

BALTIMORE CITY HEALTH DEPARTMENT

RYAN WHITE OFFICE

CLINICAL QUALITY MANAGEMENT PROGRAM (CQM)

Service Category: Mental Health Services, Adult and Pediatric

June, 2011



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SECTION 1. INTRODUCTION

The Clinical Quality Management (CQM) program's purpose is to ensure that persons living with HIV/AIDS (PLWHA) in the Greater Baltimore/Towson Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White HIV/AIDS Treatment Extension Act of 2009. The Baltimore City Health Department (BCHD) Ryan White CQM program began in 2001, looking at data on services provided during calendar year (CY) 2001. In 2010, CQM reviewed fiscal year (FY) 2009 records for adult and child/adolescent mental health services. Mental health services were also assessed in 2002 and 2006 and comparisons with the last review are made wherever possible.

As defined in the Greater Baltimore HIV Health Services Planning Council Standards of Care (Standards of Care), mental health services pertain to "psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental-health professional licensed or authorized within the state to render such services."¹ Pediatric mental health services (clients up to 24 years of age) are reported separately.

To reassess the degree to which services adhered to the standards of care across the EMA, reevaluation data was gathered and analyzed from all Part A- and MAI-funded mental health programs in the EMA. In addition to providing the results for the data collected, this report provides details of the methodology, a summary of the findings, as well as recommendations for improving the quality of mental health services. The appendix contains the standards of care used throughout the review. *Section 2* of the report contains a description of the methodology, *Sections 3-5* contain results of the chart reviews, *Section 6* contains consumer insights on mental health services received, *Section 7* contains an organizational assessment of providers' quality management activities, and *Sections 8 and 9* present findings and recommendations.

¹ Greater Baltimore HIV Health Services Planning Council, Standards of Care, Mental Health Services, revised September 2000, ratified March 2005 and Standards of Care, Mental Health Services: Children and Adolescents, revised September 1999, ratified September 2000.

SECTION 2. METHODOLOGY

In 2010, CQM reviewed all six agencies providing mental health services during fiscal year 2009. Two agencies were supported by two funding streams (Part A and Minority AIDS Initiative or MAI) and one agency had both a city and a services to surrounding counties (STSC) program. In addition, one agency had both an adult and a pediatric program. Charts for all clients thru age 24 were evaluated with the pediatric mental health tool regardless of where they were seen. Data were collected through three avenues, 1) Chart abstractions, 2) Consumer surveys, and 3) QI organizational assessments. The data presented represent a review of **45%** of the mental health records of clients receiving services in 2009 and may not reflect the experience of all Ryan White clients within the EMA.

Mental Health Record Abstraction: The client record abstraction tool was designed to assess the vendor’s adherence to the EMA standards of care. The review period focused on services provided in fiscal year 2009: 3/1/2009 thru 2/28/2010 for Part A clients and 8/1/2009 thru 7/31/2010 for MAI clients. Vendors were directed to provide a random sample of charts and CQM provided two methodologies for how to pull records. The number of charts requested from each agency was based on the number of Ryan White clients receiving mental health services in 2009 and guided by the 2008 HIVQUAL sampling methodology developed by the New York State Department of Health AIDS Institute.²

For each chart reviewed, one survey instrument was completed. A total of **381** mental health charts were reviewed at the six agencies funded for Ryan White mental health services. Again, while six agencies were reviewed, nine programs were included, two had multiple funding streams, one had both an adult and pediatric program, and one had both a city and county (STSC) program. The number of records reviewed per program ranged from **27** to **66** with an average of **42** charts per program. The portion of an agency’s charts reviewed ranged from **27%** to **79%** with an average of **45%**, *Table 1*. Information abstracted from adult clients’ charts is presented in *Section 3* and *4*. Data from pediatric chart review is presented in *Section 5*. All agencies funded by Ryan White Part A and MAI grants participated in the review.

Table 1. Mental Health Charts Reviewed, N=381

Program	Charts Reviewed	% CQM Sample	Clients Seen	% Agency Sample
Chase Brexton Part A	60	16%	120	50%
Chase Brexton MAI	27	7%	47	57%
Johns Hopkins City	65	17%	161	40%
Johns Hopkins Counties	66	17%	160	41%
Johns Hopkins Pediatrics	27	7%	34	79%
Total Health Care Part A	38	10%	139	27%
Total Health Care MAI	32	8%	86	37%
University of Maryland	34	9%	54	63%
People Community Health	32	8%	54	59%
Total	381	100%	855	45%

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

Consumer survey: The consumer survey assesses quality from the client’s perspective. CQM staff utilized a consumer questionnaire developed by the New York State Department of Health AIDS Institute.³ The tool captured demographics, specific mental health services received, and client satisfaction with services. Vendors were instructed to provide a sample of consumers for interviews during the scheduled visit. An independent consultant administered the consumer interviews while on site. When on-site interviews were not possible, telephone interviews were conducted after obtaining client consent by the agency.

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

⁴

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

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

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

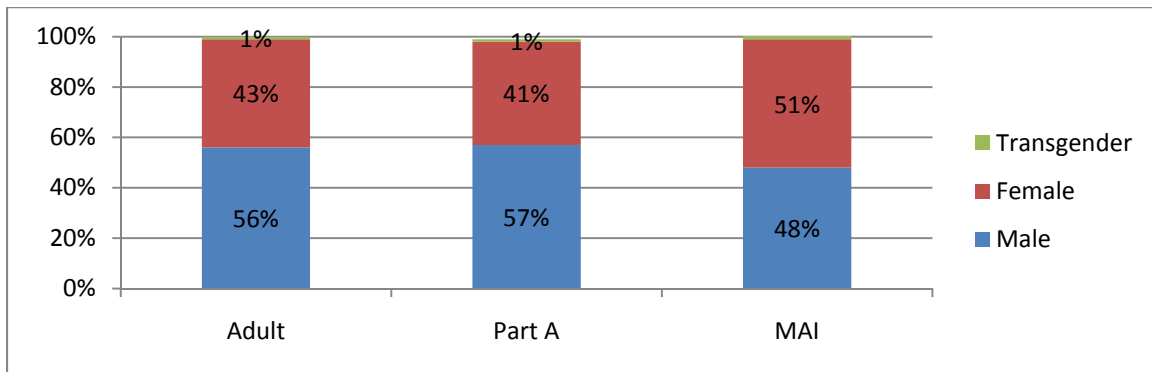
SECTION 3. DEMOGRAPHICS

Of the **381** mental health records reviewed, **29 (8%)** were pediatric clients and **352 (92%)** were adult clients. Of the adult clients, **293 (83%)** were funded by Part A and **59 (17%)** by MAI. Pediatric clients include those seen at the identified pediatric/adolescent program and those clients with a date of birth after 3/1/1985 (or 8/1/1985 for MAI-funded clients). Both demographic and service data are presented separately for adult and pediatric populations.

ADULT CLIENT DEMOGRAPHICS

Gender: Of the **352** adult records sampled, **43%** were female and **56%** were male. Five clients (**1%**) identified as transgender. Part A-funded clients (**N=293**) were **57%** male, **41%** female, and **1%** transgender. MAI-funded clients (**N=59**) were **48%** male, **51%** female, and **2%** transgender, *Figure 1*.

Figure 1. Gender, N=352



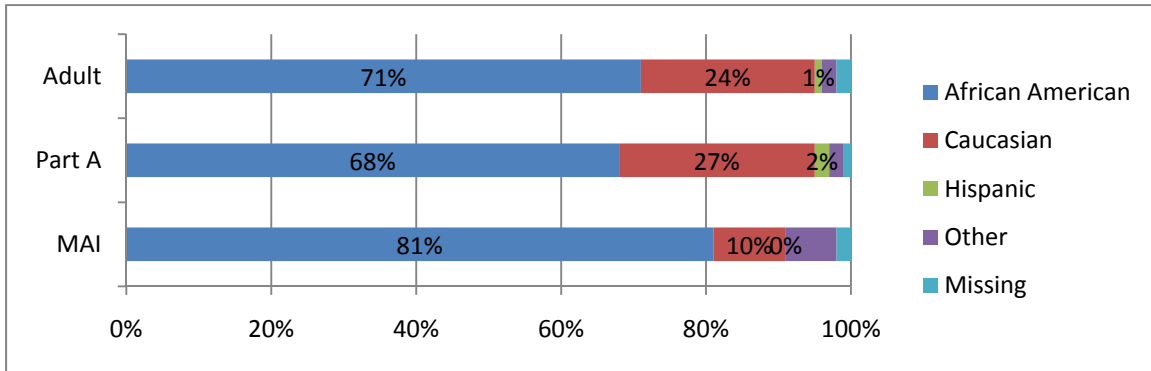
Age: Almost half (**47%**) of the clients receiving mental health services were between 40-49 years of age. Over a quarter (**27%**) were 50-59 years of age. MAI-funded clients were more likely to be in their forties, *Table 2*.

Table 2. Age, N=352

Age	Total Sample (%/#)		Part A (%/#), N=293		MAI (%/#), N=59	
25-29	5%	18	6%	17	2%	1
30s	16%	56	16%	47	15%	9
40s	47%	165	45%	132	56%	33
50s	27%	95	28%	83	20%	12
60+	5%	16	4%	13	5%	3
Missing	1%	2	0%	1	2%	1

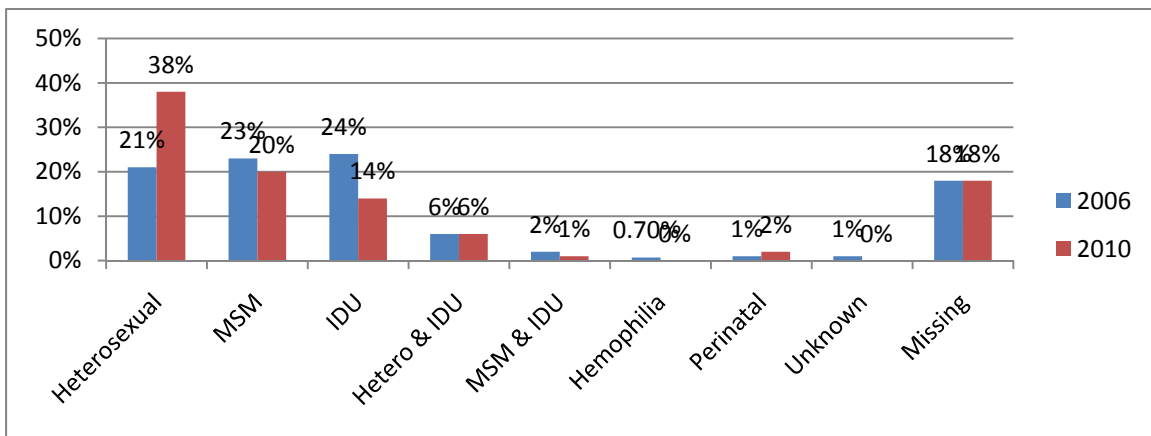
Race/Ethnicity: Most (71%) mental health records reviewed were of African Americans. Caucasians made up 24% of the sample. Few (1%) clients identified as Hispanic and 1% also reported “other” for race. Race was missing in 2% of records. Compared with Part A, a higher portion of MAI records were of African Americans, however 10% of MAI-funded clients were still Caucasian, *Figure 2*.

Figure 2. Race/Ethnicity, N=352



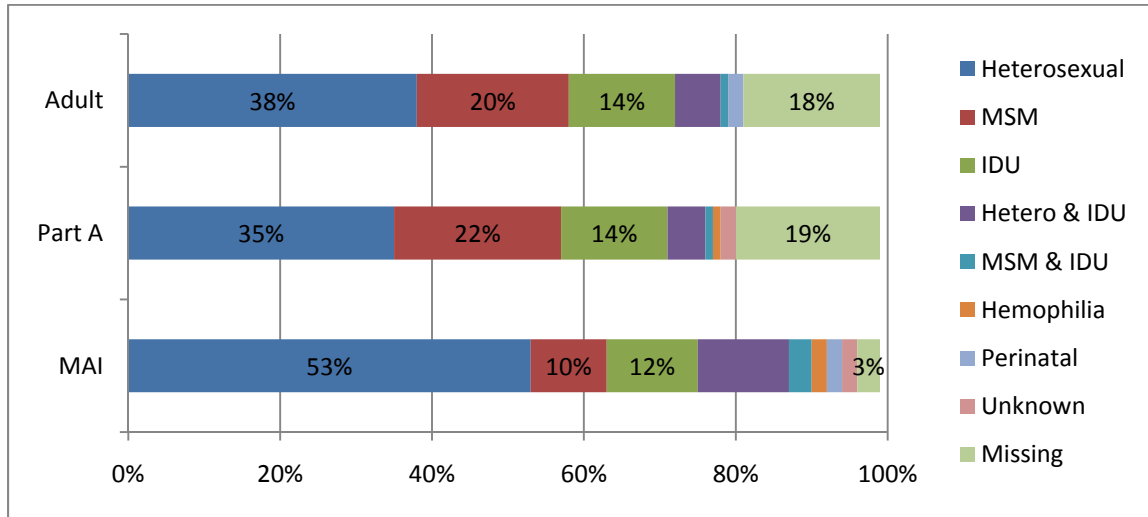
Risk Factor: As seen in *Figure 3*, 38% of the reviewed charts identified heterosexual contact as the risk factor for HIV infection, up from 21% in 2006. Injection drug use (IDU) showed a decrease since the last review of mental health services. Risk factor is still missing in 18% of records.

Figure 3. Risk Factor, N=352



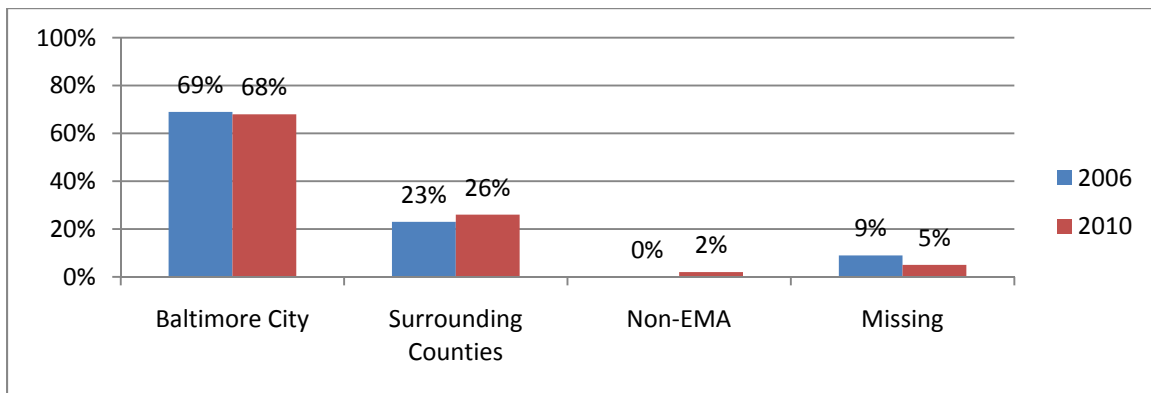
As shown in *Figure 4*, a greater portion of MAI clients identified heterosexual contact as their risk factor for HIV.

Figure 4. Risk Factor by Funding Stream, N=352



Residence: Zip codes of the client’s residence were recorded during the chart review and residence was broken out by either Baltimore City or surrounding counties. The majority (**68%**) lived in Baltimore City. The most frequently occurring zip codes in the city were 21218, 21201, 21217, 21215, 21223, 21202, 21216, and 21213. A quarter (**26%**) of clients resided in one of the surrounding counties. Where a zip code was split between city and county, clients were counted proportionally between city and counties. The zip code recorded was outside the EMA for **2%** of the sample and residence was missing in **5%** of records, *Figure 5*.

Figure 5. Residence, N=352



Insurance: The proportion of Mental Health clients with insurance coverage has increased over time. Note, a client may hold multiple insurance types. Forty percent (**40%**) of clients had Medicaid, **27%** had Medicare, **16%** has Primary Adult Care (PAC) or Maryland Health Insurance Plan (MHIP), **10%** had Maryland AIDS Drug Assistance Program (MADAP), and **11%** had private insurance. Nine percent (**9%**) had no health coverage listed. *Figure 6* shows health coverage in comparison with the last review of mental health services.

