FY13 OUTPATIENT AMBULATORY HEALTH SERVICES

PRIMARY MEDICAL CARE

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 2001, the purpose of which 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 HIV/AIDS Treatment Extension Act of 2009. The FY2013 CQM initiatives focused on Outpatient Ambulatory Health Services Primary Medical Care, Medical Case Management (including Treatment Adherence), Medical Nutrition Therapy, Food Bank (including Emergency Financial Assistance), and Legal services provided March 1, 2012 through February 28, 2013.

This report summarizes EMA wide findings of OAHS-PMC verified through chart abstraction and consumer interviews. As defined in the Greater Baltimore HIV Health Services Planning Council Standards of Care, OAHS-PMC pertains to "professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting"[1]. PMC services rendered for pediatric clients is defined as "the provision of professional, diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in a pediatric outpatient setting for both HIV-exposed infants and HIV-infected children"[2]

For each chart reviewed, one survey instrument was completed. A total of 408 charts were reviewed at the 15 agencies providing OAHS-PMC services (Table 1).

[1] Greater Baltimore HIV Health Services Planning Council, Standards of Care: Outpatient Ambulatory Health Services: Adult. Originated November 1996, Revised March 2013, Ratified May 2013

[2] Greater Baltimore HIV Health Services Planning Council, Standards of Care: Primary Medical Care – Pediatric Services. Originated October 1997, Revised April 2005, Ratified October 2005

Table 1. OAHS PMC Charts Reviewed by Provider

Provider	Charts Reviewed # (% of total)
Baltimore City Health Department Clinics	30 (7.4%)
Chase Brexton Health Services	38 (9.3%)
Health Care for the Homeless	25 (6.1%)
Johns Hopkins Bayview Comprehensive Care Practice	25 (6.1%)
Johns Hopkins HIV Women's Health Program	24 (5.9%)
Johns Hopkins Moore Clinic	39 (9.6%)
Johns Hopkins Pediatrics	12 (2.9%)
Park West Medical Center	25 (6.1%)
People's Community Health Centers	25 (6.1%)
Sinai Hospital	25 (6.1%)
University of Maryland Evelyn Jordan Center	40 (9.8%)
University of Maryland Institute of Human Virology	24 (5.9%)
University of Maryland Medical Center - Midtown	25 (6.1%)
University of Maryland PACE Clinic	25 (6.1%)
University of Maryland STAR TRACK	26 (6.1%)
Total	**408 (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 semiannual documentation of residency in the Baltimore-Towson EMA, income, and third party payer capacity.

All charts documented that the client was HIV positive. Figures 1 and 2 show the proportion of charts that documented residency and income. At least 83% of charts documented initial verification of the client's residency and income. Updates for residency and income were documented in at least 74% of charts. Charts were excluded from analysis when documentation was missing from the tool and when the client was ineligible for an update (i.e., one visit or less than 6 months of service in the review period).

Reviewers looked at documentation of insurance at any time in the review period (not shown). A majority of charts documented Medicaid (30%) or PAC coverage (29%). Other documented insurance included Medicare (11%), MHIP (7%) and private (7%). Note: This information does not imply that Ryan White was not the payer of last resort for clients receiving OAHS-PMC services.

Figure 1. Residency Eligibility Documentation, n=391

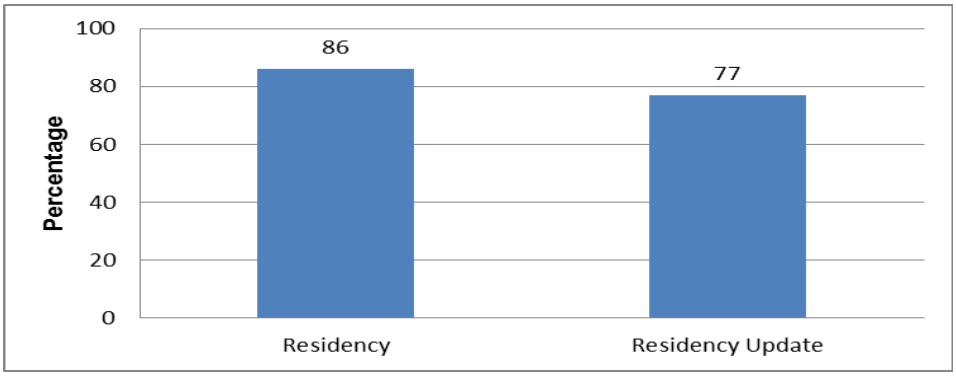
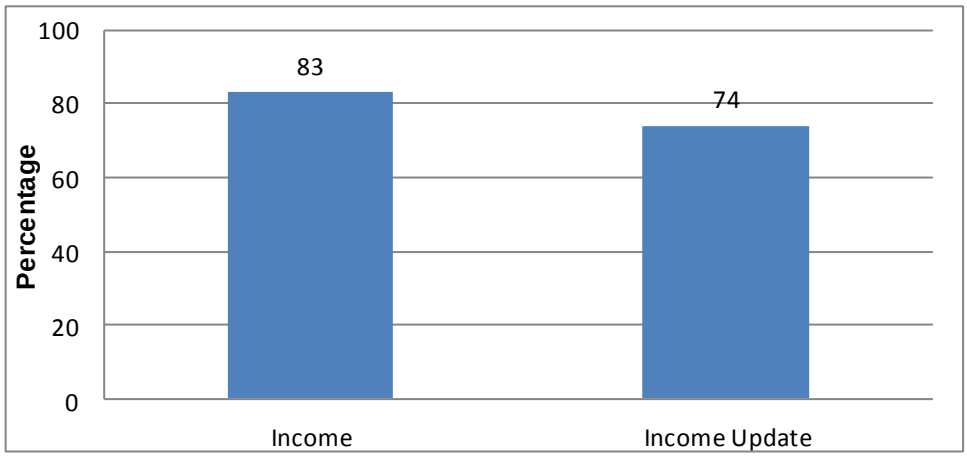


Figure 2. Income Eligibility Documentation, n=384



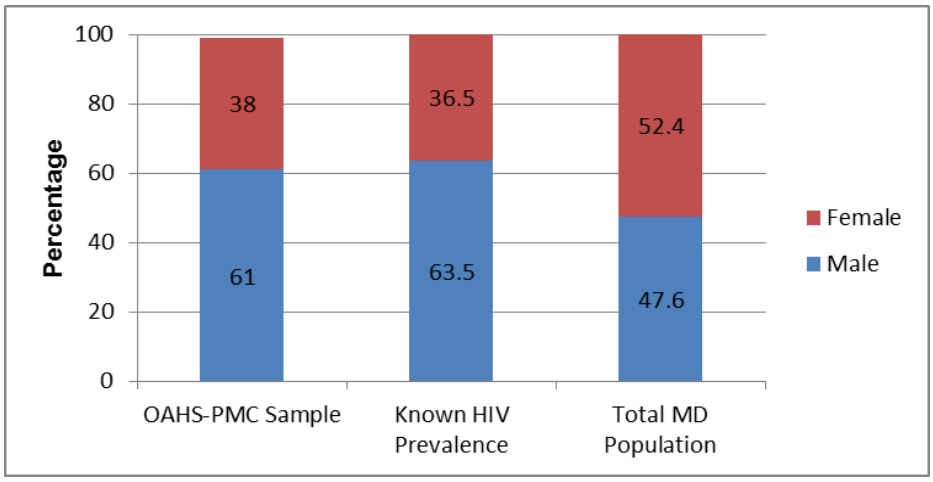
DEMOGRAPHICS

This section presents demographic data for the sampled 408 adult and pediatric clients receiving OAHS-PMC services between March 1, 2012 and February 28, 2013.

Gender

Males comprised 61% of the sample and females, 38% (Figure 3). About 1% documented gender as transgender, all of which were male-to-female (not shown). Although the OAHS-PMC sample mirrors the known HIV prevalence in the EMA, men are disproportionately impacted by HIV compared to their share of the general population.

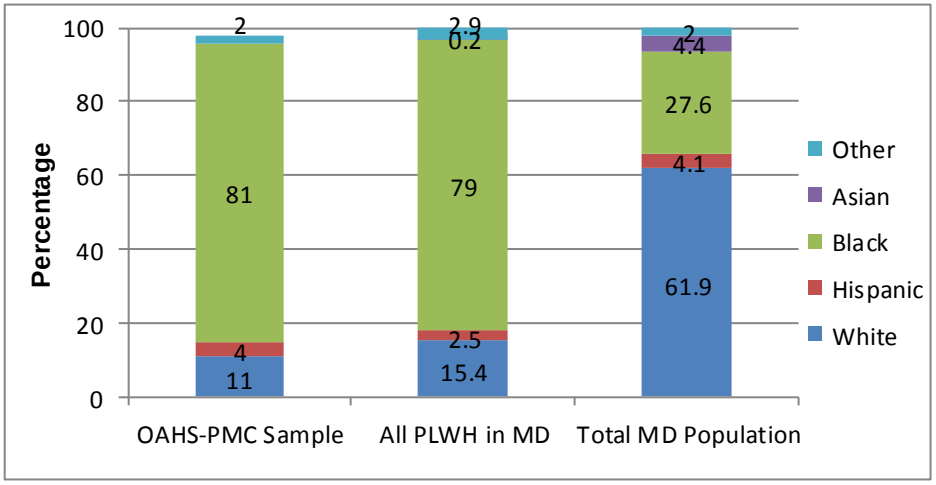
Figure 3. Gender by Sample



Race/Ethnicity

Figure 4 shows that a majority of the sample was African American (81%). Caucasians and Hispanics made up 11% and 4% of the sample, respectively. There is a continued overrepresentation of African-Americans infected with HIV compared to the general population.

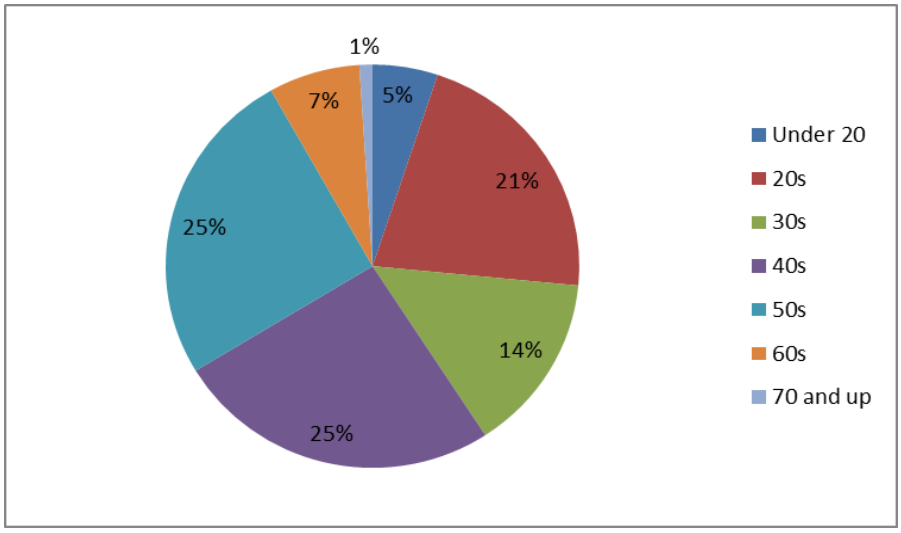
Figure 4. Race by Sample



Age

Client's date of birth was missing for three client charts reviewed. Figure 5 shows that 50% of clients were in their forties and fifties. Clients aged in their twenties were the next largest age group at 21%. Lesser proportions of clients were under age 20, in their thirties or over age 60.

