

BALTIMORE CITY HEALTH DEPARTMENT

RYAN WHITE OFFICE

CLINICAL QUALITY MANAGEMENT PROGRAM

Service Category: NON-MEDICAL CASE MANAGEMENT

June, 2012



TABLE OF CONTENTS

Section 1. Introduction.....	3
Section 2. Methodology.....	4
Section 3. Demographics.....	6
Section 4. Admissions Requirements.....	12
Section 5. Further or Continued Services.....	14
Section 6. Consumer Surveys.....	16
Section 7. QI Organizational Assessment.....	20
Section 8. Discussion.....	23
Section 9. Acknowledgements.....	24
Appendix A: Non-medical Case Management Standards of Care.....	25

SECTION 1. INTRODUCTION

The Baltimore City Health Department (BCHD) Clinical Quality Management Program (CQM) began in 2001. Our purpose is to ensure that people living with HIV/AIDS (PLWH) in the 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. In fiscal year 2011, the CQM initiative focused on adult primary medical care, oral health, non-medical case management, psychosocial and hospice services. This report presents data on non-medical case management services.

As defined in the Greater Baltimore HIV Health Services Planning Council (Planning Council) local standards of care, non-medical case management services include “the provision of advice and assistance in obtaining medical, social, community, legal, financial and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.”

To assess the degree of adherence to the standards of care across the EMA, data was gathered and analyzed from all agencies funded for this service. In addition to providing the results of the data collected, this report provides details of the methodology, as well as a summary of the findings, national comparisons, and recommendations for improving the quality of non-medical case management services. The Appendix contains the standards of care used during the review.

SECTION 2. METHODOLOGY

Clinical Quality Management reviews were conducted in 2011 at 5 agencies providing non-medical case management services. Data was collected through 1) Client chart abstractions, 2) Consumer surveys, and 3) Organizational Assessments of the agency's Quality Improvement Program. The data presented is not intended to reflect all Ryan White non-medical case management clients or services throughout the Baltimore-Towson EMA.

The client chart abstraction tool and QI organizational assessment were distributed to agencies and the Planning Council for comment prior to utilization during the reviews. CQM also conducted conference calls with all non-medical case management programs in advance of their reviews to confirm dates and location, any additional logistics, and to answer questions specific to the tools and/or review process.

Client Chart Abstraction: The chart abstraction tool, designed to assess agency compliance with the standards of care, was based on the August 2009 revisions to the standards. The review period included services provided in fiscal year 2010 (March 1, 2010 – February 28, 2011). Results of the chart abstractions are presented in *Sections 3-5*.

Agencies were directed to provide a random sample of charts and CQM provided two methodologies for doing so. CQM staff did not verify that the charts provided represented a random sample. The number of charts requested from each agency was based on the number of Ryan White clients receiving non-medical case management services in 2010 and guided by the 2008 HIVQUAL sampling methodology developed by the New York State Department of Health AIDS Institute.¹

A total of **222** client charts were reviewed. The number of charts reviewed per agency ranged from **22** to **91** with an average of **55** charts reviewed at each agency. Based on the data reported to BCHD by the agencies funded, a total of **1,013** persons received non-medical case management services during 2010.² **Twenty-two percent** of all non-medical case management charts were reviewed during the 2011 CQM reviews, *Table 1*.

Table 1. Non-medical Case Management Charts Reviewed, N=222

Part A Agency	Charts Reviewed	% CQM Sample	All FY10 Clients	% Agency Sample
Baltimore City Health Department – Druid	22	10%	38	58%
Baltimore City Health Department – Eastern	33	15%	37	89%
Park West Medical Center	46	21%	71	65%
University of MD – Evelyn Jordan Center	91	41%	823	11%
University of MD – Pediatrics	30	14%	44	68%
Total	222	100%	1,013	22%

Consumer Survey: The consumer survey assessed quality from the client's perspective. CQM staff utilized a consumer questionnaire developed by the New York State Department of Health AIDS

¹ New York State Department of Health AIDS Institute, The 2008 HIVQUAL Project Sampling Methodology, August 2009

² This data was obtained from monthly Form 8 submissions to the grantee's office. This total is unduplicated at the vendor level and then aggregated to give a duplicated EMA-wide count.

Institute.³ The tool captured demographics, services received, and client satisfaction with services. Agencies were instructed to provide a sample of consumers for interviews during the scheduled visit. A member of the CQM staff administered the consumer interviews in person at the agency. When on-site interviews were not possible, telephone interviews were conducted after obtaining client consent by the agency. This information is presented in *Section 6*.

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 a staff member at each agency and completed the organizational assessment based on agency 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 Information on the Organizational Assessment is presented in *Section 7*.

Data Comparisons: Throughout this report, where possible, these data were compared with a) the CQM FY06 review of Client Advocacy charts, b) data compiled by the Center for HIV Surveillance and Epidemiology at the Maryland Department of Mental Health and Hygiene and c) data for the entire FY11 non-medical case management sample.

³ <http://www.nationalqualitycenter.org/index.cfm/35778/index.cfm/2214265>

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

SECTION 3. DEMOGRAPHICS

GENDER

Males comprised **65%** of this sample and females made up **34%**. Gender was not documented for **one** chart and **one** other chart indicated the client was transgender. *Figure 1a* also compares 2011 findings to the FY06 Client advocacy sample. Both samples show that males were in the majority however the FY11 sample expressed a greater proportion of male clients.

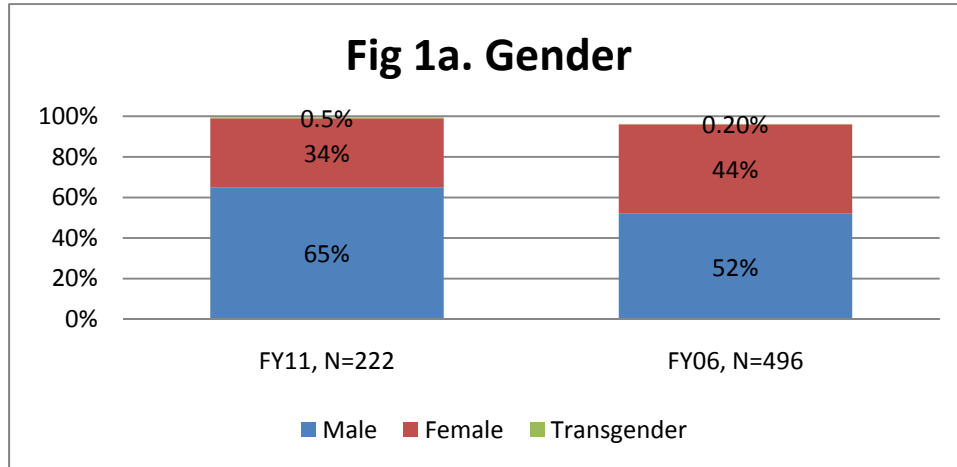
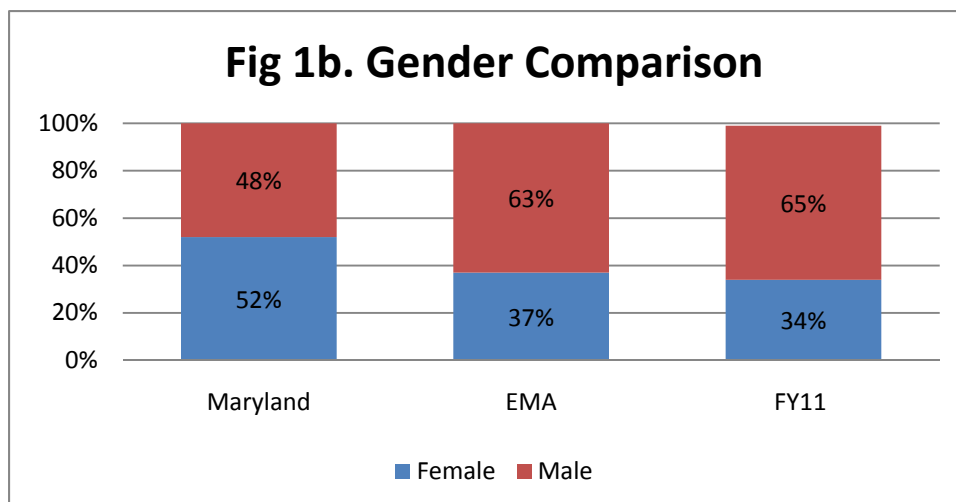


Figure 1b compares the FY11 sample to both the general population within Maryland and PLWH within the EMA. This figure illustrates the impact of HIV/AIDS on men. While males comprise **48%** of the state's general population, they are overrepresented both in the EMA (**63%**) and the non-medical case management sample (**65%**).



