BALTIMORE CITY HEALTH DEPARTMENT

RYAN WHITE OFFICE

CLINICAL QUALITY MANAGEMENT PROGRAM (CQM)

Service Category: Residential Substance Abuse Treatment Services

June, 2011

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SECTION 1. INTRODUCTION

The Baltimore City Health Department (BCHD) Clinical Quality Management Program (CQM) began in fiscal year 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWH/A) in the Baltimore/Towson Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White HIV/AIDS Treatment Extension Act of 2009. In fiscal year 2010, the CQM initiative focused on adult primary medical care, mental health, outpatient substance abuse, residential substance abuse, and outreach services. This report presents residential substance abuse services.

As defined in the Greater Baltimore HIV Health Services Planning Council local Standards of Care (Standards of Care), residential substance abuse services are defined as, "The provision of treatment to address substance-abuse problems (including alcohol and/or legal and illegal drugs) provided in an inpatient health-service setting (short-term: no longer than 190 days)."

To assess the degree to which the standards of care were adhered to across the EMA, data was gathered and analyzed from all Part A-funded residential substance abuse vendors in the EMA. In addition to providing the results of the data collected, this report provides details of the methodology, as well as a summary of the findings, national comparisons, and recommendations for improving the quality of substance abuse services. The Appendix contains the standards of care used during the review.

SECTION 2. METHODOLOGY

Clinical Quality Management reviews were conducted during 2010 at **3** agencies providing residential substance abuse services. Data was collected through two avenues, 1) Client chart abstractions and 2) QI organizational assessments. Reviewers did not have access to sufficient consumers to assure anonymity and provide meaningful feedback. The data presented is not intended to reflect all Ryan White residential substance abuse clients throughout the Baltimore/Towson EMA.

Client Chart Abstraction: The chart abstraction tool was designed to assess vendor adherence to the standards of care. The review period focused on Part A services provided in fiscal year 2009. The fiscal year covered March 1, 2009 thru February 28, 2010. Information related to the client chart abstraction is presented in *Sections 4-6.*

Vendors were directed to provide a random sample of charts and CQM provided two methodologies for doing so. CQM staff did not verify that the charts provided by the agencies represented a random sample. The number of charts requested from an agency was based on the number of Ryan White clients receiving substance abuse services from that agency and guided by the 2008 HIVQUAL sampling methodology developed by the New York State Department of Health, AIDS Institute.[1]

A total of **45** client charts were reviewed at the **3** agencies. All agencies were sub-recipients of Baltimore Substance Abuse Systems who contracts for Ryan White Part A residential substance abuse services in the Baltimore/Towson EMA. The number of charts reviewed per site ranged from **10** to **19** with an average of **15** charts reviewed per site. Based on the data reported to BCHD by the agencies receiving Part A funding, a total of **52** persons received residential substance abuse services during fiscal year 2009.[2] **Eighty seven percent** of all residential substance abuse charts were reviewed during the 2010 CQM reviews, *Table 1.*

Table 1. Residential Substance Abuse Charts Reviewed, N=45

Program	Charts Reviewed	% CQM Sample	Clients Seen	% Agency Sample
BSAS – Tuerk House	16	36%	16	100%
BSAS – Mountain Manor	19	42%	24	79%
BSAS – Powell Recovery	10	22%	12	83%
Total	**45**	**100%**	**52**	**87%**

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

[1] New York State Department of Health AIDS Institute, The 2008 HIVQUAL Project Sampling Methodology, August 2009.
[2] This data was obtained from monthly Form 8 submissions to the Grantee's office. This total is unduplicated at the vendor level, then aggregated to give a duplicated EMA-wide client count.

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. [3]

The client chart abstraction tool and QI organizational assessment were distributed to vendors and the Greater Baltimore Health Services Planning Council (Planning Council) for comment prior to utilization during the reviews. CQM also conducted conference calls with all substance abuse 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.

Data Comparison: Throughout the report where possible, chart abstraction data were compared with the fiscal year 2007 review of residential substance abuse services and with data compiled by the Center for HIV Surveillance and Epidemiology at the Maryland Department of Mental Health and Hygiene.

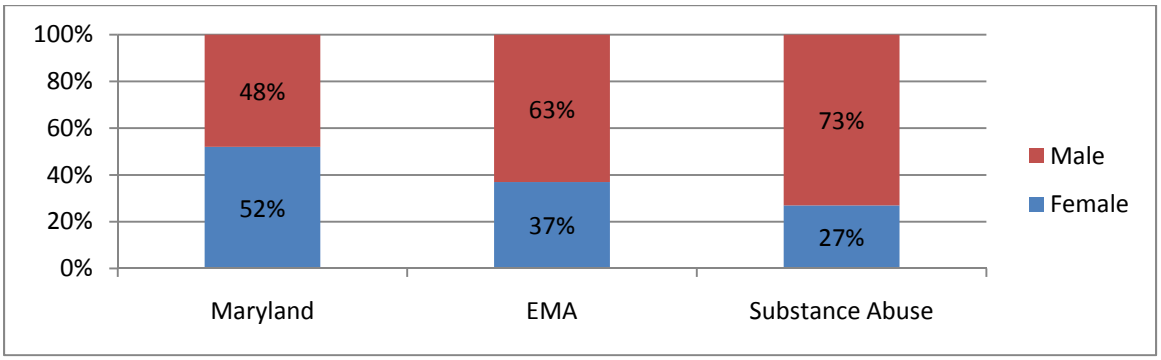
[3] http://www.hivguidelines.org/wp-content/uploads/HIVQUAL-OA.pdf

SECTION 3. DEMOGRAPHICS

GENDER

Of the **45** charts reviewed for residential substance abuse services, **27%** were female and **73%** were male. When compared to the 2007 sample, gender has remained nearly three quarters male. *Figure 1* compares the 2010 sample to the state of Maryland and to the overall PLWH/A population within the Baltimore/Towson EMA. This illustrates the impact of HIV/AIDS on men. While men comprise **48%** of the state population, they are overrepresented in the overall HIV/AIDS population **(63%),** as well as in the substance abuse sample **(73%).**

Figure 1. Gender, N=45



AGE

Table 2 displays the ages of the clients sampled in 2010, 2007, and the EMA's population of PLWH/As. This table highlights the prevalence of substance abuse treatment in older Ryan White clients. In 2010, **84%** of the substance abuse sample was over the age of 40 and makes up **74%** of PLWH/As within the EMA. Substance abuse treatment is not common in clients under age 30 and make up only **10%** of PLWH/As within the EMA.

