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

FY13 MEDICAL NUTRITIONAL THERAPY AND FOOD BANK SERVICES

Baltimore – Towson EMA

April 2014

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INTRODUCTION

The Baltimore City Health Department (BCHD) Part A Clinical Quality Management Program (CQM) began in calendar year 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWHA) in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White HIV/AIDS Treatment Extension Act of 2009. The FY2013 CQM initiatives focused on Outpatient Ambulatory Health Services Primary Medical Care, Medical Case Management (including Treatment Adherence), Medical Nutrition Therapy, Food Bank and Home Delivered Meals (including Emergency Financial Assistance), and Legal services provided March 1, 2012 through February 28, 2013 (FY 2012).

This report summarizes EMA wide findings of medical nutrition therapy and food bank and home delivered meals services verified through chart abstraction and consumer interviews. As defined in the Greater Baltimore HIV Health Services Planning Council (Planning Council) Standards of Care, medical nutrition therapy "is provided by a licensed registered dietitian outside of a primary care visit. The provision of food, nutritional services, and nutritional supplements may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian."[1]

Food bank and home delivered meals "include the provision of actual food or meals. The provision of essential household supplies such as personal hygiene items, household-cleaning supplies, and water filtration/purification devices should be included in this item. Effective October 2009, the food bank/home-delivered meals category in the Baltimore EMA also includes emergency food vouchers from the emergency financial assistance (EFA) category."[2]

For each chart reviewed, one survey instrument was completed. A total of 196 charts were reviewed: 71 medical nutrition therapy (MNT) charts at 3 agencies; and 145 food bank EFA charts at 6 agencies (Tables 1 and 2). Twenty clients received both MNT and food bank EFA services. 25 food bank and home delivered meals' charts were reviewed. Home delivered meals were provided by one agency. To avoid sharing information about individual providers, these services are not summarized in this report.

[1] Greater Baltimore HIV Health Services Planning Council. (2009). Medical nutrition therapy service category standards of care. Baltimore, MD: InterGroup Services, Inc. for the Greater Baltimore HIV Health Services Planning Council.
[2] Greater Baltimore HIV Health Services Planning Council. (2009). Food bank and home delivered meals service category standards of care. Baltimore, MD: InterGroup Services, Inc. for the Greater Baltimore HIV Health Services Planning Council.

Table 1. Medical Nutrition Therapy Charts Reviewed by Provider FY 2013

Provider	Number of Charts Reviewed (% of total)
Chase Brexton	25 (35%)
Moveable Feast	21 (30%)
University of Maryland Evelyn Jordan Clinic	25 (35%)
Total	71 (100%)

Table 2. Food Bank EFA Charts Reviewed by Provider

Provider	Number of Charts Reviewed (% of total)
Baltimore County Health Department	18 (12%)
Harford County Health Department	27 (19%)
Park West Medical Center	25 (17%)
People's Community Health Center	25 (17%
University of Maryland Evelyn Jordan Clinic	25 (17%)
University of Maryland Medical Center – Midtown	25 (17%)
Total	145 (100%)

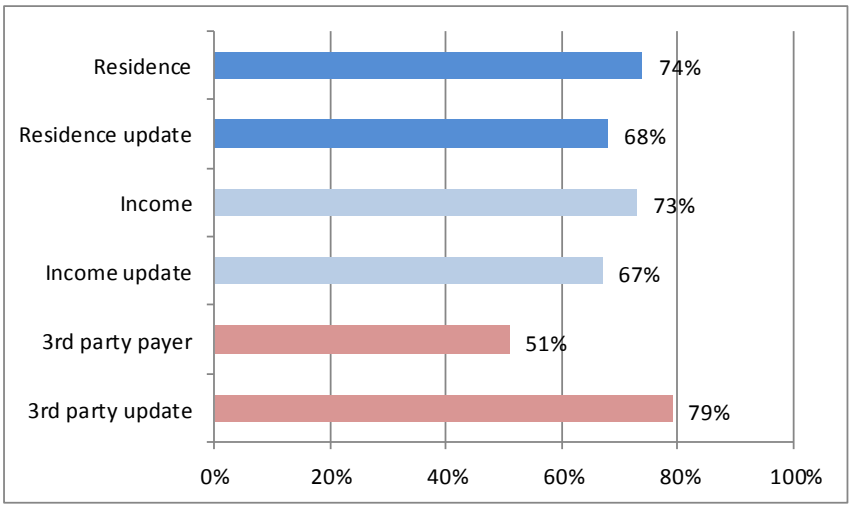
RYAN WHITE ELIGIBILITY

This section presents eligibility data for the 196 client charts sampled receiving medical nutritional therapy, food bank and home delivered meals, and/or food bank EFA services between March 1, 2012 and February 28, 2013.

Before Ryan White funds can be used, providers must establish that the client is eligible for care. This includes one-time documentation of HIV status and semiannual documentation of residency in the Baltimore-Towson EMA, income, and third party payer capacity. All (100%) charts documented HIV status (not shown). Figure 1 shows the proportion of charts that documented residence, income and third party payer verifications. Initial verification of the client's residence was documented in 74% of charts and initial verification of income in 73%. Initial documentation of third party payer capacity was assessed and 51% of all charts documented this information.

