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

FY12 Health Insurance Premiums & Cost Sharing Assistance

Baltimore-Towson EMA

May, 2013

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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 and in 2012, CQM reviewed Fiscal Year (FY) 2011 records for the following services: Outpatient Ambulatory Health Services (OAHS) Primary Medical Care, OAHS emergency financial assistance (EFA), health insurance premiums and cost sharing assistance, medical transportation, housing and housing EFA, and child care. This report details the findings of the Health Insurance review.

As defined in the Greater Baltimore HIV Health Services Planning Council Standards of Care, Health Insurance Premiums and Cost Sharing Assistance (Health Insurance Premium) services pertains to "the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, copayments, and deductibles." In the Baltimore-Towson EMA, funds are used only for the payment of ongoing medication co-pays.

To assess the degree to which the Standards of Care were adhered to across the EMA, measurement data was gathered and analyzed from all Part A Health Insurance vendors. 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 Health Insurance services. The report does not contain information specific to individual vendors. The Appendices contain the Standards of Care used during the review.

SECTION 2. METHODOLOGY

CQM chart reviews were conducted for the 3 agencies providing Health Insurance Premium services during FY11. Data were collected using 3 methods: chart abstraction, consumer surveys and an organizational assessment. The data collected through the CQM review and presented in this report are not intended to reflect all Ryan White Part A clients receiving Health Insurance services in the Baltimore-Towson EMA.

Chart Abstraction: The chart abstraction tool was designed to assess vendor adherence to the Greater Baltimore HIV Health Services Planning Council Standards of Care. The review period focused on services provided to Part A clients in FY11 (3/1/2011 – 2/29/2012). 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 Part A clients receiving Health Insurance services from that agency and guided by the 2006 HIVQUAL sampling methodology developed by the New York State Department of Health. For each chart reviewed, one survey instrument was completed. A total of **247** charts were reviewed. Based on the data reported to BCHD by the agencies receiving Part A funding for Health Insurance, a total of 2,734 persons received these services during the FY11 contract period. Nearly 10% of all Health Insurance Premium charts were reviewed during the CQM process, *Table 1*. Client chart abstraction data is presented in Section 3.

Consumer Survey: The Consumer Instrument was administered by a CQM staff member who posed the questions while completing the tool. The tool focused on two primary areas: 1) Health Insurance services received; and 2) satisfaction with services. The questions emphasized the type of services provided and client knowledge about their care. An incentive card for $25 to an area retailer or grocer was provided upon completion of the interview. Consumer Survey data is summarized in Section 6.

Organizational Assessment: CQM utilized a quality improvement organizational assessment tool to measure quality improvement activities at each agency across multiple domains including quality management, workforce engagement in quality programs, measurement and use of data, quality improvement initiatives, consumer involvement, quality program evaluation and achievement of outcomes. CQM interviewed agency staff and completed the organizational assessment based on vendor responses. The assessment was developed by the HIVQUAL-US program at the New York State Department of Health AIDS Institute[1].

Table 1. FY12 Charts Reviewed

Agency Name	# of charts reviewed	% of CQM Total	Reported # of HI clients	% of charts reviewed
Chase Brexton Health Services	50	20%	826	6%
Johns Hopkins University Moore Clinic	103	42%	607	17%
University of MD Evelyn Jordan Center	94	38%	750	13%
TOTAL	**247**	**100%**	**2,734**	**9%**

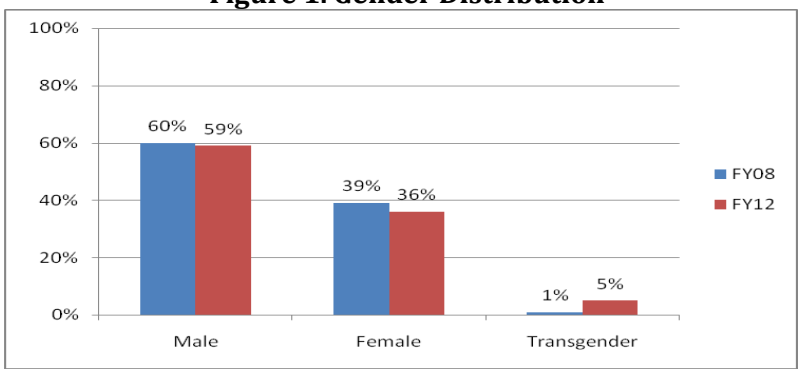
[1] http://www.nationalqualitycenter.org/index.cfm/35778/index.cfm/2214265

SECTION 3. CLIENT CHART INFORMATION

Gender

Gender distribution from FY08 to FY12 remained relatively unchanged as males made up the largest proportion of the sample (**59%**), followed by females at **36**%. Eleven transgender clients made up the remaining **5%** of the sample, *Figure 1*.