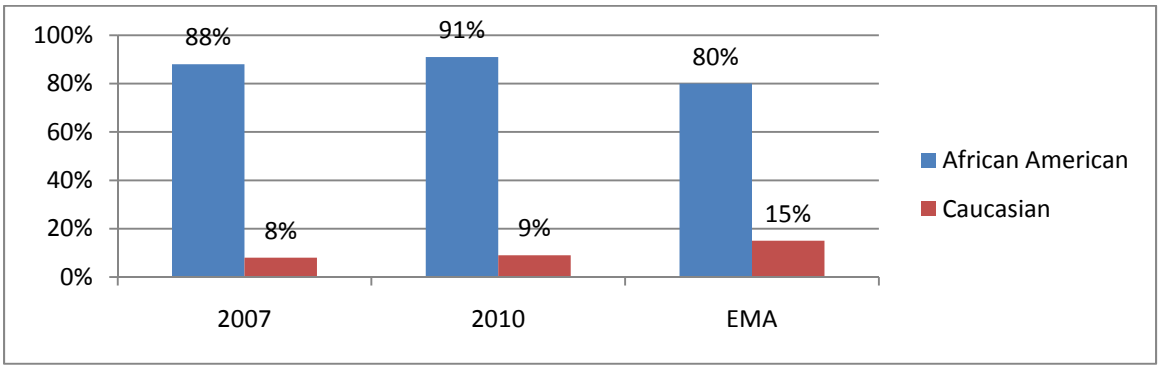
Table 2. Age, N=45

Age	2007	2010	EMA
0-19	0%	0%	2%
20s	3%	2%	8%
30s	27%	13%	16%
40s	43%	40%	38%
50s	25%	40%	28%
60+	2%	4%	8%

RACE/ETHNICITY

The majority of clients in this sample were African-American **(91%)** and **9%** were Caucasian. This trend was also seen in 2007 and in the EMA's PLWH/As, *Figure 2.*

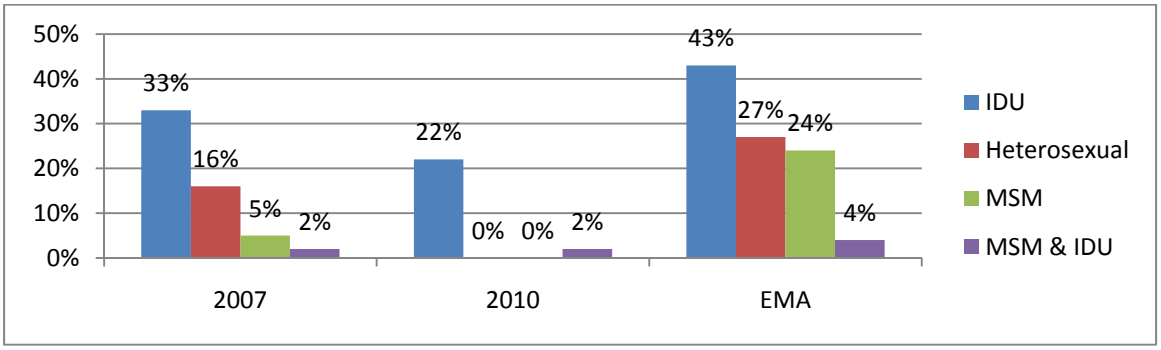
Figure 2. Race/Ethnicity, N=45



RISK FACTOR

Figure 3 displays the leading risk factors for the 2007, 2010, and EMA samples. Note, risk factor was missing for most **(76%)** of the 2010 substance abuse and was missing from **46%** of the 2007 sample as well. While the portion of IDU risk appears to have decreased over the last three years, this cannot be validated due to the large amount of missing data for rick factor. The EMA data show IDU as the leading risk factor followed by heterosexual contact and MSM.

Figure 3. Risk Factor, N=11



RESIDENCY

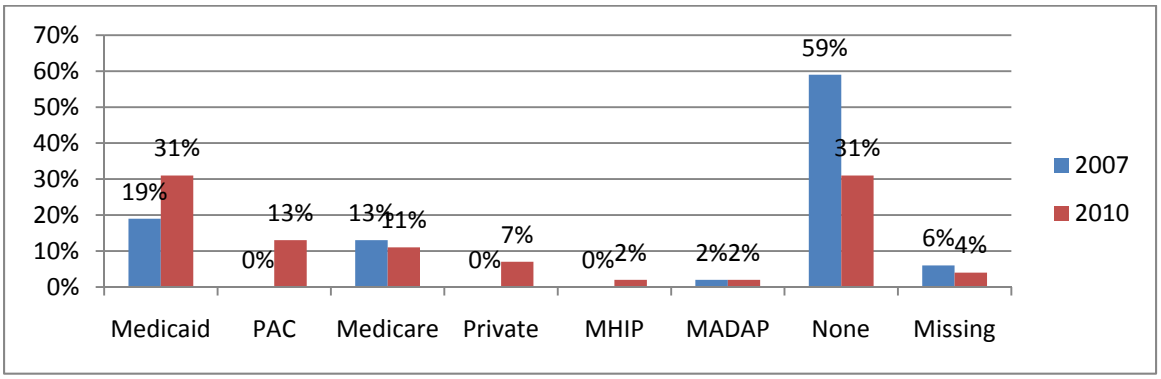
CQM reviews were conducted in Baltimore City and Baltimore County. One agency visited was outside the EMA but was still a sub-recipient of Part A funds. Baltimore City zip codes accounted for **80%** of the population followed by Baltimore County at **9%.** Anne Arundel County for **7%** of the zip

codes and one **(2%)** zip code indicated Prince George's County. One **(2%)** additional zip code was not documented.

