy of an Supplementary Security Income (SSI) award letter with client’s name and address 4. Notarized letter from a friend or family member, naming the client and attesting to his or her address 5. Support letter on official letterhead from a shelter, recovery house, transitional housing facility or other similar housing facility. | <p>Self-attestation of no change</p> <p>Self-attestation of change – documentation required</p> |
| Residency | <p>Documentation required</p> <p><u>Examples from GBHHSPC:</u></p> <ol style="list-style-type: none"> 1. Copy of a current pay stub with the client’s name 2. Copy of the client’s most recent W-2 form 3. Copy of the client’s SSI award letter 4. Signed, notarized “letter of support” from someone providing the client with financial support 5. Documentation of active Medicaid benefits, such as the client’s managed care organization card. | |
| Insurance Status | <p>Must verify if the applicant is enrolled in other health coverage and document status in client file</p> <p><u>Examples from GBHHSPC:</u></p> <ol style="list-style-type: none"> 1. Copy of the client’s insurance card 2. Documentation that provider staff have checked the client’s status in the Eligibility Verification System (EVS) of the State of Maryland 3. Verification from private insurance company that includes the date and results, with initials/signature of provider staff securing verification. | <p>Must verify if the applicant is enrolled in other health coverage</p> <p>Self-attestation of no change</p> <p>Self-attestation of change – documentation required</p> |

² Adapted from <http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf>

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