CHAPTER 9: EVALUATION AND MONITORING.

9.1 Introduction.

Monitoring and evaluation are critical steps in building the *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA, 2012-2015*. By using the programs, processes and tools described in this chapter, the EMA will be able to assess progress and identify areas of success and weakness. These activities also help create an environment of transparency and accountability among planners and partners in the EMA.

Tools such as strategic EMA report cards, client-level data, expenditure and service delivery reports, on-line category scorecards, HRSA performance measures and clinical outcomes help the EMA determine how effectively it is achieving the goals and objectives outlined in chapter 7. The grantee's Clinical Quality Management program reviews Ryan White-funded service categories to assess the quality of services and provides technical assistance. Several planning council committees — Comprehensive Planning, Evaluation, and Continuum of Care — serve specific monitoring functions. The planning council further utilizes priority setting and resource allocation, reprogramming, and consumer survey data to evaluate the continuum of care.

9.2. Measurement Data.

The strategic table presented in chapter 7 incorporates a measurement tool column. The planning council will use the identified measurements to evaluate how well the EMA — including funding and service partners — are meeting its goals.

The Comprehensive Planning Committee has created a report card tool based on the measurement tools in chapter 7. This report card, produced annually will be a streamlined way to evaluate the progress the EMA is making. The data will be collected using the methods listed in the remainder of this chapter.

9.3. Client Data.

The grantee implemented an electronic client information data system in 2009 through a Special Projects of National Significance grant (BCHD 2010). This system mirrors the requirements in the Ryan White Services Report (RSR) and increases the EMA's capacity to collect and report unduplicated client data (BCHD 2010). The program and site-level reports allow the EMA to collect more detailed, current, accurate and flexible data (Ferrari 2011). More than 100 data elements are available. These data range from demographic, service, clinical, eligibility and insurance data about PLWH/As in the EMA (Ferrari 2011).

These activities [evaluation] help create an environment of transparency and accountability among planners and partners in the EMA.

9.4. CQM Program.

Each Ryan White Part A program is mandated to establish a Clinical Quality Management program that ensures that the delivery of funded services is consistent with Public Health Service (PHS) guidelines. In FY 2011, the grantee dedicated five percent of the total grant award to carry out CQM program activities, as in previous years. The CQM program develops policies, procedures, tools, databases and data-collection methodologies to look at how well each service category is performing. Based on the assessment, the program makes improvements in the access to and quality of services (BCHD 2010).

The CQM process includes reviews of chart audits, agency reviews, and consumer surveys to

evaluate client involvement in care planning and evaluation. The CQM reports provide information that the planning council uses to evaluate its overall service system based on standards of care and PHS guidelines. Demographics and clinical indicators from client chart abstractions, documentation of eligibility and agency policies, consumer surveys, summary of strengths and recommendations on weaknesses are examples of the information provided in CQM reports (IGS 2011a).

The CQM program reviews each service category on a revolving four-year cycle. In 2010, adult primary medical care, mental health services, outreach services, and outpatient and residential substance-abuse treatment services were reviewed. In 2011, adult and pediatric primary medical care, oral health care services, hospice services, non-medical case management, and psychosocial support services were reviewed (Ungard 2011).

The amount of funding expended, number of clients served, rate of service utilization, and an explanation of expenditure variances were included in each ESD report.

Additionally, provider participation is mandatory in technical assistance meetings that implement system-wide change. CQM staff provided four category technical assistance trainings in 2011 from January to July — data rankings, project charters, fishbone analyses[18], and PDSAs (plan, do, study, act) (Ungard 2011). Ongoing assessments of provider expenditure patterns, progress toward program objectives, and adherence to federal guidelines are reviewed and monitored by the CQM program (BCHD 2010). The CQM team gives feedback on directives and carryover requests throughout the year. Vendor reports and corrective action plans also are provided throughout the year (Ungard 2011). Providers must give work-plan updates for 5- and 7-month reports. This communicates to BCHD whether the providers believe all of the funding will be spent and, if applicable, reasons for not being on track.