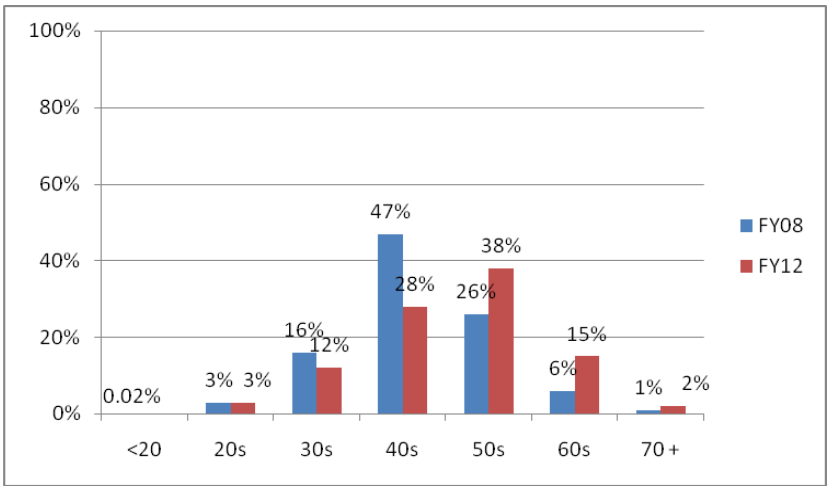
Figure 1. Gender Distribution



Age

Consistent with the FY08 review and with all Ryan White clients in the Baltimore-Towson EMA, about **80%** of clients were aged 40 and over, *Figure 2*. Specifically, about two-fifths of the sample was in their fifties, and just over a quarter in their forties. Four clients (**2%**) were aged 70 and over.

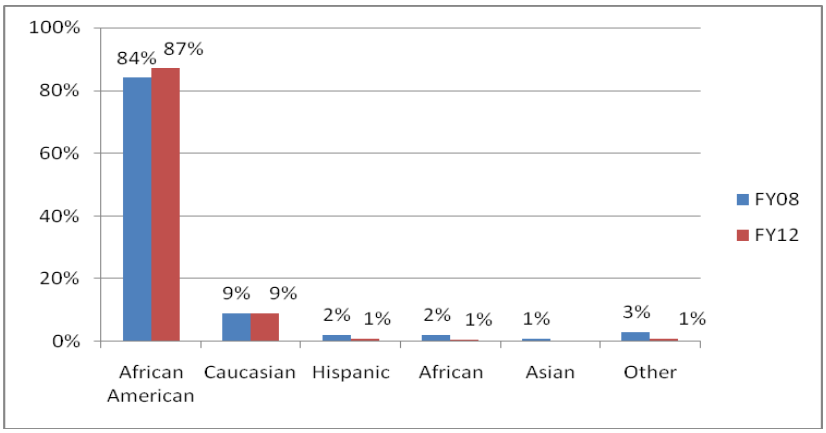
Figure 2. Age Distribution



Race/Ethnicity

Figure 3 depicts the racial/ethnic makeup of Health Insurance charts sampled in the FY12 review. Similar to the last review, African-Americans made up over **80%** of the sample, followed by Caucasians at **9%** and Hispanics, **2%**.

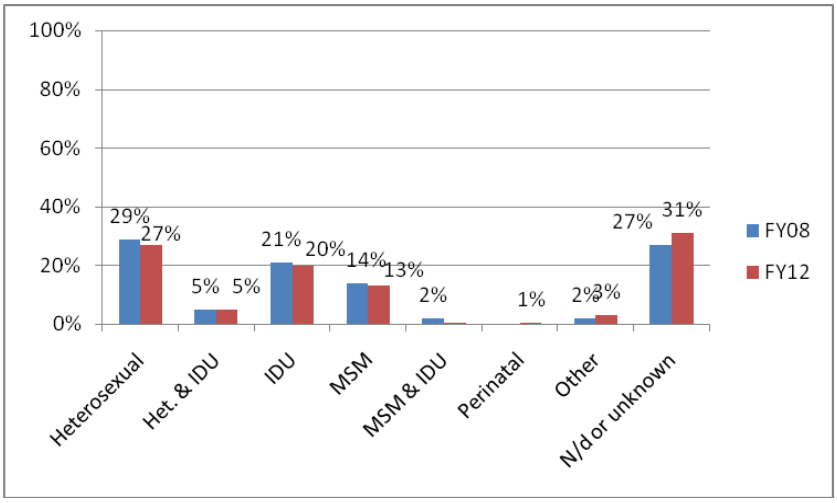
Figure 3. Racial/Ethnic Distribution



Risk Factor

Sexual contact continues to be the leading reported risk factor for HIV infection. In particular, heterosexual contact accounted for **27%**, followed by injection drug use (IDU) at **20%** and men who have sex with men (MSM) at **13%**. Nearly a third of risk factors could not be found in the chart. Many of these charts were from an agency using an electronic health record, *Figure 4*.