INSURANCE STATUS

Of the **45** charts reviewed in 2010, Medicaid was the most common form of insurance coverage followed by PAC, **31%** and **13%** respectively, *Figure 4.* An additional **11%** of the sample was covered by Medicare and **7%** were privately insured. In 2007, the leading form of insurance was also Medicaid **(19%)** followed by Medicare **(13%).** A smaller portion of clients **(31%)** were uninsured in 2010 versus in 2007 when **59%** of clients were without insurance coverage.

Figure 4. Insurance Coverage, N=45



CLINICAL INDICATORS

Clinical indicators including CD4, viral load, HIV status, and use of highly active antiretroviral therapy (HAART) were collected. CD4 values were recorded in **20%** of charts, down from **65%** in the 2007 review. Viral load values were found in **11%** of charts compared to **48%** in 2007. Treatment status and medical reports (not shown) were better documented in 2010 at **88%** and **98%** respectively, *Figure 5.*

Figure 5. Clinical Indicators, N=45

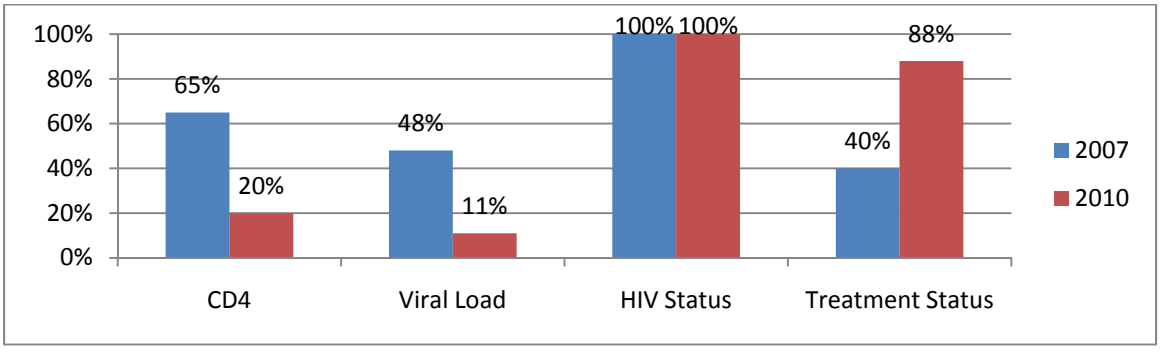


Table 3 shows CD4 and viral load values. Of the documented CD4 values, **5 (11%)** were above 500 cells/mm3. Two **(4%)** values were between 250-500, and **2 (4%)** were between 101-249. Three **(7%)** viral load values were undetectable and **2 (4%)** had viral load values above 20,000 copies/ml. Overall most charts did not contain CD4 or viral load values. Some agencies mentioned that clinical information is not contained within the substance abuse charts. CQM review debriefings emphasized the need to monitor clinical information to ensure primary medical care engagement and treatment adherence.

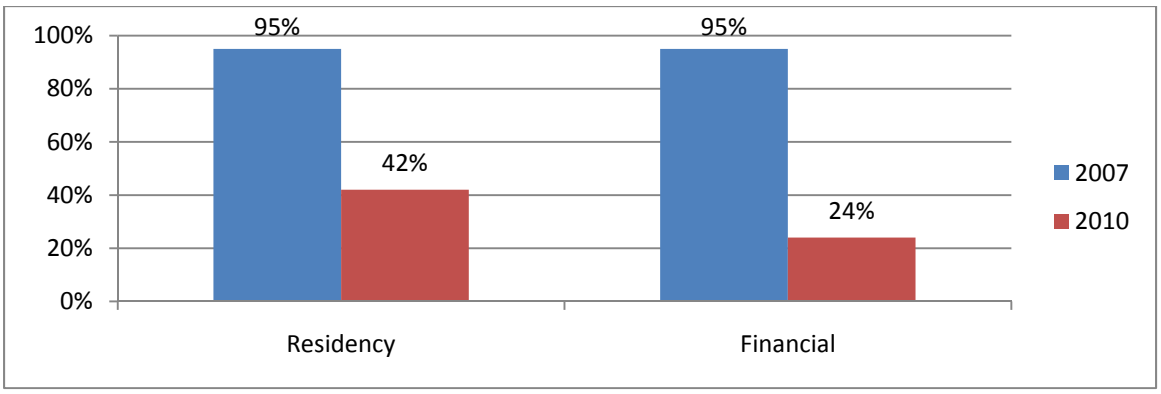
Table 3. CD4 and Viral Load Values, N=45

CD4	# (%)	Viral Load	# (%)
<50	--	**Undetectable**	3 (7%)
50-100	--	**<1K**	--
101-249	2 (4%)	**1-5K**	--
250-500	2 (4%)	**5-20K**	--
501-1K	4 (9%)	**20-100K**	1 (2%)
>1K	1 (2%)	**>100K**	1 (2%)
Missing	36 (80%)	**Missing**	40 (89%)

ELIGIBILITY

All Ryan White clients must establish initial eligibility prior to the initiation of services. Residency and financial eligibility were documented in **42%** and **24%** of charts respectively. These elements were better documented in 2007 charts at **95%** each for residency and financial eligibility, *Figure 6.* All three agencies were sub-recipients of a Ryan White Part A vendor and reported that, as such they did not establish eligibility, but received confirmation of a client's Ryan White eligibility along with the treatment referral. Note, official eligibility determinations must accompany treatment referrals or it remains the responsibility of the sub-contracted agency.