The CQM process, using standardized review tools, is critical to monitoring the continuum of care to assess the extent to which services are being delivered according to appropriate category guidelines and local standards of care.

9.5. ESD Reports.

Expenditure and service delivery reports, compiled by Baltimore City Health Department, give an overview of the performance in each service category throughout the EMA. Providers are required to supply the grantee with monthly reports on program performance and expenditures. BCHD compiles these reports and prepares ESD reports in the fifth, seventh, and twelfth month of the fiscal year. The amount of funding expended, number of clients served, rate of service utilization, and an explanation of expenditure variances are included in each ESD report. These reports guide strategic planning for reprogramming in the current year and priority setting and resource allocation for the next fiscal year.

In addition to providing ESD reports, the grantee's administrative staff conducts comprehensive programmatic and fiscal site visits. These ensure that providers are complying with standards of care, meeting their projections, and meeting the objectives outlined in the strategic plan. Providers are given technical assistance, as determined by the grantee or requested by the agency, to address challenges related to meeting the needs of the community.

9.6. Scorecards.

InterGroup Services, Inc., the planning council support office, in the late 2000s created, and has since maintained, an on-line Ryan White information portal (http://balpc.intergroupinfo.com). The portal facilitates the transfer of information from the grantee, HRSA, and other key federal, state and local agencies to the planning council (IGS 2011b).

[18] Fishbone analyses is a quality-control tool to complete a cause and effect analysis, used to discover the root cause of a problem and identify bottlenecks in a process. It is referred to as a fishbone analyses because a completed diagram can look like the skeleton of a fish.

The portal houses and is best known for its service category "scorecards" and supporting documentation. The key features of the scorecards are two-page visual dashboards that attractively display the information found in the ESD reports. Graphs and charts depict expenditures, clients and utilization across periods and historically from 2005. This is helpful to establish and evaluate trends. Comments from the grantee and PCSO are included to explain variances or highlight data. Unmet need data from the consumer survey and alternate funding stream data also are presented on each scorecard.

Scorecards are created for each funded category for the fifth-, seventh- and twelve-month ESD reports and are available on the information portal web site. They are printed by the PCSO for use during the EMA-wide and counties PSRA and reprogramming exercises. The scorecards are essential tools in helping the Baltimore EMA monitor trends within service categories, make funding decisions, and assess overall success in moving clients through the continuum of care.

9.7. Council Review.

The planning council and its committees have a broad scope of responsibilities, from producing the comprehensive plan, to reprogramming funds, to developing standards of care. These functions provide checks and balances and ensure a smoothly running continuum of care with community planning and monitoring in place.

9.7.1. Comprehensive Planning Committee.

The Comprehensive Planning Committee performs several vital functions in the preparation of the comprehensive plan. Throughout the year, the CPC works collectively with the partners identified in chapter 8 to achieve the goals set forth in chapter 7. The CPC obtains and utilizes client-level data, epidemiological data, clinical outcomes data, CQM reports, ESD reports and the scorecards to establish baseline measurements, set benchmarks and track trends.

The CPC is responsible for analyzing data and reporting progress to subcommittees, the planning council, and partnering stakeholders for planning. Utilizing the report card tool discussed in section 9.6, status updates for each objective are given yearly to help the planning council evaluate its performance. The CPC recommends which strategies should be carried forward to the next strategic plan, which are incorporated into the status quo, and if any should be modified or removed.

Directive and carryover requests are also filtered through the CPC from other committees and council members. The CPC also determines which organizations — representing various funded categories — should be invited to provide data presentations to inform the priority setting and resource allocation process.

9.7.2. Evaluation Committee.

The planning council's Evaluation Committee reviews ESD reports on the fiscal and programmatic performance of each service category during reprogramming. These reports allow the council to adjust its planned allocations of funds to meet the health and supportive services needs throughout the year. Reprogramming occurs during the seventh and ninth month of the fiscal year and is a joint meeting between the Evaluation and Counties committees. Reprogramming is essential to meet client demands and to ensure that all funding is utilized. The Evaluation Committee is also responsible for the assessment of the administration mechanism that is then part of the BCHD grant application.