Figure 4. HIV Risk Factor



Clinical and Treatment Indicators

CQM reviewers documented clients' CD4 and viral loads and whether the client was on antiretroviral treatment during the review period, *Figure 5*. CD4 and viral load values were each recorded in **94%** of charts. Documentation of the client's HAART status during the review period increased to **99%** in the 2012 review. **Ninety-five percent** of clients were on HAART at some point during the review period, not shown.

Figure 5. Documentation of Clinical and Treatment Indicators

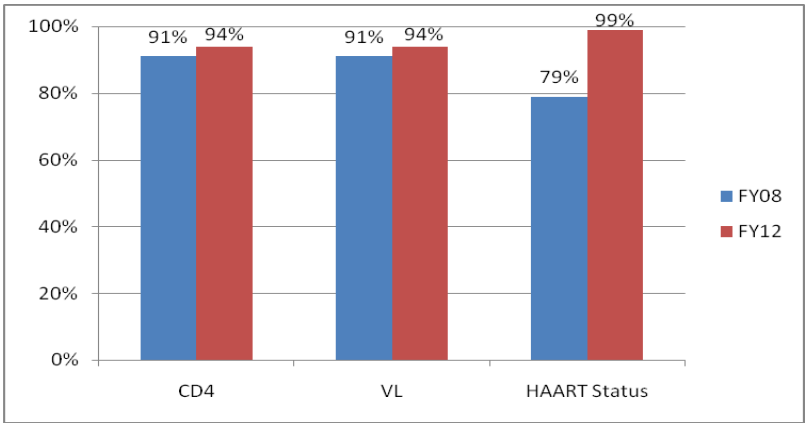


*Figure 6 c*ompares the distribution of CD4 values in FY08 and FY12. The percent of charts reviewed in FY12 that documented CD4 values less than 250 cells/mm^3 declined and the percent of records with CD4 values greater than 500cells/mm^3 increased. Nearly **three-quarters** of the sample documented undetectable viral loads, *Figure 7.*

Figure 6. CD4 Count Distribution

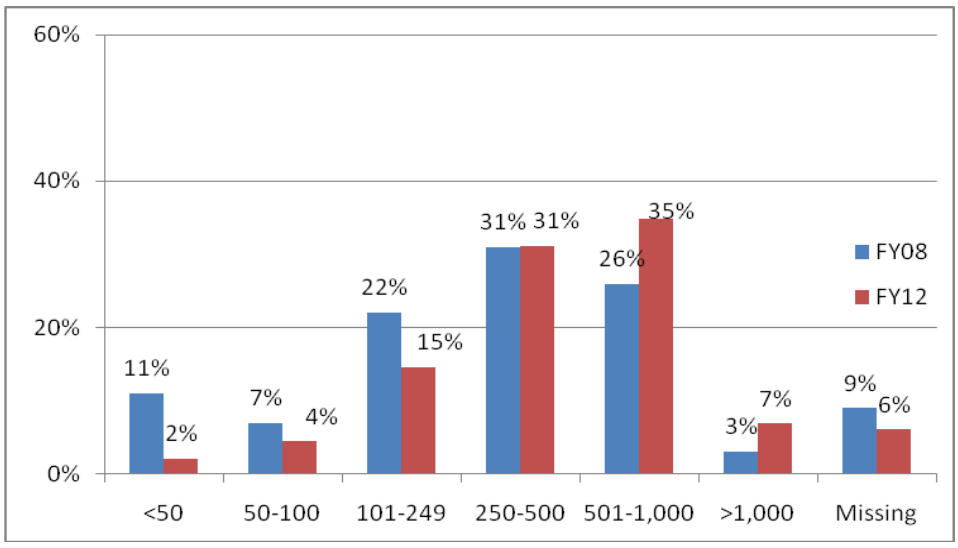
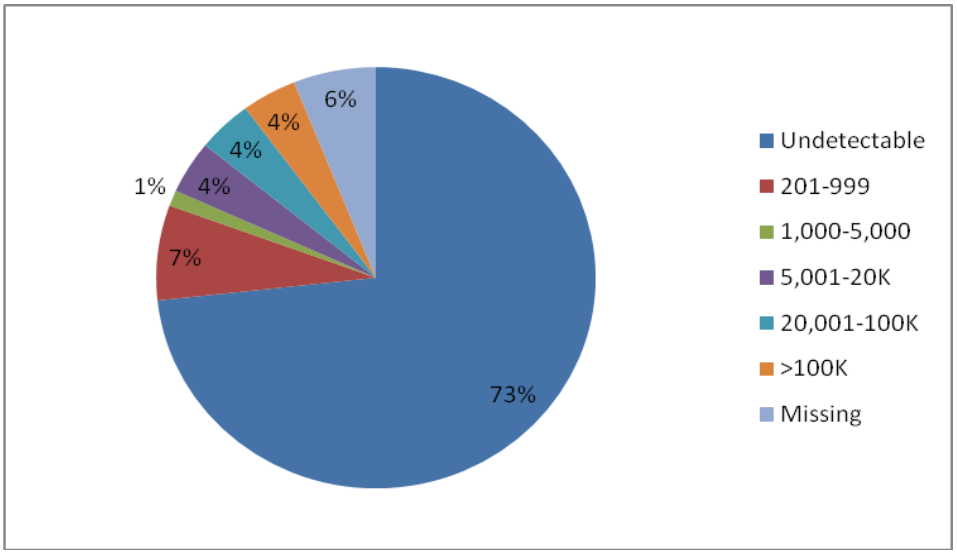