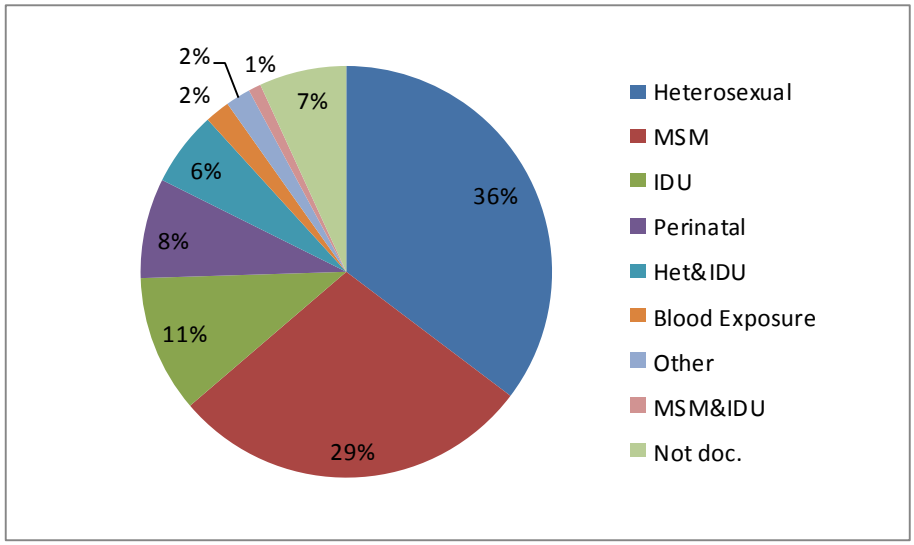
Figure 5. Age of OAHS-PMC Sample



Risk Factor

A majority of charts documented risk factor. Heterosexual and men who have sex with men (MSM) contact were each documented in 36% and 29% of charts, respectively (Figure 6). Injection drug use (IDU) was the documented risk factor in 11% of charts and perinatal exposure in 8%. Note: The total percentages for risk factors exceeded 100% as some charts documented more than one risk factor.

Figure 6. Risk Factor for OAHS-PMC Sample



RECORD ABSTRACTION

ADULT/ADOLESCENT

All adult/adolescent clients receiving primary care services were assessed for laboratory values (i.e., CD4 and viral load values). Charts were also assessed for adherence to the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) Clinical Performance Measures for Adults and Adolescents (2008-2011). Note: while sample sizes are indicated in Table 1, the N will vary by indicator based on client exclusions in instances where the indicators were not applicable.

Laboratory Values

There were 398 adult/adolescent clients in the OAHS-PMC sample. All OAHS-PMC adult/adolescent charts were reviewed for documentation of HAART status, CD4 and viral load values. A majority of clients were on HAART therapy at some point during the review period (89%) while about 11% were not on HAART. Approximately 1% of those not on HAART were treatment naïve.

The last CD4 and viral load values documented in the review period were recorded. CD4 and viral load values were each recorded for 390 (98%) of charts reviewed. Figure 7 shows the distribution of documented CD4 values, where a majority, 69%, were >350 cells/mm^3. A smaller proportion (4%) of CD4 values were <50 cells/mm^3. 14% of charts documented values less than 200 cells/mm^3, indicating the client was AIDS defined.

Figure 8 shows distribution of viral load for all clients. 69% of the charts reviewed documented viral load values below 200 copies/mL. More than half (58%) of charts documented a viral load below 50 copies/mL and 11% of values were between 50 and 200 copies/mL at the last test. Four percent of viral loads were >100,000 copies/mL. HIV resistance tests were appropriate (HIV RNA levels >1,000 copies/mL) in 57% (226) of the charts reviewed; of these, 77% documented that resistance testing was performed in the review period (not shown).

Figure 7. Distribution of CD4 Values, n=390

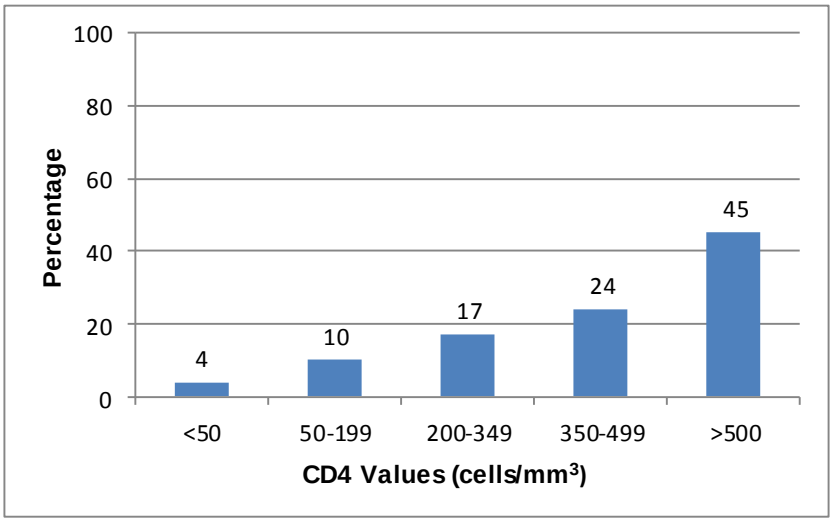
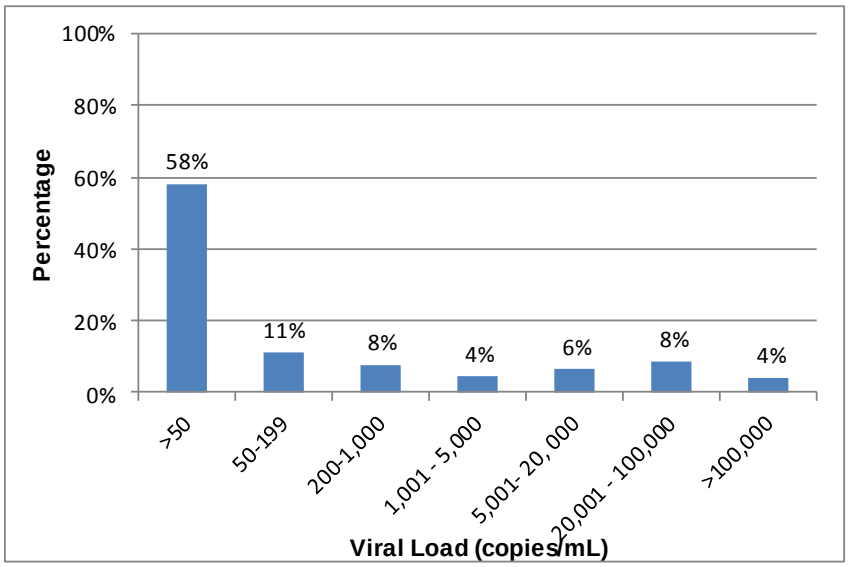


Figure 8. Distribution of Viral Load Values, n=390



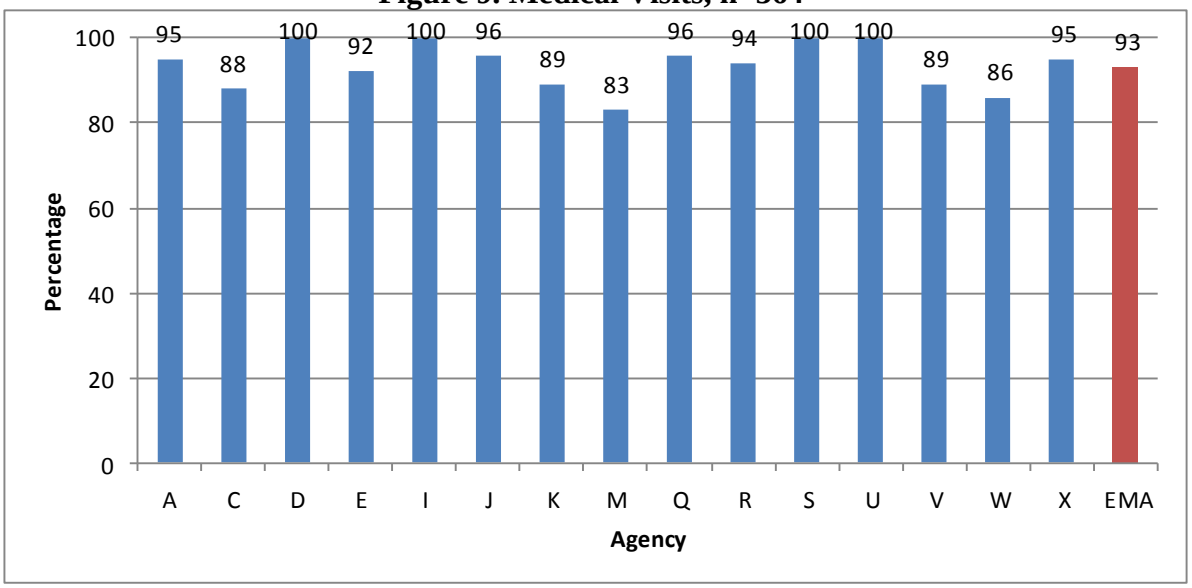
HRSA HAB Performance Measures

The HRSA HAB performance measures are used to assess vendor-level and EMA-wide compliance to clinical guidelines. Data collected through the performance measures provide an indication of an organization's performance, and identify strengths and areas in need of improvement. Each measure is presented along with vendor level and EMA compliance rates.

Medical Visits

The medical visits measure is defined as the percentage of clients with HIV infection who had two or more medical visits at least three months apart in the measurement year. Figure 9 illustrates the range of performance for this indicator across agencies, along with the average rate of compliance for the EMA. On average, 93% of clients were seen as indicated.

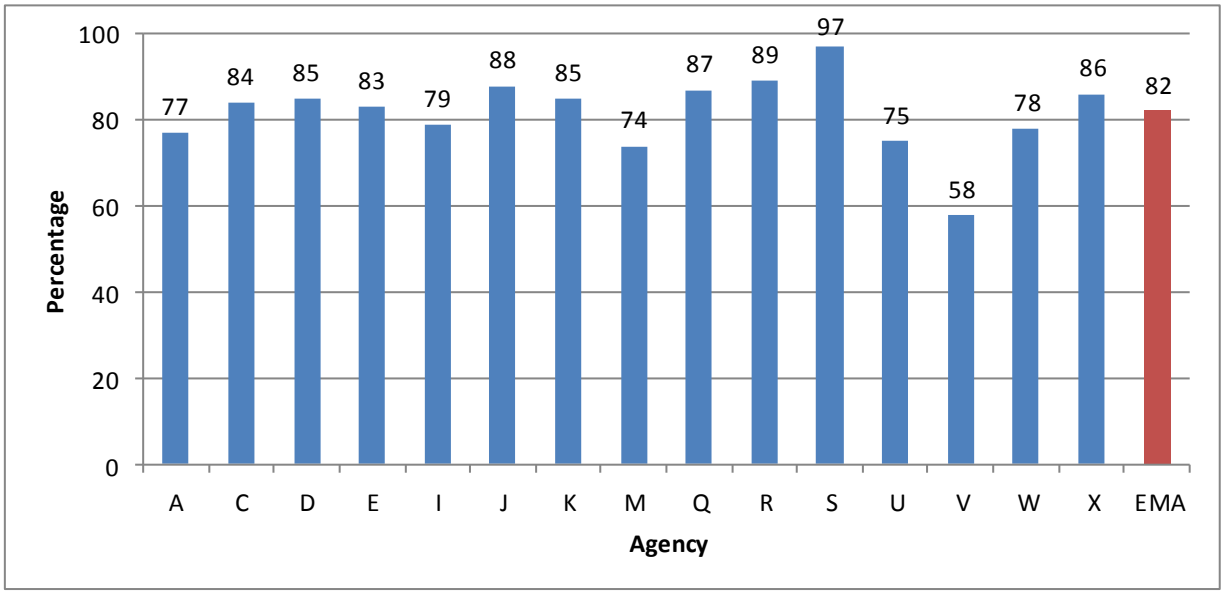
Figure 9. Medical Visits, n=364



CD4 Tests

The CD4 T-cell count measure is defined as the percentage of clients with HIV infection who had two or more CD4 T-cell counts performed at least three months apart during the measurement year. Figure 10 shows that EMA-wide, 8 in 10 clients had regular CD4 tests performed.