AGE

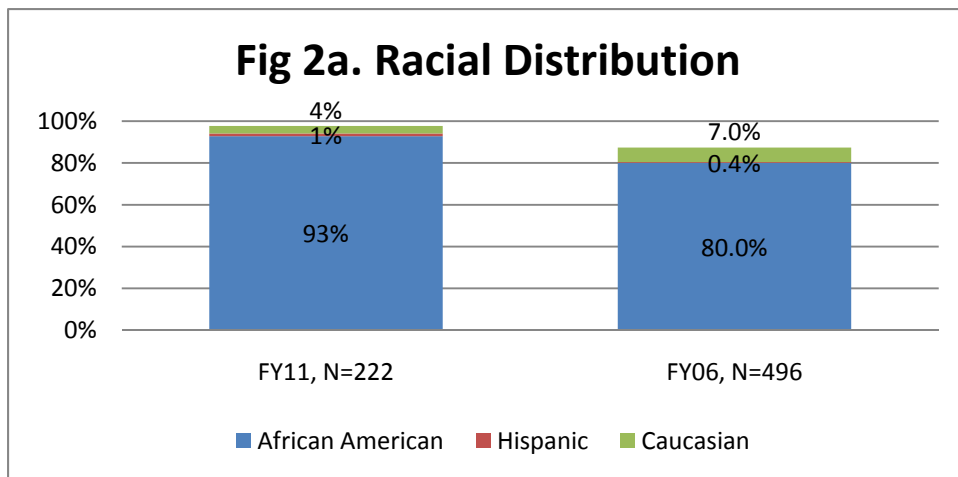
Table 2 displays age ranges for the state’s general population, within the EMA, and in the FY11 and FY06 CQM samples. Greater than half of Maryland’s general population is under the age 40. However, when compared to the EMA and FY11 sample, we see a smaller proportion of those under 40 indicating the impact of HIV on older adults. The FY11 sample contained **1%** of clients under the age of 20 although the general population of Maryland is composed of **26%** under that same age. Looking at the FY11 and FY06 sample there is little variation in the proportion of clients over 60 and under 20. A smaller proportion of people in their 40s were seen and a larger portion of those in their 50s were in the FY11 sample than in the FY06 sample.

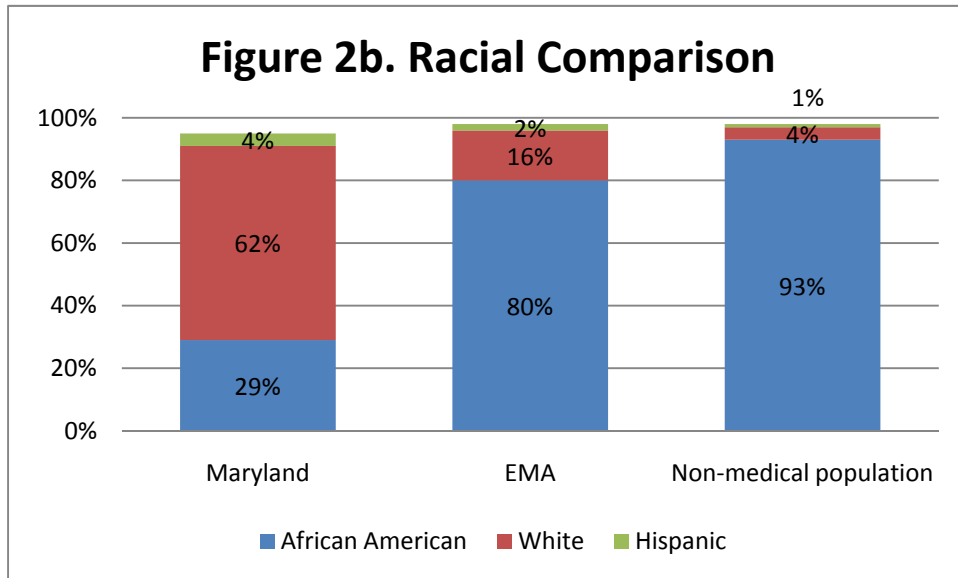
Table 2. Age Distribution

Age	Maryland	EMA	FY11 Non-medical	FY06 Client Advocacy
0-19	26%	2%	1%	1%
20s	14%	8%	15%	10%
30s	13%	15%	16%	21%
40s	15%	36%	30%	41%
50s	14%	30%	31%	22%
60+	18%	10%	8%	5%

RACE/ETHNICITY

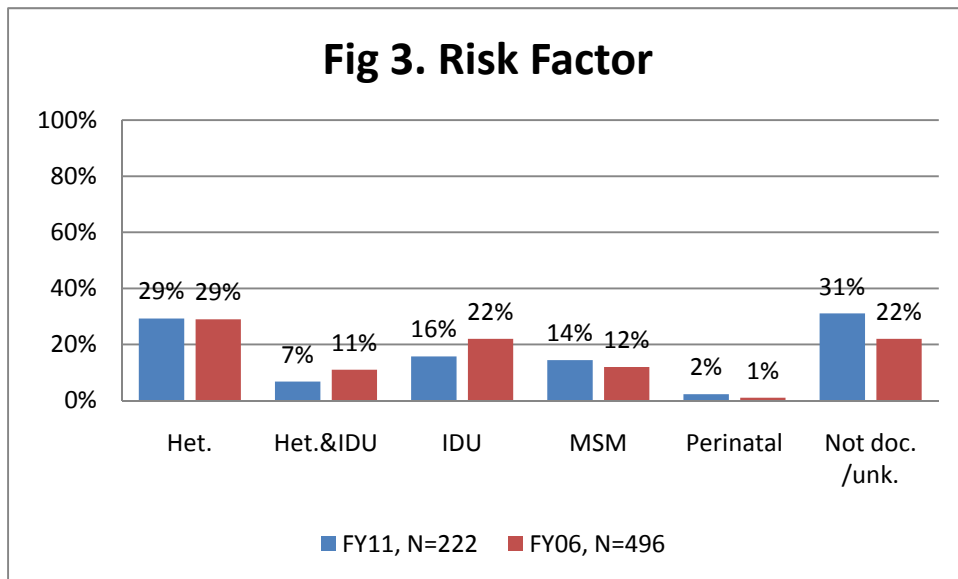
As seen throughout the EMA, this sample is mostly African American (**93%**). Caucasians made up **4%** of the sample and Hispanics **1%** (*Figure 2a*). **Two percent** of racial demographics went undocumented. More African Americans were seen in the 2011 sample, however more charts were missing race in 2006. Whites made up a slightly larger proportion in the FY06 sample. The graph in *Figure 2b* emphasizes the disproportionate impact of HIV/AIDS on African Americans in the Baltimore-Towson EMA. While making up just **29%** of the general population, they comprise **80%** of those infected with HIV.