Charts were excluded from analysis when the client was ineligible for eligibility updates (i.e., the client had one visit or less than 6 months of service in the review period). Residency and income updates were applicable for 57 clients; of these 39 (68%) documented residency update and 38 (67%) documented income updates. Twenty-nine of the charts documenting third party payer capacity documented services for more than six months; of these 23 (79%) indicated an update.

Figure 1: Initial Eligibility Status and Semiannual Updates FY 2012

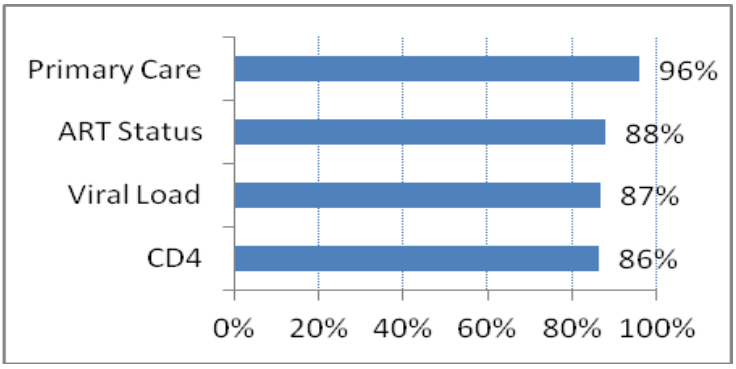


Reviewers looked at documentation of insurance at any time in the review period. About half the charts documented Medicaid coverage (49%, n=97). Other documented insurance included Medicare (15%, n=30) and MADAP (9%, n=17). Note: This information does not imply that Ryan White was not the payer of last resort for clients receiving MNT or food bank EFA services.

PRIMARY CARE ENROLLMENT AND CLINICAL INDICATORS

CQM reviewed charts for documentation of primary care enrollment (PMC) and clinical indicators including: ART treatment status found in 88% of charts (n=172), viral load in 87% (n=170), and CD4 value in 86% (n=169), Figure 2. Documentation that the client was enrolled in primary care was found in 96% (n=188) of the charts.

Figure 2: PMC Enrollment and Clinical Indicators FY 2012 N=196



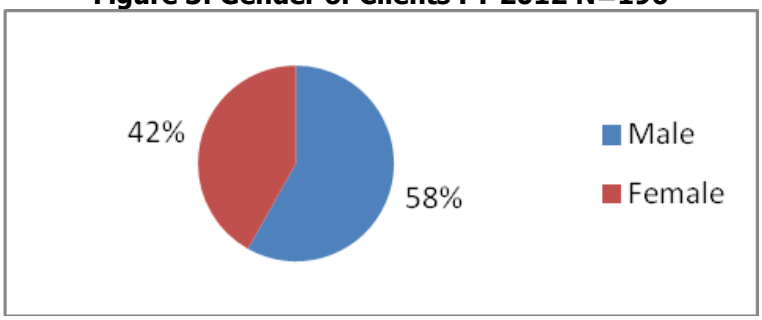
DEMOGRAPHICS

This section presents demographic data for the 196 client's sampled receiving medical nutritional therapy, food bank and home delivered meals, and/or food bank EFA services between March 1, 2012 and February 28, 2013.

Gender

Males comprised 58% (n=114) of the sample and females, 42% (n=82), Figure 3.

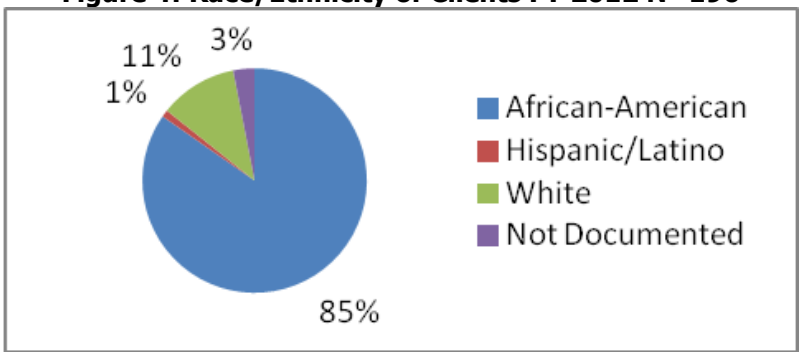
Figure 3: Gender of Clients FY 2012 N=196



Race/Ethnicity

A majority of the sample was African American (85%, n=166), Figure 4. Lesser proportions of client charts sampled documented race/ethnicity as white (11%) or Hispanic/Latino (1%).