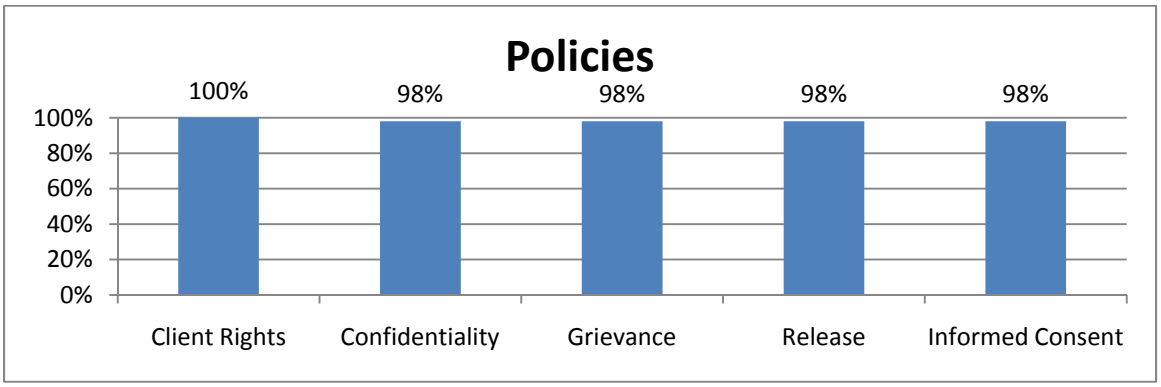
Figure 6. Eligibility, N=45



Before services are rendered, clients must be provided with copies of the agency's policies and procedures. Residential charts met these criteria at least **98%** of the time, *Figure 7.* Policy

documentation has increased since 2007 for client rights **(65%)** and grievance procedures **(0%),** *data not shown.*

Figure 7. Policies, N=45



ADMISSIONS REQUIREMENTS

An initial evaluation must be conducted by a certified/licensed clinical staff prior to the initiation of any treatment. Initial evaluations were conducted for **100%** of the sample; almost all **(93%)** by clinical staff. In 2007, **97%** completed initial evaluations.

Upon admission, the program must establish an interview date falling within ten working days of the client's initial contact. All **(100%)** charts met these criteria as well. Before services are rendered, clients must also have a complete assessment. All **(100%)** charts documented an assessment compared to **97%** in 2007. *Table 4* displays the assessment elements and completion rates seen in 2007 and 2010. With the exception of legal issues, assessment elements across the board have increased over the past three years. The screening tool, the Addiction Severity Index (ASI), was completed for **100%** of clients.

Table 4. Assessment Elements, N=45

Assessment Element	2007	2010
Physical	97%	98%
Employment	92%	100%
Drug/Alcohol	95%	100%
Legal	92%	89%
Family	93%	98%
Education	0%	100%
Mental Health	95%	100%

Treatment plans must be completed with the input of clients. They must include the client's individual needs, as well as interventions to meet those needs. Nearly all **(96%)** of clients had treatment plans, a slight decrease from 2007 when all clients had a treatment plan. Alcohol and drug use **(100%)** and socialization **(56%)** were the focus of many treatment plans. Education

(5%), legal **(5%),** and vocation **(7%)** documentation were low and had not changed significantly since 2007, *Table 5.*

Table 5. Treatment Plan Contents, N=43

Plan Element	2007	2010
Socialization	82%	56%
Alcohol/Drug	100%	100%
Psychological	23%	49%
Vocation	10%	7%
Education	7%	5%
Physical	53%	51%
Legal	3%	5%
Family	5%	12%

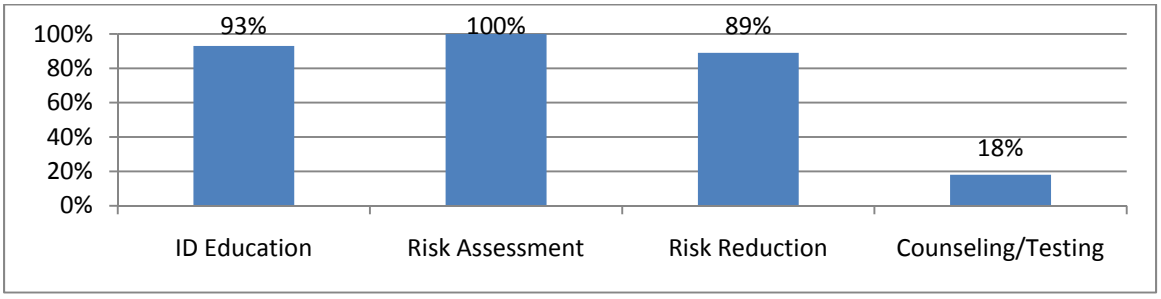
Some treatment plan interventions increased from 2007 to 2010, but target date to complete goals **(86%),** documentation of clinical services **(77%),** and criteria for successful completion of treatment **(70%)** all decreased. Other treatment plan elements increased in 2010 as seen in *Table 6.*

Table 6. Treatment Plan Interventions, N=43

Plan Intervention	2007	2010
Long/short term goals	65%	95%
Strategy to implement goals	97%	98%
Target date to complete goals	97%	86%
Schedule of clinical services	97%	77%
Criteria for successful completion of treatment	97%	70%
Referrals to ancillary services	10%	21%
Referrals to self-help groups	20%	26%

New clients are also required to receive infectious disease education within the first thirty days of treatment. All **(100%)** clients for residential substance abuse services were new. *Figure 8* shows that all **(100%)** received an HIV risk assessment and **93%** received infectious disease education. Risk reduction counseling was noted in **89%** of charts and referrals to counseling and testing were seen in **18%** of records.