HIV RISK FACTOR

Figure 3 compares risk factors in the FY11 and FY06 sample. In FY11 **31%** of risk factors were not documented or unknown which is up from **22%** in FY06. Heterosexual contact was documented in the same proportion in both samples at **29%** and MSM contact was nearly the same for both years. Injection drug use (IDU) was indicated in **16%** of charts, down from **22%** in FY06.

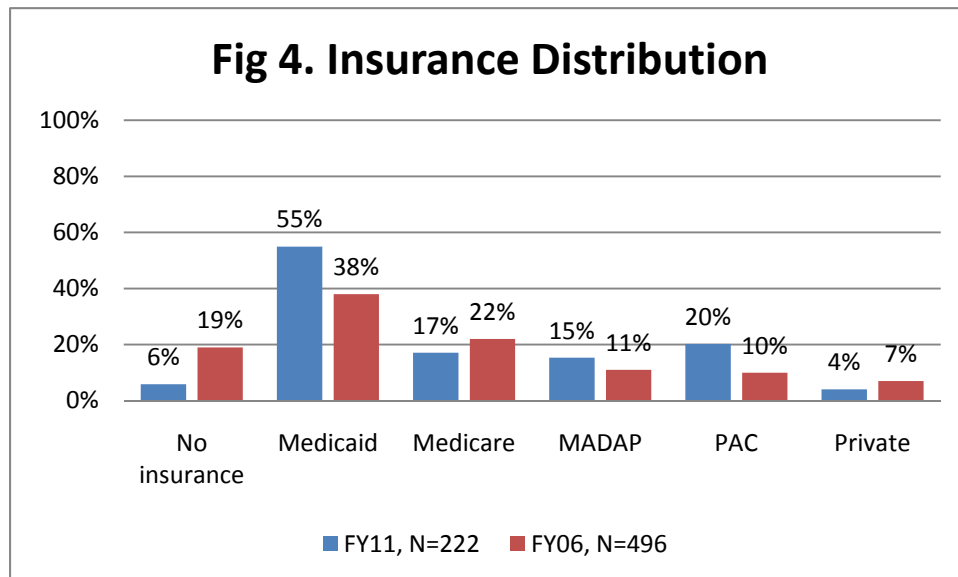


RESIDENCY

All CQM reviews for this category were conducted in Baltimore City. As expected **90%** of zip codes indicated Baltimore City and **5%** represented Baltimore County. Anne Arundel, Harford, Howard and Queen Anne’s counties were each indicated less than **1%** of the time. **Two percent** of zip codes were outside the EMA.

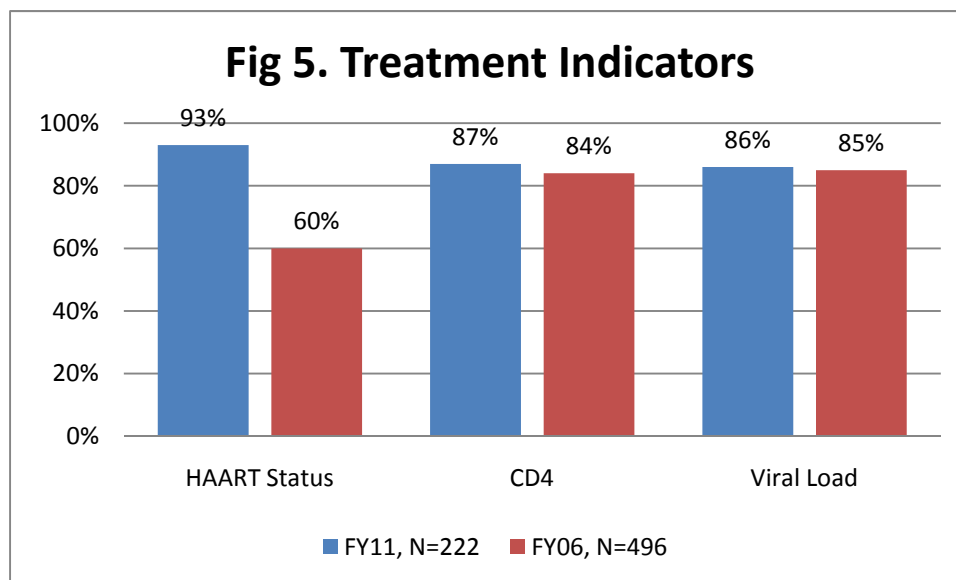
INSURANCE STATUS

In both the FY06 and FY11 samples, Medicaid and Medicare were the two leading forms of insurance coverage. From FY06 to FY11, more clients were on Medicaid (**55%**), MADAP (**15%**) and PAC (**20%**). Clients in the FY06 sample were more likely to be uninsured when compared to the FY11 sample when more received PAC and Medicaid, *Figure 4*.



CLINICAL INDICATORS

Clinical indicators include documentation of use of highly active antiretroviral therapy (HAART), as well as documentation of CD4 and viral load values. HAART status was documented in **93%** of FY11 charts, a large increase from the FY06 sample, where just **60%** of those charts documented HAART. CD4 and viral load values remained relatively unchanged from FY06 to FY11, *Figure 5*. Although not specifically required by these standards of care, CQM uses this information to trend clinical outcomes as well as to help measure the EMA’s progress in reaching national goals.



One such goal comes from the *National HIV/AIDS Strategy for the United States*. The goal, to “reduce HIV-related health disparities”, specifically focuses on viral load suppression in minority groups. In this report, viral load suppression was defined as any value that was undetectable. This value varied by agency, but in general was less than 75 copies/mL.

In the 2011 non-medical case management sample there were **95** men with a clearly defined risk factor, that is it was either heterosexual, MSM, IDU or perinatal. There were also **37** men without a documented risk factor; however a viral load value was recorded. *Table 3* compares the proportion of undetectable viral loads in men with an MSM, heterosexual, and IDU risk factor (the perinatally infected male client was left out of this analysis, therefore n=94). All **30** MSM had a documented viral load and **53%** were undetectable. Of the **37** men with a heterosexual risk factor, **33 (89%)** had a documented viral load. Of those, **52%** were undetectable. **Fifty-two percent** of men with IDU risk factor also had undetectable viral loads. This sample size is very small and does not substantiate any disparity in the medical management of HIV disease based on client risk factor (*Table 3*).