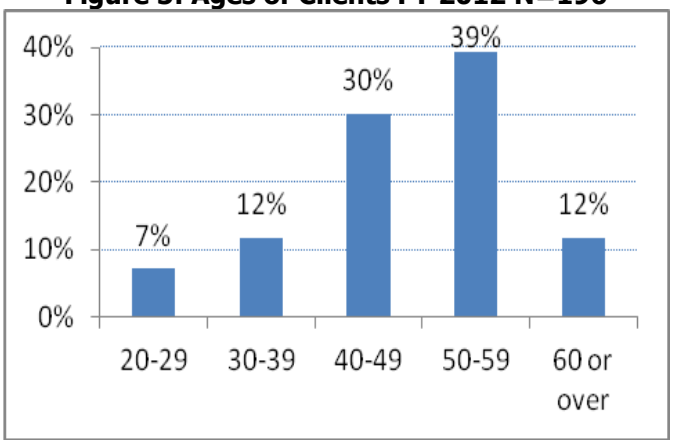
Figure 4: Race/Ethnicity of Clients FY 2012 N=196



Age

Figure 5 shows that 69% of clients were in their forties (n=59) and fifties (n=77). Clients aged in their thirties or over sixty were the next largest groups at 12% each (n=23). Lesser proportions of clients were in their twenties (7%, n=14).

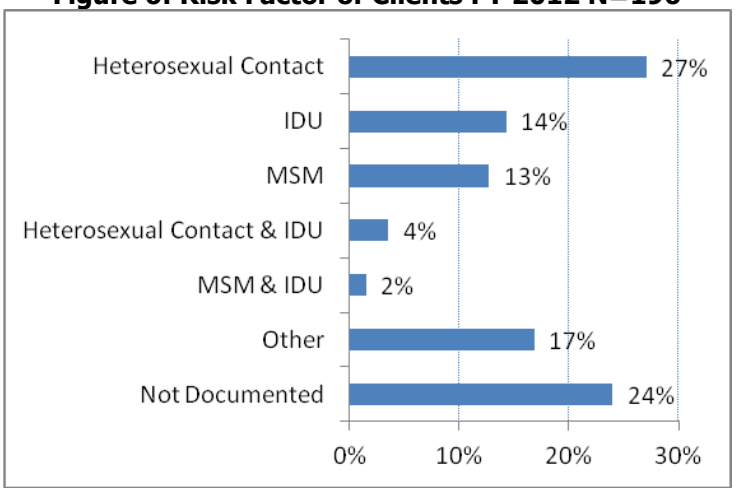
Figure 5: Ages of Clients FY 2012 N=196



Risk Factor

Heterosexual contact was documented in 27% (n=53) of the charts, Figure 6. Injection drug use (IDU) was documented risk in 14% (n=28) of charts. Men who have sex with men (MSM) contact was the risk factor in 13% (n=25). Less than 5% of the charts noted heterosexual or MSM and IDU contact (2%, n=3). Risk factors marked as 'Other' were documented in 17% (n=33) of charts. Risk factor was not documented in 24% (n=47).

Figure 6: Risk Factor of Clients FY 2012 N=196



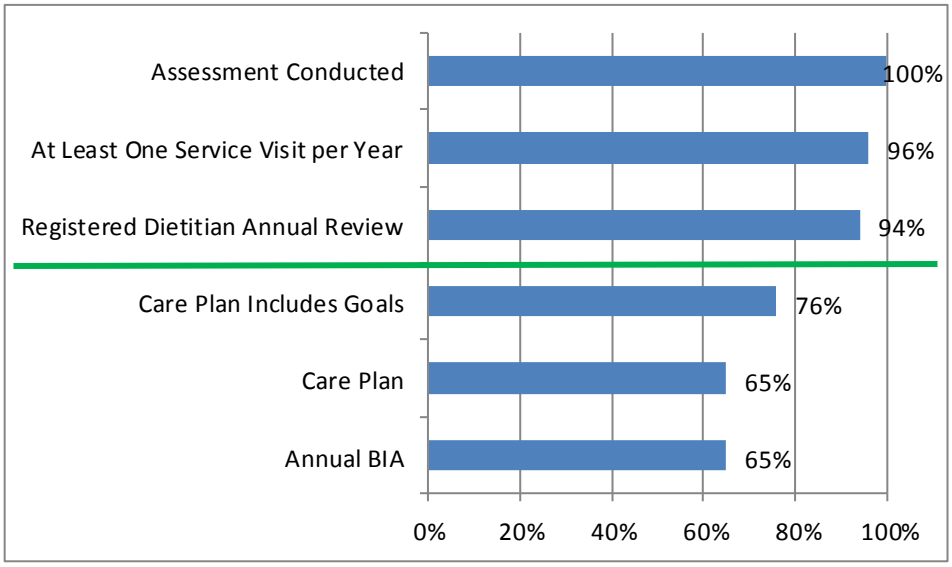
MEDICAL NUTRITIONAL THERAPY

The Planning Council sets forth Standards of Care that providers are required to meet or exceed. These Standards of Care are used to assess vendor-level and EMA-wide compliance to the service guidelines developed by HIV positive consumers and providers of HIV services in the EMA. Data collected on these measures provide an indication of an organization's performance and identify areas of strength and improvement. First, an MNT service overview graph for the EMA is presented (notated by the red bar in each graph). Then, each measure where EMA-wide performance was less than 80% is compared to individual provider performance.