Figure 6. Insurance, N=352

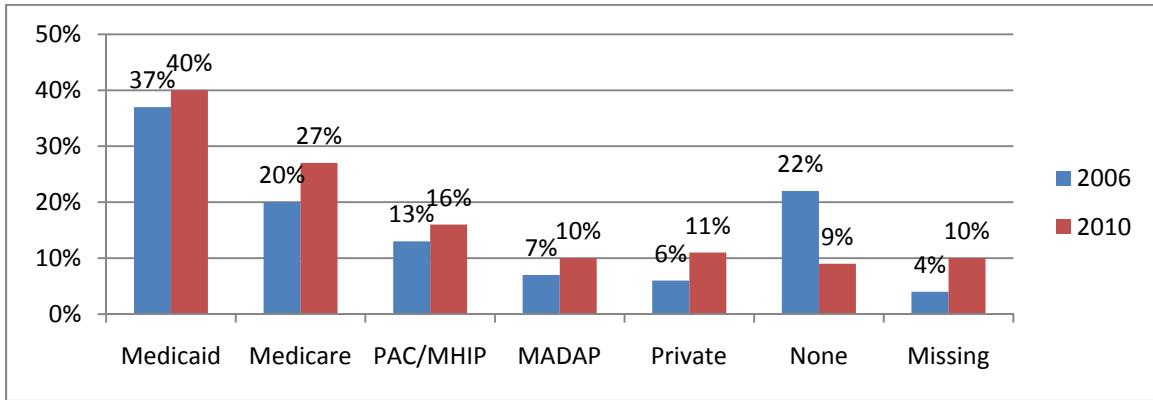
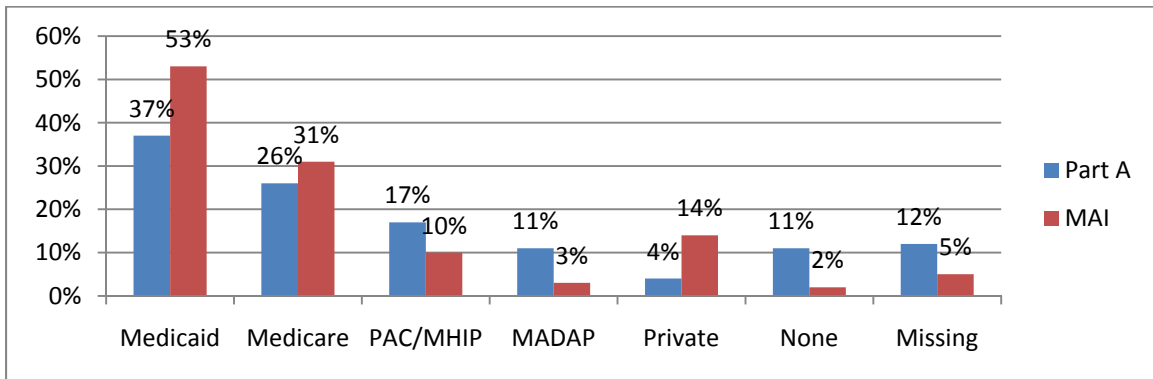


Figure 7 shows insurance coverage by funding stream. Higher portions of MAI clients received Medicaid and private insurance. Note, some clients have multiple insurance coverage.

Figure 7. Insurance by Funding, N=352



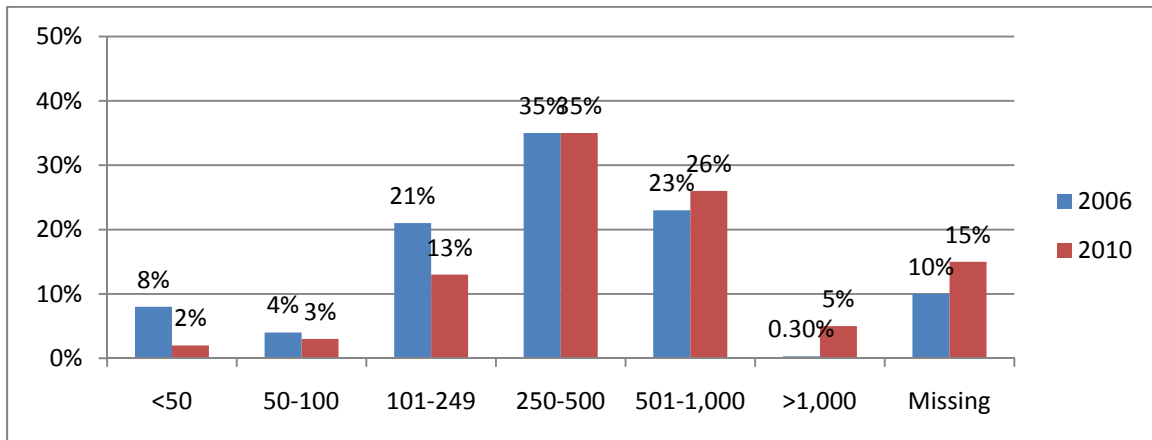
Clinical Indicators: In an effort to examine clinical indicators, reviewers examined clients’ laboratory values (CD4 and viral load), HIV/AIDS diagnosis, and use of highly active antiretroviral therapy (HAART). CD4 counts were available in **299 (85%)** charts, viral load values in **295 (84%)** charts, HIV/AIDS diagnoses in **347 (99%)**, and use of HAART in **304 (86%)** records. Documentation of all indicators remained high since the last review, *Table 3*.

Table 3. Clinical Indicators, N=352

Indicator/Sample	2002, # (%)	2006, # (%)	2010, # (%)
CD4	124 (67%)	260 (90%)	299 (85%)
Viral Load	110 (59%)	252 (87%)	295 (84%)
HIV/AIDS Diagnosis	151 (81%)	282 (98%)	347 (99%)
HAART Status	120 (65%)	249 (86%)	304 (86%)

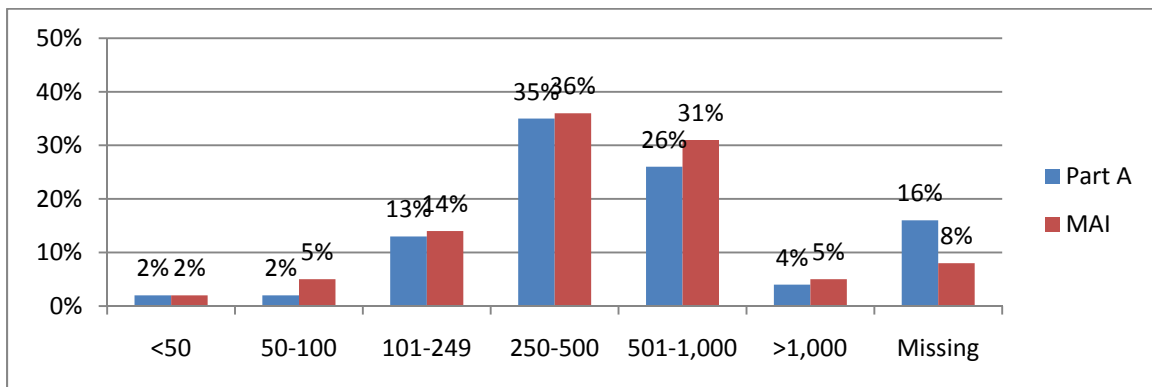
Of the records that captured client CD4 counts, **35%** had a CD4 of 250-500 cells/mm3, **26%** had a count of 501-1,000, and **13%** had a count of 101-249, *Figure 8*. The CD4 counts shifted toward higher values over the past four years, however more values were also missing from mental health records in 2010.

Figure 8. CD4 Range, N=352



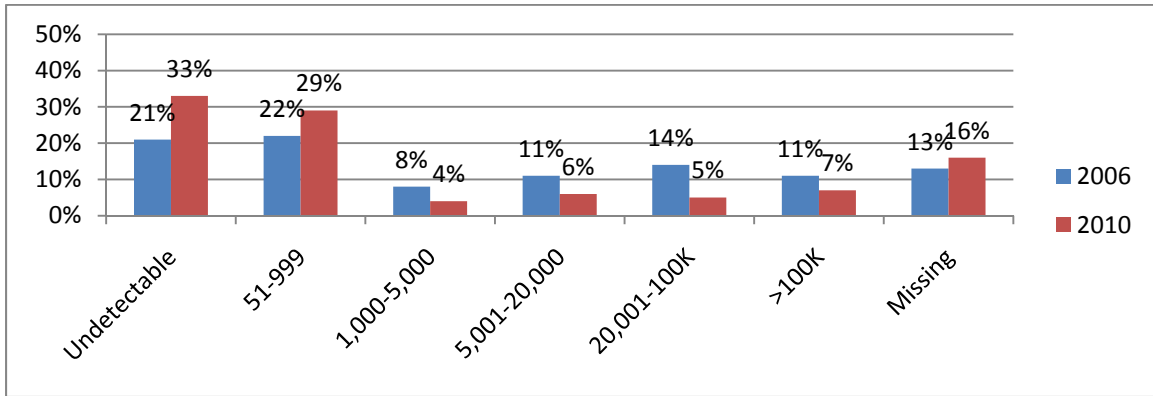
Most (**92%**) MAI-funded clients had CD4 counts available in their records, while **84%** of Part A records contained CD4 values. *Figure 9* shows CD4 distributions by funding source.

Figure 9. CD4 Range by Funding, N=352



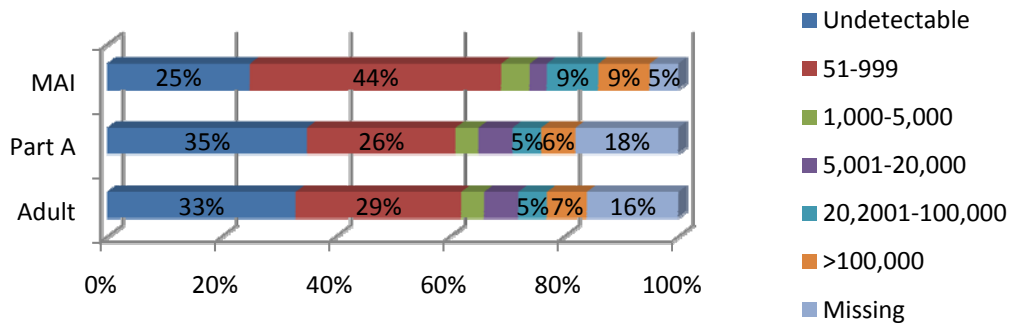
Viral load values also shifted toward lower ranges since 2006 with **33%** of mental health records showing undetectable and another **29%** between 50-999. Viral load was missing in **16%** of records, *Figure 10*.

Figure 10. Viral Load Range, N=352



As shown in *Figure 11*, a smaller portion of MAI clients had undetectable viral load values.

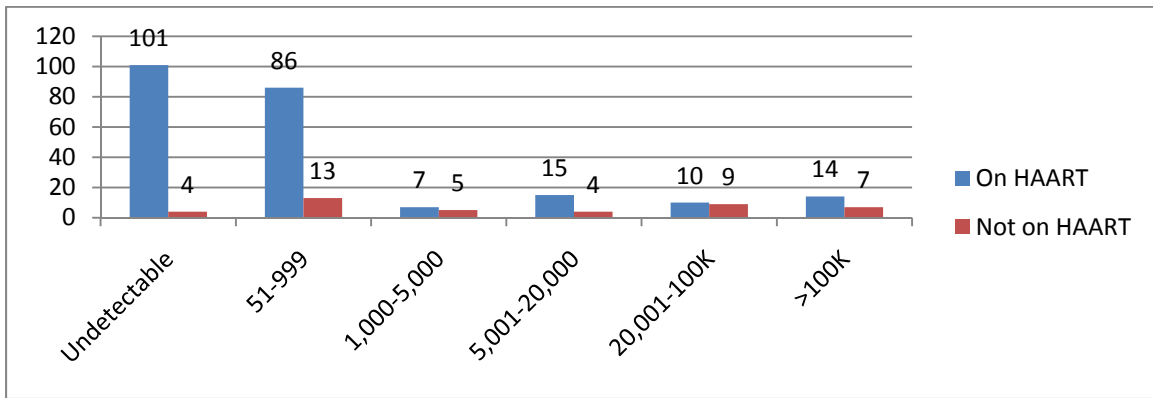
Figure 11. Viral Load Range by Funding, N=352



Treatment with HAART decreases morbidity and mortality for persons with HIV/AIDS, although some reasons are cited by providers for not prescribing HAART such as HIV non-progression or lack of client medication adherence readiness. Treatment status was reported for **84%** of Part A-funded clients and **96%** of MAI-funded clients. Of the **247** Part A clients, **83%** were on HAART and of the **57** MAI clients, **82%** were also on HAART.

To assess HAART efficacy, viral load ranges were examined against HAART treatment status. For the **295 (84%)** records that documented viral load ranges, *Figure 12* shows the number of clients receiving HAART. Note, these are actual numbers of clients, not percentages. The majority (**69%**) of clients for whom viral load is documented had levels under 1,000 and almost all of them (**92%**) were on HAART. Only **65%** of clients with viral loads over 1,000 were on HAART.

Figure 12. Viral Load Range by HAART, N=295



SECTION 4. ADULT CLIENT CHART ABSTRACTION

ELIGIBILITY

Once a client presents to an agency for mental health services, it is expected that the agency will conduct an evaluation to determine the client's needs and if the client is eligible for services. As part of the evaluation, service providers are required to document the client's eligibility for Ryan White services through proof of HIV-status, proof of income below 300% of the federal poverty level, and proof of residence within the Baltimore/Towson EMA. As part of the intake process, providers are also required to share the agency's policies and procedures related to client rights and responsibilities, grievance procedures, and client confidentiality, as well as obtain the client's informed consent to receive mental health services and consent to release information, if applicable.

Of the 352 adult mental health records reviewed, 99% had proof of the client's HIV status, 52% had documented proof of client income, and 53% had documentation of a residence within the Baltimore/Towson EMA, *Figure 13*. A six month review of the client's financial eligibility was present in 20% of records and residence eligibility in 22%, while in 2006 only 5% of charts had updated eligibility information. *Figure 14* shows there are no differences in eligibility by funding source.

Figure 13. Eligibility, N=352

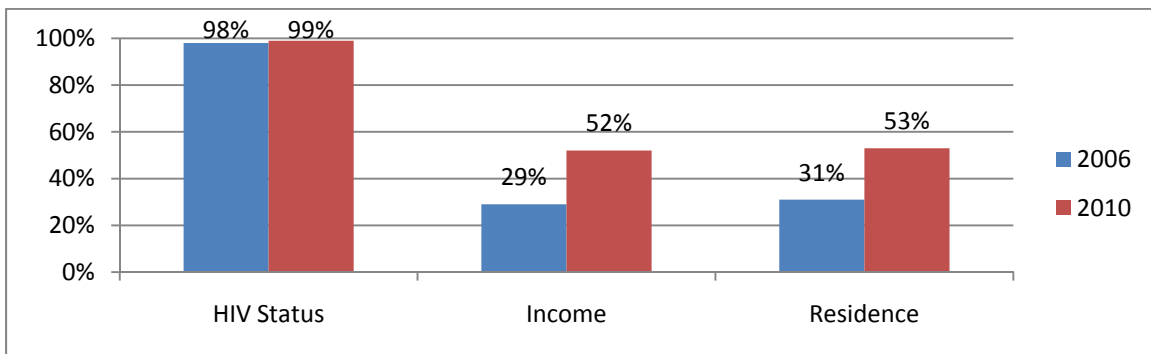
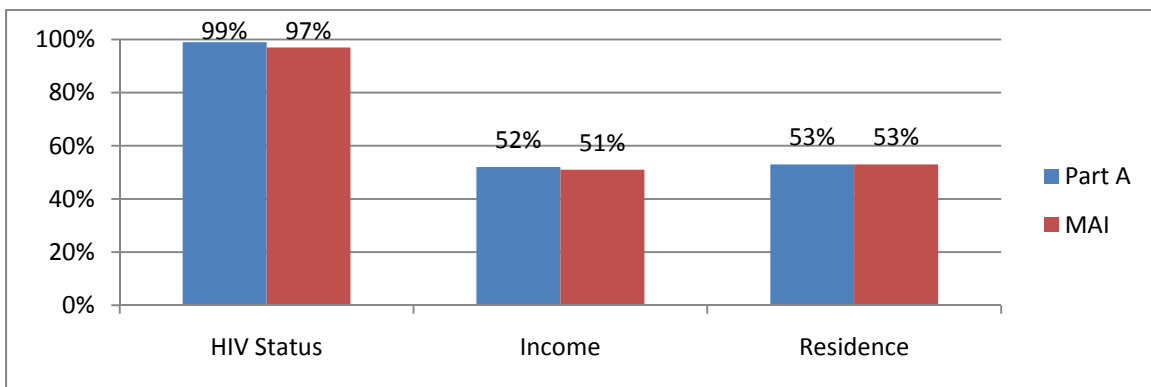


Figure 14. Eligibility by Funding, N=352



Two-thirds (**69%**) of records documented client receipt of rights and responsibilities, **62%** confidentiality, **65%** grievance policy, **71%** had a client consent for the release of information, and **76%** had client informed consent to treatment, *Figure 15*. Client signatures for receipt of client rights and grievance policies showed improvement while signatures for confidentiality and informed consent decreased. *Figure 16* shows that MAI-funded agencies were more likely to document client receipt of most information.