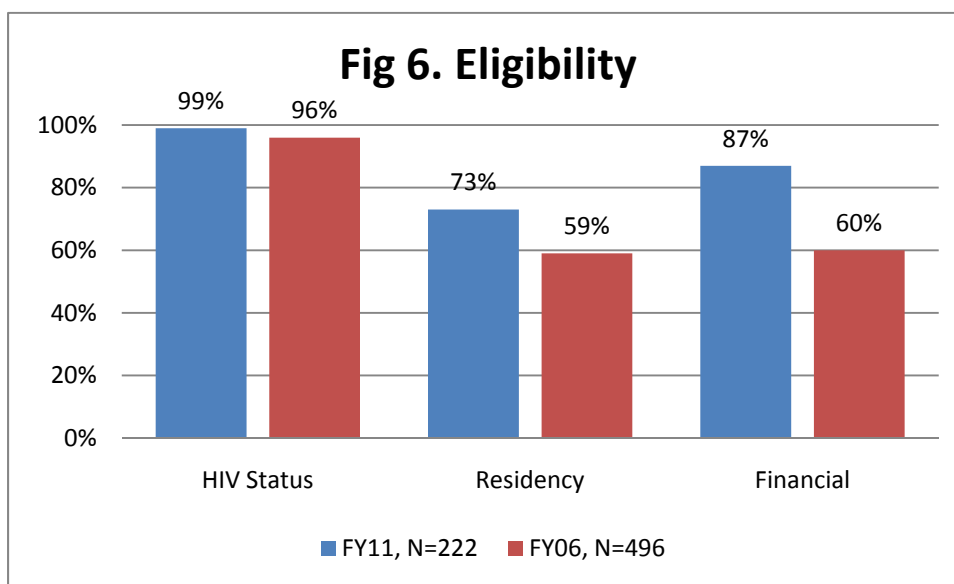
When viral load suppression was viewed by race/ethnic background, Whites and Hispanics had equal proportions of suppression (**67%**) however their numbers were small. Viral suppression in African-Americans was about **52%**. For purposes of this report, the cross-tabulations will serve as baselines for comparisons in future reviews. Some limitations to keep in mind include risk factor data is self-reported, men with multiple risk factors were excluded from analysis, and only the last viral load value during the review period was used.

Table 3. Viral Load Suppression by Race and Risk Factor

Demographic	# (%) w/ VL	# (%) Undetectable
Risk		
Men with MSM exposure (N=30)	30 (100%)	16 (53%)
Men with Heterosexual exposure (N=37)	33 (89%)	17 (52%)
Men with IDU exposure(N=27)	27(100%)	14 (52%)
Men with missing Risk Factor (N=37)	35(95%)	19 (54%)
Race/Ethnicity		
All African American (N=206)	181 (88%)	94 (52%)
All Caucasian (N=8)	6 (75%)	4 (67%)
All Hispanic (N=3)	3 (100%)	2 (67%)

ELIGIBILITY AND POLICIES DOCUMENTATION

All Ryan White clients must establish initial eligibility prior to the initiation of services. This includes verification of positive HIV status, residence and financial status. HIV positivity was documented in at least **96%** of charts from both fiscal years. The FY11 review showed better performance in documenting residency and financial status, (*Figure 6*). This progress suggests improved efforts by programs to better document Ryan White eligibility.



Before services are rendered, clients must be provided with copies of policies and procedures. Policy distribution was often lower in FY11 with just **11%** of charts documenting every policy (*data not shown*). *Table 4* gives specific breakdowns for each policy and compares it to the FY06 sample. FY06 had stronger documentation of HIPAA, grievance and release of information forms while the FY11 sample had better documentation of client rights and consent to receive services.

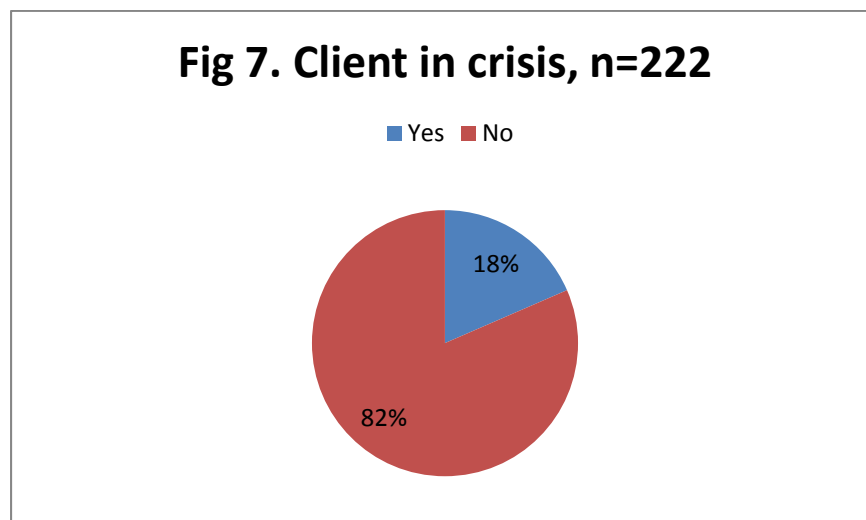
Table 4. Policy and Procedure Documentation

Policy	FY11 charts documenting	FY06 charts documenting
Client Rights	62%	45%
Privacy/HIPAA	46%	65%
Grievance	28%	45%
Release of Information	45%	69%
Consent to Service	64%	58%

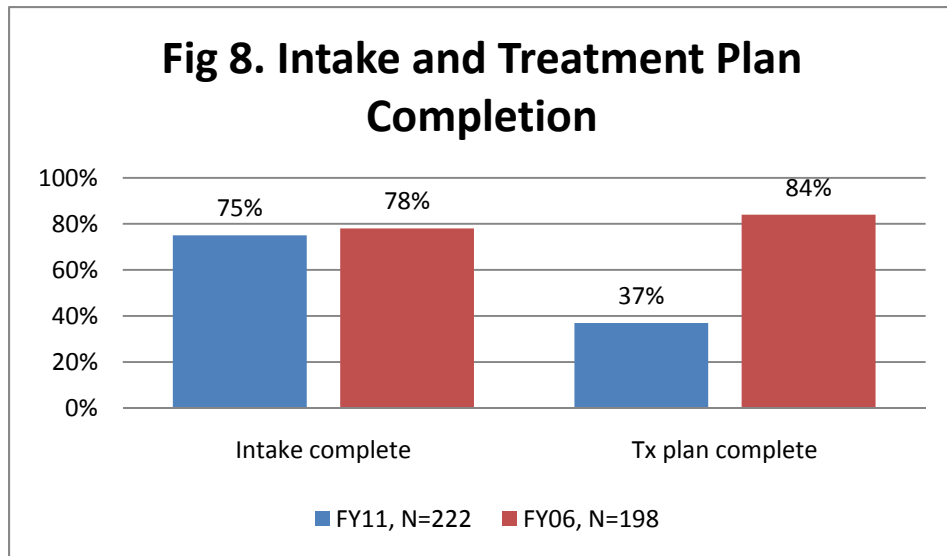
SECTION 4. ADMISSIONS REQUIREMENTS

INTAKE AND TREATMENT PLAN

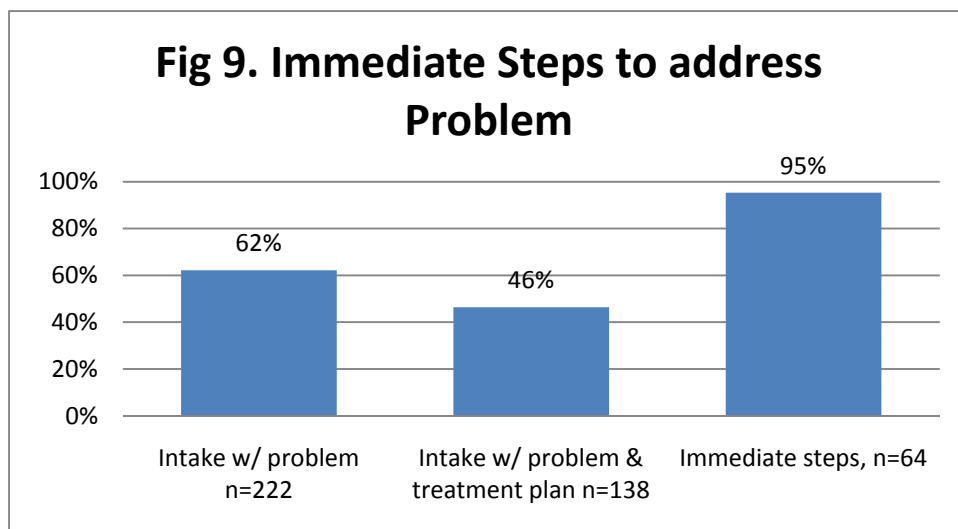
Upon admission to the agency the standards require that the case manager determine if the client is in crisis. Crisis was defined as being of suicidal nature or experiencing some other current life threatening event. Of the **222** clients in the sample, **18%** were determined to be in crisis (*Figure 7*). If the client is in crisis, then immediate action must be taken. In this case, **85%** of crises were resolved, *data not shown*.