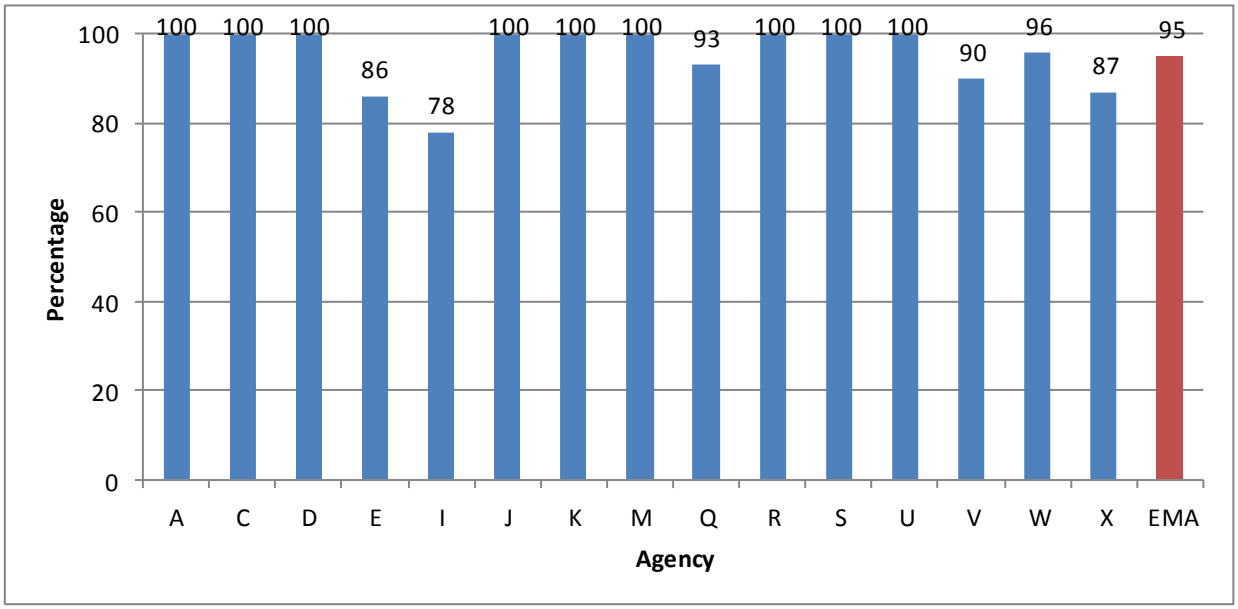
Figure 10. CD4 Tests, n=364



HAART Prescription

The HAART measure is defined as the percentage of clients with AIDS who were prescribed a HAART regimen within the measurement year. EMA-wide, 95% of AIDS defined clients were prescribed HAART, Figure 11.

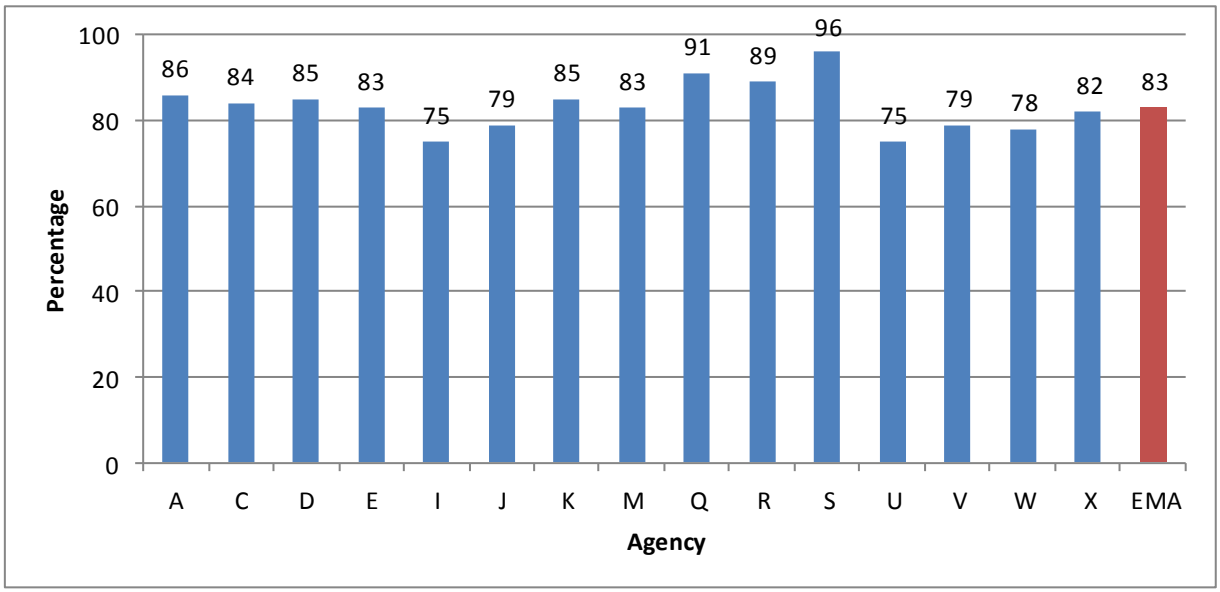
Figure 11. HAART Prescription, n=146



Viral Load Monitoring

CQM defined viral load monitoring as the percentage of clients with HIV infection who had two or more viral load tests performed at least three months apart in the measurement year. Figure 12 shows that overall about 8 in 10 charts were compliant with this measure.

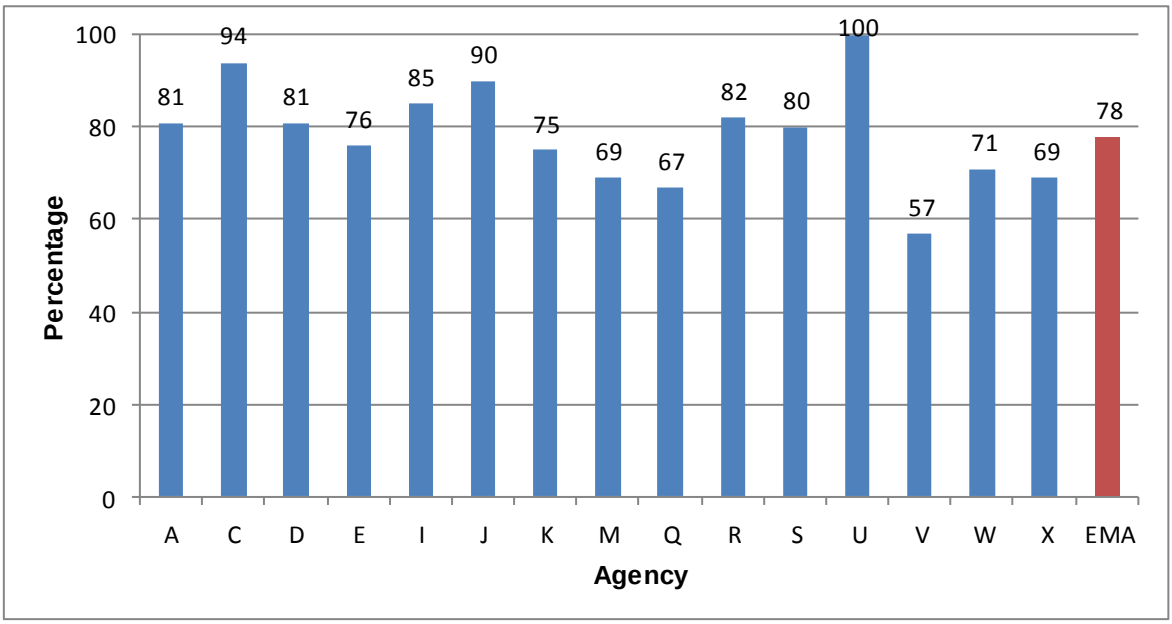
Figure 12. Viral Load Monitoring, n=364



Viral Load Suppression

CQM defined viral load suppression as the percentage of clients with at least two medical visits in the year who were on HAART and had viral load values <200 copies/mL at the last test during the measurement year. EMA wide, 78% of clients were virally suppressed (Figure 13).

Figure 13. Viral Load Suppression, n=305



PCP & MAC Prophylaxis

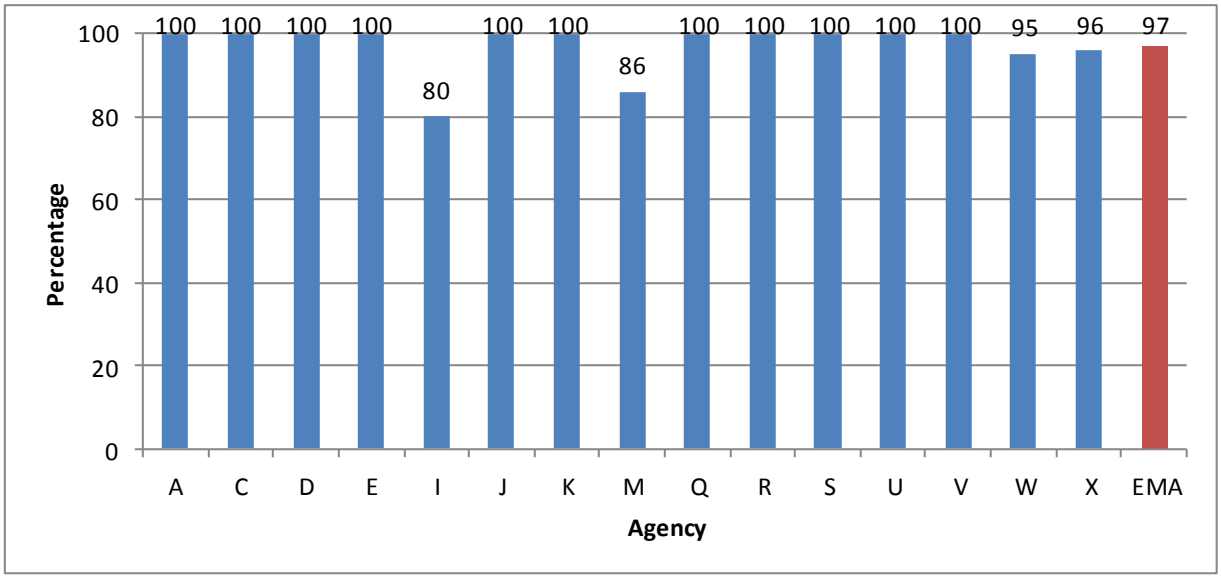
The PCP prophylaxis measure is the percentage of clients with a CD4 count <200 cells/mm^3 who were prescribed PCP prophylaxis. EMA-wide, 71 clients were clinically indicated for this measure; of these 62 (87%) charts documented PCP prophylaxis.

The MAC prophylaxis measures is the percentage of clients with CD4 count <50 cells/mm^3 who were prescribed Mycobacterium avium Complex (MAC) prophylaxis in the measurement year. EMA-wide, 30 clients were clinically indicated for this measure; of these 22 (73%) charts documented adherence to this measure.

Hepatitis B (HBV) Screening

The HBV measure is defined as the percentage of patients (for whom there was no documentation of HBV infection or immunity) screened for HBV since HIV diagnosis. Documentation at most agencies exceeded the EMA average (97%) for this measure, Figure 14.

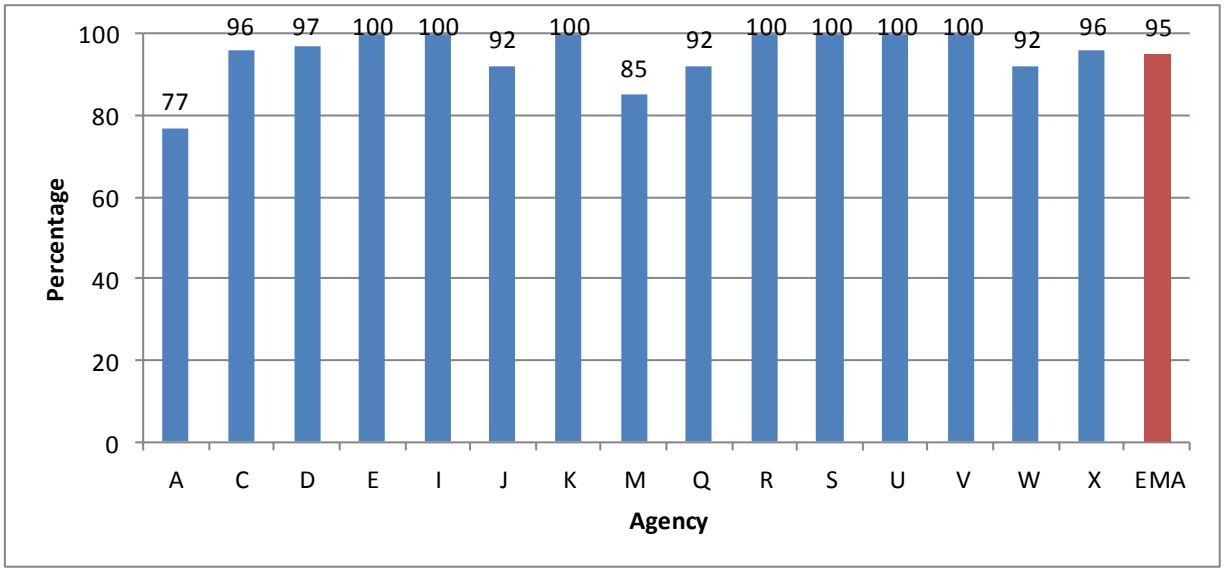
Figure 14. HBV Screening, n=353



Hepatitis C (HCV) Screening

HCV screening refers to the percentage of clients for whom there was no documentation of HCV infection and for whom HCV screening was performed at least once since diagnosis of HIV infection. Average HCV screening across the EMA stands at 95%, Figure 15.