Figure 15. Policies, N=352

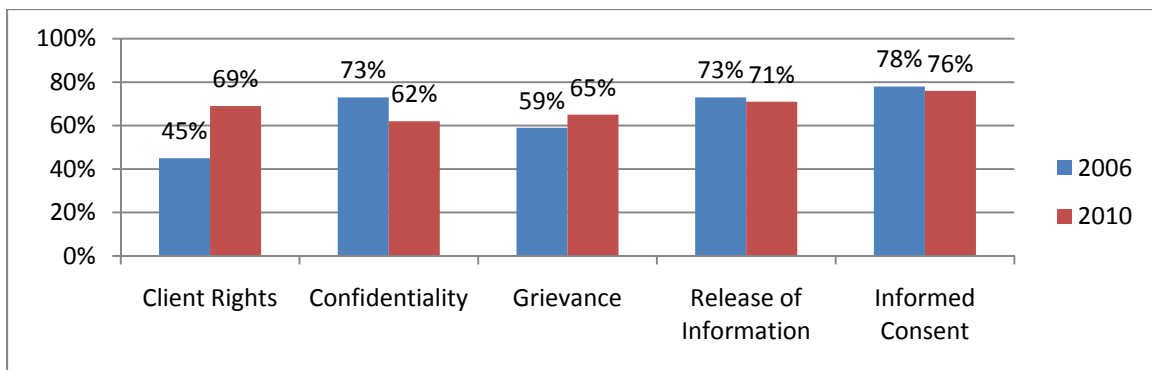
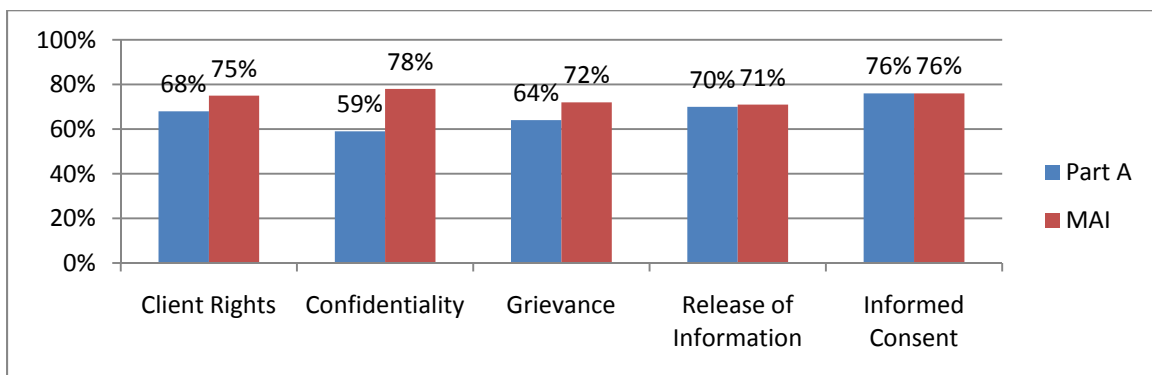


Figure 16. Policies by Funding, N=352



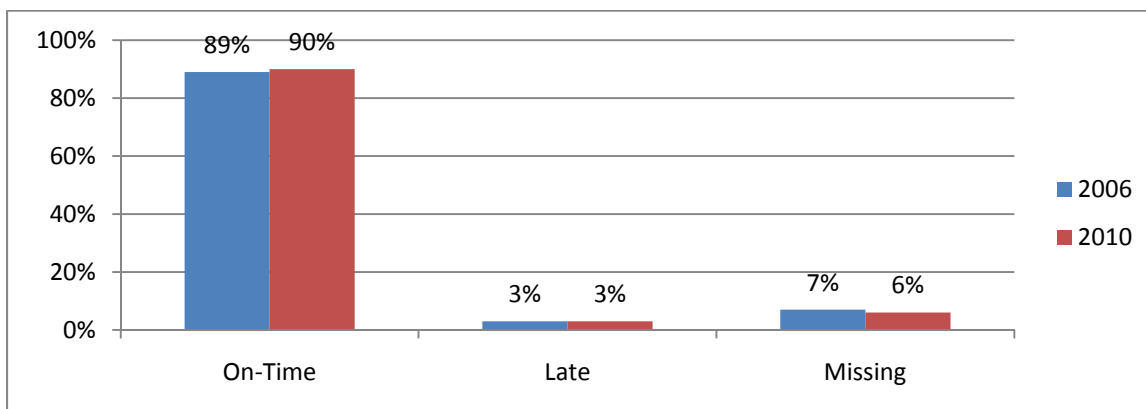
INTAKE

Prior to the initiation of any treatment, an evaluation by a licensed mental health professional must take place. As outlined in Standard 2.1, the evaluation must consist of the following: 1) Client history, 2) Complete mental status screening, 3) Cognitive assessment, 4) Multi-axial differential diagnosis, and 5) Development of an appropriate plan of care with treatment goals.

Forty percent (**141**) of the adult mental health records reviewed were opened as new cases during fiscal year 2009. Of these, **93%** had at least one aspect of a baseline evaluation by a licensed mental health professional. Most (**90%**) were conducted prior to the initiation of treatment and **3%** were done after treatment began. Some (**6%**) did not have evidence of a baseline assessment within the chart, *Figure 17*. Most (**91%**) of the Part A-funded clients had a baseline assessment and all

(100%) MAI-funded client records contained a baseline assessment. Details for the 131 new clients with a baseline assessment follow.

Figure 17. Baseline Evaluation, N=141



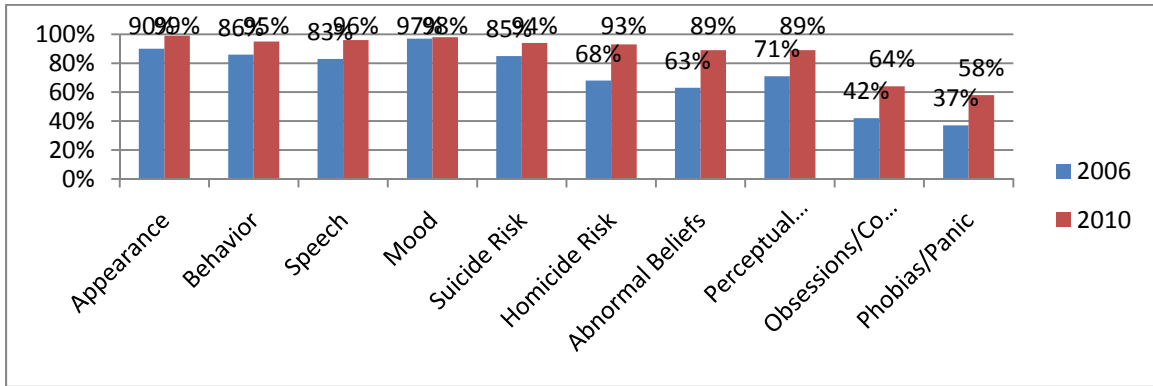
Initial evaluations must document client history including chief complaint, present illness, past psychiatric history, family history, personal history, substance-use history, medical history, current and recent medications, and pre-morbid personality. Of the 131 records with a baseline evaluation, 128 (98%) contained at least one element of client history. The elements contained in baseline assessments vary and are presented in Table 4. The average completeness of intake histories in 2010 was 89% versus 85% in 2006. Almost all (99%) Part A charts and 93% of MAI charts contained a client history in the baseline evaluation.

Table 4. Client History, N=128

Client History Element/Year	2006, # (%)	2010, # (%)
Chief complaint	111 (90%)	127 (99%)
Present illness	114 (92%)	128 (100%)
Past psychiatric history	115 (93%)	126 (98%)
Family history	106 (86%)	124 (97%)
Personal history	111 (90%)	127 (99%)
Substance-use history	118 (95%)	128 (100%)
Medical history	110 (89%)	124 (97%)
Current and recent medications	100 (81%)	105 (82%)
Pre-morbid personality	57 (46%)	58 (45%)

The initial evaluation must also document a complete mental status screening including appearance, behavior, speech, mood and affect, suicide risk, homicide risk, abnormal beliefs, perceptual disturbances, obsessions/compulsions, and phobias or panic attacks. Most (98%) new records with a baseline assessment documented a mental status screening in 2010, while 92% included a mental status screen in 2006. The items included in the mental status exams varied and can be found in Figure 18. The average completeness of mental status exams in 2010 was 78%, while in 2006 it was 72%. Almost all (99%) Part A charts had a mental status exam and 96% of MAI records contained the mental status exam.

Figure 18. Mental Status Exam, N=129



Cognitive functioning must be assessed during the initial evaluation and referrals must be documented if there are questions regarding cognitive functioning. Two thirds (**67%**) of new clients that had a baseline evaluation documented a cognitive assessment while in 2006 nearly three quarters (**74%**) of charts assessed cognitive functioning. Of the current charts reviewed, only one (**1%**) record showed a need for a follow-up compared with **11%** of the 2006 sample. A referral for cognitive assessment was made in the one case needed. Sixty one percent (**61%**) of Part A charts with a baseline evaluation contained a cognitive assessment while **93%** of MAI charts had a cognitive assessment.

The initial evaluation must document a multi-axial differential diagnosis that is developed from information obtained during the client evaluation. Almost all (**99%**) charts with a baseline assessment contained at least one multi-axial diagnosis; all (**100%**) Part A charts and **96%** of MAI charts contained a formal diagnosis.

The most frequent diagnosis for Axis I was major depressive disorder or depression (**N=77**), followed by cocaine abuse (**N=45**), opiate or heroin abuse or dependence (**N=37**), alcohol dependence (**N=28**), bi-polar disorder or rule out bi-polar disorder (**N=23**), anxiety disorder (**N=18**), cannabis abuse (**N=14**), and mood disorder or rule out mood disorder (**N=12**).

The majority of Axis II diagnoses were deferred (**N=90**), with the most commonly identified diagnoses being personality disorder or anti-social personality disorder (**N=14**).

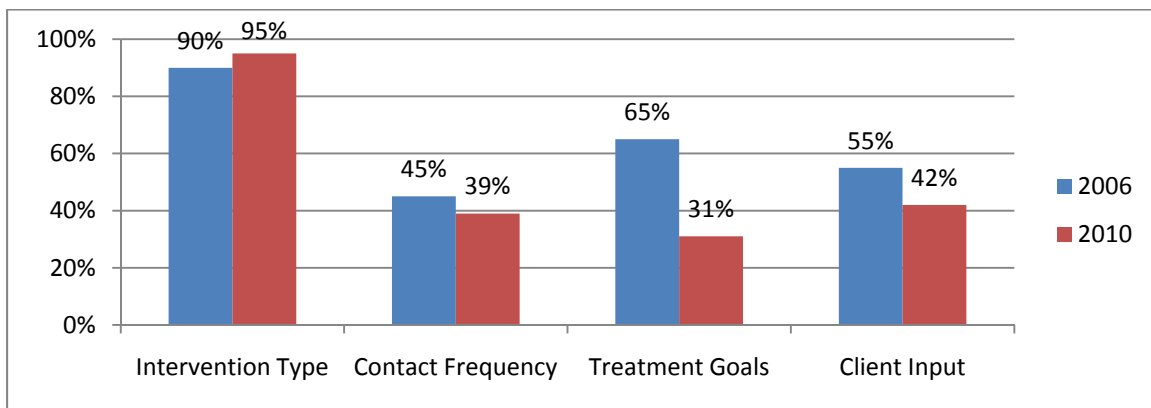
HIV/AIDS was listed as a diagnosis in all (**100%**) of the charts having an Axis III diagnosis (**N=125**). Other Axis III diagnoses included hypertension (**N=21**), Hepatitis C (**N=19**), and lung disorders or asthma (**N=18**).

Axis IV diagnoses were present in **124** records with most clients having three to five items indicated. The largest percentage of records indicated challenges of primary support group/social support (**N=75**), financial/economic (**N=67**), employment/career/occupation (**N=43**), social environment (**N=36**), health/medical access (**N=34**), housing (**N=31**), and legal (**N=20**). Of note, in 2006 **29%** of charts with Axis IV diagnoses indicated financial/economic issues compared to **54%** in 2010.

Most (**90%**) records with a multi-axial differential diagnosis had a documented current global assessment of functioning (GAF) score on Axis V with scores ranging from **6-78**. The mean current GAF was **51**, virtually the same as four years ago. Only **22%** of records contained documentation of the highest GAF score achieved in the previous 12-months, while in 2006 **35%** contained a history of GAF.

Upon intake, care plans with a statement of the type of intervention, frequency of contact, and treatment goals are to be developed for all clients after the initial evaluation. Almost all (**95%**) new charts with a baseline assessment had at least one element of a care plan contained within the charts; **93%** of Part A and **96%** of MAI charts had care plans. The type of intervention was documented in **94%** of care plans, the frequency of contact in **39%**, and the treatment plan goals in **31%** of care plans, *Figure 19*. The standards of care also require that care plans have input from the client. This was documented in **42%** of the care plans through either client signature or notation in a progress note.

Figure 19. Care Plans, N=124



The modality of treatment was documented in **94%** of the care plans; **94%** of Part A and **96%** of MAI charts. Note, several modalities may be documented. Three quarters (**76%**) of clients had individual therapy recommended, half (**53%**) were prescribed psychotropic medications, **9%** were referred to group therapy, and a few were referred for substance abuse treatment or further psychiatric evaluation, *Table 5*. Despite high numbers of clients seen with substance abuse diagnoses on Axis I, few referrals to formal drug treatment were seen.

Table 5. Treatment Modality, N=124

Treatment Modality/Year	2006, # (%)	2010, # (%)
Individual, Cognitive-Behavioral	1 (6%)	6 (5%)
Individual, Interpersonal	2 (11%)	0 (0%)
Individual, Psychodynamic	1 (6%)	0 (0%)
Individual, Supportive Psychotherapy	8 (44%)	41 (33%)
Individual, Theory Not Specified	6 (33%)	52 (42%)
Group, Theory Specified	1 (6%)	7 (6%)
Group, Theory Not Specified	1 (6%)	4 (3%)
Drug Treatment	1 (6%)	5 (4%)
Psychotropic Medications	1 (6%)	66 (53%)

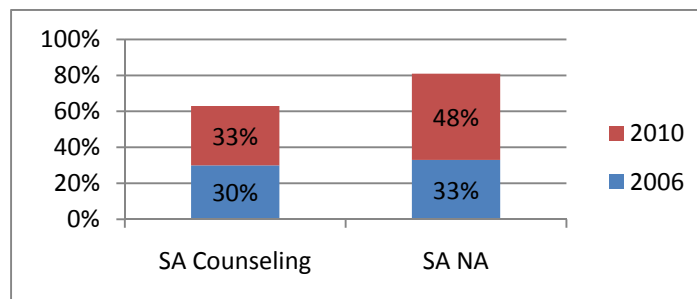
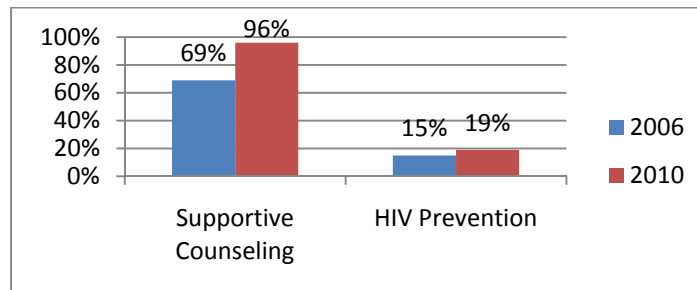
CONTINUED SERVICES

Mental health standard B.3.2.2 outlines a series of key activities related to the provision and monitoring of care and treatment over time. These activities include, 1) Appropriate frequency of visits, 2) Appropriate counseling during visits, 3) Prescription and monitoring of psychotropic medications, 4) Linkages and continuity of care, and 5) Reassessment of the care plan. All records were reviewed (**N=352**) for continued services.