Standards of Care for medical nutritional therapy include: an assessment of the client's nutrition status, at least one service visit per year, an annual review by a registered dietitian, an annual bioelectric impedance analysis (BIA), a care plan, and goals for care. (Standards of Care March 2009: 1.1.1- 1.1.9, 2.1.2.1 – 2.1.2.10, 2.1.3, and 2.2)

Figure 7 shows three areas where EMA-wide performance exceeds 80% adherence to the standard. An assessment of the client's nutrition status was documented in all charts (100%, n=71). 96% (n=68) of clients had at least one service visit per year. In 94% (n=67) of the charts, an annual review by a registered dietitian was noted. Adherence to the standard was below 80% in three areas. An annual BIA was completed for 65% (n= 46) of client charts reviewed. In 65% (n=46) of charts, a care plan was found and goals for care were found in 76% (n=35) of the care plans.

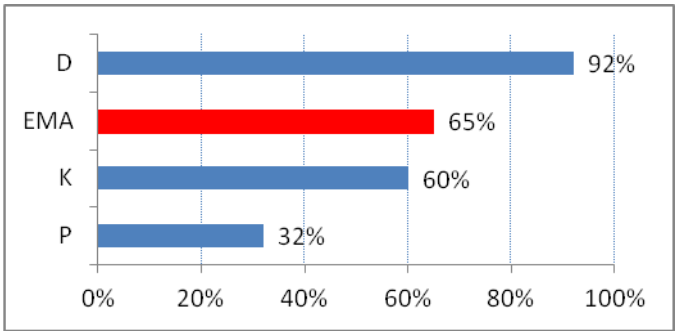
Figure 7: Overview of Medical Nutritional Therapy Services
FY 2012 N=71



Annual BIA

Performing a BIA with interpretation at least annually to monitor muscle mass is a "key service". (Standards of Care March 2009: 1.1.5) Figure 8 shows the EMA-wide average is 65% (n= 46).

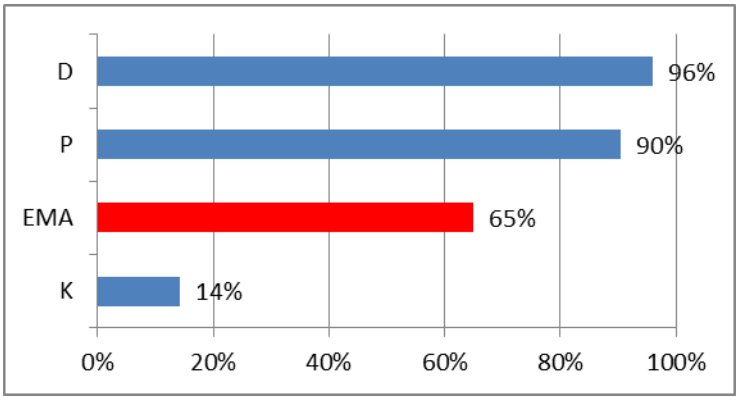
Figure 8: An Annual BIA for Clients Receiving Medical Nutritional Therapy Services FY 2012 N=71



Care Plan Developed

Developing a care plan in cooperation with the client is required in the March 2009 Standards of Care (2.1.3). The EMA-wide average was 65%, Figure 9.

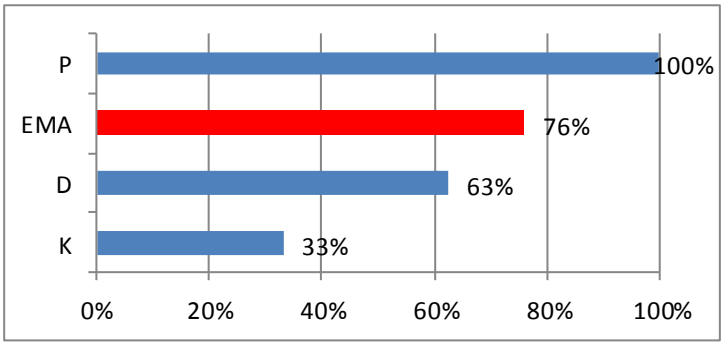
Figure 9: Care Plan Developed for Clients Receiving Medical Nutritional Therapy Services FY 2012 N=71



Care Plans Includes Goals

The care plan must include goals and outcomes (Standards of Care March 2009: 2.1.3) The EMA-wide average was 76%, Figure 10.

Figure 10: Care Plans Include Goals for Clients Receiving Medical Nutritional Therapy Services FY 2012 N=71



Assessment

The Standards of Care (2.1.2) specify that the medical nutritional therapy services assessment include sixteen elements. EMA-wide documentation of the required elements for the assessment ranged from 100% for weight (n=71) to 13% for medical symptoms of non-HIV conditions (n=9), Table 3.