The council can vote to accept the grantee's recommendations or provide alternative recommendations of its own.

9.7.3. Continuum of Care Committee.

The planning council's Continuum of Care Committee uses CQM reports and other data in the development of standards of care. Based on HRSA service category definitions, standards of care are minimum requirements that must be met by providers receiving Ryan White funds. The standards of care are the basis for the contracts established by the grantee and for the subsequent evaluation of provider performance. The committee oversees the performance of the service categories in meeting the needs of PLWH/As

using CQM reports, ESD reports, and the latest implementation plan.

9.7.4. Priority Setting and Resource Allocation.

The planning council determines the overall continuum of care by identifying and prioritizing the service categories during the annual priority setting and resource allocation conference. The 40-member planning council uses a wealth of data to set priorities and funding allocations. Service category definitions, clarifications, history, directives, other funding-streams date, ESD reports, CQM reports, category scorecards — all were evaluated during the FY 2012 PSRA meeting, held in summer 2011 (IGS 2011a). The planning council has numerous data presentations from DHMH, BCHD, Ryan White Part A providers, Medicaid and CQM representatives, and others to inform their decisions.

The first step of the PSRA process is to rank the service categories. This is typically done on line using a survey tool. During the two-day PSRA meeting, the council members hear recommended allocations from the grantee, and are afforded an opportunity to ask for further clarification. The council can vote to accept the grantee's recommendations or provide alternative recommendations of its own. Allocation percentages are voted on and approved for each category. When the Ryan White grant award is received, the percentages are converted into dollar allocations. The grantee establishes and monitors Part A provider contracts based on the established allocations made by the planning council during PSRA for that fiscal year.

9.7.5. Consumer Survey.

The planning council utilizes the results of the triennial consumer survey to understand what services have the highest need and unmet demand. Section 3.3 details the development, results, and analysis of the consumer survey.

9.8. HRSA Clinical Measures.

The HRSA HIV/AIDS Bureau has created six sets of performance measures to be used to monitor the quality of care. Grantees are encouraged to select the measures most important to their agencies' needs and relevant to the populations they serve to incorporate into the CQM programs (HRSA 2011).

9.8.1. Adult and Adolescent Core Clinical Performance Measures.

Core clinical performance measures for adults and adolescents are broken down into three groups based on their ease of integration and data collection.

9.8.1.1. Group One.

Group one measures provide a foundation on which to build. The Baltimore EMA included this set of measures in the previous plan, the *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA, 2009-2011*. These indicators measure the percentage of clients who receive the following:

- Antiretroviral therapy for pregnant women.
- CD4 T-Cell count.
- Antiretroviral therapy.
- Medical visits.
- PCP prophylaxis (HRSA 2011).

9.8.1.2. Group Two.

Group two measures should be seriously considered for incorporation into a clinical management program. They measure the percent of clients that receive:

- Adherence assessment and counseling.
- Cervical cancer screening.
- Hepatitis B vaccination.
- Hepatitis C screening.
- HIV Risk counseling.
- Lipid screening.
- Oral exam.
- Syphilis screening.
- TB screening (HRSA 2011).

9.8.1.3. Group Three.

Group three measures data that are more difficult to collect and they represent "best practices." Many of these may lack written clinical guidelines and are expensive to implement and collect data for. They include the percentage of clients that receive:

- Chlamydia screening.
- Gonorrhea screening.
- Hepatitis B screening.
- Hepatitis/HIV alcohol counseling.
- Influenza vaccination.
- Mycobacterium avium complex (MAC) prophylaxis.
- Mental health screening.
- Pneumococcal vaccination.
- Substance use screening.
- Tobacco cessation counseling.
- Trigomonus screening for HIV positive women who are sexually active.
- Toxoplasma screening (HRSA 2011).

9.8.2. Medical Case Management Performance Measures.

This group of performance measures reviews how well medical case management services are performing. They assess the percentage of clients that received the following in the measurement year:

- Care plan development.
- Two or more medical visits in an HIV care setting (HSRA 2011).