Patient visits must be documented, as must the visit frequency that is appropriate based on the patient’s diagnosis, severity of need, and treatment plan. Of the reviewed records, **96%** documented patient visits and **62%** contained documentation that visit frequency was appropriate to care. Consequently, more than a third of charts did not show client visit frequency recommended by the provider. Some charts reflect attempts to reschedule clients to reach appropriate visit frequency, however repeated “no-shows” were a consistent challenge. Of the Part A-funded clients, **96%** showed visits with **59%** achieving appropriate visit frequency and **98%** of MAI records showed ongoing visits with **76%** showing appropriate visit frequency for their diagnosis.

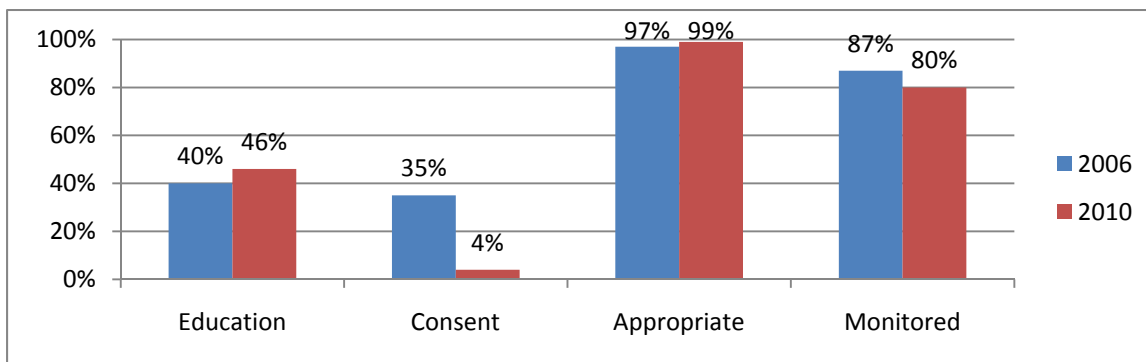
According to standard B.3.3.3(b), supportive services and educational counseling must be provided at all mental health visits. This must include counseling regarding the prevention of HIV-transmitting behaviors and, as clinically indicated, substance abuse counseling. Of clients with documented visits, **96%** had documentation of supportive and educational counseling at each visit. Only **19%** of mental health records showed documentation of HIV-prevention counseling, *Figure 20*. Four fifths (**81%**) of the charts documented that substance abuse counseling was either provided or not indicated, *Figure 21*. Both Part A- and MAI-funded charts showed supportive services and educational counseling at high rates, **96%** and **97%** respectively. Eighteen percent (**18%**) of Part A charts documented HIV prevention counseling, while **28%** of MAI records did so. Finally, **83%** of Part A charts either received substance abuse counseling or were not in need of it, while **71%** of MAI records showed appropriate substance abuse counseling.

Figures 20 and 21. Counseling Type, N=338



According to standard B.3.2.2(d), “The prescription and monitoring of appropriate psychotropic medications must occur as indicated by the clinical situation and in accordance with evidence-based practice guidelines. Clients must be educated on the risks and benefits of treatment with psychotropic medications and must give informed consent to treatment. Psychotropic medications must be provided and monitored under the supervision of a psychiatrist or a primary care provider. Clients must have the opportunity to develop ongoing relationships with the provider prescribing their psychotropic medication(s).” Three quarters (**75%**) of clients were prescribed psychotropic medications compared with **58%** in 2006. Of those receiving psychotropic medications, **46%** of charts documented client education regarding the risks and benefits of the medication. Only **4%** of records showed informed consent to treat with psychotropic medication. Nearly all (**99%**) of the charts showed that the medication prescribed was clinically appropriate and indicated by treatment guidelines. Most (**80%**) records documented routine and appropriate monitoring of the medications under the supervision of a psychiatrist or primary care provider. Medication monitoring was almost always conducted through patient interviews, *Figure 22*. Most (**94%**) of those receiving prescriptions had the opportunity to establish relationships with the prescribing provider.

Figure 22. Psychotropic Medication, N=167



By funding source, **74%** of Part A charts showed prescriptions for psychotropic medications. Of these, **36%** documented medication education, **5%** documented client consent for medication, and **98%** of the medications were seen as clinically appropriate. Of those receiving medication, **81%** of charts documented medication monitoring, while **94%** showed the patient could establish a relationship with the prescribing provider. **Eighty percent** of MAI charts showed the prescription of psychotropic medications. Of these, **94%** documented medication education, no charts showed client informed consent to take medication, but all the charts showed that the medications were clinically appropriate. Of those receiving medication, **77%** documented medication monitoring, while **96%** documented the client could establish a relationship with the prescribing provider.

Charts showed very little need for referrals to other mental health, substance abuse treatment, or primary care services. Most clients were already engaged in these services appropriately as needed. Specifically, **14%** needed referral to other mental health services (**11%** Part A; **34%** MAI). Referrals were documented for **88%** and visits for half of those referred. In 2006, **10%** needed referrals to additional mental health services and three quarters of these were referred.

For substance abuse treatment, **15%** of clients needed referrals (**14%** Part A; **20%** MAI). Referrals were documented for two thirds (**65%**) and visits were documented for half (**50%**) of those needing referral. In 2006, **16%** needed referral to substance abuse treatment and referrals were documented for three fifths of these.

Only **2%** of charts showed a need for primary medical care, all Part A records. Referrals were seen for five of the six clients needing primary care and three initiated primary care visits. In 2006, **4%** needed primary care referrals and three quarters of these were referred.

Standard 3.2.2.2(g) requires that each client’s care plan be reassessed at least every three months. For each quarter of the review period, the second column in *Table 6* shows the number of clients enrolled during the quarter as a percent of the sample. Note, the fourth quarter does not show **100%** enrollment because fourteen clients had neither intakes nor visits. Column three shows clients who had a plan in place during the quarter as a percent of those enrolled. Most enrolled clients had some components of a care plan in place. The final column shows whether care plans were reassessed as needed. Only clients remaining in care during the quarter are included; those newly enrolled or terminated from care during the quarter were excluded from analysis. On average, **53%** of care plans were reassessed every three months as required.

Table 6. Treatment Plan Reassessment, N=352

Quarter	Enrolled this Quarter	Plan in Place	Plan Reassessed *(new pts excluded)
Q1	71% (250/352)	94% (234/250)	56% (124/221)
Q2	81% (284/352)	93% (263/284)	58% (139/240)
Q3	91% (321/352)	93% (299/321)	53% (136/259)
Q4	96% (338/352)	94% (317/338)	46% (147/317)

Of the **317** care plans, **37%** established outcomes (**29%** Part A; **54%** MAI). Of the plans with outcomes established, **81%** documented progress toward achieving those outcomes. Just over half (**57%**) of the plans with outcomes documented client input as well. Outcomes were often contained within provider notes.

While there are not standards specific to termination and discharge, of the **352** charts reviewed, **25 (7%)** discontinued their care (**7%** Part A; **3%** MAI). Of those, four clients completed care and were discharged and twenty one were terminated by the provider. Half of those terminated were due to no shows. Nearly half (**48%**) documented discharge planning and most (**83%**) of those included client involvement in the discharge plan.

HEALTH DISPARITY

Key indicators were analyzed for differences by gender, race, and HIV risk factor. Indicators included were CD4 and viral load range, treatment with HAART, mental health visits, prescription of psychotropic medications, and development of a care plan including outcomes. No systematic disparity was seen, however several trends were noted. Intake documentation for Caucasians was not as strong as that seen for African Americans. Similarly, intake documentation for MSM was not as strong as that seen across other HIV risk factor groups. A smaller proportion of MSM achieved

viral load suppression than in other risk groups as well. Finally, a greater proportion of females had outcome goals included in their care plans than males.

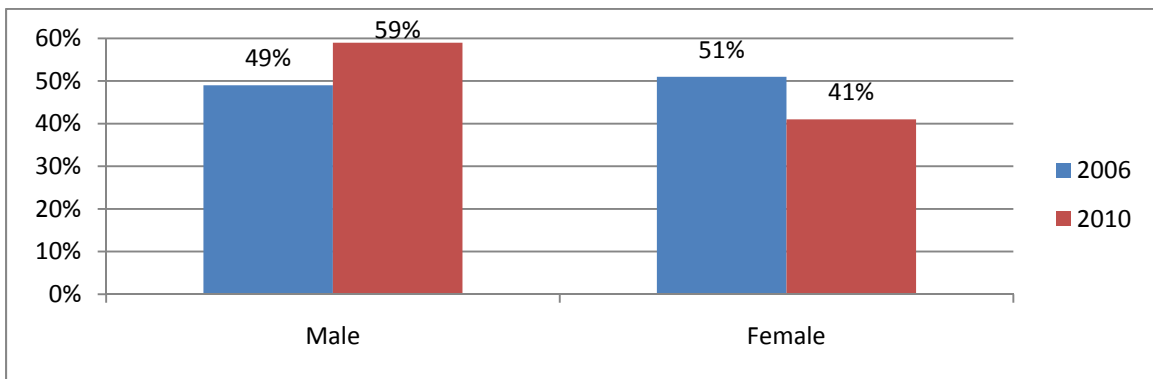
SECTION 5. PEDIATRIC CLIENT CHART ABSTRACTION

DEMOGRAPHICS

All clients under age 25 were evaluated as pediatric/adolescent cases and their records were assessed using the planning council's pediatric mental health standards of care. Twenty nine (29) charts were reviewed from three agencies, a smaller sample than the 51 pediatric clients reviewed in 2006.

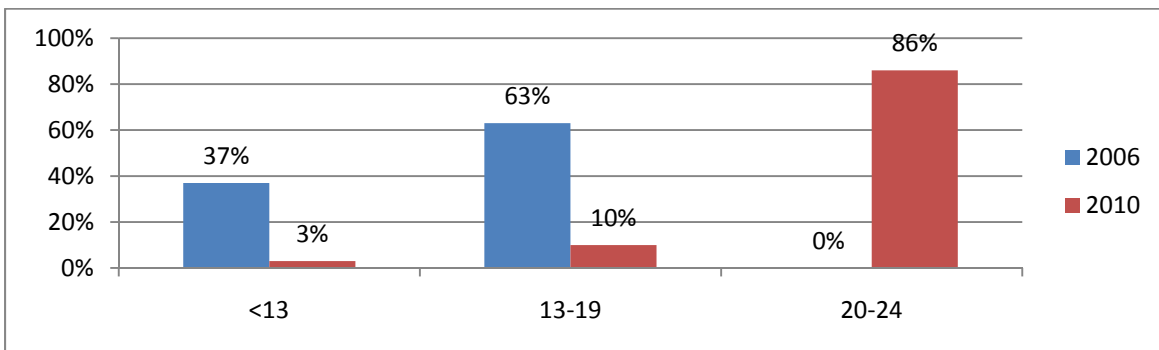
Gender: Of the 29 records reviewed, 59% were male and 41% were female, *Figure 23*. In 2006, 49% of the pediatric sample was male.

Figure 23. Gender, N=29



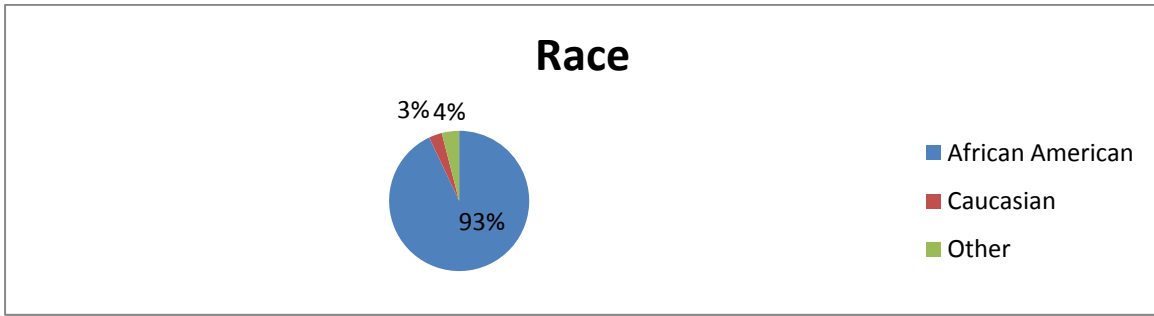
Age: Twenty five (86%) of the pediatric clients were in their early 20s, with 4 clients under 20 years of age, *Figure 24*. In 2006, 63% were 13-19 years of age and 37% were under 13 years old.

Figure 24. Age, N=29



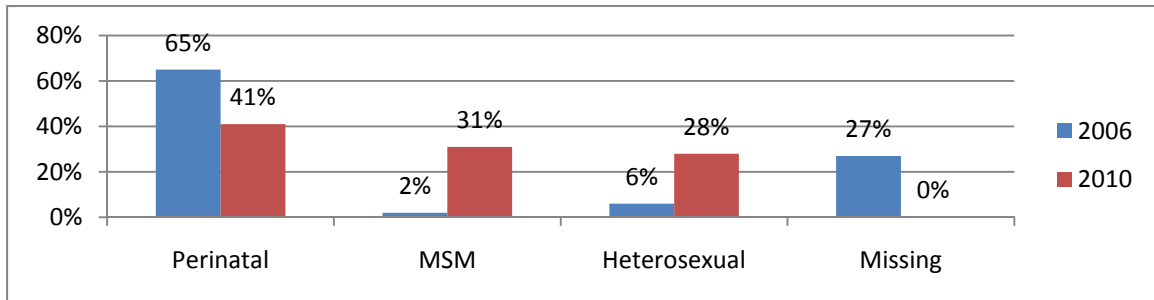
Race/Ethnicity: The majority (93%) of clients were African American, 3% were Caucasian, and 4% documented other races, *Figure 25*. This is similar to the race distribution seen in 2006.

Figure 25. Race/Ethnicity, N=29



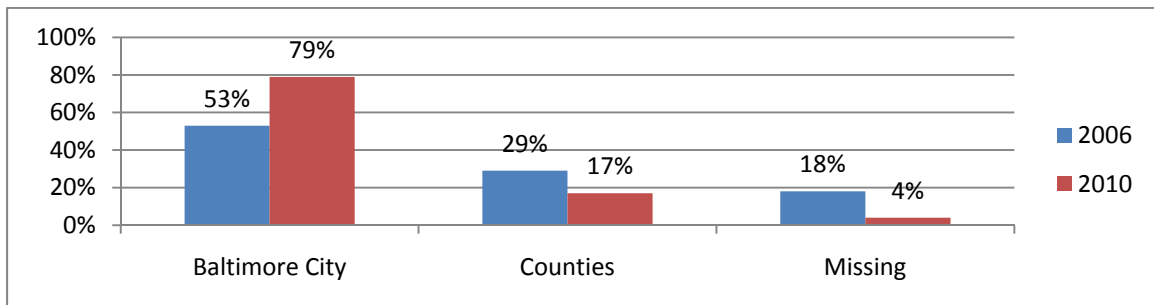
Risk Factor: Forty one percent (41%) of charts reviewed identified perinatal transmission as the risk factor for HIV infection. MSM was identified in 31% of the records and heterosexual contact in 28%, Figure 26. In 2006, a larger proportion of the sample was infected through perinatal transmission and a smaller proportion through sexual contact, reflecting the younger age of that sample.