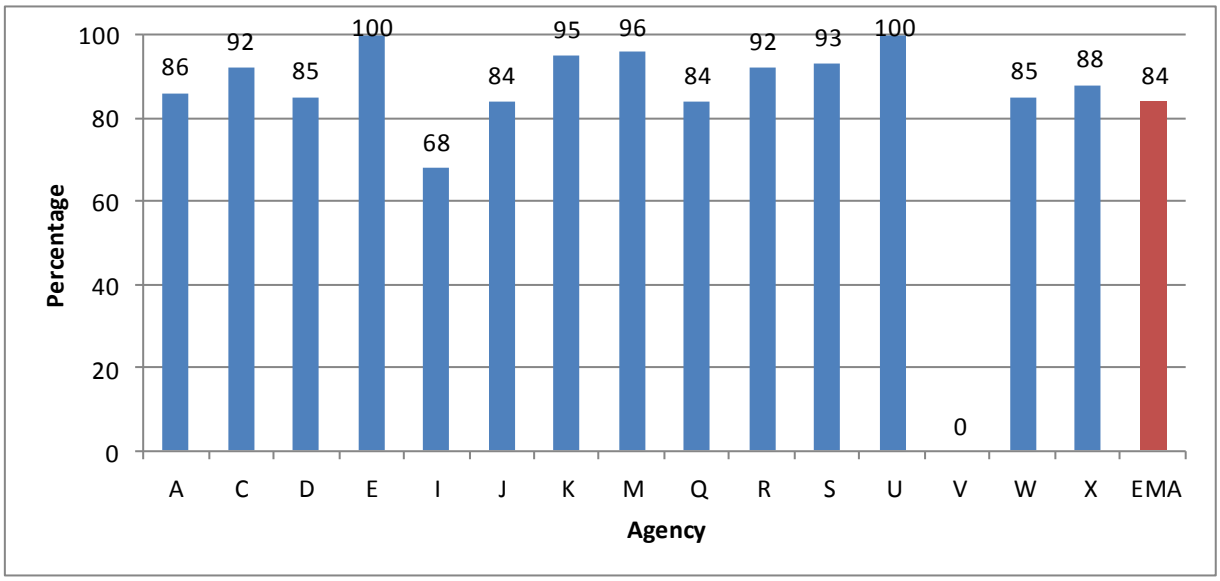
Figure 15. HCV Screening, n=395



Toxoplasma Screening

The toxoplasma screening measure is defined as the percentage of clients who received screening at least once since diagnosis of HIV infection. On average, 84% of charts documented compliance with this measure across the EMA, Figure 16

Figure 16. Toxoplasma Screening, n=393



Chlamydia and Gonorrhea Screening

Figures 17 and 18 show the percentage of clients with HIV infection at risk for sexually transmitted infection (STI) who had a test for Chlamydia or gonorrhea within the measurement year. Average screening rates across the EMA for Chlamydia and gonorrhea were 72% and 71%, respectively.

Figure 17. Chlamydia Screening, n=372

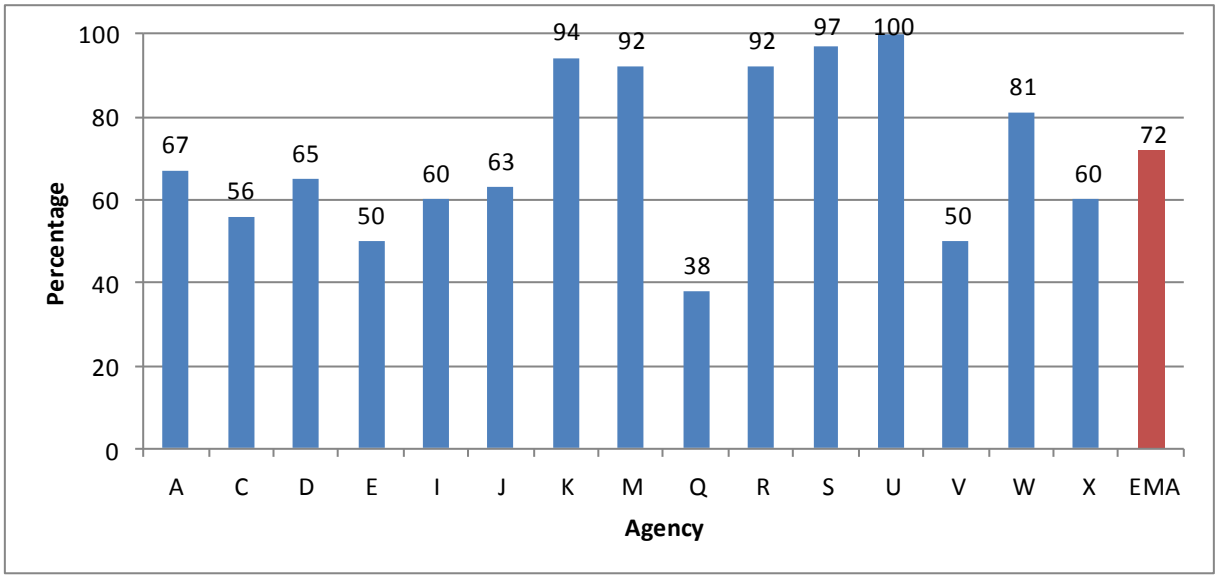
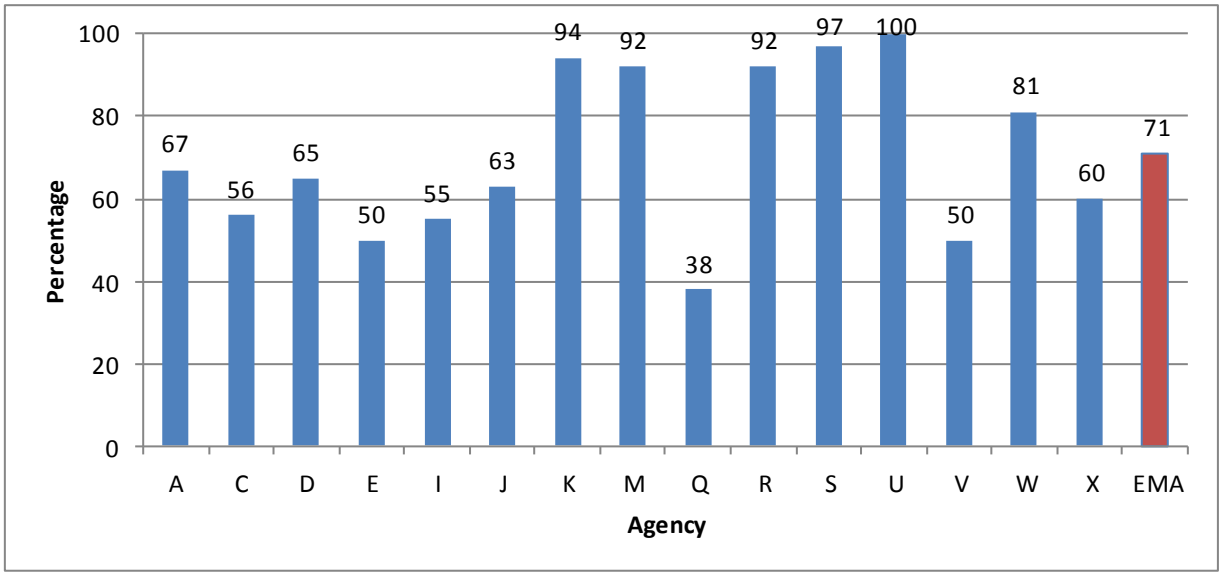


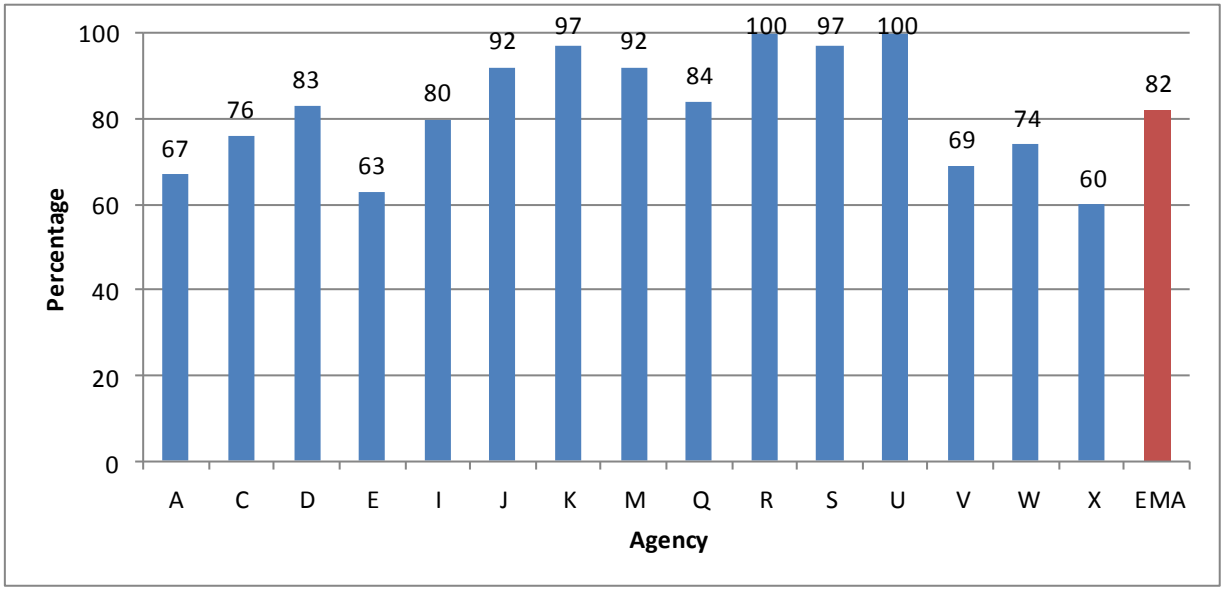
Figure 18. Gonorrhea Screening, n=372



Syphilis Screening

This measure refers to the percentage of adults who had a test for syphilis performed within the measurement year. EMA-wide, 82% of charts documented syphilis screening (Figure 19). Twenty-nine clients tested positive for syphilis; of those, treatment was documented for 24 (83%).