9.8.3. Oral Health Services Performance Measures.

The third group of performance measures monitors oral health services and targets all clients. They provide the percentage of clients who receive the following in the measurement year:

- Dental and medical history.
- Dental treatment plan.
- Oral health education.
- Periodontal screening or examination.
- Phase 1 treatment plan completion (HSRA 2011).

9.8.4. ADAP Performance Measures.

These performance measures assess the state's AIDS Drug Assistance Program. Although Ryan White Part A does not administer the ADAP program, the state collects this information each year. Performance measures include the percentages of the following in the measurement year:

- Application determination within 14 days.
- Enrollees reviewed for continued eligibility recertification.
- New antiretroviral classes included in the ADAP formulary after inclusion by DHHS.
- Inappropriate ARV regimen components resolved by ADAP (HSRA 2011).

9.8.5. Systems-level Performance Measures.

Systems-level performance measures address aspects of access and entry to care and can be utilized by any system or network. They evaluate the percentages of the following:

- Waiting time for initial access to outpatient/ambulatory medical care less than 15 business days.
- HIV test results for PLWH/As.
- Disease status at time of entry into care.
- Quality management program.
- System-level performance (HSRA 2011).

9.8.6. Pediatric Performance Measures.

The final group of performance measures monitors the range of clinical, social, and system issues common to programs that serve pediatric clients. They calculate the percentage of clients that received the following in the measurement year:

- Adherence assessment and counseling.
- ARV therapy.
- CD4 value.
- Developmental surveillance.
- Diagnostic testing to exclude HIV infection in exposed infants.
- Health care transition planning for HIV-infected youth.
- HIV drug resistance testing before initiation of therapy.
- Lipid screening.
- Medical visit.
- MMR[19] vaccination.

[19] Measles, mumps and rubella (MMR)

- Neonatal zidovudine prophylaxis.
- PCP prophylaxis for HIV-exposed infants.
- PCP prophylaxis for HIV-infected children.
- Planning for disclosure of HIV status to child.
- TB screening (HRSA 2011).

Many of these measures are incorporated into the strategies described in chapter 7. Since 2009, the CQM program has utilized the web-based, client-level data system described in section 9.2 to track these clinical performance measurements (also examined during CQM reviews). These results and outcomes are reported to the planning council (Ferrari 2011).

9.9. Clinical Outcomes in the Baltimore EMA.

The CQM team reports on the progress of the Baltimore EMA based on the HRSA clinical performance measures described in the previous section. Several clinical indicators speak strongly to the high quality of services in the EMA.

The medical visit retention indicator can be thought of as a proxy for engagement. The percentage of clients with HIV infection who had two or more visits at least three months apart in an HIV care setting in FY 2011 was 93 percent (Ungard 2012). This represents an increase from 90 percent in FY 2010 and 87 percent in FY 2009.

A proxy for stabilization and maintenance in the continuum of care is the viral load suppression indicator. In FY 2011, 75 percent of primary medical care clients on HAART had a viral load of less than 200. In FY 2011, 51 percent had a viral load that was undetectable, up from 42 percent in FY 2007 (Ungard 2012).

9.10. Conclusion.

This chapter has expressed the importance of monitoring and the commitment HRSA, the grantee, the planning council and PCSO have towards evaluation of the comprehensive plan. The programs, processes, and tools described in this chapter will help the EMA evaluate and modify the comprehensive plan outlined in chapter seven.

The future is uncertain and many laws, policies and strategies are likely to change between 2012 and 2015. Conscientious evaluation, however, will put the Baltimore EMA in a good position to adapt. Assessment of the achievements and potential shortcomings will ideally result in a continuum of care that is effective in adapting to the evolving needs of PLWH/As. The goals of prevention, engagement, stabilization, and maintenance will help to decrease incidence of HIV and AIDS in the EMA. The *Comprehensive Plan for HIV Health Service Delivery in the Baltimore EMA, 2012-2015* will coordinate and inform planning council and committee objectives and services for the next four years.

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