Figure 26. Risk Factor, N=29



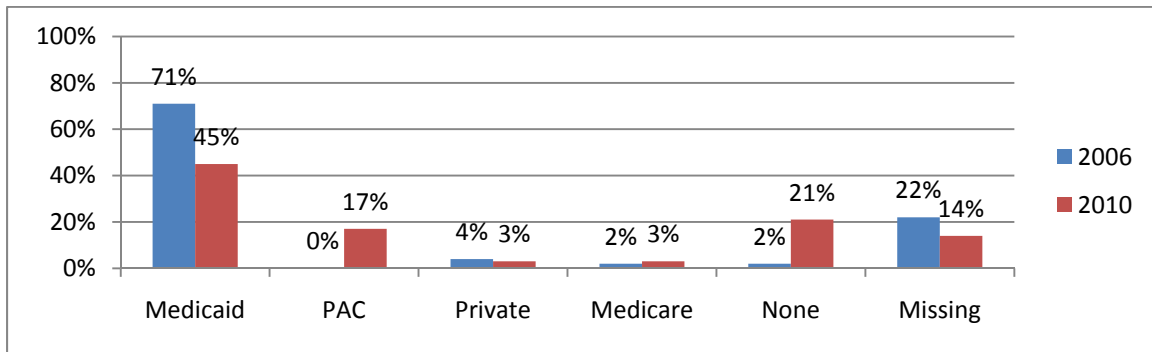
Residence: Most (79%) clients resided in Baltimore city and 17% in Baltimore county. Residence was missing in one (3%) record, Figure 27. In 2006, 53% of pediatric clients resided in Baltimore city.

Figure 27. Residence, N=29



Insurance: Nearly half (**45%**) of clients had Medicaid coverage, **17%** had Primary Adult Care (PAC), and six (**21%**) clients had no health insurance coverage. *Figure 28* shows insurance and reflects the older sample with less Medicaid coverage, more with PAC, and more uninsured compared to 2006.

Figure 28. Insurance, N=29



Clinical Indicators: In an effort to examine clinical indicators, reviewers examined clients' laboratory values (CD4 and viral load), HIV/AIDS diagnosis, and use of highly active antiretroviral therapy (HAART). CD4 values were recorded in **86%** of charts, viral load measures in **83%**, HIV/AIDS diagnosis in **100%**, and HAART treatment status in **97%**. These all show improvement over 2006 documentation, *Table 7*.

Table 7. Clinical Indicators, N=29

Indicator/Sample	2006, # (%)	2010, # (%)
CD4	33 (65%)	25 (86%)
Viral Load	35 (69%)	24 (83%)
HIV/AIDS Diagnosis	38 (75%)	29 (100%)
HAART Status	40 (78%)	28 (97%)

Of the pediatric charts reviewed, **31%** had a CD4 of 250-500 cells/mm³ and **24%** had a count of 501-1,000. The portion of young clients with a CD4 under 50 has increased to **17%**. CD4 count was missing in **14%** of records, an improvement over 2006, *Figure 29*. Only **10%** of clients had an undetectable viral load. Viral load values were missing in **17%** of records, fewer than in 2006, *Figure 30*.

Figure 29. CD4 Range, N=29

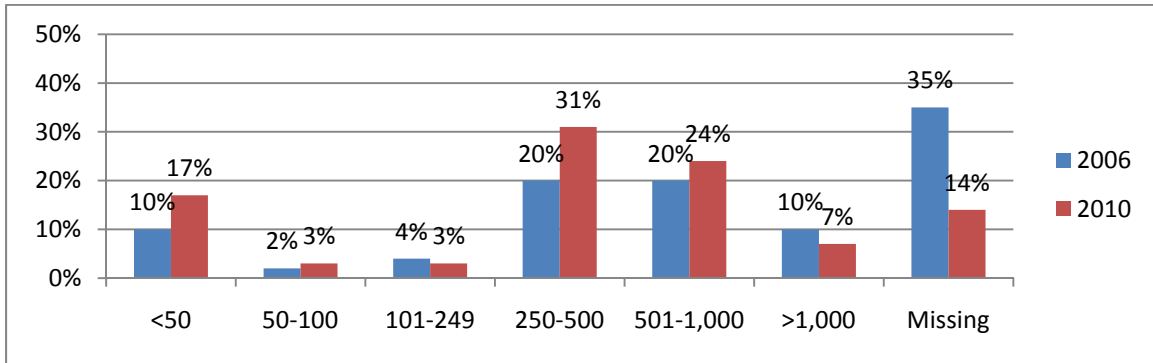
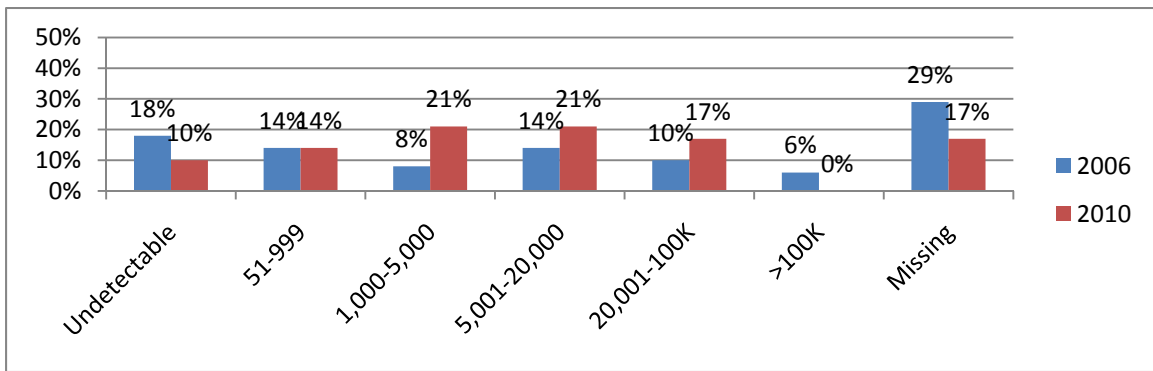
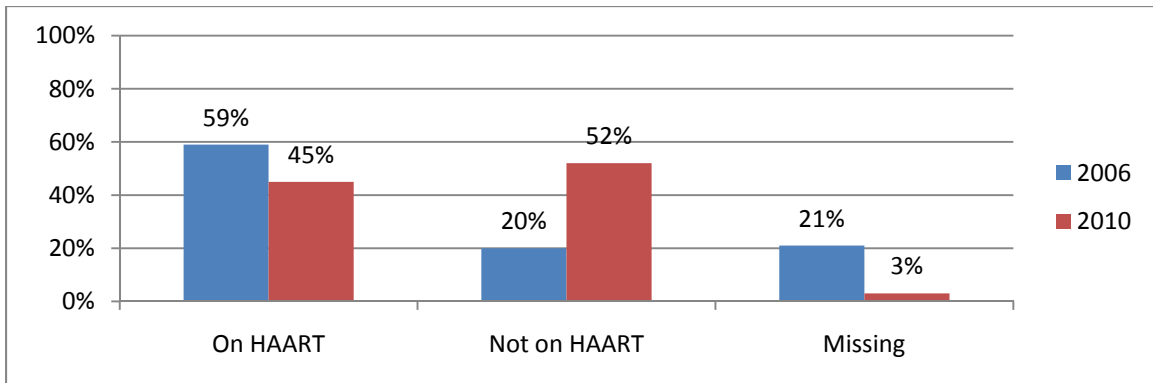


Figure 30. Viral Load Range, N=29



Treatment with HAART decreases morbidity and mortality for persons with HIV/AIDS, although some reasons are cited by providers for not prescribing HAART such as HIV non-progression or lack of client medication adherence readiness. Less than half (**45%**) the client records documented HAART during the review period, a smaller proportion than the **59%** receiving HAART in 2006, *Figure 31*. Fewer records were missing treatment status in 2010.

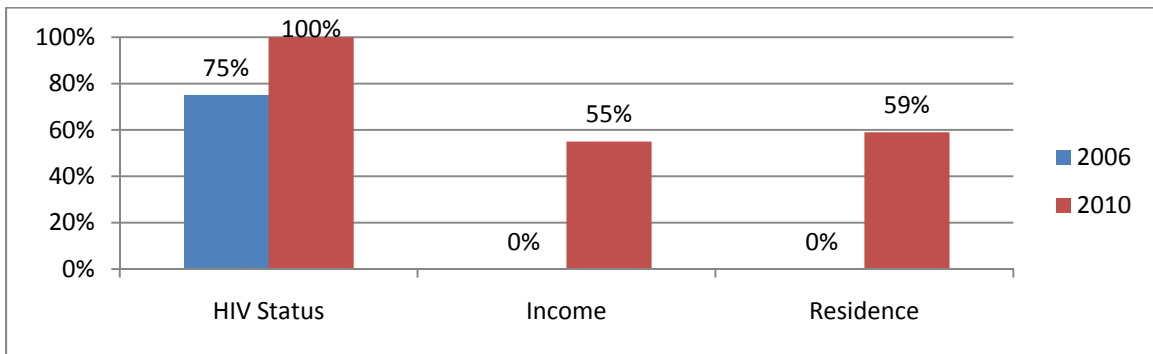
Figure 31. HAART Treatment Status, N=29



ELIGIBILITY

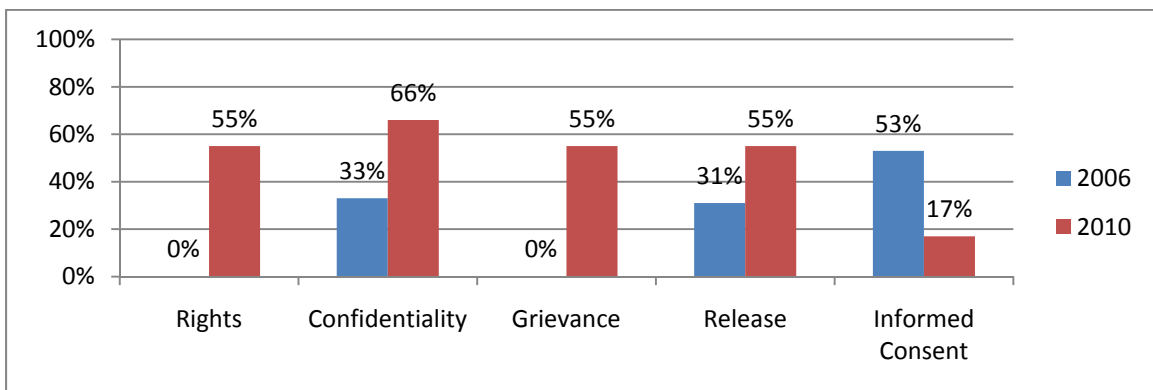
As with adult mental health clients, providers are expected to complete a baseline evaluation and determine the client's eligibility for services. As part of eligibility, providers are to document the client's HIV-positive status, income level, and residence within the EMA. Intake procedures shall include sharing the agency's policies and procedures including client rights and responsibilities, confidentiality, and grievance procedures. Providers must also obtain informed consent for mental health services and a release of information as indicated. Of the **29** records reviewed, all had proof of HIV status. Over half (**59%**) had proof of residence and **55%** had proof of financial eligibility. This is significant improvement over the 2006 review, none of which showed evidence of a 6-month update of client financial or residence eligibility. In 2010, **38%** of charts documented EMA residence a second time and **28%** documented financial eligibility twice, *Figure 32*.

Figure 32. Eligibility, N=29



Client signatures indicating they had received documentation were present in a higher proportion of 2010 charts. Over half (**55%**) of clients signed they had received rights and responsibilities, **66%** confidentiality policies, and **55%** signed a release of information. However, only **17%** of clients or guardians signed informed consent for mental health treatment, down from **53%** in 2006, *Figure 33*.

Figure 33. Policies, N=29



INTAKE

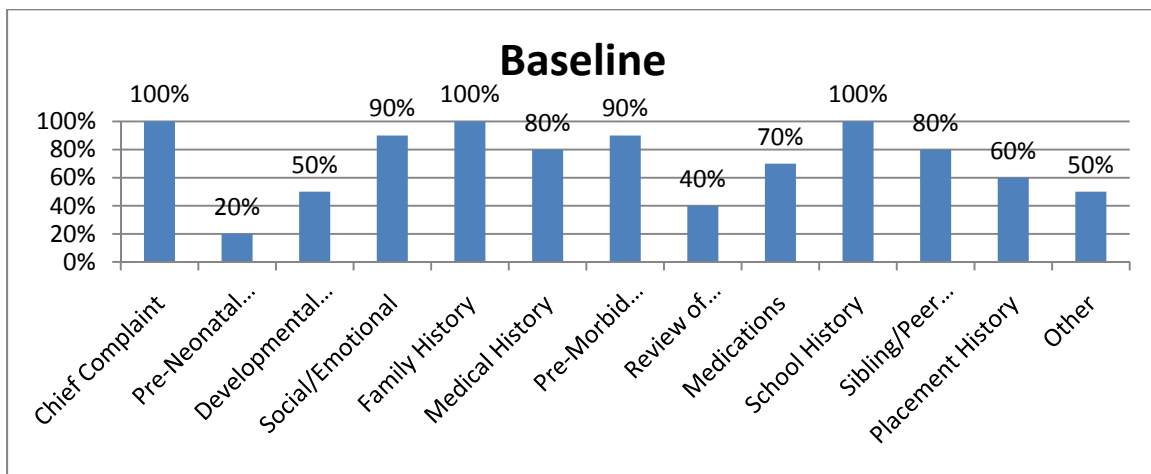
Prior to the initiation of any treatment, an evaluation by a licensed mental health professional must take place. Standard 4.2.1 states the evaluation must consist of the following: 1) Client history, 2) Mental status, 3) Cognitive, emotional, or behavioral assessment, 4) Multi-axial differential diagnosis, and 5) Development of an appropriate plan of care with treatment goals.

Twelve (**12**) pediatric mental health charts were opened during the review period and assessed for a baseline evaluation. Ten (**83%**) had a baseline evaluation conducted prior to the initiation of treatment. This is an improvement over 2006 when only three new clients had a baseline completed prior to treatment.

Initial evaluations must be completed by a licensed mental health professional working as part of an interdisciplinary team. **Five** of the intakes were completed by a child psychiatrist, **2** by a psychologist, and **3** by a social worker.

The evaluation must document client history, including chief complaint, prenatal and neonatal history, developmental history, social/emotional factors, family history, medical history, pre-morbid functioning, review of systems, current and recent medications, school history, sibling/peer relations, placement history, and review of other treatments or evaluations. Intake history items completed are shown in *Figure 34*. Seven items were completed in **8** or more of the ten charts containing an evaluation and four items in half or fewer of the charts.

Figure 34. Baseline Evaluation, N=10



A mental status evaluation was documented in **8 (80%)** of the records containing a baseline assessment. Standard B.4.2.1(c) requires a cognitive, emotional, or behavioral assessment. Half (**50%**) the records contained a cognitive assessment and **6 (60%)** had an emotional assessment. Six (**60%**) also had a behavioral assessment documented; two done by a psychiatrist, two by a psychologist, and two by a social worker.

Six (**60%**) of the new clients who had a baseline evaluation completed had diagnoses on one or more Axes. On Axis I, **2** charts listed major depressive disorder, **2** adjustment disorder, **1** acute

stress reaction, 1 ADHD NOS, 1 phonological disorder, 1 PTSD, 1 history of sexual abuse, and 1 history of alcohol abuse. Two charts had deferred Axis II diagnoses. On Axis III, 5 charts noted HIV, 1 asthma, 1 latex allergy, 1 headaches, 1 laryngeal papillomas, 1 obesity, 1 Type II diabetes, and 1 ischemic CVA or stroke. On Axis IV, 1 chart noted issues with primary support group, 1 noted parent/child relational problems, 1 extreme stressors, 1 “moderate,” 1 “moderate to severe,” and 1 “severe.” For Axis V, 3 charts showed current GAF in the 60s, 2 reported GAF in the 70s, and 1 in the 80s. No charts documented a need for initial laboratory assessments.