Figure 8. Infectious Disease Education, N=45

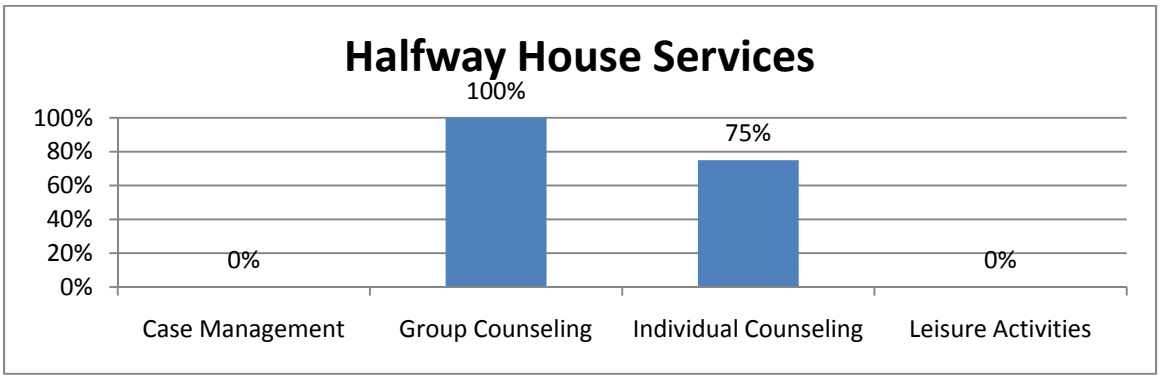


SECTION 4. HALFWAY HOUSE

Halfway House services are, "Clinically managed low intensity treatment programs that offer treatment services at least five hours a week directed toward preventing relapse, applying recovery skills, promoting personal responsibility, and reintegration," (COMAR 10.47.02.06). Clients must have an assessment completed within two weeks of admission, as well as have a treatment plan signed within seven days of the assessment. Services under this category include case management, periodic group counseling, individual counseling at least monthly, and leisure activities for the client.

There were **4** clients receiving halfway house services. All **(100%)** of them had assessments completed and signed treatment plans, *data not shown. Figure 9* shows that all **4 (100%)** clients received group counseling and **3 (75%)** received individual counseling as well. Case management and leisure activities were not documented in any charts. Client progress notes were found in all **4 (100%)** records reviewed.

Figure 9. Halfway House Services, N=4



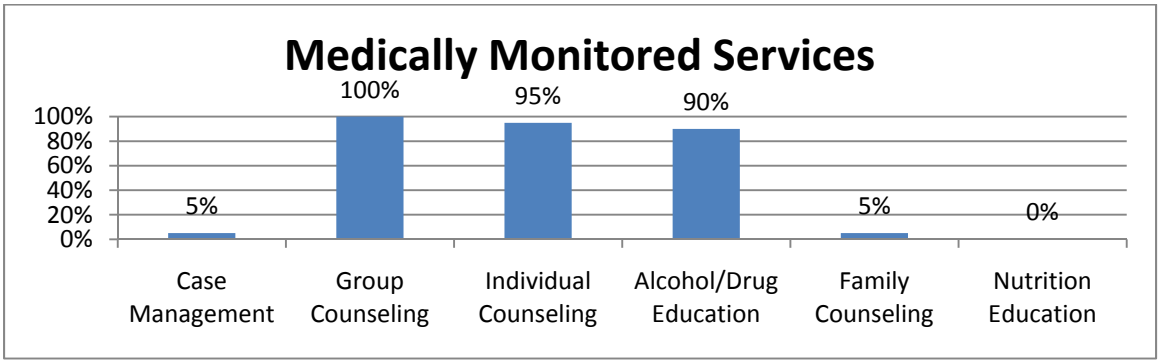
SECTION 5. MEDICALLY MONITORED INTENSIVE INPATIENT TREATMENT SERVICES

Medically Monitored services provide, "A planned regiment of 24-hour professional directed evaluation, care, and treatment in an inpatient setting," (COMAR 10.47.02.09). In addition to an assessment and treatment plans, clients also receive nursing and physician services, as well as counseling, education, and case management.

Twenty clients received Medically Monitored services. All **(100%)** had assessments completed within two weeks of admission. All but one **(95%)** client had a treatment plan. Treatment plans are required to be signed by both the counselor and client and be updated. All **(100%)** treatment plans were signed by the counselor and **84%** were signed by the client as well. Most **(89%)** treatment plans were also updated, *data not shown.*

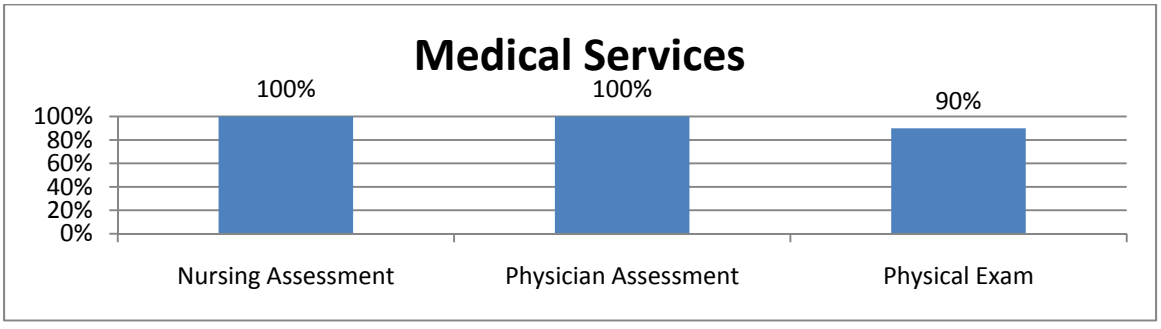
A majority of clients received group counseling **(100%),** individual counseling **(95%),** and alcohol and drug education **(90%).** Case management and family counseling were each seen in just **1 (5%)** record and no charts **(0%)** contained documentation of nutrition education, *Figure 10.* Progress notes were seen in all **(100%)** charts reviewed.

Figure 10. Medically Monitored Services, N=20



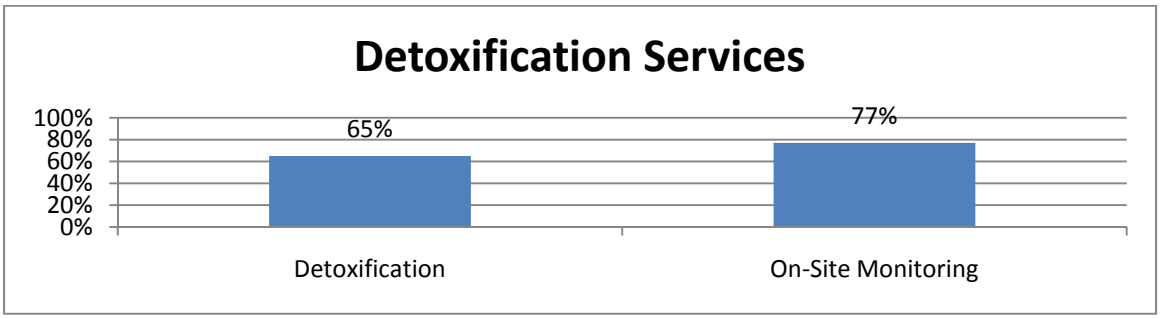
All **(100%)** the clients received a nursing assessment upon admission and all **(100%)** assessments were approved by a qualified staff member. All **(100%)** clients were also assessed by a physician within 24-hours of admission and **90%** received a physical exam, *Figure 11.*