Another requirement pertains to the intake process and completion of treatment plans. Intakes were completed for **75%** of FY11 clients while treatment plans were completed for just **37%**. The FY06 sample outperformed FY11 with **78%** of charts documenting an intake and **84%** documenting a treatment plan (*Figure 8*). Intakes must also be completed within two visits and document the client’s presenting problem. Overall in FY11 intakes were almost always completed within two visits at **94%** and **83%** identified the presenting problem, *data not shown*. All treatment plans should be signed by the case manager. Just over half (**55%**) of all charts with treatment plans were signed by the case manager (*data not shown*).



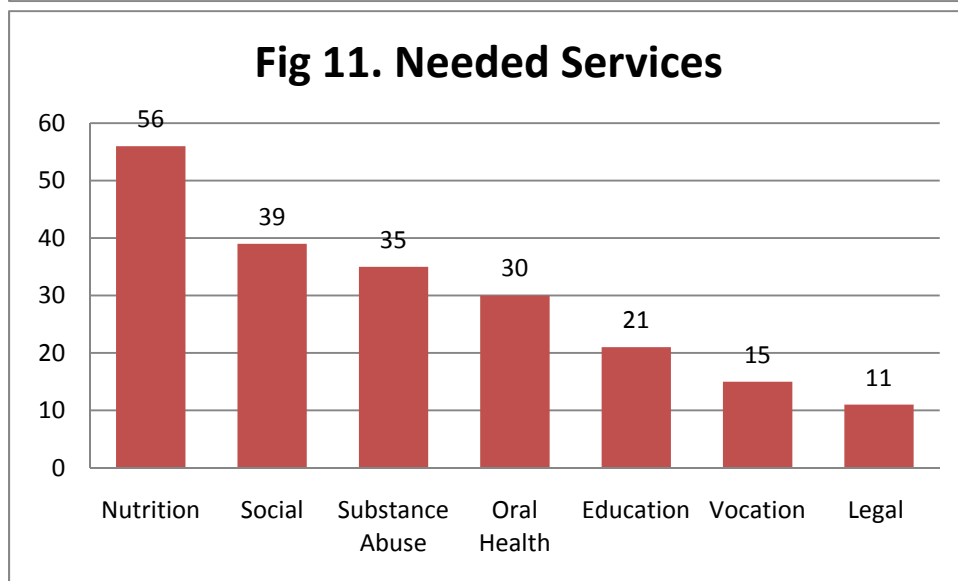
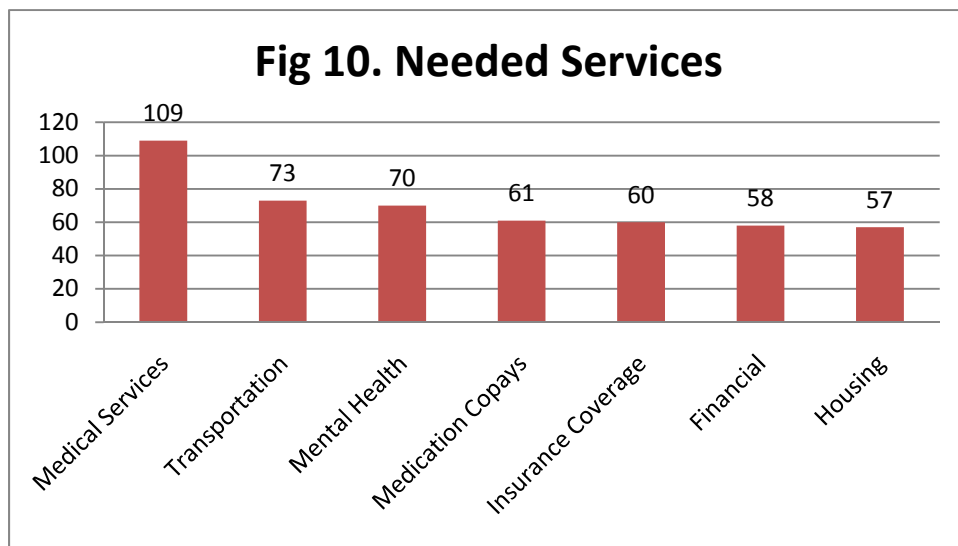
Treatment plans must document the immediate actions to be taken to address the presenting problem. To capture these clients, CQM staff looked at charts containing an intake that also identified the presenting problem. There were **138 (62%)** charts meeting this requirement. Of those, **64 (46%)** also contained a treatment plan. Of these **64 charts, sixty-one (95%)** addressed the immediate steps to address the problem (*Figure 9*).



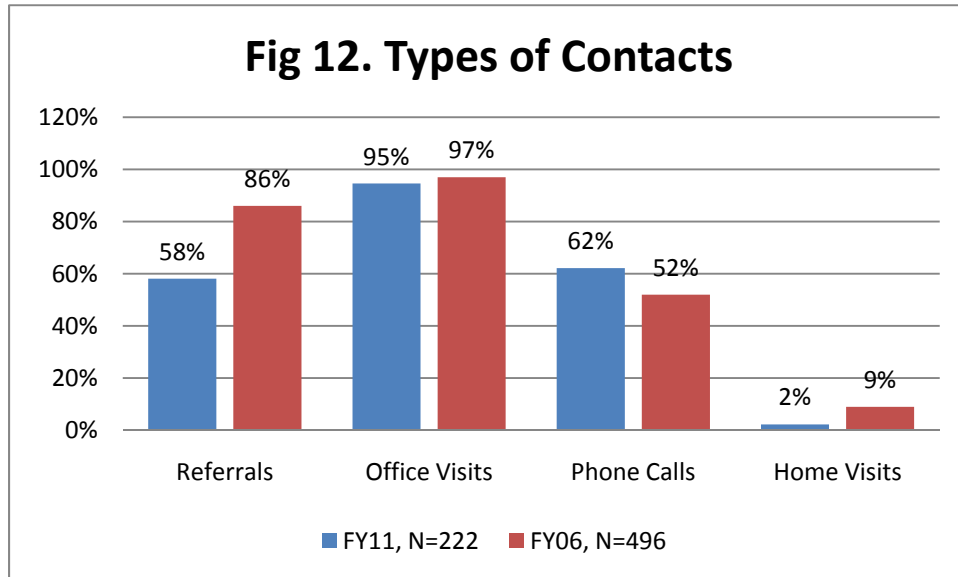
SECTION 5. FURTHER OR CONTINUED SERVICES

Through referrals, office or home visits and making phone calls, the non-medical case manager can assist clients in obtaining services. Clients received assistance with many services from transportation to housing. *Figure 10* shows that most clients received some type of assistance obtaining medical services (**109**), followed by transportation (**73**) and mental health services (**70**).

Similar numbers of clients also received assistance with medication and insurance coverage, financial assistance and housing. Other services requested were oral health (**30**), legal (**11**), substance abuse (**35**), nutrition (**56**), education (**21**), vocation (**15**) and social (**39**), *Figure 11*. There were other forms of assistance that fell into the 'other' category. **Twenty-five** clients received newborn assistance and education, **1** received partner notification services, another **1** optical, and **1** more received medication adherence assistance, *data not shown*.