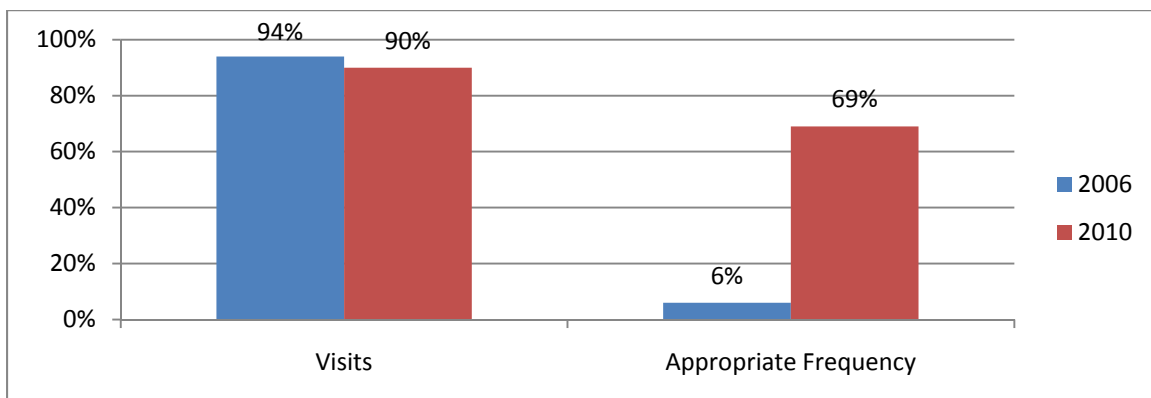
Care plans, with specific measurable treatment goals through the appropriate use of outcome assessment, are to be developed for all clients after the initial evaluation. Half (6/12) of the new pediatric clients had care plans developed at intake, while in 2006 no charts had care plans developed at intake. Four (67%) of the plans included measurable treatment goals and 1 (17%) indicated a method of outcome assessment. All six charts with a care plan identified a treatment modality; 4 specified individual supportive psychotherapy and 2 individual psychotherapy, theory not specified. Three (50%) of the charts with a care plan addressed issues related to the clients’ HIV-related care. Four (67%) indicated client input in the providers’ notes, although no client signatures were found on care plans. Only 1 (17%) chart did not adhere to treatment guidelines because the last two pages of the assessment were missing from the record. One (17%) of the charts with a baseline also indicated communication of the assessment with the primary care provider.

CONTINUED SERVICES

Standard 4.2.2 outlines a series of key activities related to the provision and monitoring of care and treatment over time. These activities include: 1) Appropriate frequency of visits, 2) The prescription and monitoring of psychotropic medications, 3) Reassessment of the care plan, and 4) Discharge planning. Continued services were assessed in all 29 pediatric/adolescent records.

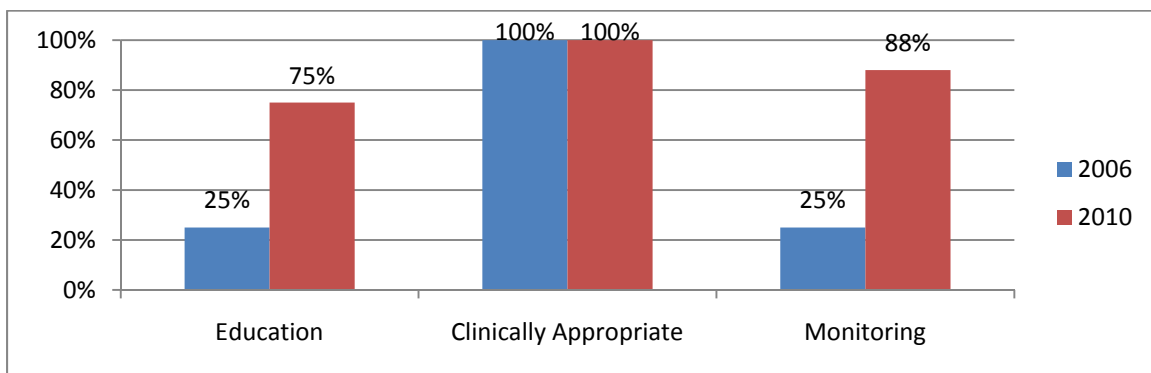
Appropriate visit frequency based on the patient’s diagnosis, severity of need, and treatment plan must be documented. Of the 29 charts reviewed, 90% documented patient visits and 69% contained visit frequency appropriate to care. Visit documentation was comparable to that seen in 2006 and appropriate frequency was much improved, *Figure 35*.

Figure 35. Visits, N=29



The prescription and monitoring of appropriate psychotropic medications must occur as indicated by the clinical situation and in accordance with evidence-based practice guidelines. Psychotropic medication must be provided and monitored under the supervision of a psychiatrist or primary care provider. Clients or their caregivers must be educated about medication administration and side-effect monitoring. Only **8 (28%)** clients were prescribed psychotropic medications. Of these, **6 (75%)** were prescribed by a child psychiatrist, **1 (13%)** by a physician, and **1 (13%)** did not specify the prescriber by position. All of the records showed the medication was clinically appropriate and indicated by treatment guidelines. Seven (**88%**) records documented routine and appropriate monitoring of medications under the supervision of a psychiatrist or primary care provider. All monitoring was done by patient or caregiver interview. Six (**75%**) charts documented teaching the patient or caregiver about medication administration and side-effect monitoring, *Figure 36*.

Figure 36. Psychotropic Medication, N=8



Standard B.4.3.3(h) requires that each client’s care plan be reassessed at least every three months. In addition, it is expected that the mental health provider will communicate with the primary care provider every three months. Of the **27** clients who were in treatment more than three months, **5 (19%)** had their treatment plans reviewed at least once and **4** of these had their plans reviewed a second time. Only **3 (11%)** of the charts reviewed documented communication with the primary medical care provider or referral source. Only **2 (7%)** records contained an outcome assessment, such as a parental report, child self-report, or school report.

Of the **29** charts reviewed, all but one (**97%**) continued to receive services through the end of the review period. One (**3%**) client was terminated due to no shows. This chart did not contain documentation of discharge planning, client involvement in discharge, or follow-up/aftercare recommendations.

SECTION 6. CONSUMER SURVEY

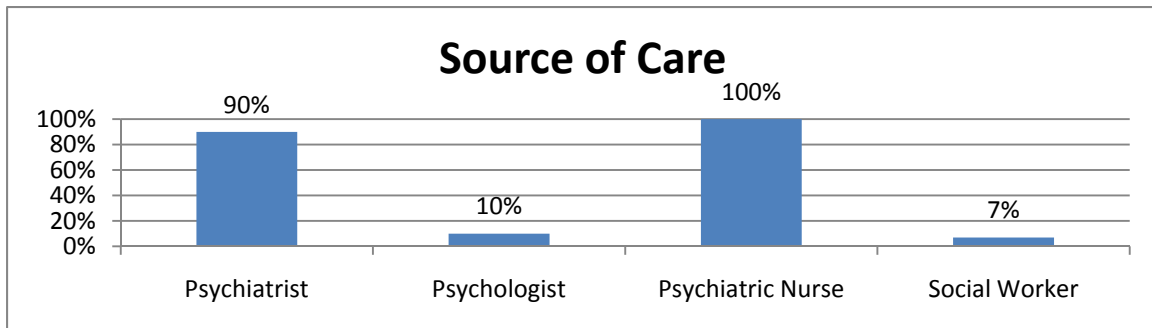
Consumers for the mental health survey were directly recruited from the Ryan White agencies. Consumers were surveyed about their mental health service experiences during the past twelve months. A total of **62** mental health consumers were interviewed at six sites. Survey questions were administered by a consultant interviewer either in-person or by telephone. The consumers represent a convenience sample and consent for permission to contact clients by telephone was obtained prior to calling individual clients. Note, results may total above or below **100%** due to rounding and all survey participants were 18 years of age or older. *Table 8* shows the number of clients surveyed at each site. Three adult interviews from the pediatric site were included in the analysis.

Table 8. Mental Health Consumer Surveys, N=62

Agency	Surveys	% of Total
Chase Brexton	6	10%
Johns Hopkins City	7	11%
Johns Hopkins County	7	11%
Johns Hopkins Pediatrics	3	5%
Total Health Care	16	26%
University of Maryland	16	26%
Peoples Community Health	7	11%
Total	62	100%

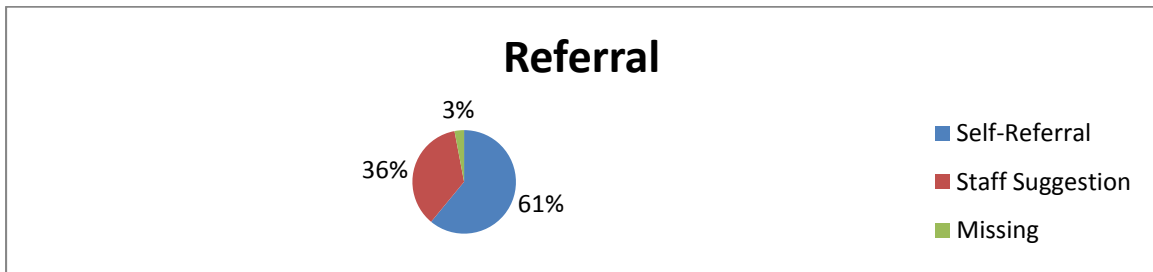
As shown in *Figure 37*, all clients (**100%**) reported they saw a psychiatric nurse, and **90%** also saw a psychiatrist. Note, consumers can be seen by multiple providers.

Figure 37. Source of Care, N=62



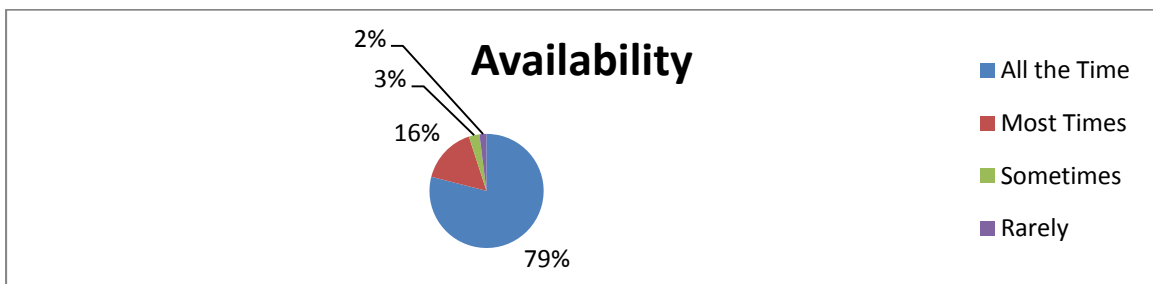
As shown in *Figure 38*, when asked why they were seen for mental health treatment, **61%** of consumers self-referred and **36%** were referred by someone else.

Figure 38. Mental Health Referral, N=62



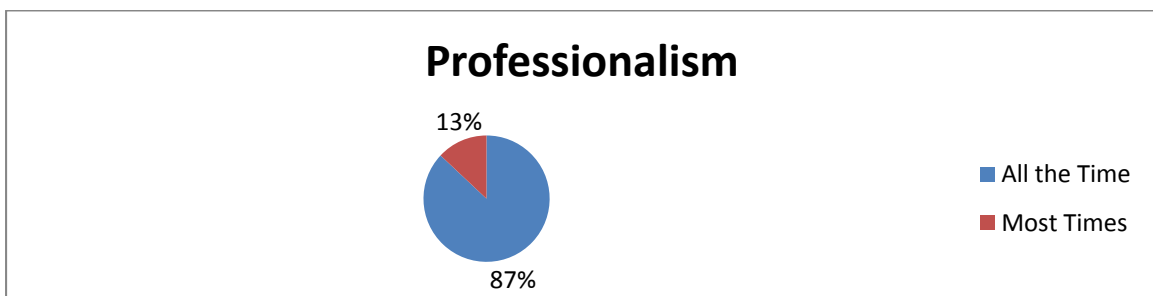
When asked whether they were able to see their provider soon enough to meet their needs, most consumers (**79%**) responded all of the time. As shown in *Figure 39*, only **2%** reported they rarely could see their provider as needed.

Figure 39. Provider Availability, N=62



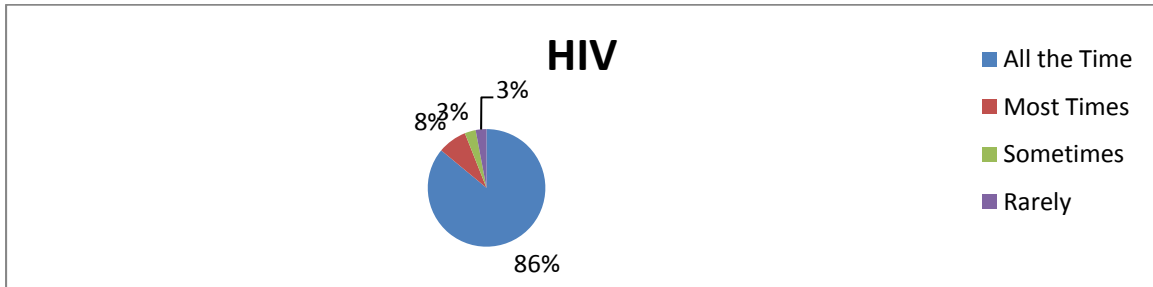
All consumers (**100%**) reported their providers were professional all or most of the time, *Figure 40*.

Figure 40. Provider Professionalism, N=62



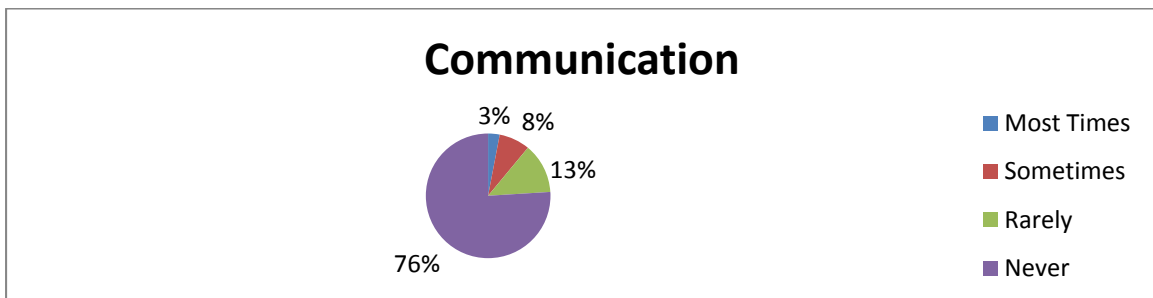
Only **3%** of consumers reported their provider rarely knew how HIV affected their mental health, *Figure 41*.

Figure 41. Understanding HIV, N=62



Only **11%** of consumers found it hard to communicate with their provider some or most of the time, *Figure 42*.

Figure 42. Provider Communication, N=62



Most (**89%**) consumers were comfortable sharing their feelings and problems with their providers all or most of the time, *Figure 43*.