Table 3. Assessment Factors for Medical Nutrition Therapy FY 2012 N=71

Assessment Factor	Number of Clients	Percent of Clients
Access to essential cooking equipment	53	75%
Activity/exercise	61	86%
Appetite	64	90%
BIA	41	58%
Capacity to prepare food	53	75%
Cultural or religious food constraints	21	30%
Diet	66	93%
Food allergies	52	73%
Food intake	65	92%
Medical symptoms of HIV	31	44%
Medical symptoms of non-HIV conditions	9	13%
Medication side effects	16	23%
Nutritional supplement intake	36	51%
Oral health	36	51%
Psychosocial	41	58%
Weight	71	100%

Policies

Table 4 shows the client rights and confidentiality policies stipulated in the MNT Standards of Care (3.2). EMA-wide documentation of policies ranged from 66% (n=47) for consent for requesting to releasing information to 0% for Ryan White services available in the EMA.

Table 4. Policies for Medical Nutrition Therapy Clients FY 2012 N=71

Policy	Number of Clients	Percent of Clients
Agency expectations of clients, including termination	37	52%
Agency fee structures	16	23%
Confidentiality/HIPAA	41	58%
Consent for requesting or releasing information	47	66%
Grievance	32	45%
Hours of operation, procedures for notifying clients of unscheduled closings, and procedures for after-hours emergencies	16	23%
Procedure for closing client records	34	48%
Procedure for managing waiting lists	17	24%
Procedure for scheduling appointments	19	27%
Procedures for intake and discharge of clients	17	24%
Referral process	17	24%
Rights and responsibilities	32	45%
Ryan White Part A services available in agency	22	31%
Ryan White Part A services available in the EMA	0	0%
Security of client records	32	45%

The Planning Council sets forth Standards of Care that providers are required to meet or exceed. Food Bank EFA services include vouchers for food and nutritional supplements. The October 2009 Food Bank and Home Delivered Meals apply to Food Bank EFA, but it does not include specific guidelines for services.

Ryan White CQM assesses vendor-level and EMA-wide adherence to three criteria: assessing emergency need , documenting the voucher amount, and checking for other resources. Data collected on these measures provide an indication of an organization's performance and identify areas of strength and improvement. 134 charts documented food bank EFA services which include provision of emergency food vouchers. 11 charts documented the receipt of nutritional supplements. The first food bank EFA service received during the review period was examined.

EMA-wide, 73% (n=98) of the charts contained an assessment that the client's need was an emergency, Figure 11. In 72% (n=97) of charts the voucher amount was documented (Figure 12) and checking for other resources was found in 37% (n=53) of charts (Figure 13).

Figure 11: Assessing Emergency Need for Clients Receiving Food Bank EFA FY 2012 N=134

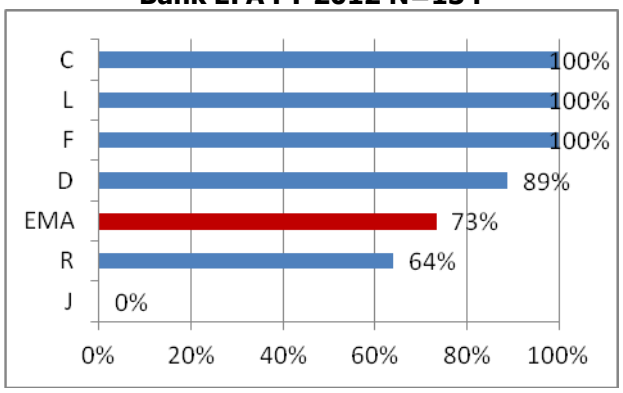


Figure 12: Documenting Voucher Amount for Clients Receiving Food Bank EFA FY 2012 N=134

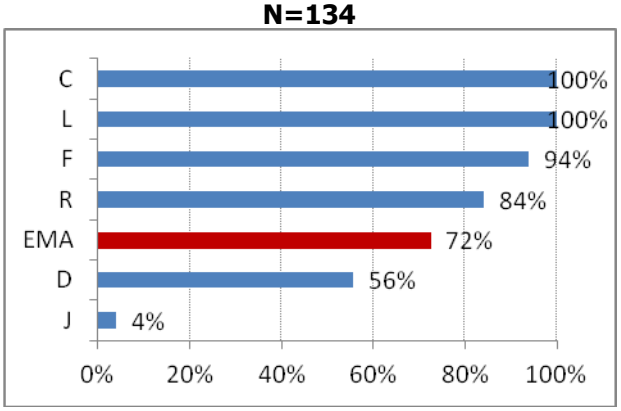
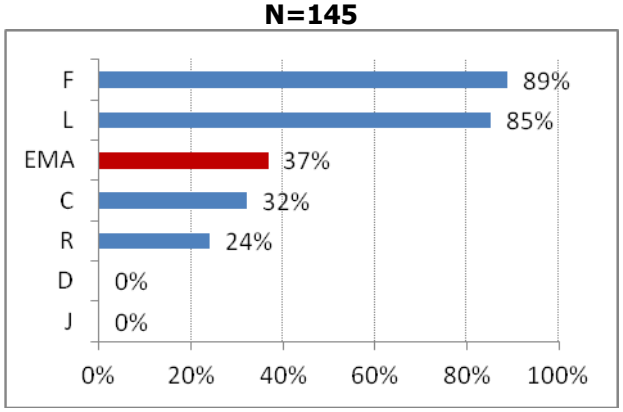