Consistent with both fiscal years, clients primarily visited the non-medical case manager’s office. FY06 clients interacted less by phone with their case managers than in FY11. FY11 clients were less likely to receive referrals than in those clients sampled in FY06. Home visits occurred less in FY11 than in FY06, *Figure 12*.



For clients receiving medical services, the standards require that the chart document follow through with the medical case manager to ensure continuity of care. **One hundred nine** clients received medical assistance; of those **89 (82%)** of their charts documented continuity of care.

The standards also require that the non-medical case manager act on behalf of the client with other agencies. **Seventy-nine percent** of charts indicated the non-medical case manager worked on behalf of the client. A chart met this requirement if for example it documented that a non-medical case manager had completed and faxed a MADAP application for the client. Finally, progress note documentation was strong at **95%**.

CHART CLOSURE

Five (2%) client charts were closed during the review period. Reasons for closure were due to the transfer of the client (**3**), followed by client relocation (**1**) and client transitioned off the service (**1**). In the FY06 sample, **64 (13%)** records were closed with the most common reason for closure listed as 'lack of client contact', at **42%**.

SECTION 6. CONSUMER SURVEYS

Consumers were directly recruited from the Ryan White agencies. Consumers were surveyed about their non-medical case management service experience during the past 12 months. A total of **32** consumers were interviewed at **5** sites. A 24-item questionnaire was administered by Ryan White staff 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 that the results may total above or below **100%** due to rounding. All survey participants were 18 years of age or older.

DEMOGRAPHICS

Sex and Age

The majority (**65%**) of the **32** consumers surveyed were male (*Figure 13*). Almost half (**44%**) of the consumers surveyed were in their 50s and a quarter (**25%**) were in their 40s. Less than twenty percent (**16%**) were in their 30s and (**13%**) were in their 20s (*Figure 14*).

Figure 13. Gender distribution

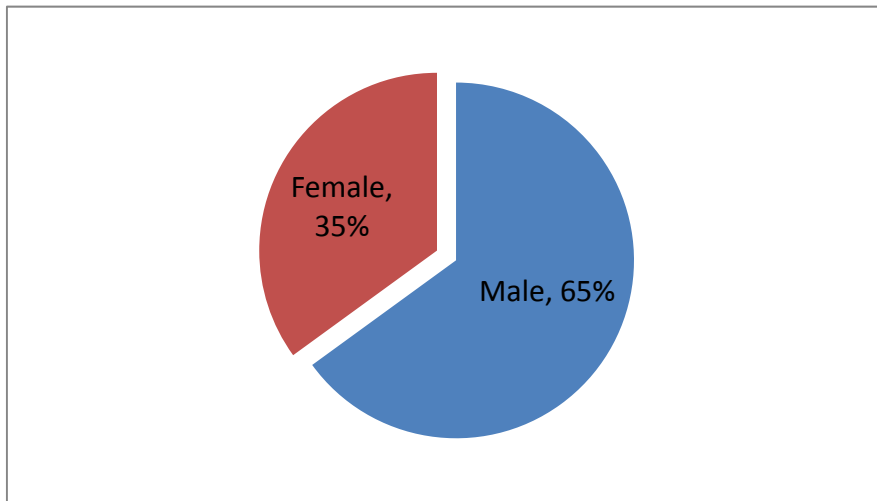
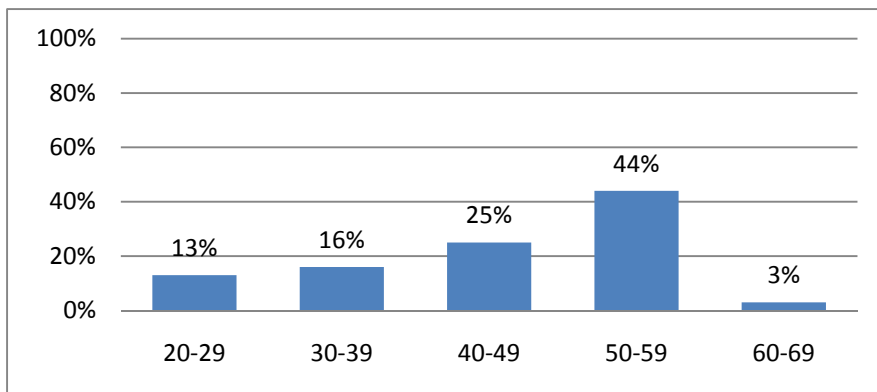
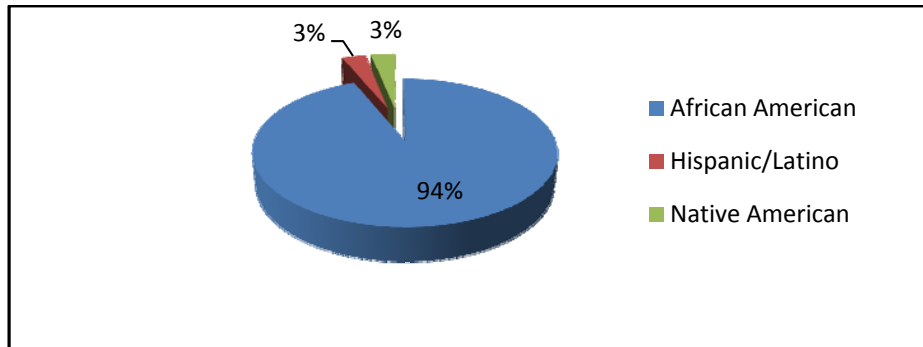


Figure 14. Age



Ninety-four percent of consumers surveyed were African American, **(3%)** were Hispanic/Latino and **(3%)** Native American (*Figure 15*).

Figure 15. Race

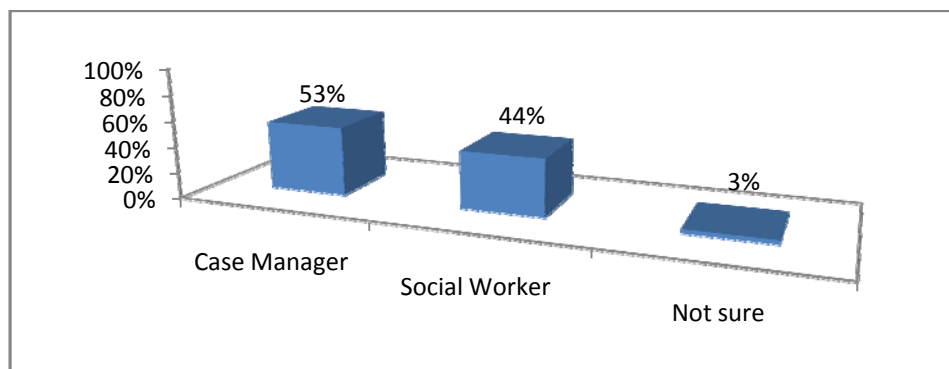


RECEIPT OF NON-MEDICAL CASE MANAGEMENT SERVICES

Non-Medical Case Management Profession

More than half **(53%)** of consumers indicated they were assigned to a non-medical case manager, **(44%)** a social worker and **(3%)** were uncertain of their non-medical case manager’s credentials (*Figure 16*).