Figure 43. Sharing Feelings with Providers, N=62

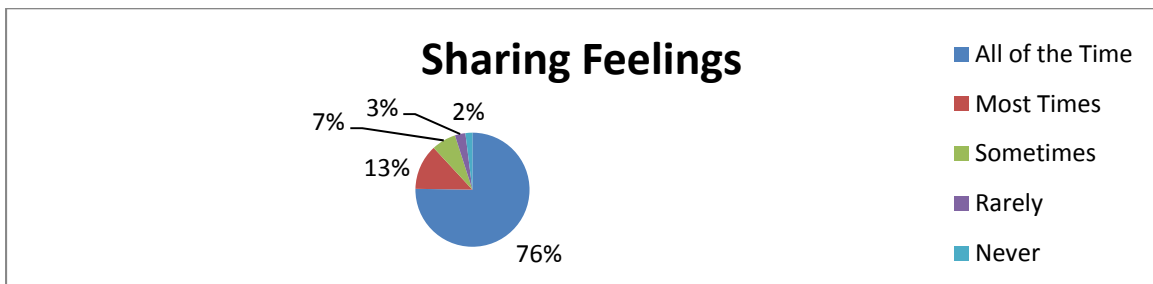
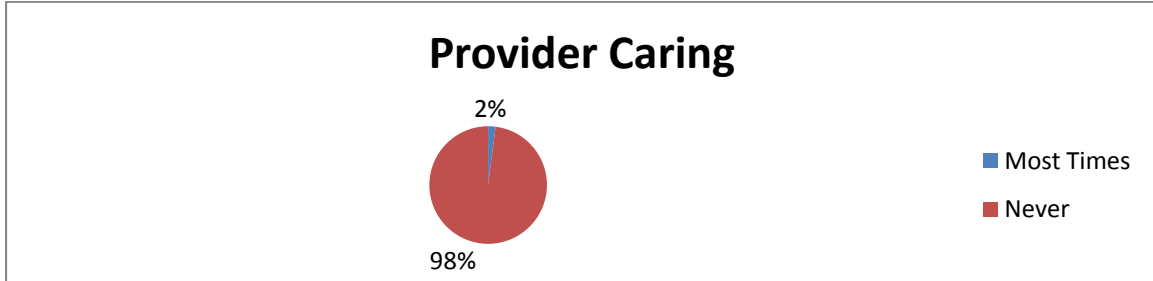


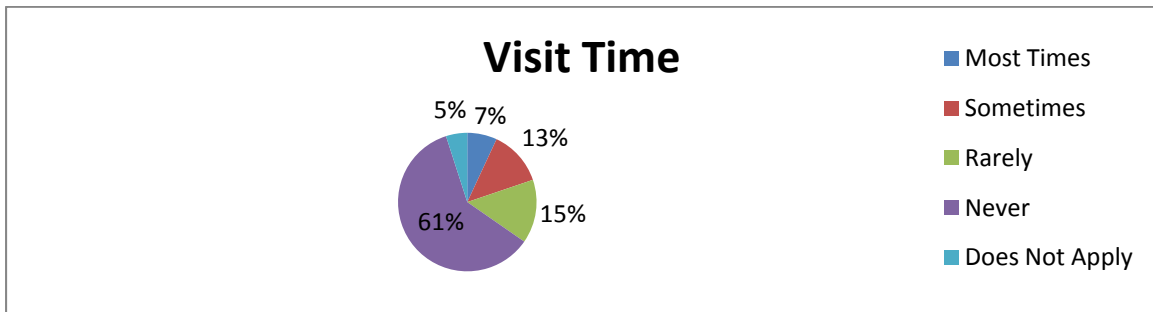
Figure 44 shows nearly all (98%) clients surveyed thought providers cared how they were feeling as evidenced by their response to the question, “My mental health providers didn’t seem to care how I was feeling.”

Figure 44. Provider Caring, N=62



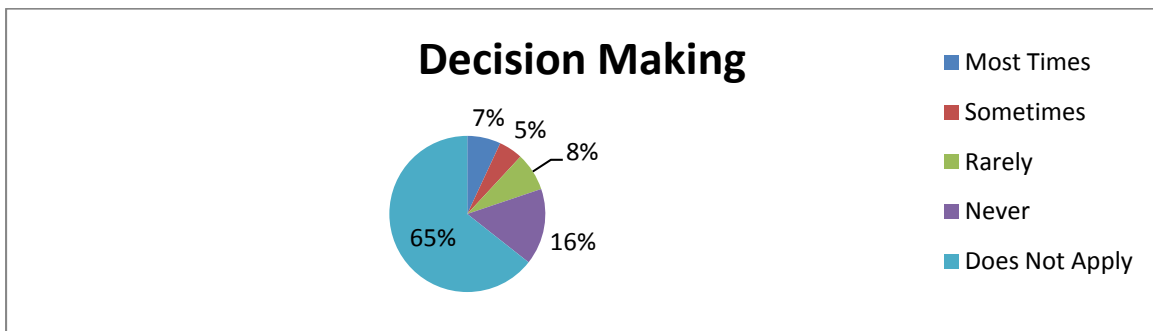
In response to the item, “I wanted my mental health providers to spend more time with me to help me deal with my problems,” 61% of consumers indicated they were satisfied with the amount of time allocated for visits, Figure 45.

Figure 45. More Visit Time Needed, N=62



Clients were presented the statement, “I wanted to be more involved in making decisions about my mental health treatment.” While 12% of consumers selected “most” or “some” of the time, a majority (65%) found the question not applicable, Figure 46.

Figure 46. Desire Decision Involvement, N=62



As shown in *Figure 47*, **73%** of respondents expressed satisfaction with the level of involvement of family or friends during the treatment process.

Figure 47. Family Involvement, N=62

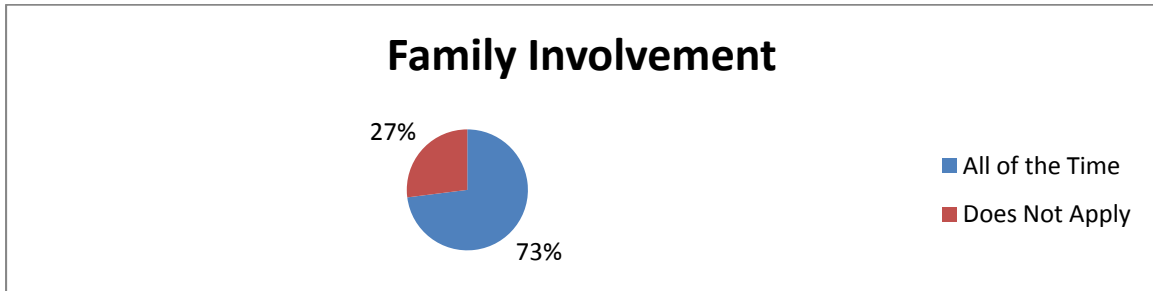


Figure 48 shows **81%** of those surveyed were “never” concerned they would get into trouble for disagreeing with or complaining about mental health providers.

Figure 48. Disagreement with Providers, N=62

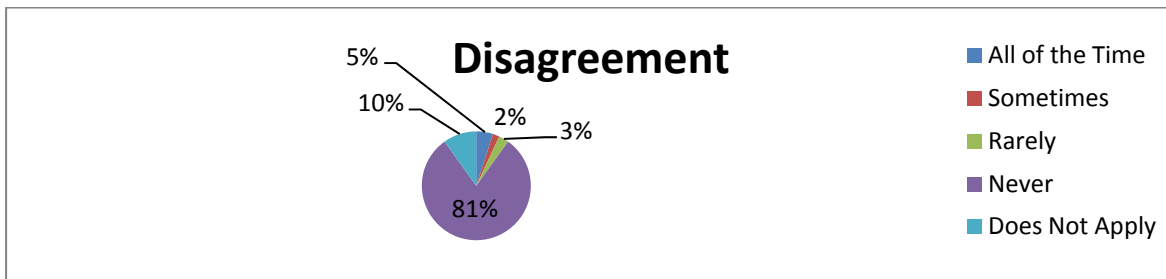
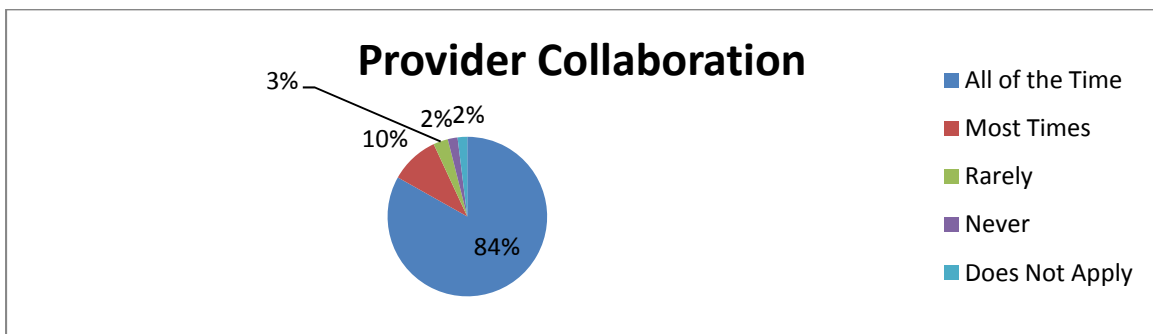


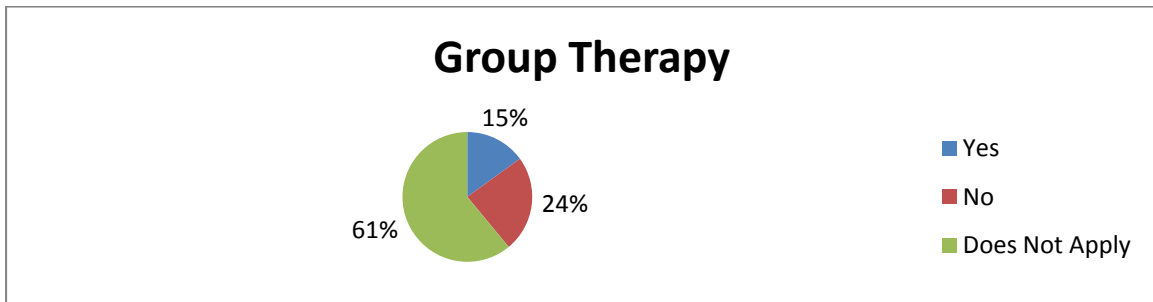
Figure 49 shows that most (**94%**) survey responses concluded that “all” or “most” of the time collaboration between mental health providers and HIV medical providers occurs.

Figure 49. Provider Collaboration, N=62



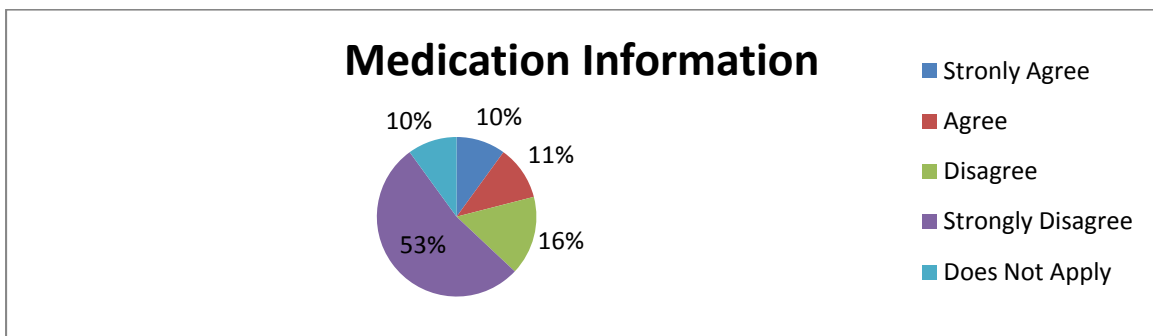
A few (15%) consumers expressed a desire for more time in group therapy, *Figure 50*.

Figure 50. More Group Therapy, N=62



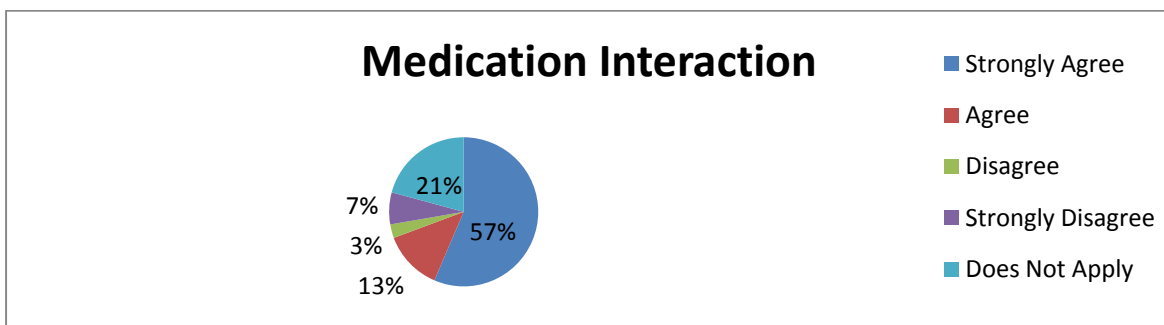
Sixty nine percent (69%) of consumers understood providers' explanation of medication side effects as evidenced by "disagree" or "strongly disagree" responses to the question, "I needed more information about the purpose of my psychiatric medications and their side effects," *Figure 51*.

Figure 51. More Medication Information, N=62



Similarly, in response to the question, "I understood my providers' explanation of how my psychiatric and HIV medications interact," 70% of consumers "agreed" or "strongly agreed," *Figure 52*.

Figure 52. Medication Interactions, N=62



Almost all (**95%**) consumers surveyed saw an improvement as a result of mental health treatment, *Figure 53*.

Figure 53. Treatment Effective, N=62

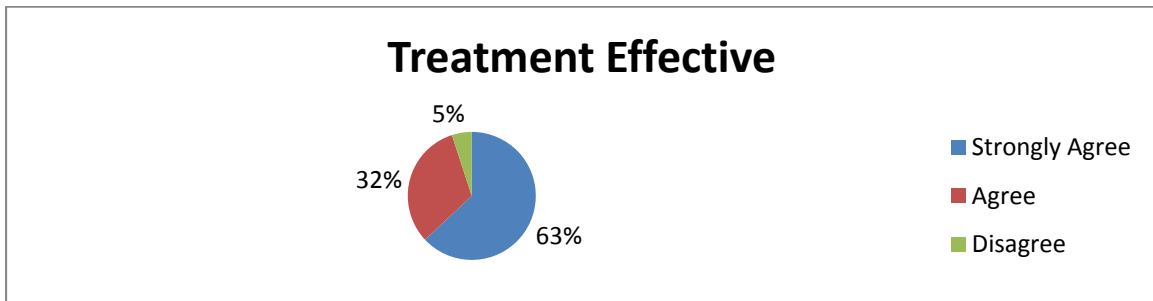
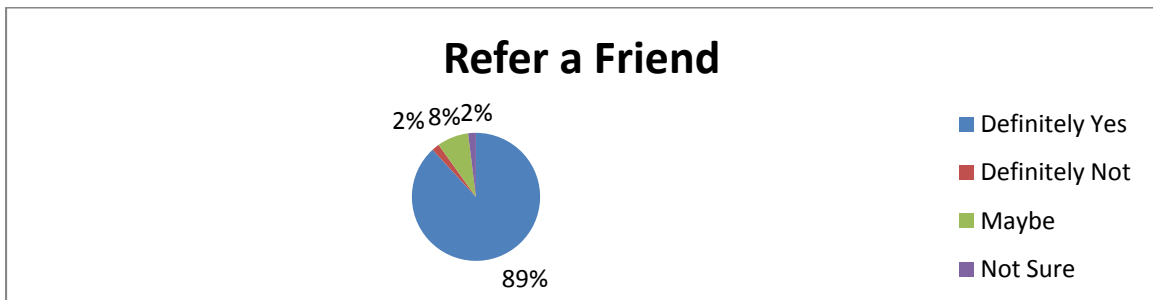


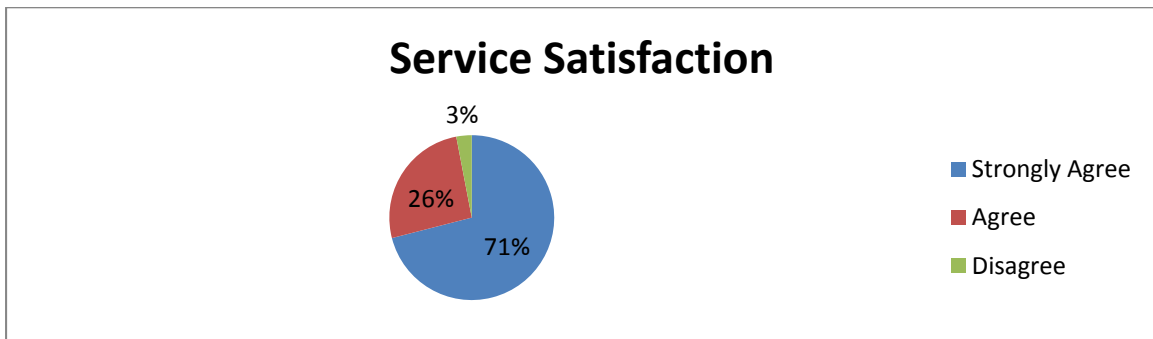
Figure 54 shows most (**89%**) clients surveyed would definitely refer other HIV positive people with mental health problems to their clinic.

Figure 54. Refer a Friend, N=62



Nearly all (**97%**) of those responding expressed overall satisfaction with the mental health services received over the past twelve months, *Figure 55*.