Figure 13: Checking for Other Resources for Clients Receiving Food Bank EFA FY 2012 N=145



CONSUMER SURVEYS

Food Bank

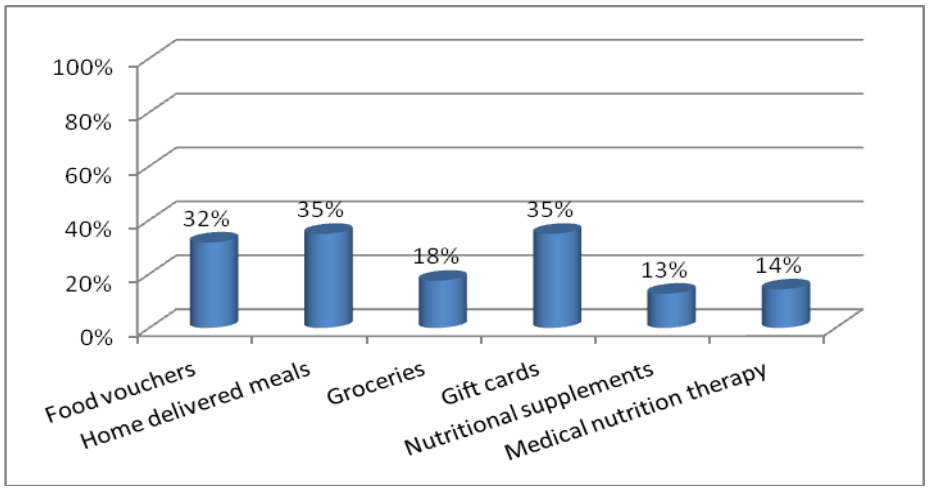
Agency compliance with food bank and medical nutrition therapy standards of care was assessed through a survey of consumers currently receiving these services. Data were collected measuring consumer knowledge of food bank and medical nutrition services, communication between provider and consumer, and satisfaction with the quality of services received. A convenience sample was provided by each site. A total of 63 consumers at 7 agencies completed the survey. Surveys were administered by Ryan White CQM staff. A $25 incentive card to a local retailer or grocer was provided for completion of the survey.

Length of time receiving Food Bank

Consumers were asked how long they had been receiving food bank services. One-third were in care for "less than 6 months -1 year". 27% of consumers had been receiving Food Bank services for "greater than 5 years", and the same percentage received services at their specified agency for "1-2 years". Another 16% were in care for "3-5 years".

Consumers were asked to identify the type of service received at the agency. Grocery store gift cards (35%) and home delivered meals (35%) represented the major portion of services received, Figure 14.

Figure 14: Service received, N=63



Kitchen Access

Clients were asked if they had access to a fully equipped kitchen (i.e., running water, microwave, stove, refrigerator, utensils etc.). Eighty-nine percent responded "yes".

Treatment Planning

The Standards of Care require that "The provider, in cooperation with the client, develop a treatment plan with identified, quantifiable goals and outcomes following the completion of the intake assessment." A majority of clients (65%) responded that they had participated in treatment plan development.

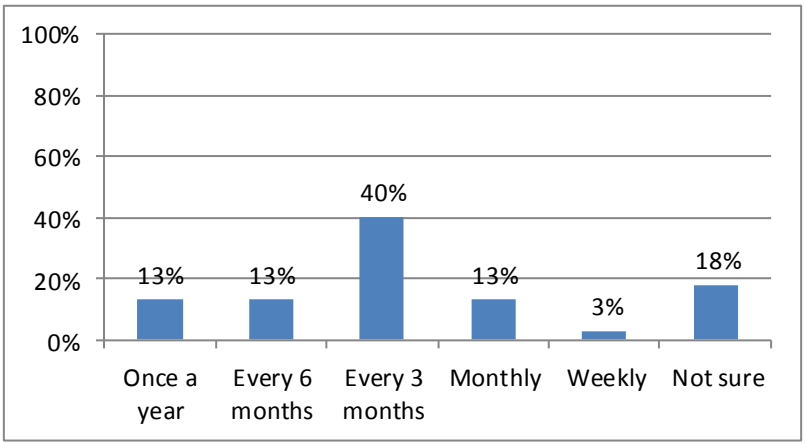
Home Delivered Meals

Consumers were surveyed regarding the receipt of home delivered meals, and how smoothly the program operated. Thirty-five percent of food bank clients received home delivered meals. 20% had missed receiving a meal in the last year; of these, a majority (86%) indicated they missed the meal because they were not at home and 14% indicated scheduling conflicts. After missing the meal, 43% of consumers were subsequently contacted by the agency.