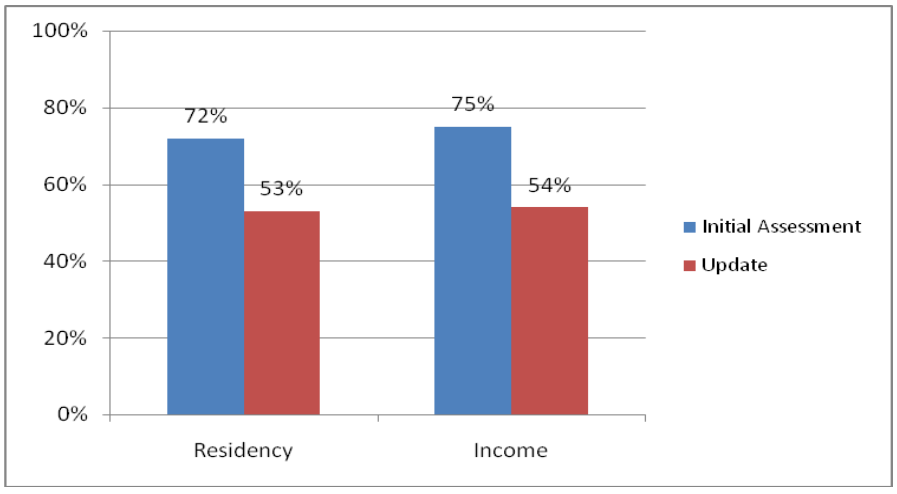
Figure 7. Viral Load Distribution



Eligibility

Before Ryan White funds can be used, providers must establish that the client is eligible for care. This includes documentation of HIV status, residency and income. All charts documented HIV status, verified through a written diagnosis or documentation of CD4 and/or viral load values. Agencies are documenting residency and income status at over **70%** (*Figure 8*). This is an improvement from FY2008 where no more than **53%** of charts documented either requirement, not shown. Documenting residence and income eligibility has been a long-standing challenge and was a quality improvement project initiated by at least one of the providers since the last review of the Health Insurance category. Consequently, the number of records containing eligibility documentation rose by nearly 20% from the FY2008 review. Reassessing client's status continues to be a challenge where no more than **54%** of charts documented residency or income updates. Note: Client records that 1) documented initiation of services after September 15, 2012 or 2) documented one instance of health insurance services during the review period were not included in eligibility reassessment analysis.