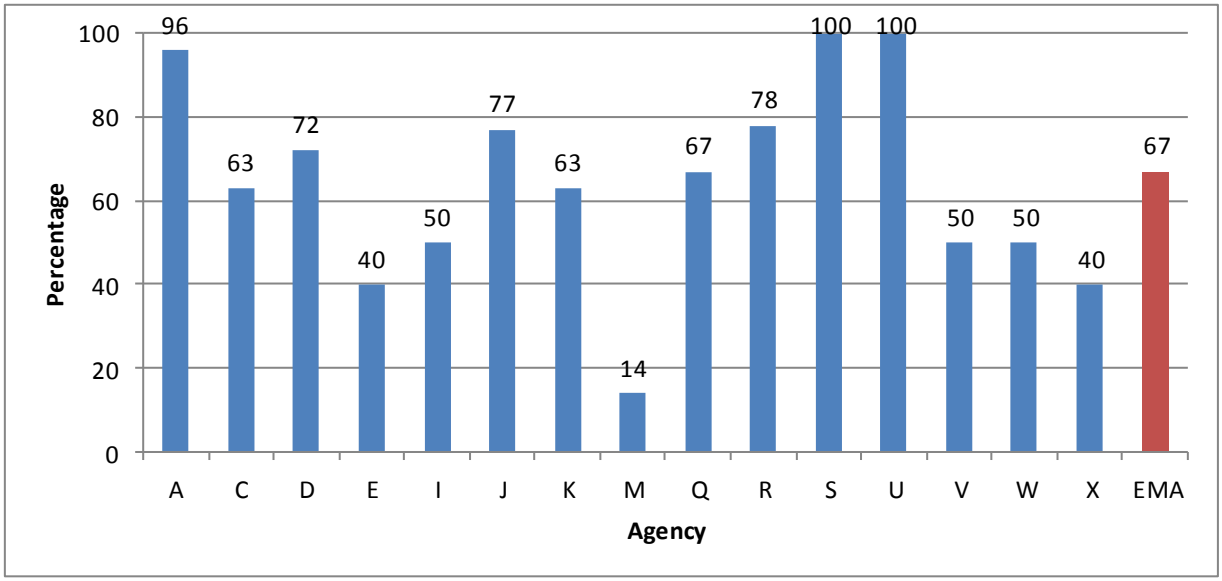
Figure 19. Syphilis Screening, n=395



Cervical Cancer Screening /ARV Therapy for Pregnant Women

The records for female clients were also abstracted for cervical cancer screening. The EMA average for cervical cancer screening was 67%, Figure 20. Thirty-three clients had abnormal screening results; of those 27 (82%) were sent for colposcopy (not shown). Charts were also abstracted for the prescription of antiretroviral therapy for pregnant women (not shown). Of the four documented pregnancies, all clients were prescribed ARV.

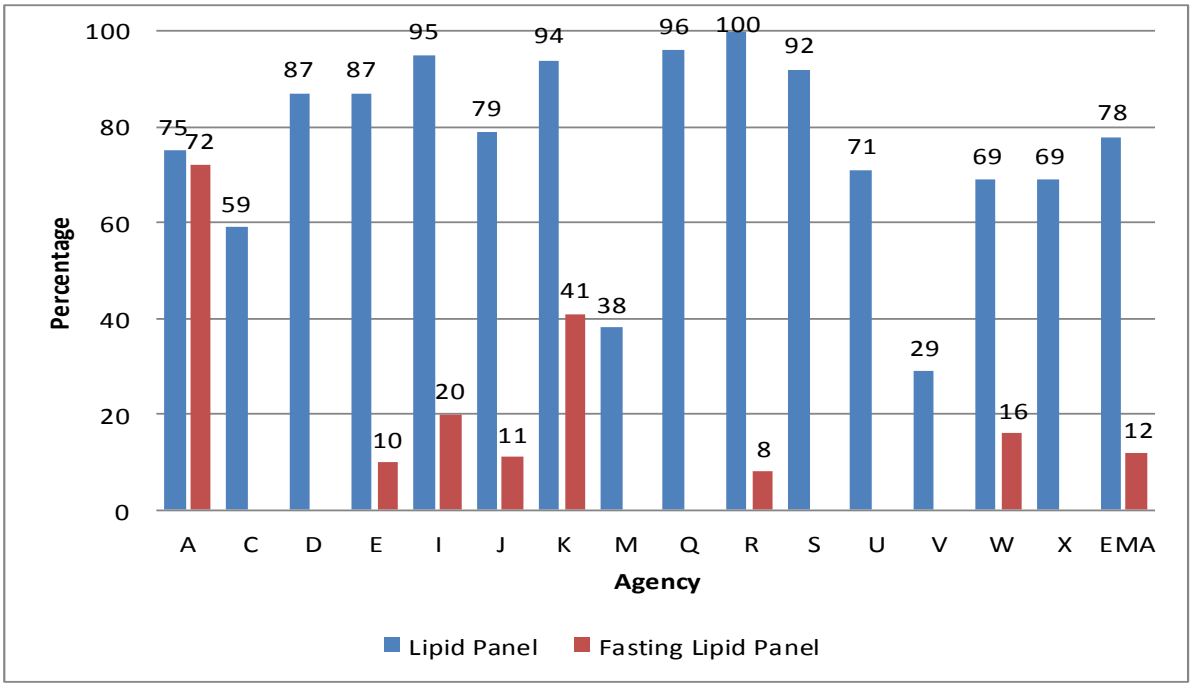
Figure 20. Cervical Cancer Screening, n=140



Lipid Screening

Lipid screening refers to the percentage of clients who were prescribed HIV antiretroviral therapy and had a fasting lipid panel during the measurement year. The EMA average showed that 12% of charts documented fasting lipid panels, Figure 21. A majority of records contained a lipid panel, however it was often unclear whether or not the client was fasting when it was drawn.

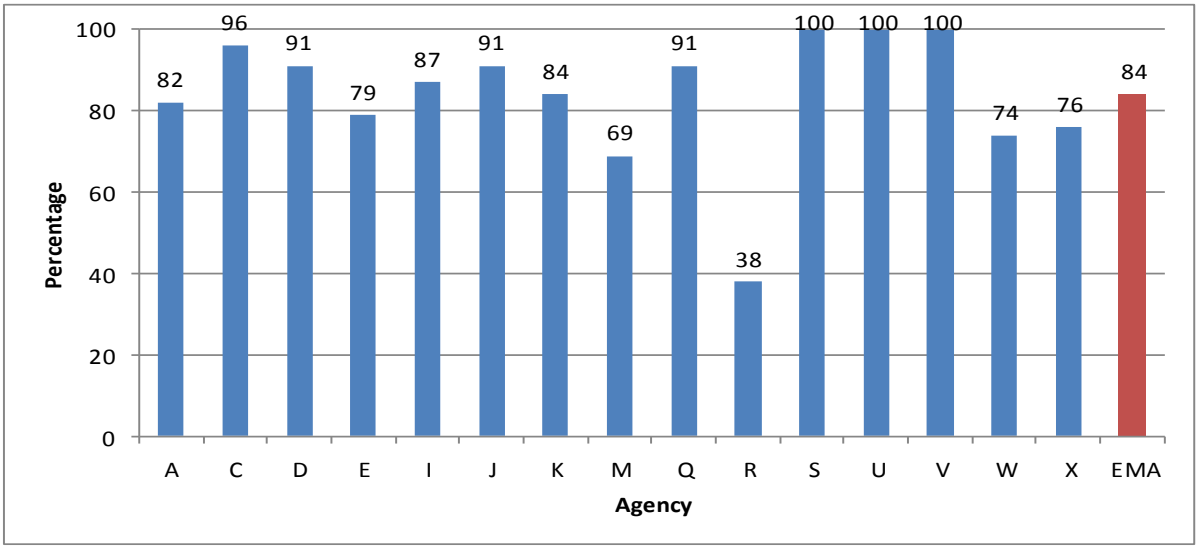
Figure 21. Lipid Screening, n=357



Latent Tuberculosis (TB) Screening

Figure 22 presents the percentage of clients who received testing with results for latent TB infection since HIV diagnosis. 84% of charts documented latent TB screening. Eight clients were positive for TB. Three had active TB. All infected clients received treatment.

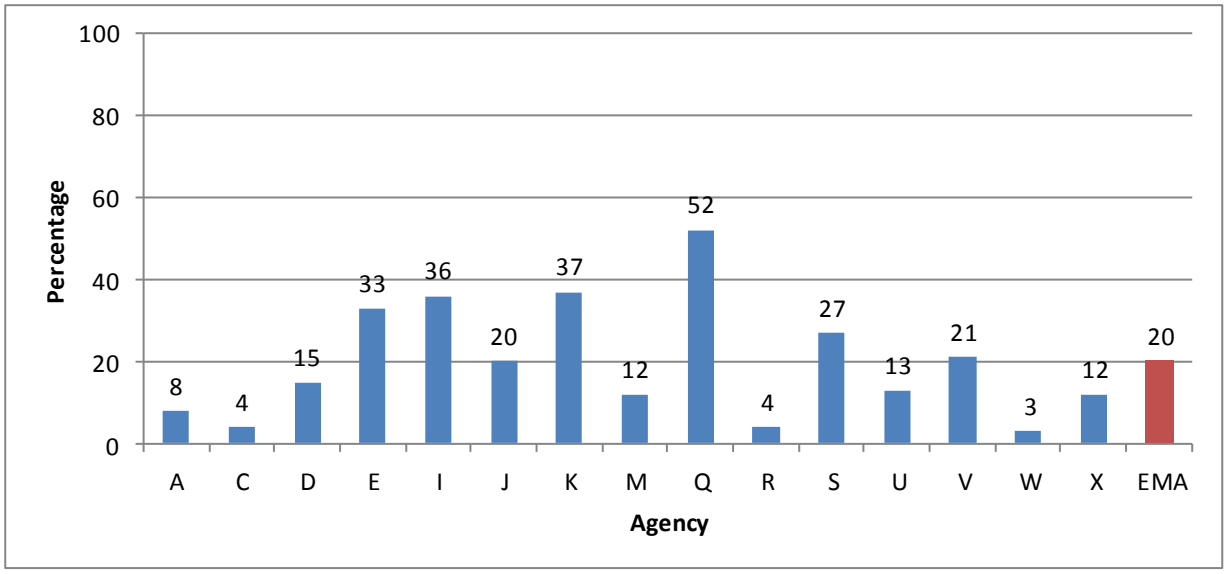
Figure 22. Latent TB Screening, n=377



Oral Examination

Oral exams refer to the percentage of clients who received an oral exam by a dentist at least once during the measurement year. 20% of charts EMA-wide documented oral exams, Figure 23. Reviewers also abstracted referrals for an oral exam. A quarter of charts (99) documented the client had been referred for an exam (not shown).

Figure 23. Oral Exam, n=398



Substance Use & Mental Health Screening

The substance use and mental health screenings measures refer to the percentage of *new* clients screened for alcohol and drugs and mental health during the measurement year. A client was considered new if care began on or after March 1, 2012. 96% of charts documented substance use screening (Figure 24) and 85%, mental health screenings (Figure 25). There were no new charts reviewed at one site.