Frequency of FB and MNT Office Visits

Consumers were asked with what frequency they met with a nutritionist. 40% visited a nutritionist quarterly, Figure 15.

Figure 15: Nutritionist Office visits, N=63



Medical Nutrition Therapy

Consumers were surveyed regarding the different nutrition therapy and counseling services they had received. As Table 5 shows, the services most often received were nutrition counseling (54%), nutrition education (49%), and assessment of nutrition status (46%). Note: The total percentages for services rendered exceeded 100% as some consumers received more than one type of nutrition therapy services.

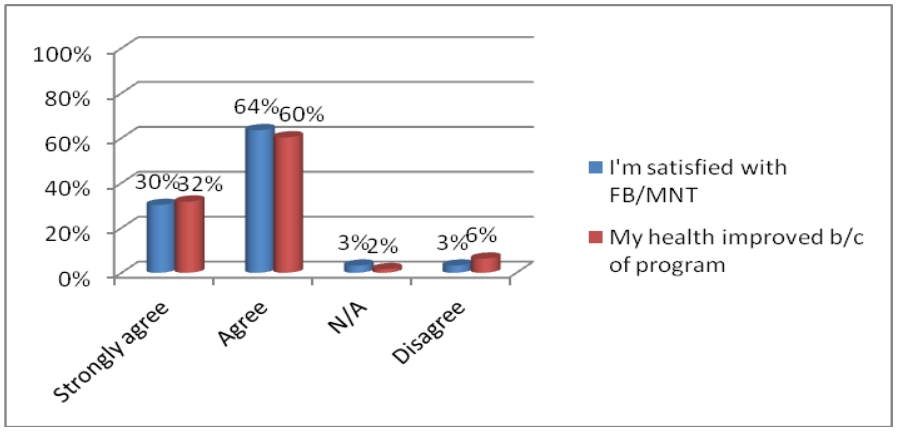
Table 5: Delivery of Services, N=47

Service Rendered	% clients
Nutritional counseling	54%
Nutrition education	49%
Assessment of nutrition status/immunity/well-being	46%
Referral to food assistance programs	21%
Bioelectric impedance analysis (BIA) and interpretation	32%
Nutritional screening and assessment	16%
Assistance with menu planning	44%

Consumer Satisfaction

Overall, 94% of consumers agreed or strongly agreed they were satisfied with food bank and medical nutritional therapy services. 92% of consumers agreed or strongly agreed that their health had improved because of the food and nutrition services provided, Figure 16. Of those surveyed, 96% stated that they would recommend their agency to someone with similar needs, not shown.

Figure 16: Consumer Satisfaction, N=63



Summary

27% of consumers had been receiving services for more than 5 years. Nearly all consumers considered their health improved because of the food and nutrition services. More than half of respondents received nutrition counseling. Thirty-five percent received home delivered meals. Thirty-five percent of food services clients did not have a treatment plan.

Consumers were given the opportunity to provide any other comments or feedback on food bank and medical nutrition therapy services. Participants receiving home delivered meals indicated they would like to see more variety of foods and flavors. Additionally, several would like to receive more food vouchers and gift cards throughout the year.

DISCUSSION AND RECOMENDATIONS

Regarding medical nutritional therapy services, all providers documented greater than 90% adherence to the standards with regard to conducting assessments, documentation of annual service visits with clients, and an annual service review by a registered dietitian. Charts reviewed at one agency documented that a majority (92%) of clients received an annual BIA as required in the standards of care. Two providers performed at or above the EMA average for documentation of care plans and including measureable goals in the care plans.

Regarding food bank services including food bank EFA, 4 providers performed at or above the EMA in assessing the client's emergency need. Four performed at or above the EMA average in documenting the voucher amount, and 2 performed at or above the EMA in checking for other resources.

Below is an EMA-wide summary of strengths and areas for improvement for medical nutritional therapy and food bank and home delivered meals services. **Refer to the cover letter of this document for your agency's strengths and areas for improvement.**

Strengths

EMA- wide adherence to Planning Council Standards of Care was documented at 81% or better in the following areas:

- HIV status: 100%
- Enrollment in primary care: 96%
- ART status: 88%
- Viral load: 87%
- CD4: 86%
- MNT assessment conducted: 100%
- MNT at least one service visit per year: 96%
- MNT annual review by a registered dietitian: 94%
- MNT assessment included documentation of the following elements in more than 80% of charts: activity/exercise, appetite, diet, food intake and weight.

Areas for Improvement

EMA- wide adherence to Standards of Care was documented at less than 80% in the following areas:

- Residence eligibility (74%) and residency update (68%)
- Income eligibility (73%) and income update (67%)
- Third party payer verification (51%) and third party update (79%)
- MNT Annual BIA: 65%
- MNT Care plan: 65%

- MNT Care plan includes goals: 76%
- MNT assessment included documentation of the following elements in less than 80% of charts: access to cooking equipment, documentation of BIA, client's capacity to prepare food, cultural/religious food constraints, food allergies, medical symptoms of HIV and non-HIV condition, medical side effects, nutritional supplement intake, oral health, and psychosocial factors.
- All 15 policies for MNT clients (ranging from 0% to 66% documentation)
- Food bank EFA assessing emergency need: 73%
- Food bank EFA documenting voucher amount: 72%
- Food bank EFA checking for other resources: 37%

Standards of Care Observations

CQM assessed providers' adherence to the March 2009 Medical Nutritional Therapy Standards of Care. However, they were revised in March 2013 and two changes were made:

2.1.2.10 BIAs should be performed at initial intake and annually thereafter.
2.1.2.11 Obtain the following labs: lipids, metabolic panel, and CD4 count, as available.