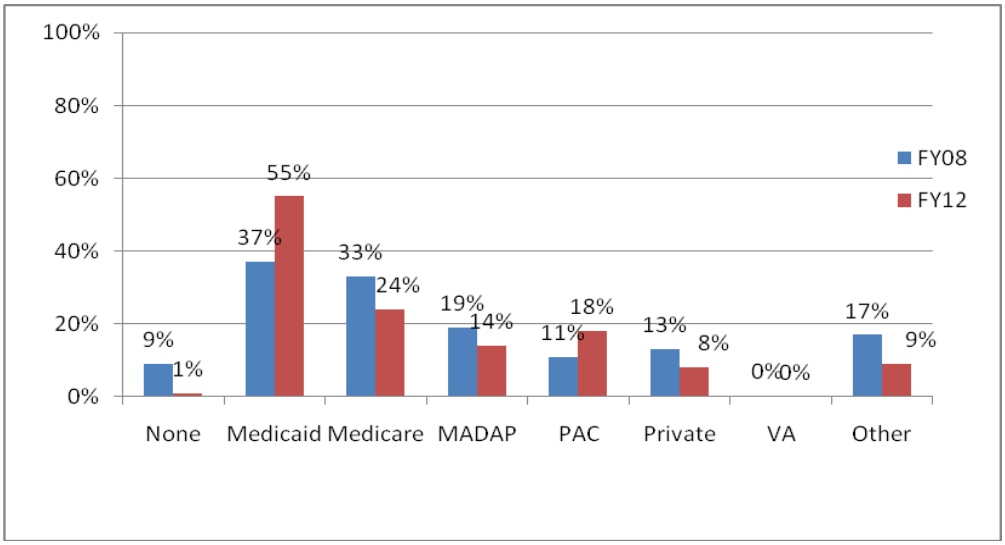
Figure 8. Ryan White Eligibility



Insurance/Pharmacy Coverage

CQM reviewers documented the type of insurance or pharmacy coverage a client had at any point in the review period. Almost all clients had some insurance coverage. More than half the clients in FY12 were covered by Medicaid, up from **37%** in FY08, and Medicare covered about a quarter of clients, *Figure 9*. Note: *Figure 9* is not meant to imply that Ryan White was not the payer of last resort for clients receiving Health Insurance services. Additionally, percentages will add up to more than 100% as clients may receive coverage by more than one insurance.

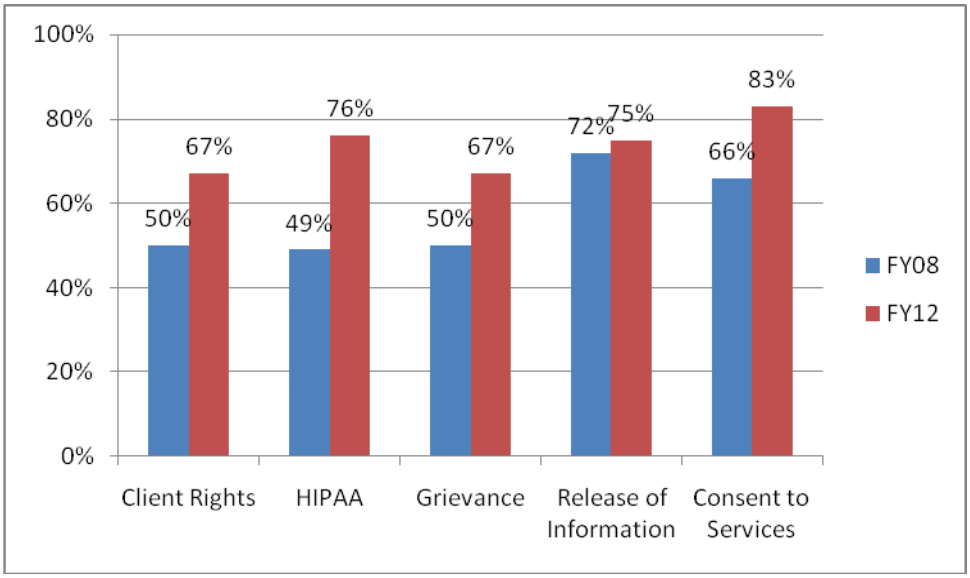
Figure 9. Insurance Distribution



Policies Documentation

Before services are rendered, clients must be provided with copies of the agency's policies and procedures including client rights, HIPAA, grievance, signed release of information and consent to services. At least **67%** of FY12 charts documented every policy, *Figure 10*.

Figure 10. Policies Documentation



Assessment and Treatment Planning

Agencies must complete an initial assessment and a treatment plan for all Health Insurance clients. Assessments should identify the medications requiring co-pays and other payment resources. Treatment plans should include the scope of service to be provided, a timeframe for the review of continuing need and eligibility for continuing services. *Figures 11* and *12* compare FY12 and FY08 EMA performance. Assessment documentation was strong in both years with about 9 in 10 charts meeting the requirement. A list containing the client's medication was documented in 66% of charts reviewed, an increase from the FY2008 review. This could be the result of the use of an electronic medical record. Documentation of other payment resources has also increased from the FY08 review. The percent of charts with treatment plans specific to health insurance has declined between the two reviews of the category, *Figure 12*. However, when a treatment plan was present, it contained the scope of service. Documenting a timeframe for the review of continuing need is still a challenge for providers.