Figure 11. Medical Services, N=20



Thirteen **(65%)** clients required detoxification services and **10 (77%)** charts documented on-site monitoring by a physician, *Figure 12.*

Figure 12. Detoxification Services, N=13

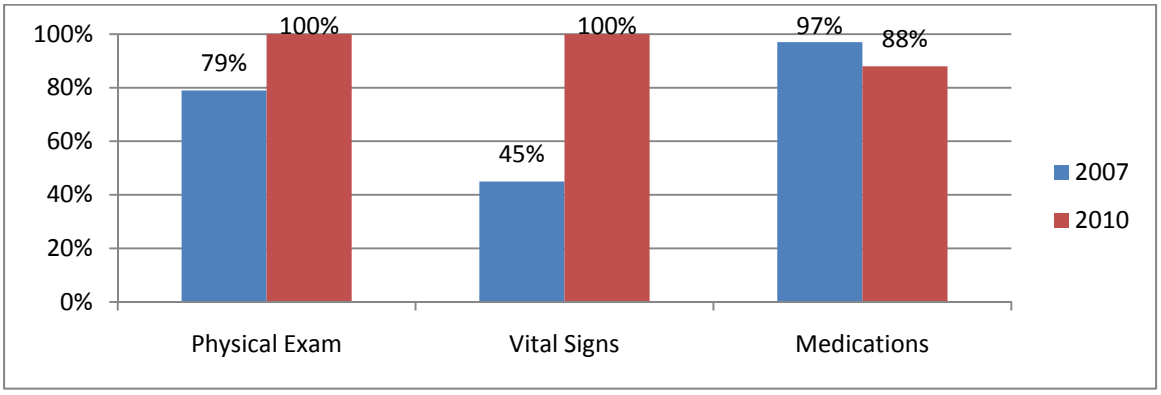


SECTION 6. CLINICALLY MANAGED RESIDENTIAL DETOXIFICATION SERVICES

Level III.7D detoxification services, "Are provided for patients whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support," (COMAR 10.47.02.10). Clients receiving this service must have a nursing assessment upon admission, as well as a physical exam within 24 hours of admission. Treatment planning and adjunct activities are also part of this service.

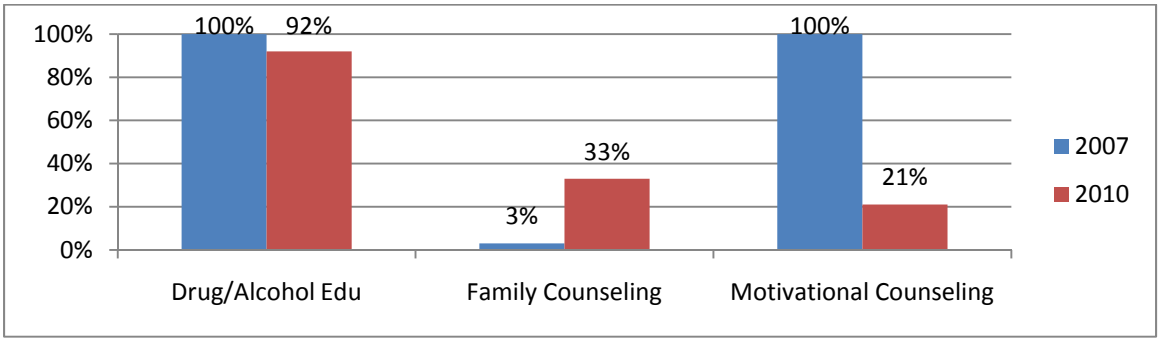
Twenty four clients received Level III.7D services. Assessments were found in **58%** of charts compared to 2007 when all **(100%)** charts contained an assessment. *Figure 13* shows that in 2010, all **(100%)** clients received a physical exam within 24 hours of admission and had their vital signs monitored. This was an improvement since 2007 when **79%** received a physical exam and **46%** had their vital signs monitored. Documentation of medications decreased from **97%** in 2007 to **88%** in 2010.

Figure 13. Detoxification Services, N=24



Adjunct services including alcohol and drug education were documented in **92%** of charts while family and motivational counseling were documented in **33%** and **21%** of charts respectively, *Figure 14.* Family counseling increased since 2007 while motivational counseling decreased. Progress notes were seen in all **(100%)** records. Client notes were documented in 83% of charts.

Figure 14. Adjunct Services, N=24



SECTION 7. OTHER SERVICES

Per COMAR 10.47.01.04, a program may provide education and support services to a patient's family. Of the **45** clients receiving residential substance abuse services, **42%** were assessed for family involvement. Of those, **26%** documented that education and support was provided to their families.

Half **(51%)** of the residential clients received referrals to other services. Referrals are required to contain the reason for referral, the client's name, referring and receiving program, as well as the final disposition of the referral. Just over half **(57%)** of the referrals gave a reason for the referral, all **(100%)** contained the client's name, **96%** showed the referring program, and **78%** showed the receiving program. Only a few **(17%)** documented the final disposition of the referral. Most reasons for referrals were for additional substance abuse services **(57%)** and medical services **(43%).** *Table 7* shows the reasons for the **23** referrals seen in the residential substance abuse records.

Table 7. Referrals, N=23

Referral	%
Rehabilitation	13%
Vocation	4%
Mental Health	22%
Substance Abuse	57%
Physical	9%
Education	13%
Medical	43%
Social	4%
Other	13%

Most **(93%)** clients were discharged from residential substance abuse treatment, similar to the **98%** discharged in 2007. Of those, all **(100%)** documented a discharge summary and **95%** were completed within thirty days of discharge. Discharge summaries are required to contain the reason for admission, reason for discharge, client address, services the client received, diagnosis and prognosis at discharge, medications, continuing service recommendations, summary of the transition process, and the extent of the client's involvement in the discharge plan. *Table 8* highlights the discharge plan elements. Discharge summaries contained many of the required elements at least **86%** of the time. Client address **(60%)** and summary of the transition process **(48%)** were seen less often in the residential discharge summaries.