Food bank and home delivered meals services were assessed for adherence to the October 2009 Standards of Care. In May 2013 they were revised as follows:

- Three new sections were added to the minimum requirements:
  - 2.1 Eligibility for Food Bank/Home Delivered Meals
  - 2.2 Eligibility for Emergency Financial Assistance
  - 2.5 Treatment Plan for Food Voucher Clients
- Two items were added to 2.3 Baseline Evaluation:
  - 2.2.3.3 Obtain the following labs: lipids, metabolic panel, and CD4 count.
  - 2.2.3.4 To qualify for EFA services, need for services must be established (see section 2.2).
- A new key service was added: 1.1.3. emergency food vouchers
- An item was added to Administrative Standards of Care: 3.17 Agency supervisors working with food handling and preparation staff, must be graduates of an accredited culinary school and have a Food Manager Certification with a current valid ServSafe Certification issued from the State.

Ryan White Eligibility

All clients receiving Ryan White services must be screened for eligibility requirements including one-time verification of HIV status, and semi-annual verifications of residency and income. At least one of the income and residency verifications in each 12 month period must be accompanied by supporting documentation. Self-attestation is sufficient for the second verification. Please note that while self-attestation of no change is sufficient, self-attestation of change **must** be accompanied by supporting documentation. On the next page, Table 5 describes the type of documentation required for each eligibility requirement.

Initial residence and income verification were found in 74% and 73% of charts, respectively. When the client had been in care for more than 6 months, reviewers checked that residence and income were updated. 68% of charts documented a residence update and 67% of charts documented income updates (refer to Figure 1). Since Ryan White is the payer of last resort, all clients should have been screened for eligibility and all clients' eligibility should have been reassessed.

RW Eligibility and the Affordable Care Act[3]

As health care reform is implemented, more PLWH will become eligible for public or private insurance. Ryan White providers are required to make efforts to secure other funds to provide services to clients. Other funding streams include Medicaid and Medicare, CHIP, or other private health insurance. Ensuring that Ryan White funds are used as a last resort helps provide services to new clients and leaves funds for other needed services.

For more information please see HRSA Policy Clarification Notice #13-03.

RW Eligibility and Electronic Health Records (EHR)

With the increased use of EHRs throughout the EMA, providers will need to consider how they will document initial and semi-annual verification of Ryan White eligibility. Hard copy verification of eligibility is required once per year for every client served. When clients are seeking Ryan White services for the first time or are re-entering care, they must provide hard copy documentation of their eligibility. If after initial or annual eligibility verification the client has reported a change in residence or income, then they must also provide hard copy documentation.

Providers using EHRs will need to either maintain a paper chart containing RW eligibility or scan these documents into the EHR. Written documentation of eligibility notated in the client's record will only be accepted once per year and only if the client reports no change in their eligibility.

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

Table 5. Required Documentation Table[4]

	Initial Eligibility Determination & Once a Year/12 Month Period Recertification	Recertification (minimum every 6 months)
HIV Status	Documentation required for Initial Eligibility Determination	Not applicable
Income	Documentation required **Examples from the Greater Baltimore HIV Health Services Planning Council (GBHHSPC):** **1**. Copy of a signed lease with client's name and address **2**. Copy of a current or previous month's utility bill or rent receipt with client's name and address **3.** Copy of an Supplementary Security Income (SSI) award letter with client's name and address **4.** Notarized letter from a friend or family member, naming the client and attesting to his or her address **5**. Support letter on official letterhead from a shelter, recovery house, transitional housing facility or other similar housing facility.	Self-attestation of no change
Residence	Documentation required **Examples from GBHHSPC:** **1**. Copy of a current pay stub with the client's name **2**. Copy of the client's most recent W-2 form **3**. Copy of the client's SSI award letter **4**. Signed, notarized "letter of support" from someone providing the client with financial support **5**. Documentation of active Medicaid benefits, such as the client's managed care organization card.	Self-attestation of change – documentation required
Insurance Status	Must verify if the applicant is enrolled in other health coverage and document status in client file **Examples from GBHHSPC:** **1**. Copy of the client's insurance card **2**. Documentation that provider staff have checked the client's status in the Eligibility Verification System (EVS) of the State of Maryland **3**. Verification from private insurance company that includes the date and results, with initials/signature of provider staff securing verification.	Must verify if the applicant is enrolled in other health coverage Self-attestation of no change Self-attestation of change – documentation required

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

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