Figure 11. Assessments

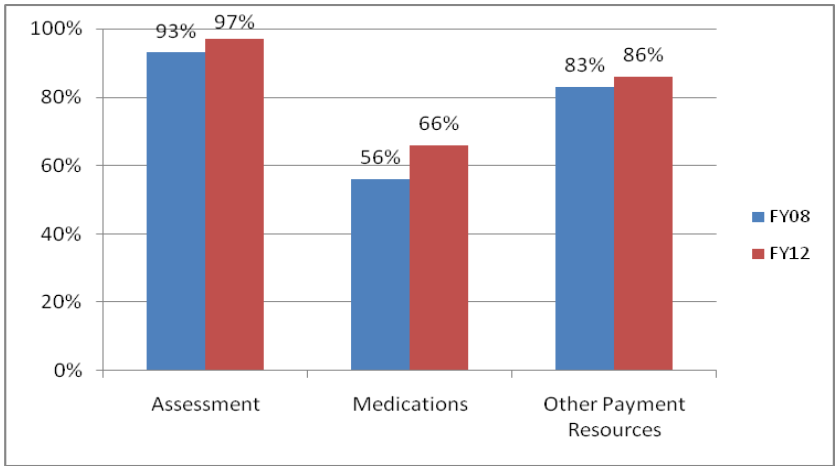
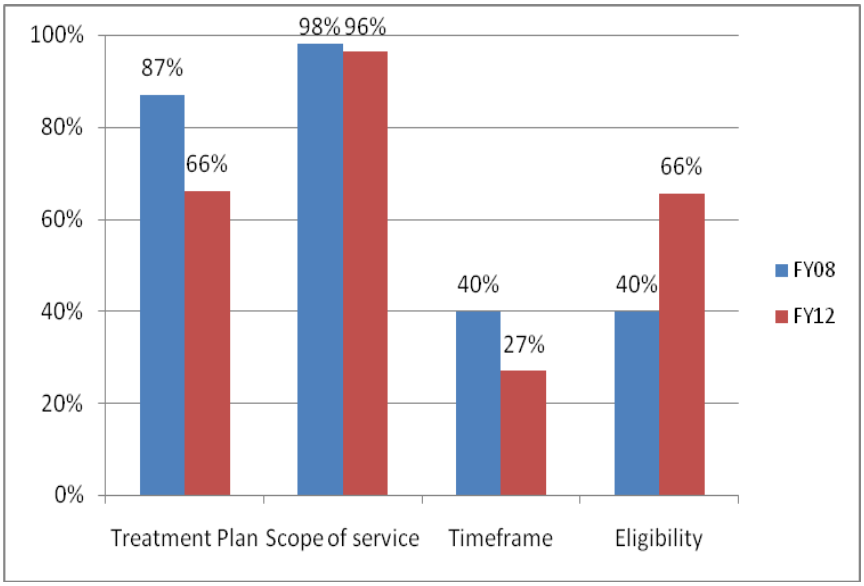


Figure 12. Treatment Plans



Provision of Services

Health Insurance premium funds were used to cover the cost of medication co-pays which is in compliance with the Standards of Care. The CQM team abstracted information for up to **two** instances of health insurance services during the review period, per chart reviewed. Shown in *Table 2*, **73** of the charts reviewed had just one instance of service during the review period and **174** had more than one. Overall, of those services documenting the amount of the co-pay, the median cost was $4.00 per instance and ranged from $1.00 to $375.53.

Table 2. FY12 Cost of Health Insurance Provision

	# of Clients Charts	Charts w/ documented dollar amount	Cost Range	Average Cost	Median Cost
Charts with 1 instance of HI during review year	73	59	$1-75	$8.33	$3.00
Charts with >1 instance of HI abstracted (2 instances abstracted)	174	146	$1-375.53	$10.50	$4.00
Total	247	205	$1-375.53	$10.13	$4.00

SECTION 5. CONSUMER SURVEYS

Thirty-three clients receiving Health Insurance services were interviewed. The clients were a convenience sample and were not intended to be representative of the total client population. Clients were asked to complete a survey to provide another method of assessment of agency compliance with the Standards of Care. The questions focused on the services provided and the knowledge of their care as well as satisfaction with services. A similar subset of the questions was contained in each of the consumer surveys used for all reviewed service categories.

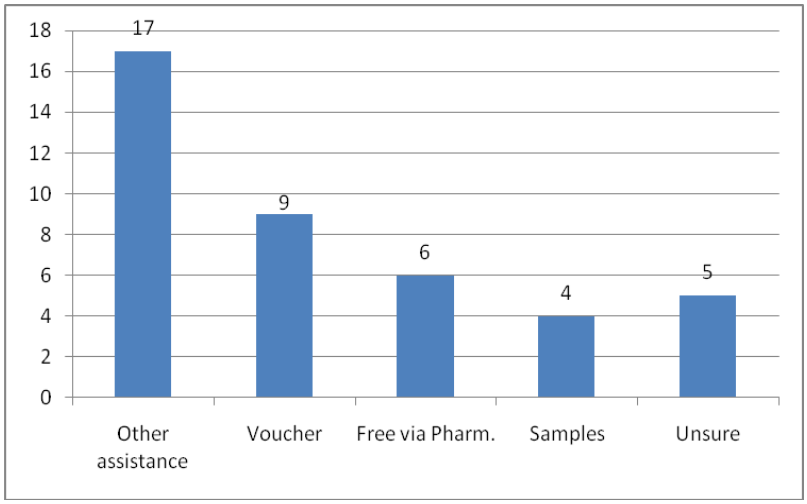
Demographics and Client Information

- This sample was primarily African-American (**28**), male (**22**) and aged 50 and over (**22**).
- All but one of the clients interviewed were currently taking medications.
- Medications were taken for HIV (**29**), psychiatric conditions (**20**) and blood pressure (**16**).