Table 8. Discharge Summaries, N=42

Element	%
Reason for Admission	95%
Reason for Discharge	95%
Client Address	60%
Services Received	100%
Diagnosis at Discharge	100%
Medications	90%
Continuing Service Recommendations	86%
Summary of Transition Process	48%
Client Involvement in Discharge Plan	86%

In the event that the client is transferred to another substance abuse program, a transfer summary must be completed at discharge. No clients were transferred from residential substance abuse programs.

SECTION 8. QI ORGANIZATIONAL ASSESSMENT

Three agencies, including one with both inpatient and outpatient services, completed the organizational assessment. The **15** items covered the programs' quality structure, planning, performance measurement, improvement activities, staff involvement, consumer involvement, evaluation, and data systems. The survey was administered by CQM staff and agencies were asked to score themselves on a scale from 0-5 where 0 was the lowest score and 5 the highest. Agencies were asked to provide an explanation of each ranking and, where backup documentation was available, it was reviewed. Each question is presented along with the average score. *Figures 15A & 15B* show the average scores per item across residential substance abuse treatment programs.

SECTION A. QUALITY STRUCTURE

1. Does the HIV program have an organizational structure to assess and improve the quality of care? – Average score **3.7.** Overall, most agencies had regular quarterly meetings attended by clinicians and various levels of staff who were involved in the committee's process.

2. Were appropriate resources committed to support the HIV quality program? – Average score **3.3.** 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 **3.7.** Most agencies report that HIV program leadership set quality priorities and established a commitment to quality. Agency's overall quality program was interdepartmentally linked.

4. Does the HIV quality program have a comprehensive quality plan? – Average score **3.7.** Written quality management plans existed at most agencies. Plans were updated annually but all staff members were not involved in the plan's development or update.

SECTION B. QUALITY PLANNING

1. Were annual goals established for the HIV quality program? – Average score **3.0.** Annual goals are discussed by the HIV quality committee and were based on part performance. Some staff were aware of the quality goals.

2. Does the HIV program have clearly described roles and responsibilities for the HIV quality program? – Average score **3.0.** Key roles for the quality program are clearly described; leadership and governance are established; staff is informed about different roles; QI team roles are described; follow-up for quality activities is clear.

3. Is there a document in place to specify timelines for the implementation of the HIV quality program? – Average score **1.0.** Most agencies do not have a formal work plan in place that assigns QI tasks to individual staff members with timelines for completion. If work plans are in place, they are not reviewed and updated on a regular basis.

SECTION C. QUALITY PERFORMANCE MEASUREMENT

1. Were appropriate quality indicators selected in the HIV quality program? – Average score **2.3.** Agencies only selected indicators that were required externally and were not reviewed or updated annually. Staff were not involved in the selection of indicators.

2. Did the HIV program routinely measure the quality of care? – Average score **3.7.** Performance measurement was completed with the input of most staff with the results reviewed by a quality committee. The process of performance measurement was described to some extent, but action may not have been taken on the results.

SECTION D. QUALITY IMPROVEMENT ACTIVITIES

1. Did the HIV program conduct quality projects to improve the quality of care? – Average score **3.3.** A score of **3** indicates that quality improvement activities focused on processes and that projects were based on data. Findings were submitted to the quality committee and at least one data-driven quality improvement project was completed.

2. Was a team approach utilized to improve specific quality aspects? – Average score **3.7.** Team approaches were common among agencies surveyed. All staff had a basic knowledge about the QI team approach and basic methodologies. 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 **3.7.** Nearly all staff members are involved in quality activities and some may attend annual quality trainings and participate in quality projects. Staff members are most knowledgeable about quality principles and may participate in identifying priorities and goals for the quality program. There is no formal process for training on QI principles.

SECTION F. CONSUMER INVOLVEMENT

1. Are consumers involved in quality related activities? – Average score **4.3.** Agencies report that patient needs are assessed and discussed in quality meetings. These findings are sometimes integrated into the quality program. Staff seek input from consumers. Results of quality activities are not always shared with consumers.

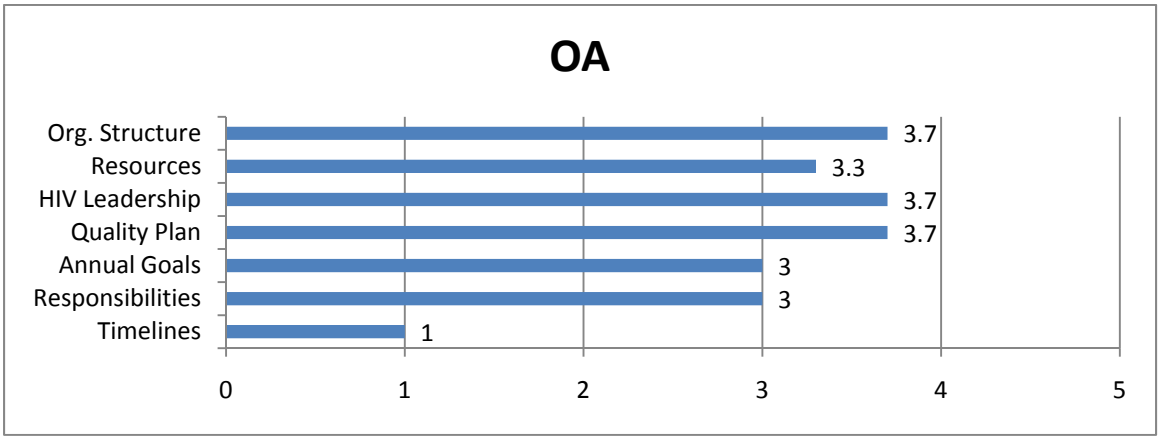
SECTION G. EVALUATION OF QUALITY PROGRAM