Figure 24. Substance Use Screening, n=106

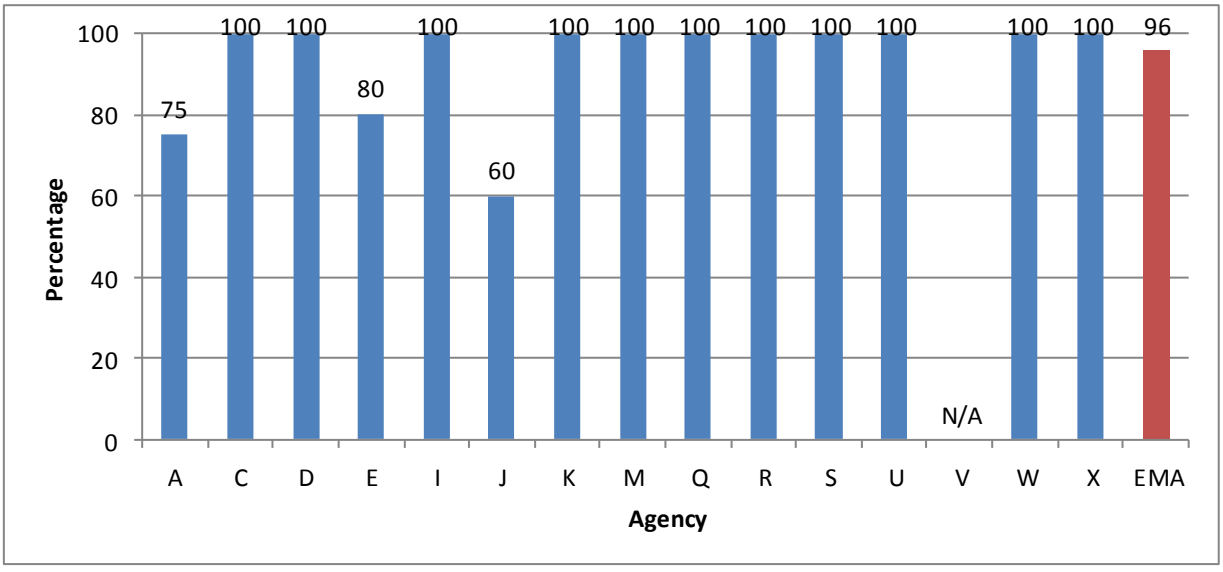
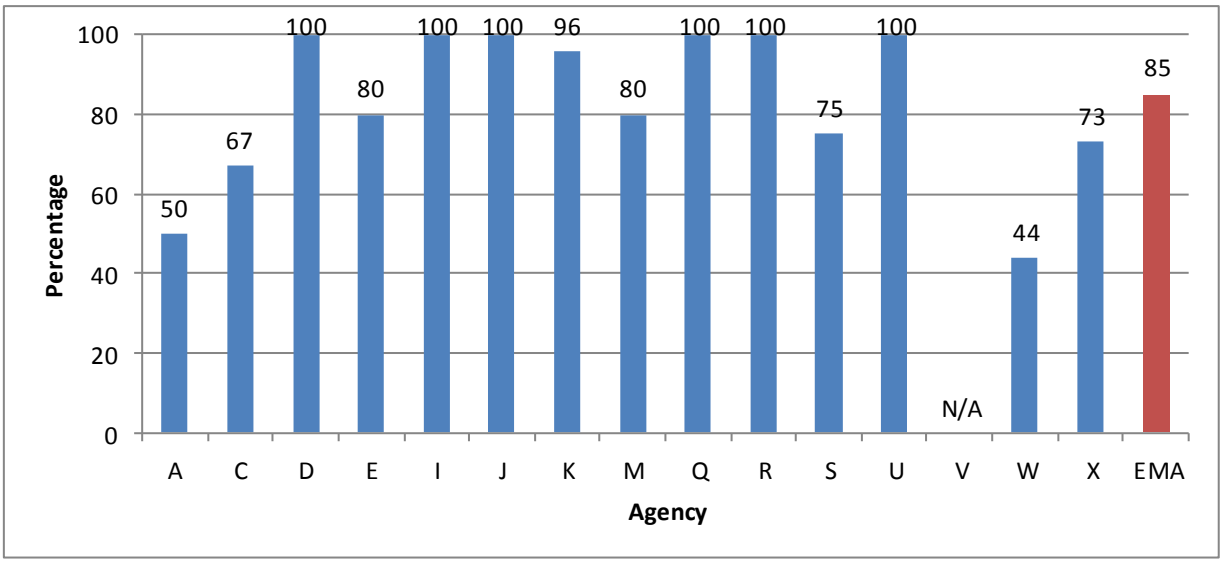


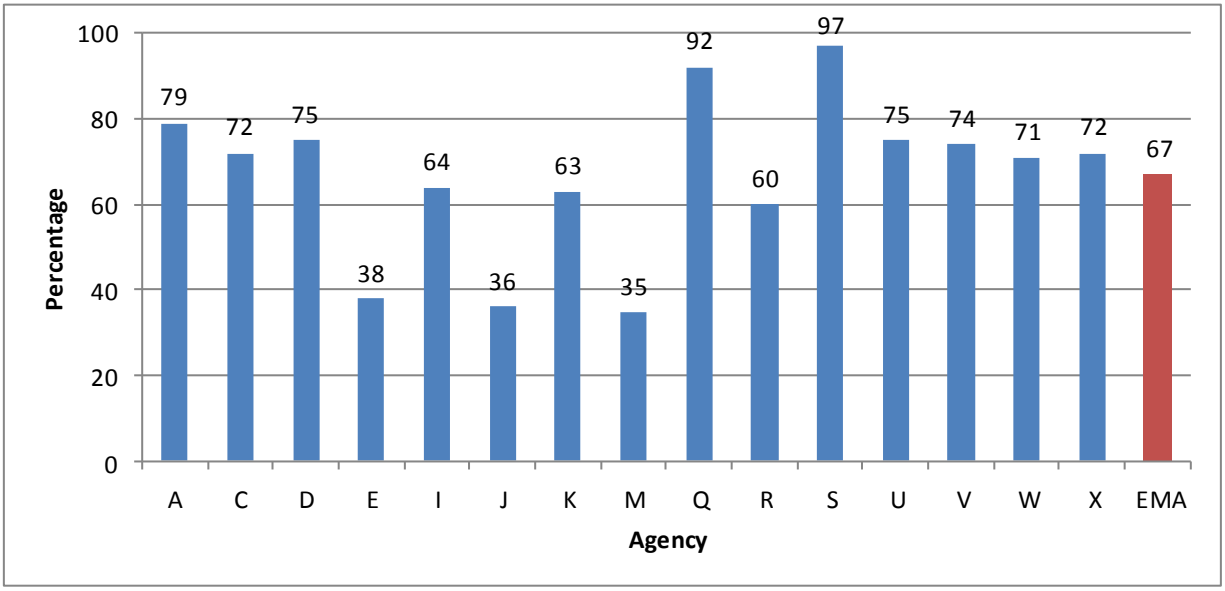
Figure 25. Mental Health Screening, n=106



Influenza Vaccination

Charts were also abstracted for the percentage of patients receiving an influenza vaccination within the measurement year. Roughly two-thirds of EMA charts documented flu vaccination, Figure 26. In some instances, the flu vaccine was deferred for clinical reasons (4 clients) or the client declined (20 clients), data not shown.

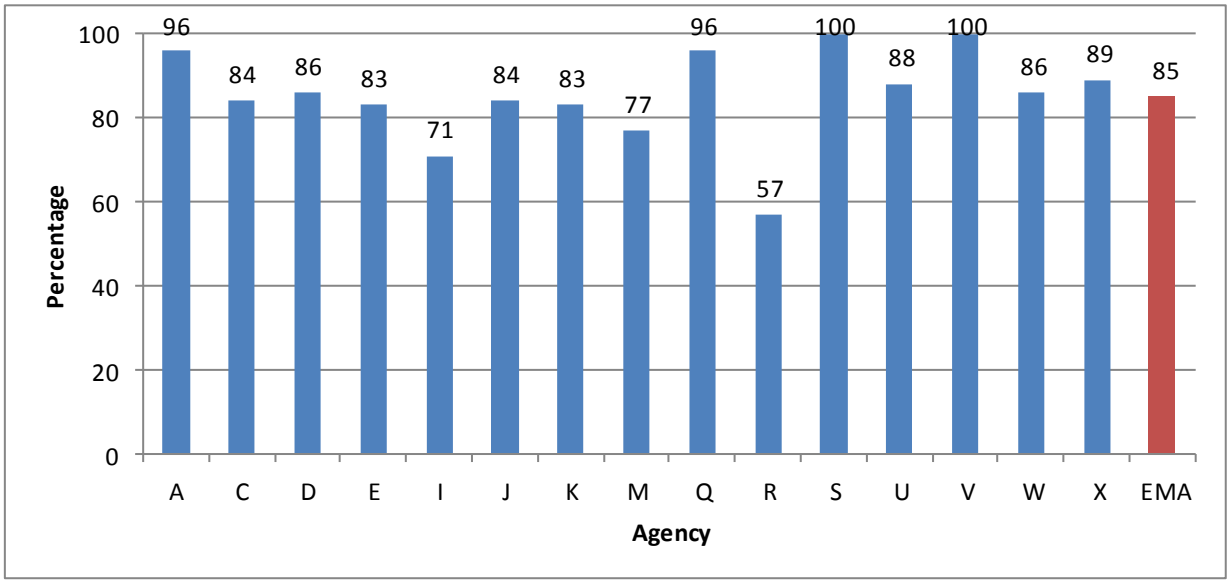
Figure 26. Influenza Vaccination, n=398



Pneumococcal Vaccination

Figure 27 shows the percentage of clients who received pneumococcal vaccination since HIV diagnosis. The EMA average for this measure was 85%.

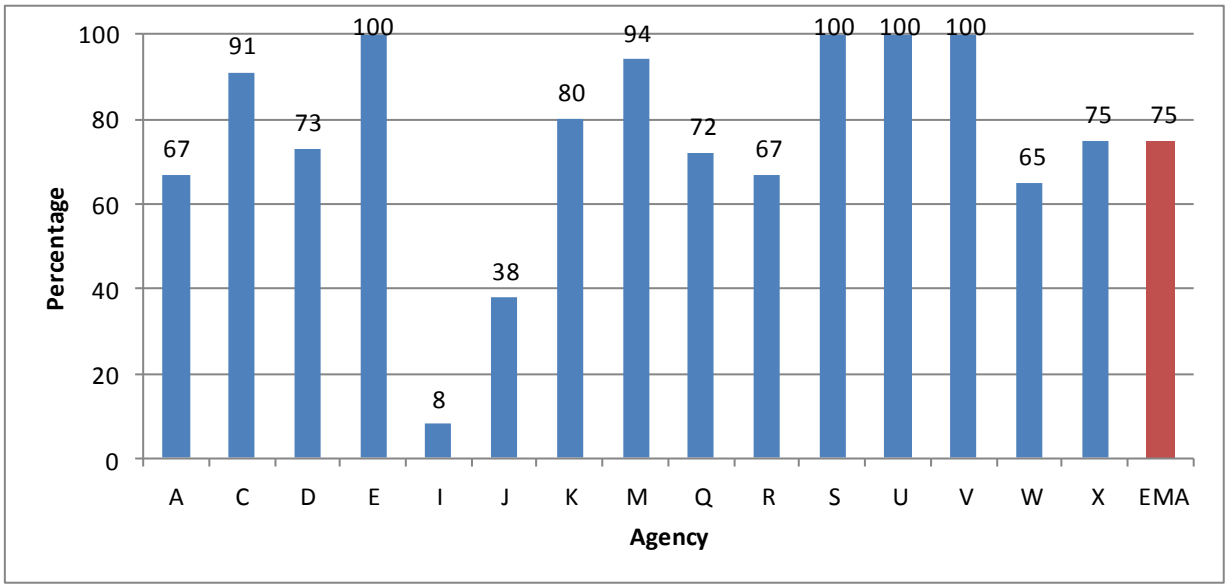
Figure 27. Pneumococcal Vaccination, n=385



Hepatitis B Vaccination

The Hepatitis B Vaccination measure is defined as the percentage of clients without documented HBV infection or immunity who have ever completed the HBV series. Three-quarters of EMA charts reviewed documented completion of the HBV series, Figure 28.

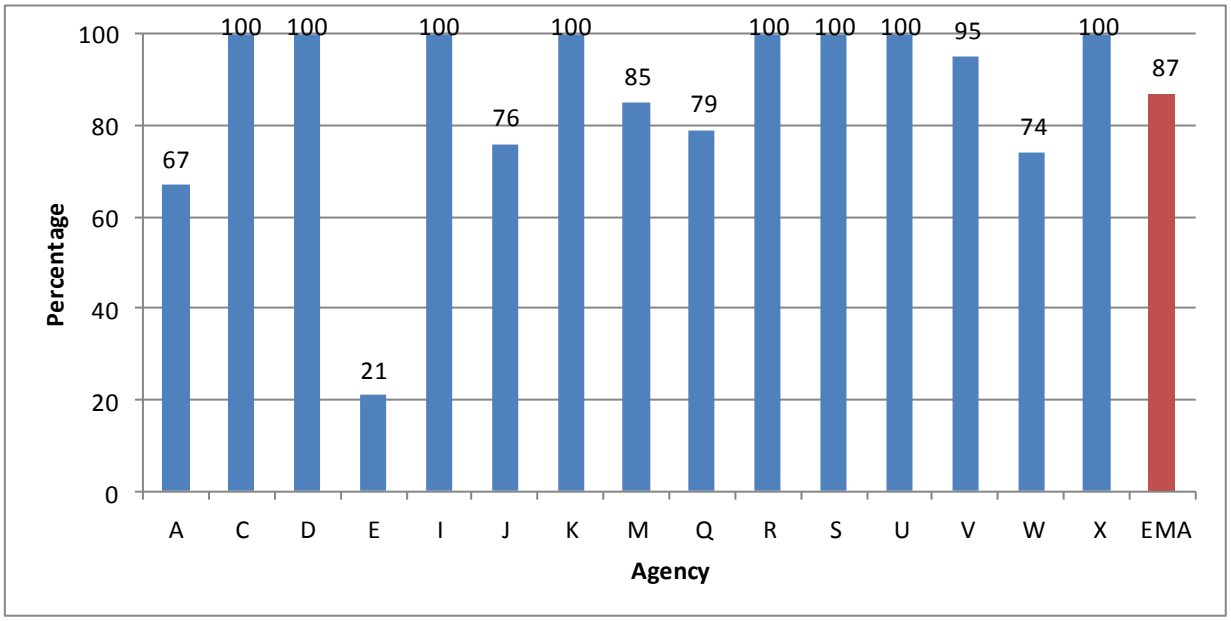
Figure 28. Hepatitis B Vaccination, n=180



HIV Risk Counseling

Figure 29 shows the percentage of clients who received HIV risk counseling within the measurement year. Eight in ten charts across the EMA documented HIV risk counseling.