Figure 55. Service Satisfaction, N=62



SECTION 7. QI ORGANIZATIONAL ASSESSMENT

Nine programs were assessed during the CQM review however because some programs are under the umbrella of parent agencies, six organizations participated in the QI organizational assessment. The **15** question items evaluated 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 read the question and then asked to rate themselves on a scale from 0 to 5. 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 across agencies. *Figures 56 and 57* show the average scores on each question across mental health agencies. For all aspects of quality improvement programs, mental health providers scored **3.8** on the five point scale.

SECTION A. QUALITY STRUCTURE

1. Does the HIV program have an organizational structure to assess and improve the quality of care? – Average score **4.0**. Overall, most agencies had regular quarterly meetings attended by clinicians and multidisciplinary representation involved in the process.
2. Were appropriate resources committed to support the HIV quality program? – Average score **3.5**. Most agencies reported that key staff had allotted time for QI activities and that their programs were headed by a full time quality manager.
3. Did the HIV leadership support the HIV quality program? – Average score **4.2**. Most agencies report that HIV program leadership set quality priorities and established a commitment to quality.
4. Does the HIV quality program have a comprehensive quality plan? – Average score **3.5**. Written quality management plans existed at most agencies. Plans were updated annually but all staff members were not involved in their development or update.

SECTION B. QUALITY PLANNING

1. Were annual goals established for the HIV quality program? – Average score **4.7**. Annual goals are discussed by the HIV quality committee and were based on past performance. However, quality goals were not always communicated to all staff nor were all staff involved in the selection process for the goals.
2. Does the HIV program have clearly described roles and responsibilities for the HIV quality program? – Average score **4.0**. Many agencies report that key roles and responsibilities are described for the quality program. There is some staff involvement in the design of these roles and responsibilities.
3. Is there a document in place to specify timelines for the implementation of the HIV quality program? – Average score **3.8**. Agencies report that work plans and timelines are in place and are updated periodically. Some staff are aware of the work plan.

SECTION C. QUALITY PERFORMANCE MEASUREMENT

1. Were appropriate quality indicators selected in the HIV quality program? – Average score **3.8**. Agencies selected indicators based on results of their quality initiatives and were reflective of the standards of care. Staff was not always involved in the development of the indicators.
2. Did the HIV program routinely measure the quality of care? – Average score **4.0**. Performance measurement was completed with the input of most staff with the results reviewed by a quality committee. The process to measure performance was moderately described 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 quality of care? – Average score **3.7**. A score of **4** indicates that quality improvement activities focused on processes and that projects were based on data. Findings were committed to the quality committee and at least one data-driven quality improvement project was completed.
2. Was a team approach utilized to improve specific quality aspects? – Average score **4.2**. Team approaches were common amongst agencies surveyed. All staff had a basic knowledge about the QI team approach and basic methodologies to include PDSAs and root-cause analyses. Team approaches were used to identify and address complex quality issues.

SECTION E. STAFF INVOLVEMENT

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

SECTION F. CONSUMER INVOLVEMENT

1. Are consumers involved in quality related activities? – Average score **3.0**. Agencies report that patient needs are assessed and discussed in quality meetings. These findings are not always integrated into the quality program. Results of quality activities are not always shared with consumers.

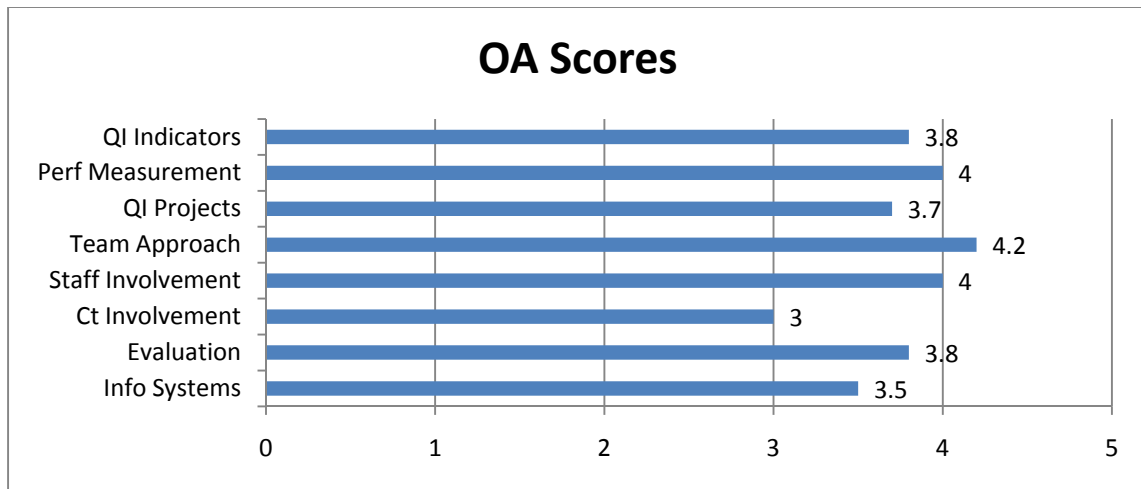
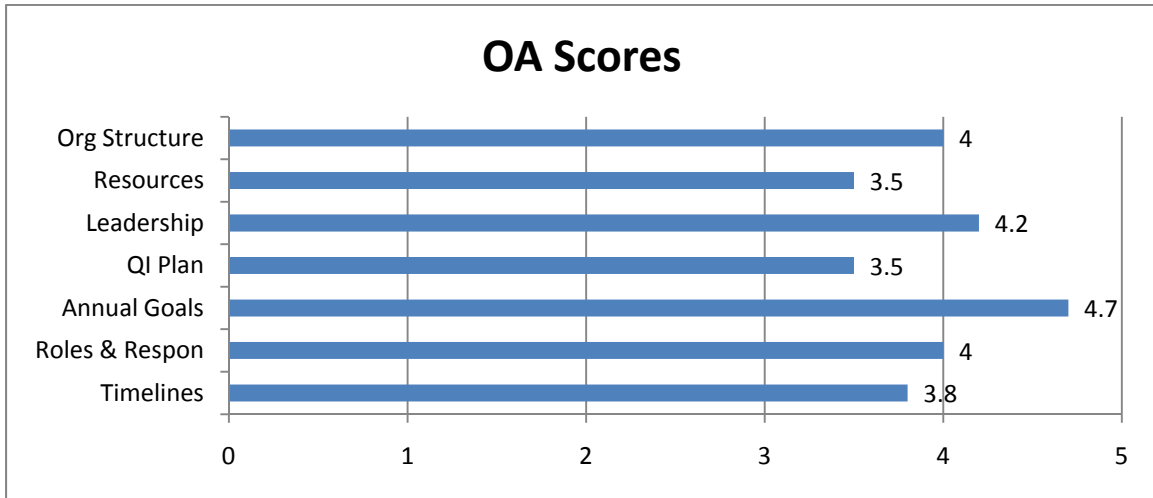
SECTION G. EVALUATION OF QUALITY PROGRAM

1. Is a process in place to evaluate the HIV quality program? – Average score **3.8**. The quality program is reviewed using a team approach and the results may be used to plan ahead for the future. Past results may be used to update the work plan, annual goals, and timelines.

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

Figures 56 and 57. QI Organizational Assessment, N=6



SECTION 8. SUMMARY OF FINDINGS

The CQM process provided a systematic review of compliance to the EMA standards of care for **100%** of Part A- and MAI-funded agencies providing adult mental health (**N=5**) and pediatric/adolescent mental health (**N=1**) services during fiscal year 2009. A total of **381** mental health charts were reviewed, **352** adults and **29** child/adolescents representing approximately **45%** of Part A and MAI mental health clients receiving services. In addition to the chart abstractions, **62** adult consumers were surveyed. All six agencies providing mental health services completed a quality improvement organizational assessment as well. The following section highlights strengths and areas for improvement based on all evaluation data. Adult and pediatric/adolescent outcomes are addressed separately.

ADULT OUTCOMES

Strengths- Based on the review of **352** adult client charts, the following items have a high rate of compliance with the standards of care. Documentation of HIV status was **99%**. Documentation of insurance was **90%** and **80%** of those were enrolled. CD4 and viral load values have improved since 2006. Intakes are more complete in all areas including history, mental status screening, and multi-axial differential diagnoses. The percent of new and continuing clients with care plans has improved. The number of clients who received an appropriate number of visits according to their treatment plans has improved, however patient retention remains a challenge. Finally, medications are almost always (**99%**) clinically appropriate and medication monitoring was documented in **80%** of records.

Areas for Improvement- Analysis of the data collected during the review also identified areas with lower rates of compliance with the standards of care. Again, the following points are based on the review of **352** adult mental health charts. Although improved since the last review, only half of the charts documented residence and income eligibility. A few items within the intakes were incomplete including pre-morbid personality (**44%**), obsessions/compulsions (**64%**), and panic attacks (**58%**). Cognitive assessments were documented in **67%** of new patient charts. Documentation that clients had input into their care plans could be improved. Where present, this is generally seen in provider notes rather than by client signature indicating participation and agreement to the plan. About two thirds of charts had signatures that clients received program policies. Only **41%** of new client care plans included the expected visit frequency and a third contained specific patient goals.

For all clients, a third of charts specified treatment outcomes. Few charts (**18%**) showed HIV prevention for positives counseling. Substance abuse counseling is documented for about two thirds of those needing it. About half of charts showed that clients prescribed psychotropic medication received medication education. When clients needing additional mental health or addictions services receive referrals, follow-up on referrals is about **50%**. Finally, quarterly care plan reassessment is shown for about half of continuing clients each quarter.

PEDIATRIC/ADOLESCENT OUTCOMES

Strengths- Based on the **29** pediatric/adolescent client charts reviewed, the following items have a high rate of compliance with the standards of care. Documentation of baseline evaluations, clinical labs, and care plans all increased. Appropriate visit frequency also showed a **63%** increase from 2006. Instructions and appropriate monitoring of psychotropic medications also increased.

Areas for Improvement- The following areas were also identified as being in lower compliance with the standards of care. Only **17%** of charts documented informed consent for mental health treatment services. Only **11%** of charts showed communication with the primary care provider or referral source. Only **8%** of charts documented outcome assessments. While in 2006, **30%** of treatment plans were reassessed, in 2010 only **19%** of the treatment plans were revisited. Finally, although HIV labs were better documented, clinical outcomes fared poorer in 2010 among the pediatric/adolescent sample.

CONSUMER SURVEY

Strengths- Consumers reported high levels of satisfaction with the mental health services received and reported improvement as a result of receiving treatment. Consumers indicated that collaboration between mental health providers and HIV medical providers takes place.

Areas for Improvement- Twenty one percent of consumers reported they needed more information about the purpose of psychotropic medications and their side effects. A quarter (**25%**) of clients also suggested therapy flexibility.

ORGANIZATIONAL ASSESSMENT

Agencies showed a high level of awareness of the need for organizing quality improvement teams and for planning and implementing quality improvement activities. Agencies could still benefit from capacity building around increasing their level of consumer involvement in quality improvement activities.

SECTION 9. DISCUSSION AND RECOMMENDATIONS

Providers: The following points are based on the summary findings from the adult mental health services. In general, it is recommended that agencies providing mental health services review the standards of care and their agency processes to ensure alignment. Outlined below are the specific areas in which mental health agencies need to focus their attention. These areas also apply to the pediatric/adolescent mental health services.

- Documentation of a client's income level and residency are part of the eligibility verification for Ryan White services. As part of the intake, providers need to collect the proper documents from clients and maintain copies in the client's chart. If an agency is unsure of what qualifies as proper documentation, they should contact the CQM office for clarification. Without complete eligibility information, timely enrollment into other funding streams is affected, which results in the loss of program income as consumers are transitioned off of Ryan White.
- While client baseline evaluations are completed at improved rates, there are a few items that are not completed at high rates. Agencies should review the standards of care and their evaluation forms and/or processes to ensure that all required components are being addressed. In particular, compliance rates were low for cognitive assessments.
- Although some aspect of a care plan is present in more charts during this review, key components such as visit frequency, goals, and outcomes still fall short. Care plans are a significant part of treatment as they serve to identify the issues, map out treatment, and identify measurable goals. As such, care plans are distinct from progress notes and service providers need to ensure care plans are being developed as part of their practice. In addition, care plans need to be reassessed more frequently. Quarterly care plan reassessment has increased since 2006, but is only present half of the time.
- The vast majority of records reviewed did not note HIV prevention for positives counseling was delivered. Ryan White funds are used exclusively to provide services for HIV-positive individuals and it is expected that prevention counseling will be conducted.
- A quarter of consumers expressed a desire for therapy flexibility. Although not required in the standards, providers may wish to verify whether clients are benefiting from their specific therapy modality.
- Regarding the use of psychotropic medications, mental health providers must document that the client is given education regarding the risks and benefits of the medication. Only **40%** of the records reviewed showed documentation of medication education. Consumers also expressed a need for more information about their medications. It is also important to document the client's consent to treatment with medications. Often these documentation issues can be resolved with forms or checklists to serve as a reminder to the mental health provider of what is required.
- The pediatric client population is smaller and older than four years ago. Documentation of pediatric care has improved dramatically overall. Areas continuing to require improvement include, 1) Review of care plans including outcomes, 2) Documentation of communication with the primary care provider, 3) Client or guardian consent to receive services, and 4) Documentation of prenatal history and review of systems.

Planning Council: Regarding the standards of care, CQM again recommends that the planning council consider incorporating discharge planning and chart closure guidelines in the next revision of the mental health standards of care. As written, neither the adult nor pediatric mental health standards outline these procedures.

Baltimore City Health Department: Based on the findings, the following steps have been taken, or are in progress:

1) Following each 2010 review, CQM staff debriefed with agency personnel to highlight program strengths and weaknesses. Areas for improvement were emphasized so agencies could incorporate improvement activities prior to receiving their formal vendor reports.

2) Following data analysis, CQM staff held a Technical Assistance (TA) session for Mental Health providers on February 24th, 2011. All **(100%)** providers sent a representative to the TA session. During the session, chart abstraction, agency, and consumer data were presented to providers. Strengths and areas for improvement were identified. After prioritizing the data presented, providers were broken into groups where they used quality improvement tools to brainstorm an improvement project. Providers developed a “fishbone” diagram to identify root causes of low performing indicators and mapped out a “Plan-Do-Study-Act” improvement project cycle specific to their agency.

3) In addition to this report, each agency will receive a vendor report that assesses their individual performance in comparison to the category performance overall. Each vendor report identifies specific areas of improvement and requires the agency to submit an improvement project to address any issues identified.

Tables 9 and 10 outline quality indicators developed for mental health services. A comparison of performance from 2002 to the present review, as well as performance goals are presented.

Table 9. Adult Mental Health Indicators

Indicator	2002	2006	2010	Goal
% of client records which document completion of initial evaluation by a licensed mental health professional prior to initiation of treatment	93%	89%	90%	90%
% of client records which document completion of multi-axial differential diagnosis	60%	70%	99%	90%
% of client records which document completion of a treatment plan	66%	62%	94%	90%
% of client records which document reassessment of the treatment plan and progress every three months	8%	13%	53%	80%
% of client records which document medication education and side effect assessment	54%	40%	46%	80%

Table 10. Pediatric Mental Health Indicators

Indicator	2002	2006	2010	Goal
% of client records which document completion of initial evaluation by a licensed mental health professional prior to the initiation of treatment	50%	33%	83%	90%
% of client records which document completion of multi-axial differential diagnosis	23%	0%	60%	90%
% of client records which document completion of a treatment plan	32%	12%	50%	90%
% of client records which document reassessment of the treatment plan and progress every three months	0%	13%	19%	80%
% of client records which document medication education and side effect monitoring to patient/caregiver	20%	25%	75%	80%
% of client records which document written documentation with patient's primary care provider at points of regular review (three month intervals)	33%	10%	11%	80%

APPENDICES

- Appendix A: Mental Health Services Standards of Care, Greater Baltimore HIV Health Services Planning Council, Ratified March 2005.
- Appendix B: Mental Health Services Children and Adolescent Standards of Care, Greater Baltimore HIV Health Services Planning Council, Ratified April 2005.