Services Received

- When asked what kind of assistance they received, **9** received vouchers for their medications and **6** clients received free medications through the agency pharmacy. **Seventeen** received some other type of assistance, *Figure 13*.
- **Thirty-one** clients said their provider prompts adherence to their medication and reminds them to keep their prescriptions current.
- When asked what happens when they run out of medications, **14** clients said they call the pharmacy for a refill, **12** physically go to the pharmacy and **9** said their provider calls them before they run out.

Figure 13. Services Received



Summary

Almost all the clients interviewed were currently on medications. They usually received a voucher for their medications or some other type of assistance. Overall, consumer satisfaction was very high for clients receiving this service. Clients indicated an easy process for obtaining assistance with this service. One client requested that agencies provide a listing of all Ryan White services available in the EMA.

SECTION 6. ORGANIZATIONAL ASSESSMENT

Organizational assessments were completed at all three agencies providing Health Insurance Services. The assessment was administered by CQM staff and agencies were asked to rate themselves on a scale from 0 – 5, with 5 as the maximum score. Each question is presented along with the average score across agencies in *Figure 14.* No historic comparisons are available since the FY12 review was the first time the tool was used.

Section A. Quality Management

A1. To what extent does senior leadership create an environment that supports a focus on improving the quality of HIV care? – Average score **4.** Overall, agencies reported that leaders support development of a culture of QI and allocate staff time for QI. Leaders were also actively engaged in QI planning and evaluation and used patient outcomes to inform program priorities.

A2. To what extent does the HIV program have an effective quality committee to oversee, guide, assess, and improve the quality of HIV services?– Average score **3.** Many agencies reported having a formally established multi-disciplinarian quality committee with defined roles and responsibilities.

A3. To what degree does the HIV program have a comprehensive quality plan that is actively utilized to oversee quality improvement activities? - Average score **3.3.** Quality plans at most agencies are in the implementation phase, meaning quality plans were written to reflect the essential QI components and contained an annual work plan outlining key QI activities.

Section B. Workforce Engagement in Quality Programs

B1. To what extent are physician and staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills and methodology needed to fully implement QI work on an ongoing basis? - Average score **3.** Engagement of core staff in quality improvement includes QI training, involvement in QI projects and project development.

B2. To what extent is staff satisfaction included as a component of the quality management program?- Average score **4.7.** Staff satisfaction is part of a formal process. Staff satisfaction data are shared with staff and used to determine areas for improvement.

Section C. Measurement, Analysis and Use of Data

C1. To what extent does the HIV program routinely measure performance and use data for improvement? – Average score **4.** Performance measures are externally defined and reflect priorities of the organization, staff and clients. Performance data are validated for accuracy and used to identify areas for improvement.

Section D. Quality Improvement Initiatives

D1. To what extent does the HIV program identify and conduct quality improvement initiatives using robust process improvement methodology to assure high levels of performance over long periods of time?– Average score **2.3.** Agency progress toward conducting quality improvement initiatives were in the beginning implementation phase. In this phase, QI initiatives involve team leaders and begin to use specific QI methodology to understand causes of problems.

Section E. Consumer Involvement

E1. To what extent are consumers effectively engaged and involved in the HIV quality management program? – Average score **2.7.** Consumer involvement is addressed by soliciting consumer feedback. Most agencies engage their consumers through a consumer advisory board (CAB).

Section F. Quality Program Evaluation

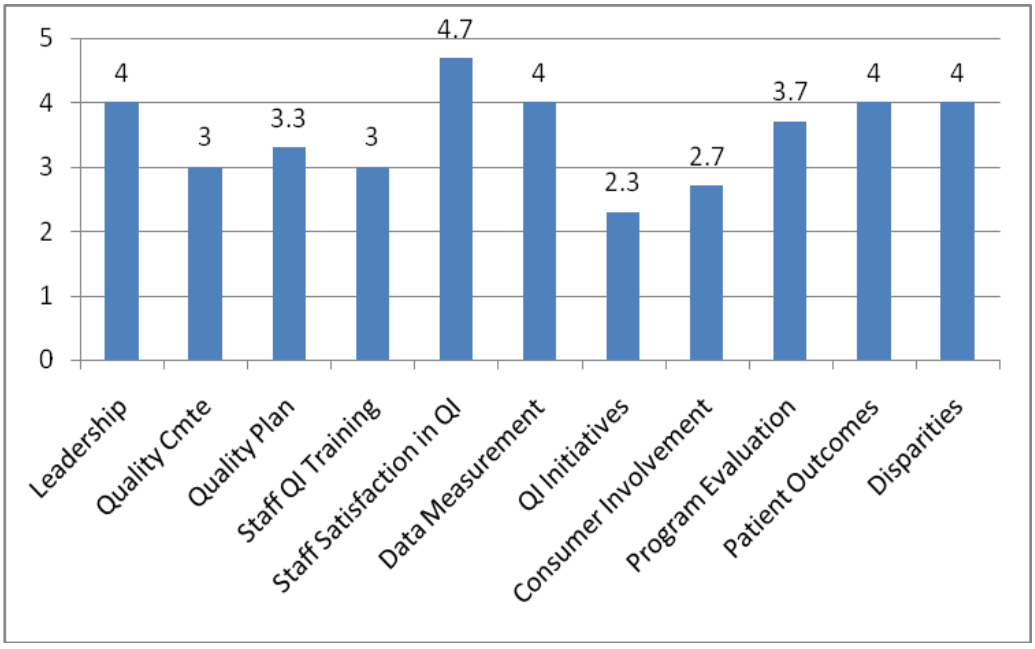
F1. Is a process in place to evaluate the HIV program's infrastructure and activities, and processes and systems to ensure attainment of quality goals, objective and outcomes? – Average score **3.7.** Quality program evaluation is part of a formal process occurring annually. Quality goals are revised to reflect current needs and results of the evaluation are used to plan for future quality efforts.