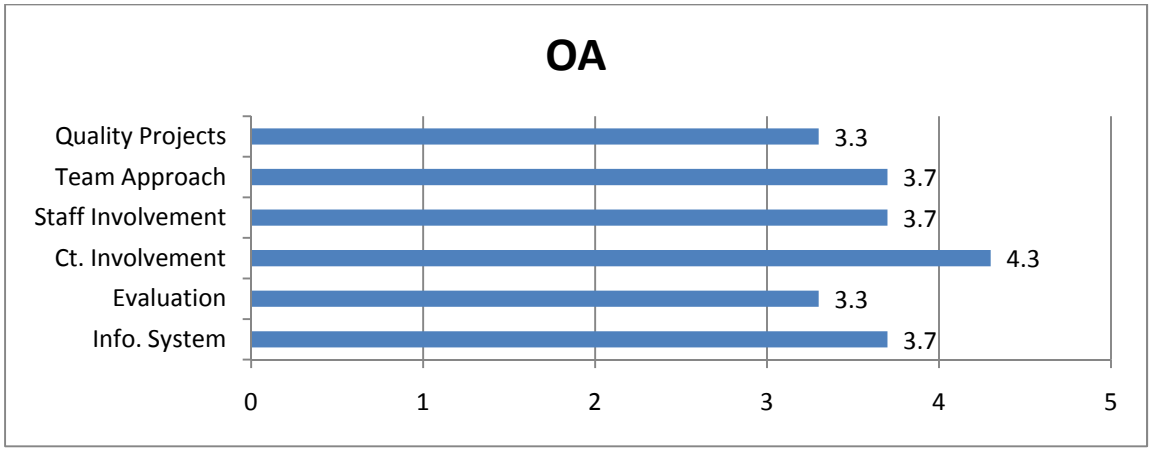
1. Is a process in place to evaluate the HIV quality program? – Average score **3.3.** Review of ongoing quality activities is done by group involved in leading HIV quality efforts including routine evaluating improvements achieved through a team approach; some results from evaluations are used to plan ahead for future quality efforts, but not in a comprehensive approach; summary of findings are documented.

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 **3.7.** 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 15A & 15 B. QI Organizational Assessment, N=3





SECTION 9. SUMMARY OF FINDINGS

The CQM process provided a systematic review of compliance to the EMA standards of care for **3** agencies providing residential substance abuse services under Ryan White Part A during fiscal year 2009. A total of **45** residential substance abuse charts were reviewed, representing approximately **87%** of residential clients receiving services in 2009. Following are both strengths and areas for improvement from the review of residential substance abuse services.

Strengths- Demographics, insurance coverage, HIV status, and treatment with HAART were all documented at high rates. Policies were distributed to clients and medical reports were present in records as well. Admissions requirements including initial evaluations, intake assessments, and treatment plans were all conducted at good rates. Infectious disease education was provided and progress notes documented the care delivered. Discharge summaries were also completed within the required timeframe.

Specific to halfway house services, group and individual counseling were seen at good rates. Medically monitored detoxifications services included drug and alcohol education, nursing assessments, and physician services. Clinically managed detoxification services documented physical exams within twenty four hours, monitored patient vital signs, and documented medication administration. Agencies for the most part have functional continuous quality improvement practices in place.

Areas for Improvement- Risk factor and HIV labs were both missing in many substance abuse records. This information is helpful in tracking the trends of the HIV epidemic in Baltimore and ensuring client engagement in primary medical care.

Residency and financial eligibility were missing in most residential substance abuse records. For any client to receive Ryan White services, proof of residence and income requirements must accompany the referral or be established by the agency providing services.

Specific to substance abuse services, many treatment plans focused on drug use exclusively. Documentation of vocation, education, legal status, and needed family services were not well incorporated into the treatment plans. Plans should address each element as determined by client need as stipulated in COMAR. Most clients interested in family services, did not receive education or support services for their families. Also, final dispositions on client referrals were missing in most charts.

Specific to halfway house services, case management and leisure activities were not documented in client charts. For medically monitored detoxification services, case management and nutrition education were not provided for these clients.

SECTION 10. DISCUSSION AND RECOMMENDATIONS

Baltimore City Health Department: The CQM program held a technical assistance session with the substance abuse providers on March 17th, 2011. During this session, chart abstraction, consumer, and agency data were presented to attendees. Strengths and areas for improvement were identified and presented to the group. After prioritizing the data presented, providers were broken into teams and they utilized quality improvement tools to brainstorm an improvement project. Providers ranked data and used a fishbone diagram to identify root causes of low performing indicators. Participants then used the Plan, Do, Study, Act (PDSA) cycle to plan an improvement project specific to their individual agencies. After returning to their agencies, providers were instructed to share their QI project and form an improvement project team for implementation.

In addition, each agency receiving a substance abuse review in 2010 will receive a vendor report that compares their performance to that of the EMA. Each vendor report identifies specific areas of improvement required by the agency and that the agency submits documentation of an improvement project addressing the issues identified.

Providers: Providers must ensure proper documentation of client risk factor, HIV labs, and eligibility for Ryan White services. At minimum, attempts to gather clinical information should be contained within the client chart. Treatment plans should be initiated and completed for each client and each element outlined in COMAR should be assessed for potential goals.

Planning Council: Since January, 2010, Primary Adult Care (PAC) has extended coverage to substance abuse services to include assessment, methadone, intensive outpatient services, group, individual, and family counseling services. Providers experienced a decrease in Ryan White enrollment as a result of PAC. The planning council should consider how this will affect the need for funding in the substance abuse categories moving forward. The planning council should also emphasize the eligibility requirements for substance abuse services in the standards of care. Particularly for agencies referring to sub-recipients, while an initial eligibility certification may accompany the referral, all agencies are responsible for eligibility re-determinations every six months and specific documented must be collected and maintained in the client chart. A list of acceptable documents to establish initial and ongoing client eligibility may be obtained by request from the Ryan White Office at any time.

Appendix A: Residential Substance Abuse Standards of Care