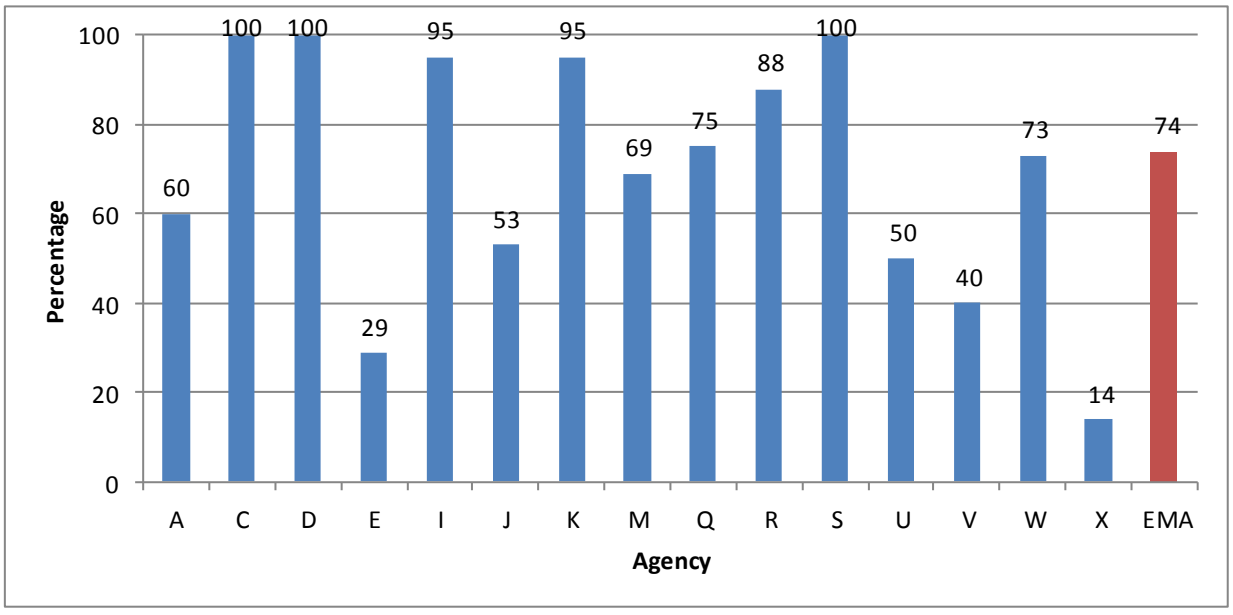
Figure 29. HIV Risk Counseling, n=398



Tobacco Cessation Counseling

Tobacco cessation counseling is defined as the percentage of clients who received tobacco cessation counseling within the measurement year. Clients who did not smoke were excluded from analysis. On average, 74% of charts reviewed documented tobacco cessation counseling, Figure 30.

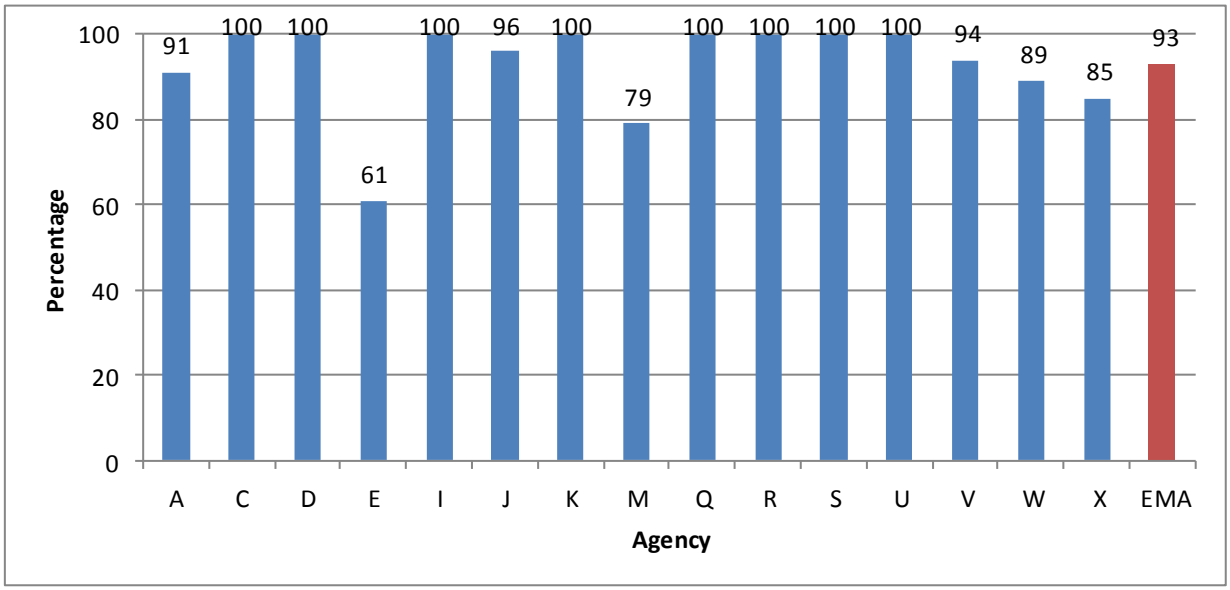
Figure 30. Tobacco Cessation Counseling, n=222



Adherence Assessment and Counseling

Figure 31 shows the percentage of clients with HIV infection on antiretroviral therapy who were assessed and counseled for adherence two or more times in the measurement year. Adherence assessment and counseling was documented in 93% of all charts reviewed.

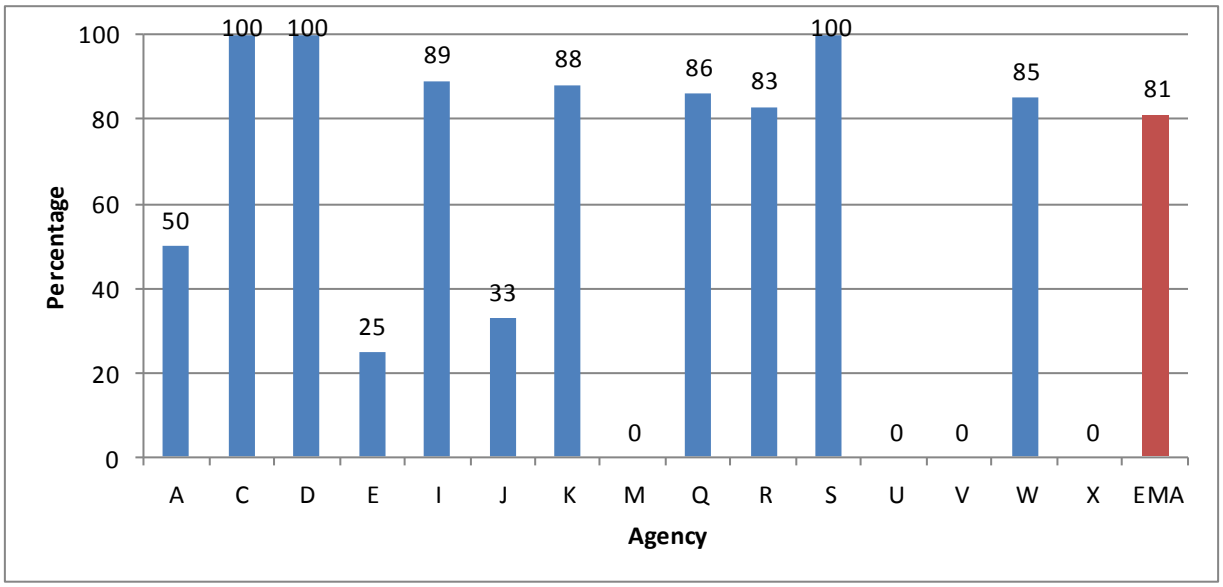
Figure 31. Adherence Assessment and Counseling, n=337



Hepatitis/HIV Alcohol Counseling

The Hepatitis/HIV Alcohol counseling measure refers to the percentage of clients with HIV and Hepatitis B or Hepatitis C infection who received alcohol counseling within the measurement year. Clients with no history of alcohol use, or with immunity to Hepatitis or without a diagnosis of HBV or HCV were excluded from this measure. Figure 32 shows the EMA average for this measure was 81%.

Figure 32. Hepatitis/HIV Alcohol Counseling, n=88



HIV Disclosure & Transition Planning

HIV disclosure refers to the percentage of clients (aged 13 to 24) who know their HIV status, or for whom there is a documented discussion about disclosure between the provider and guardian in the measurement year. All 53 (100%) client charts documented that the client knew their status or that a discussion had been documented.

Health Care Transition Planning for HIV-infected youth is defined as the percentage of adolescents who had a discussion about health care transition planning from an adolescent care site to an adult care site in the measurement year. Clients newly diagnosed with HIV in the measurement year and those younger than 17 were excluded from this measure. Of the 42 charts, 55% (23) documented a discussion about health care transition planning. At one agency, discussions about transition planning do not occur until the client is aged 24 which accounts for the low adherence to this measure.

PEDIATRICS

Adherence to pediatric indicators was abstracted for HIV-exposed infants and for HIV positive children through age 12.

Exposed Infants

Eight clients were born to HIV infected mothers during the measurement year. Adherence to the following measures was assessed: HIV testing to exclude HIV infection, neonatal zidovudine (ZDV) prophylaxis, developmental surveillance, and PCP prophylaxis. All (100%) charts documented testing to exclude HIV infection, ZDV prophylaxis and developmental surveillance. PCP prophylaxis is necessary for infants with indeterminate HIV infection status until they are determined to not be infected with HIV. Documentation of PCP prophylaxis was found in the one chart for which it was applicable (100%).

HIV positive children

Two records of HIV positive children were abstracted for adherence to the following measures: MMR vaccination, medical visits, developmental surveillance, CD4 testing, PCP prophylaxis, HIV resistance testing, ARV therapy, adherence assessment and counseling, lipid screening, and TB screening.

MMR vaccination and documentation of at least three medical visits in the year was documented in the one chart for which it was indicated (Note: this measure excludes clients who began care after June of the measurement year).

Both charts (100%) documented CD4 testing, developmental surveillance, ARV therapy, adherence assessment and counseling and tuberculosis screening. Lipid screening was documented in one chart. PCP prophylaxis was not indicated for either client due to the client's age and/or CD4 count. Resistance testing was not indicated for either client because both had begun ARV before the measurement year.

CONSUMER SURVEYS

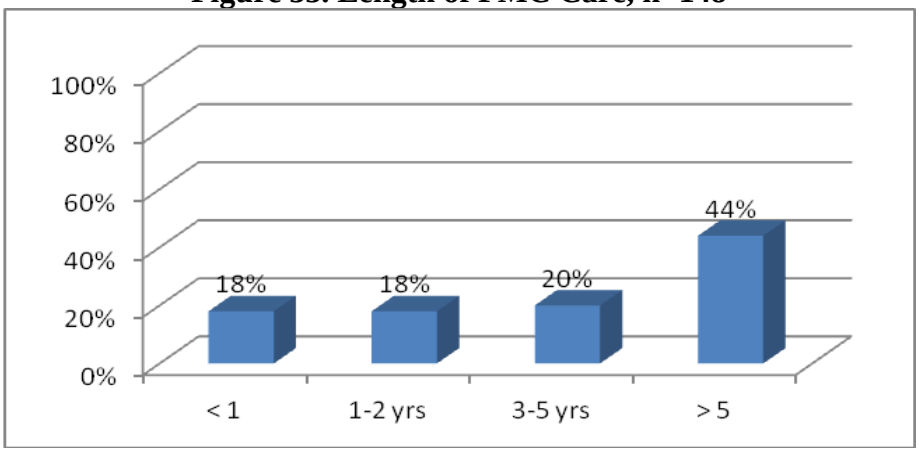
Agency compliance to the primary medical care (PMC) standards of care was assessed through a survey of clients currently receiving PMC services. Consumers were directly recruited from agencies funded by Ryan White Part A. Consumers were surveyed about their primary care experiences during the past twelve months. A total of 148 primary care consumers were interviewed at 13 of the 15 sites providing PMC surveys. Consumer interviews were not conducted at pediatric sites. Surveys were administered in person by CQM staff. The consumers represented a convenience sample. Note: Results may total above or below 100% due to rounding.