Section G. Achievement of Outcomes

G1. To what extent does the HIV program monitor patient outcomes and utilize data to improve patient care?– Average score **4.** Programs report that patient outcome data, specifically viral load suppression and retention in care, are trended over time and help to guide improvement activities

G2. To what extent does the HIV program measure disparities in care and patient outcomes, and use performance data to improve care to eliminate/mitigate discernible disparities? – Average score **4.** Programs report that performance measures are stratified for disparities by gender, age, SES, risk factor, etc. The data are used to identify disparities and to develop improvement strategies.

Figure 14. Quality Improvement Organizational Assessment



SECTION 7. SUMMARY OF FINDINGS AND RECOMMENDATIONS

Health Insurance services are delivered in accordance with the Greater Baltimore HIV Planning Council's Standards of Care. A vast majority of consumers were very satisfied with Health Insurance services and noted an uncomplicated process for obtaining assistance with medication co-pays. The organizational assessment showed that agencies have quality improvement programs whose programs and activities are guided by a quality committee and the goals outlined in their quality plan. In almost all cases, quality improvement processes are being implemented and continuous quality improvement activities are increasingly common staff responsibilities.

Strengths

- Documentation of chart information(demographics, CD4 and Viral Load values, HAART status)
- Policies documentation
- Assessment for service including documentation of other payment resources
- Scope of services and eligibility for continuing need outlined in treatment plans

Areas for Improvement

- Documentation of Ryan White Eligibility – No more than **53%** of charts documented semiannual assessments of income or residency
- Documentation of medications – **65%** of charts contained a list of medications
- Treatment plans – **66%** of charts documented a treatment plan
- Treatment plans – **27%** indicated a timeframe for review of continuing service needs
- Quality Management Program – Quality Initiatives and Consumer Involvement

Recommendations for Providers

- Ryan White is a funding stream of last resort for eligible individuals with HIV/AIDS. It is important that all clients provide proof of income and residence before services are rendered and that this information is documented in the chart every 6 months. Note: if an annual award letter (e.g. SSI Award letter) is used for documentation for client income and/or residence, the document is valid for the entire year.
- While assessments were documented for a majority of the population, **65%** documented the medications for which assistance would be provided. As a category whose definition allows payment for co-pays of MADAP formulary medications, it is important to document during intake which medications the client is currently prescribed as well as the associated cost, if known.
- Treatment plans must be created for each client receiving services to serve as a guide for the services provided.
- To improve quality of services delivered, programs should continue to engage in peer learning activities conducted by the Ryan White Clinical Quality Management office to gain better understanding and application of quality improvement methodologies. QI methodologies include identifying the root cause of a problem and finding solutions for the most important causes through cycles of change (or Plan-Do-Study-Act cycles). Consumer involvement in program activities is demonstrated mainly through consumer advisory boards (CAB). However to ensure formal integration of consumers into the quality program,

providers should not only solicit their feedback about the quality of care but also use it to drive improvement activities.

Recommendations to the Planning Council

In light of the Patient Protection and Affordable Care Act (PPACA) and the impact it will have on Ryan White Services, there will be an increased need to continue to ensure that not only are Ryan White funds those of last resort but that the dollars are spent efficiently. HRSA's Monitoring Standards[1] released in April, 2012, related to Health Insurance services state that organizations providing these services should:

- Document an annual cost-benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and or deductibles for eligible low income clients, compared to the costs of having the client in the ADAP program
- Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications
- Where funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infections

The Planning Council should consider the HRSA/HAB monitoring standards in updating the Standards of Care for Health Insurance Services.

[1] http://hab.hrsa.gov/manageyourgrant/files/programmonitoringparta.pdf

SECTION 8. ACKNOWLEDGMENTS

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

APPENDIX