Figure 16. Case Management Professional

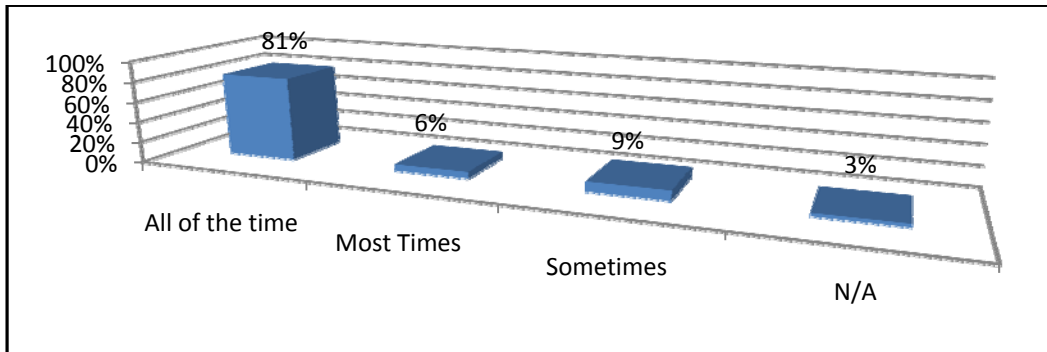


CONSUMER CONTACT WITH NON-MEDICAL CASE MANAGER

Plan of care

As shown in *Figure 17*, most **(81%)** consumers surveyed reported having an individualized care plan that was reevaluated every 3 months. Another **(15%)** reported the existence of a care plan “some” or “most” of the time.

Figure 17. Care Plan Updates



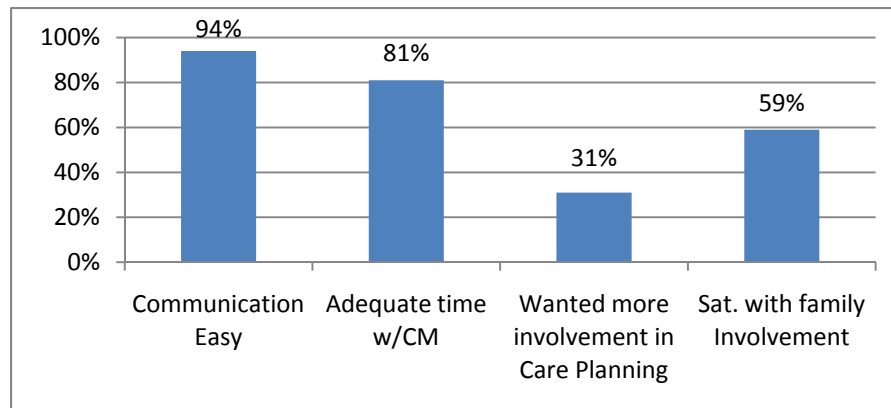
As seen in *Table 5*, responses to questions regarding Non-Medical Case Management Service Delivery were consistently high.

Table 5. Service Delivery

Non-Medical Case Management Service Delivery	Percentage
CM available for convenient appointments	97%
CM got me services here and made referrals	97%
CM delivered services quickly	94%
CM showed me how to help myself	97%
CM was responsible and professional	97%

The majority (**94%**) of clients were comfortable sharing feelings and problems with their non-medical case manager. However, one third (**31%**) indicated they would have preferred more involvement in care plan development. While (**59%**) were satisfied, the question of satisfaction with the level of participation by family members or friends was not applicable for (**28%**) of respondents (*Figure18*).

Figure 18. Client Interaction

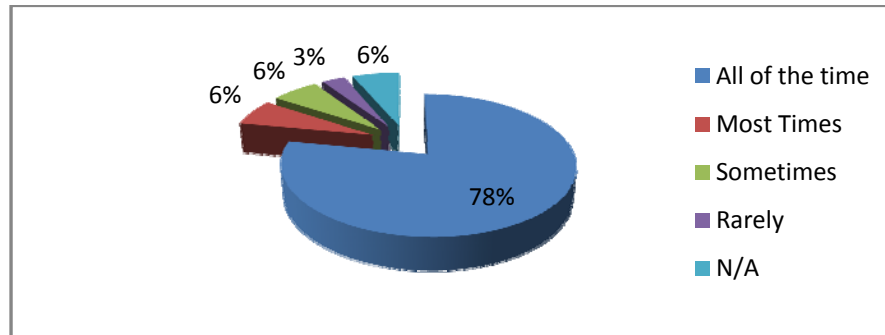


CONSUMER SATISFACTION RATING

Satisfaction with Services

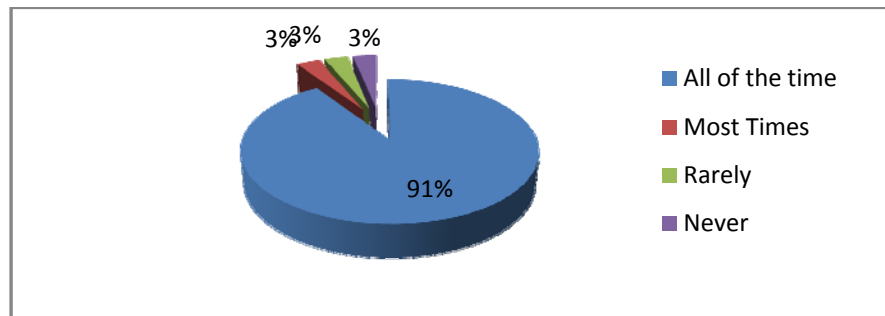
Eighty-four percent (84%) of the consumers surveyed reported that life ran more smoothly “all” or “most of the time” as a result of the services received from their non-medical case manager (Figure 19).

Figure 19. Life Ran Smoothly



Most (**94%**) consumers were confident that their non-medical case manager and primary care provider worked in concert to help them (Figure 20).

Figure 20. CM and PMC worked together



Ninety-seven percent of those surveyed were satisfied with the services received during the past 12 months. All (**100%**) would refer others with similar needs.

SECTION 7. QI ORGANIZATIONAL ASSESSMENT

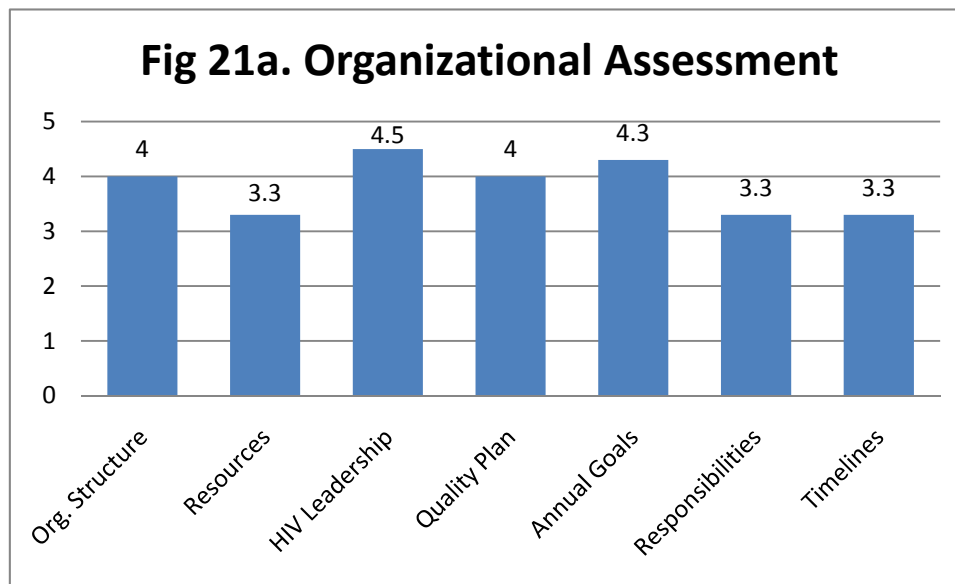
Four agencies completed the organizational assessment. **One** program had **two** site locations, but only **one** organizational assessment was required. The **15** items covered the programs' quality structure, planning, performance measurement, improvement activities, staff involvement, consumer involvement, evaluation, and data systems. The survey was administered by CQM staff and agencies were asked to score themselves on a scale from 0 (lowest) to 5 (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 21a & 21b* show the average scores per item across the non-medical case management category.