Current primary care clients at the fifteen adult agencies reviewed were asked to complete a 28-item survey to provide another method of assessment of the agencies' compliance with the Standards of Care. The questions focused on the services provided, the patient's knowledge of their care as well as their satisfaction with services. Demographic data were also collected. .A $25 incentive card to a local retailer or grocer was provided for completion of the survey.

Length of Time in Care

Figure 33 indicates how long clients have been in care at their respective primary medical care agencies. More than half 56% of consumers were in care less than 5 years.

Figure 33. Length of PMC Care, n=148



PMC Assignment and Care Planning

Almost all (98%) clients reported having assigned primary care physicians. Eighty-nine percent reported they had developed a medical care plan with agency staff. In addition, 96% were assigned a medical case manager.

Seventy-two percent of clients attempted to contact their primary care programs by telephone at some point in the past 12-months. Of those, virtually all (98%) reported that they received the help they needed.

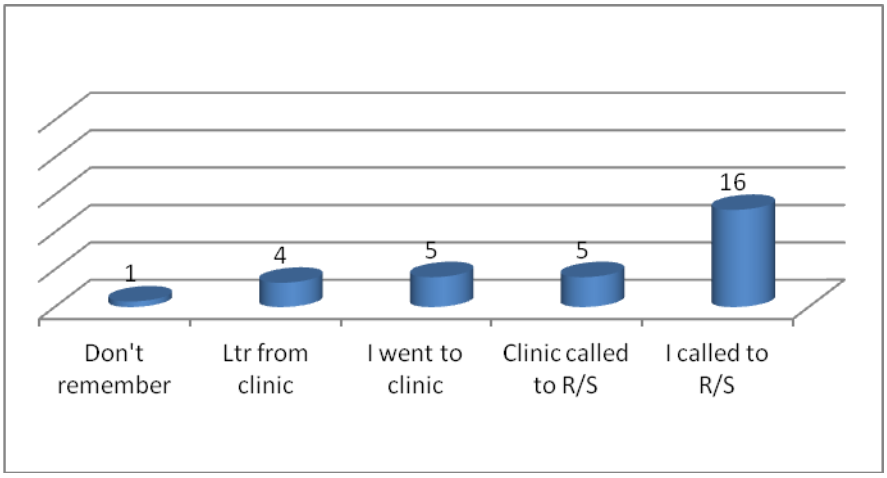
Communication

Ninety-two percent of respondents indicated strong agreement when asked if they felt comfortable asking their provider about medical conditions or problems.

Missed appointments

Consumers were asked about missed appointments during the review period. Nearly a quarter 21% had missed an appointment. Figure 34 shows that more than half 52% called to reschedule after a missed appointment.

Figure 34. Response to missed appointments, n=31



Medication Adherence

Adherence to antiretroviral therapy has been correlated with viral suppression, increase in survival and an improved quality of life[3]. When asked, 86% of respondents indicated they were currently on HAART. Also, a majority (90%) were usually asked about medication adherence during office visits.

Ryan White Available Services

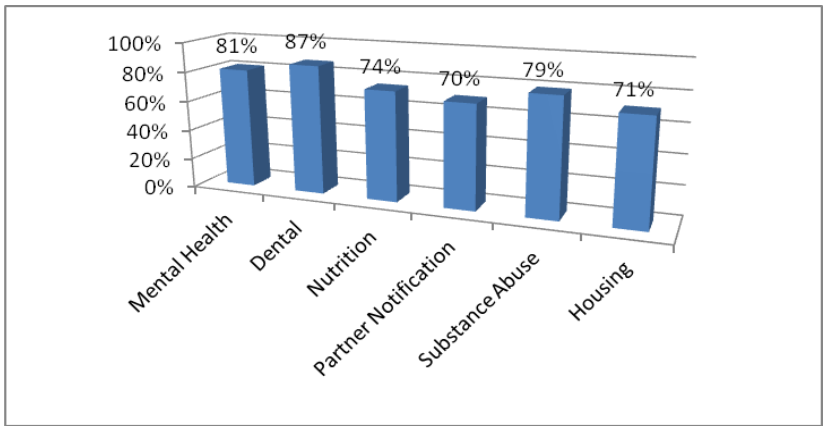
Referrals for health care and other support services are offered in continuing effort to meet the health care needs of persons living with HIV by engaging and retaining them in primary medical care. These services may include: referrals for specialty care, dental, case management, substance abuse services, mental health, food and nutrition services, and partner notification. Twenty percent of those responding were not offered these services.

[3] http://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/30/adherence-to-art

Support Services

When clients were asked about referrals to any other service, 90% were able to obtain the service "All of the time", Figure 35.

Figure 35. Additional Screening and Referrals Offered, n=148



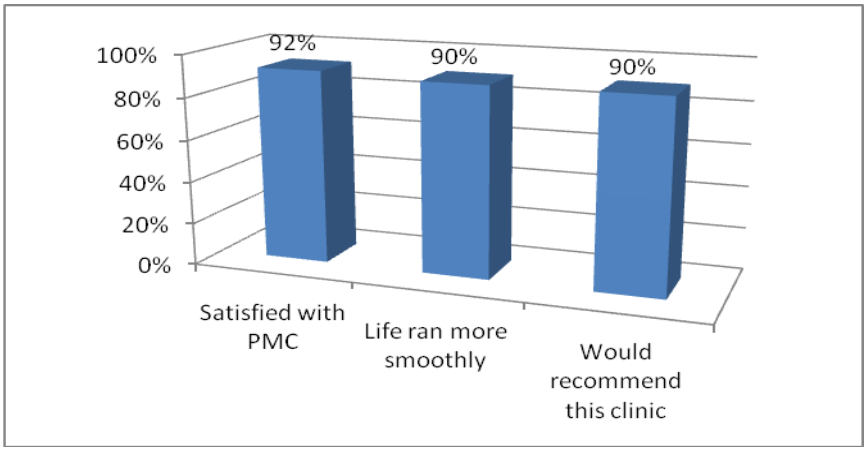
The Need for Consumer Involvement

Experience has shown that PLWHA provide a critical and necessary perspective on the development, implementation, and evaluation of programs and services that are designed to ultimately meet their needs as the consumers of those services[4]. When respondents of the survey were asked about participation in an agency consumer advisory board, almost one third 29% of consumers were not informed of the existence of a CAB.

Service Quality Rating

Overall clients were satisfied with the care they received. As Figure 36 shows, nearly all participants rated satisfaction with provider services at 90% or higher.

Figure 36. Consumer Satisfaction, n=148



[4] New York State Department of Health AIDS Institute: A Guide to Consumer Involvement of Improving the Quality of Ambulatory HIV Programs

Summary

More than half of consumers were in care less than 5 years. Almost all had a PCP and an assigned case manager. One in ten had not developed medical care plan. Ninety percent were regularly asked about medication adherence. The majority had regular discussions with staff about taking precautions to prevent the spread of HIV. Almost all were comfortable discussing medical conditions or problems with providers. Virtually all who attempted telephone contact received the assistance sought. One third of consumers were unaware of the existence of a CAB. Consumers offered additional comments or feedback on Primary Care Services. Clients indicated they were not made aware of the range of available Ryan White services. The majority of the feedback was very positive and included comments such as “Everybody here is so friendly, willing to help with problems”, “Excellent job!” “Clinic staff is my family”. Additionally, some consumers indicated they would like to receive more snacks during office visits, referrals for housing and food assistance, GED classes and smoking cessation offered at agencies.

DISCUSSION & RECOMMENDATIONS

Overall, OAHS-PMC providers continue to deliver care in accordance with a majority of the HRSA HAB performance measures. Clients are seen regularly by an HIV medical provider and in general are being screened and vaccinated for conditions common in the HIV infected population. Counseling for medication adherence and to decrease the risk of spreading HIV is also being provided for a majority of clients. Overall, consumers were satisfied with the primary care services.

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

Strengths

Of the 25 HRSA HAB performance measures assessed, the EMA documented strong adherence to 60% (15) of the measures. EMA- wide adherence to HRSA HAB performance measures were documented at 81% or better in the following categories:

- Hepatitis B screening – 97%
- Substance abuse screening (new clients) – 96%
- HAART prescription – 95%
- Hepatitis C screening – 95%
- Medical Visits – 93%
- Medication adherence and counseling – 93%
- HIV risk counseling – 87%
- Pneumococcal vaccination – 86%
- Mental Health screening (new clients) – 85%
- Toxoplasma screening – 84%
- Latent TB screening – 83%
- Viral Load monitoring – 83%
- CD4 Tests – 82%
- Syphilis screening – 82%
- Hepatitis/Alcohol counseling – 81%

Areas for Improvement

EMA-wide adherence to HRSA HAB performance measures fell below 81%. These areas include screening, counseling and vaccination measures:

- Viral Load Suppression - 77%Tobacco Cessation – 74%
- MAC Prophylaxis – 73%
- Chlamydia – 72%
- Gonorrhea – 71%
- Cervical Cancer Screening – 67%
- Influenza Vaccination – 67%
- Transition Planning – 55%
- Oral Health – 20%
- Lipid screening (fasting) 12%

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. On the next page, Table 2 describes the type of documentation required for each eligibility requirement.

Initial residency and income documentation were found in 86% and 83% of charts, respectively. When the client had been in care for more than 6 months, reviewers checked that residency and income had been updated. 77% of charts documented a residency update and 74% 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 Act[5]

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.

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.

[5] http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1303eligibilityconsiderations.pdf

Table 2. Required Documentation Table[6]

	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	Documentation required **Examples from the Greater Baltimore HIV Health Services Planning Council (GBHHSPC):** **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.	Self-attestation of no change Self-attestation of change – documentation required
Residency	Documentation required **Examples from GBHHSPC:** **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	Must verify if the applicant is enrolled in other health coverage and document status in client file **Examples from GBHHSPC:** **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.	Must verify if the applicant is enrolled in other health coverage Self-attestation of no change Self-attestation of change – documentation required

[6] Adapted from http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1302clienteligibility.pdf

Recommendations

The planning council should:

- Revise the OAHS-PMC Standards of Care to align with the HRSA HAB performance measures released in November 2013. The planning council should also consider that while HRSA HAB performance measures should be implemented immediately, CQM cannot begin to collect data on these measures until providers have had at least one full year to implement the measures.
- Revise the Standards of Care in all categories to reflect eligibility documentation requirements found in HRSA Policy Clarification Notice #13-03.
- Consider additional forms of Ryan White eligibility documentation to help streamline the eligibility process; to reduce client burden; and to support eligibility coordination between other insurance programs or other programs that require the same documentation.

Ryan White providers should:

- Become familiar with the new HRSA HAB performance measures released in November 2013.
- Ensure that reviewers have sufficient access to the EMR to gather all necessary data.
- Ensure EHR can store documentation of Ryan White eligibility or otherwise maintain paper documentation.
- Incorporate at least 2-4 areas for improvement into their program's quality improvement activities over the next 12-18 months.
- Respond to all requests for corrective action.

Clinical Quality Management should:

- Determine which of the new HRSA HAB performance measures to adopt for the upcoming fiscal year. Selection of performance measures will incorporate feedback from OAHS-PMC providers to ensure that measures are selected based on the needs of the Baltimore-Towson EMA. Input would also be incorporated from the Ryan White Part B program to ensure implementation of the measures so that all clients receive a uniform standard of quality care.

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