SECTION A. QUALITY STRUCTURE

1. Does the HIV program have an organizational structure to assess and improve quality of care? – Average score **4.0**. Overall, many agencies met quarterly to discuss quality of care. Meetings were attended by all levels of staff.
2. Were appropriate resources committed to support the HIV quality program? – Average score **3.3**. Agencies largely scored themselves as moderately meeting this standard. A score of **3** indicates that 'key staff members had time allotted for quality activities; half-time quality manager position was available at larger HIV programs; moderate resources for information systems.'
3. Did the HIV leadership support the HIV quality program? – Average score **4.5**. On average agencies were confident in the support provided by the HIV leadership at their organizations.
4. Does the HIV quality program have a comprehensive quality plan? – Average score **4.0**. 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 **4.3**. While annual goals were based on past performance and discussed at HIV quality meetings, they were not shared throughout the agency.
2. Does the HIV program have clearly described roles and responsibilities for the HIV quality program? – Average score **3.3**. 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 **3.3**. A score of **3** indicates that 'quality activities include moderate planning for the near future; work plan in place and reviewed and updated periodically; quality committee was aware of timetable.'



SECTION C. QUALITY PERFORMANCE MEASUREMENT

1. Were appropriate quality indicators selected in the HIV quality program? – Average score **3.5**. Indicators were reflective of the required standards of care and based on findings from quality projects. All staff were not involved in the development of indicators.

2. Did the HIV program routinely measure the quality of care? – Average score **4.3** Overall, agencies were confident in the process of measuring quality of care. 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 **3.8**. 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 **3.8**. 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 **4.5**. 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

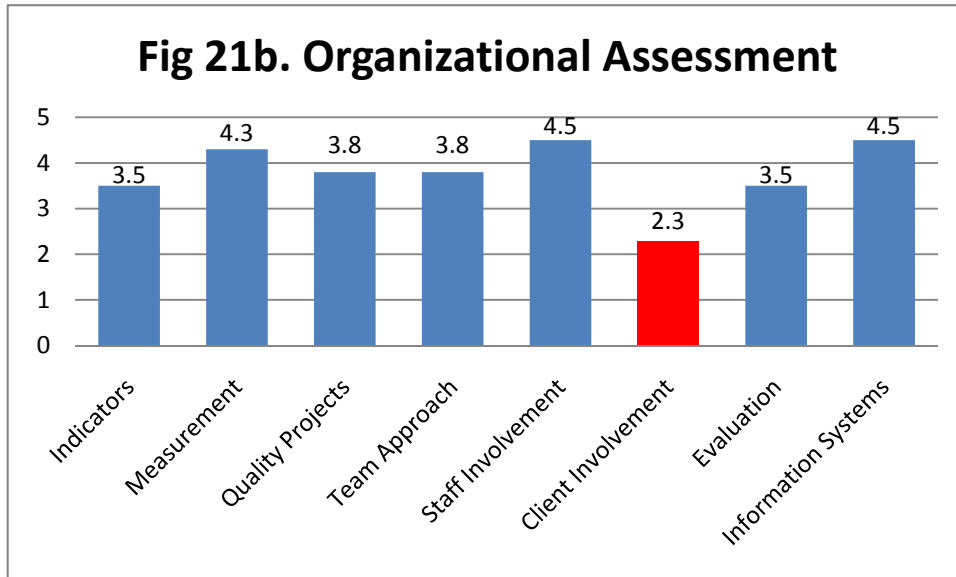
1. Are consumers involved in quality related activities? – Average score **2.3**. Consumer involvement was a struggle for agencies. Consumer needs were not regularly assessed. Needs were mainly addressed as they arose. Results of consumer assessments were not discussed specifically in staff meetings.

SECTION G. EVALUATION OF QUALITY PROGRAM

1. Is a process in place to evaluate the HIV quality program? – Average score **3.5**. The quality program is reviewed although a team approach may not be used. The results are sometimes used to plan ahead for the future.

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 **4.5**. Most agencies report a functional information system to track patient care and to produce reports. Some of the data collected are used for quality activities.



SECTION 8. DISCUSSION

The CQM process provided a systematic review of compliance to the EMA standards of care for 5 agencies providing non-medical case management services. A total of 222 non-medical case management charts were reviewed, representing approximately 22% of all non-medical case management clients receiving services in 2010. Following are both strengths and areas for improvement from the review of non-medical case management services.

Strengths – Demographics, treatment indicators, determining Ryan White eligibility and completion of intakes were all strengths of the chart abstraction for this category. The organizational assessment revealed that agencies have functioning quality improvement programs.

All consumers surveyed indicated they would refer others to case management services and almost all perceived case management as available, accessible and helped to increase their self reliance. A majority of consumers also reported that their care plans were reviewed and updated.

Areas for Improvement – Policies and procedures were poorly documented as were the completion of treatment plans. Treatment plan documentation dropped significantly from the FY06 client advocacy review. Treatment plans are integral to the achievement of a client's goals in non-medical case management.

One in five consumers wished to have more time with their case managers and about 3 in 10 wanted more involvement in developing their care plans.

Technical Assistance: The Baltimore City Health Department Ryan White CQM program held two technical assistance sessions with the non-medical case management and psychosocial support service providers on March 15th and May 17th, 2012. During the first meeting, chart abstraction, consumer, and agency data were presented to attendees. Strengths and areas for improvement were then identified and presented. After prioritizing the data, providers were broken into teams and utilized quality improvement tools to brainstorm improvement projects. Participants then used the Plan, Do, Study, Act (PDSA) cycle to plan improvement activities specific to their individual agencies. After returning to their agencies, providers were instructed to share their QI projects and form an improvement project team for implementation. Providers updated one another on their improvement projects at the next scheduled meeting on May 17th, 2012 and received additional QI training focusing on capacity building and QI sustainability.

In addition, each agency that received a review in 2011 will receive a vendor report that compares their performance to that of the EMA. Each vendor report identifies specific areas of improvement required by the agency and that the agency submits documentation of an improvement project addressing the issues identified.

Providers: Providers of this service should focus on completing treatment plans for every client and identifying and documenting their specific need upon intake. This practice not only guides the actions to resolve the client's problems but provides documentation of the work case managers do.

Planning Council: This report details adherence to the non-medical case management standards of care which were revised and ratified in 2009. Since then, in 2011, the standards were again revised; based on the definition of the category and the key service requirements, the standards are sufficient for clients with intermittent service needs.

SECTION 9. ACKNOWLEDGMENTS

Funding for the Clinical Quality Management Program at the Baltimore City Health Department is made possible by the Ryan White HIV/AIDS Treatment Extension Act of 2009 administered by the Health Resources and Services Administration under the Department of Health and Human Services. Thank-you to the Clinical Quality Management staff including Iris Allen, MPH; Evelyn Bradley, DrPh; Hilda Ndirangu, MS; Tracy Olivier, MS; Christy Skipper, BS; and Jesse Ungard, MA; as well as members of the administrative team, the Greater Baltimore HIV Health Services Planning Council, Carolyn Massey, Chair; additional partners including InterGroup Services, Inc.; Associated Black Charities, Inc.; The Taylor-Wilks Group, Ltd.; Training Resources Network, inc.; and the Pennsylvania/MidAtlantic AIDS Education and Training Center, Johns Hopkins Local Performance Site. Finally, a special thanks to the Baltimore service providers and consumers, without whom this work would not be possible.

Appendix A: Non-medical case management standards of care