Continuum of Care Administrative Overview Ryan White Part A

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Agenda

- Introduction to Continuum of care
- Components of a continuum of care and Planning Council Overview
- Program Components & What's New
- Questions and Comments

What is an HIV Continuum of Care?

An integrated service network that guides and tracks HIV clients over time through a comprehensive array of clinical, mental, and social services in order to maximize access and effectiveness.

National HIV/AIDS Strategy Goals

1. Reducing new HIV infections
2. Increasing access to care and improving health outcomes for PLWH
3. Reducing HIV-related health disparities

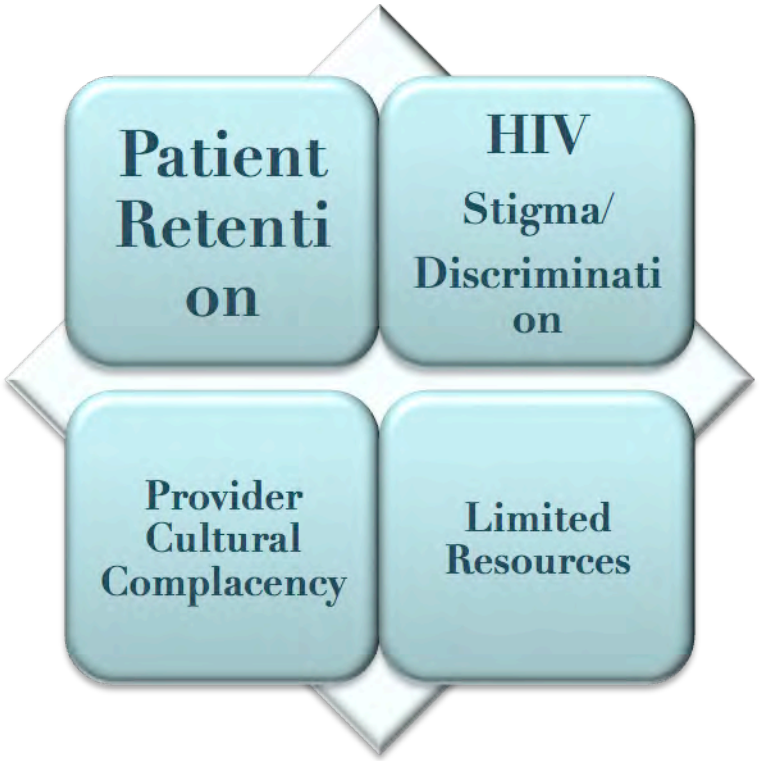
Changing Systems of Care

HIV/AIDS as a chronic disease:

- Increase in number of PLWH needing care (~56,000 new cases, ~15,000 deaths annually)
- Changes necessary in system of care -- emphasis on:
  - "Front-loaded" services
  - Peer navigators/community health workers
  - Disease self-management
- Less intensive services for many consumers after first few years

Characteristics of a Continuum

Common CoC Barriers/Challenges



CoC Strategy & Implementation

- There is no right or wrong way to implement the Continuum of Care in any given location.
- The local context will strongly influence the approach in design and implementation.

Partnerships and Collaboration

- In a continuum of care, HRSA expects to see collaboration, partnering and coordination between multiple sources of treatment, care and prevention service providers.

- In a mature continuum of care, collaboration between HIV testing sites, non-Ryan White Program providers, all Ryan White Program Parts (A, B, C, D, and F), Medicaid, and VA should be established and maintained in the planning and implementation of services.

Statewide Coordinated Statement of Need (SCSN)

Does Part A Have a Role? Yes!

- The SCSN is a collaborative process and must be developed with input from all Ryan White HIV/AIDS Programs Parts. The Part B grantee is responsible for periodically convening a meeting for the purpose of developing an SCSN.
- All Ryan White Parts are equally responsible for the development of the process, participation in the process, and the development and approval of an SCSN.
- The mechanism for developing an SCSN can be a statewide meeting or may be some other locally developed process.

The 2012 Comprehensive Plan (Comp Plan)

- The Division of Service Systems requires Ryan White Part A and B grantees to submit an updated Comprehensive Plan every three years.
- The purpose of this multi-year plan is to assist grantees in the development of a comprehensive and responsive system of care that addresses needs and challenges as they change over time.
- The Comprehensive Plan is a **living document** that serves as a roadmap for the grantee and should be continually updated as needed. The comprehensive plan should also reflect the community's vision and values regarding how best to deliver HIV/AIDS services, particularly in the light of the cutbacks in federal, State and local resources.
- The Comprehensive Plan must be compatible with existing State and local service plans including the Statewide Coordinated Statement of Need (SCSN).

Comp Plan 2012 – What's New?

1. Monitoring and Evaluation

- Grantees are required to evaluate their 2009 Comprehensive Plan to identify successes and challenges experienced in the implementation of the plan and how they plan to meet those challenges.

2. Early Identification of Individuals with HIV/AIDS

- The Early Identification of Individuals living with HIV/AIDS (EIIHA) is a legislative requirement that focuses on individuals who are unaware of their HIV status and how best to bring HIV positive individuals into care, and refer HIV negative individuals into services that are going to keep them HIV negative. An important element in assessing statewide need includes describing the needs of individuals who are unaware of their HIV status.

Comp Plan 2012 – What's New (continued)

- The National HIV/AIDS Strategy (NHAS) advocates for the adoption of community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV.
- In the Comprehensive Plan, grantees will discuss how the plan will address the goals of the National HIV/AIDS Strategy, as well as identify the specific goals being addressed.
- The Comprehensive Plan should discuss how the Healthy People 2020 objectives will be addressed.

Comp Plan 2012 – What's New (continued)

- The intent of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Reconciliation Act of 2010 (P.L. 111-152) (collectively referred to as the health reform law) is to expand health insurance coverage while also reforming the health care delivery system to improve quality and value.
- The comprehensive plan should outline how efforts are coordinated with and adapt to changes that will occur with the implementation of the Affordable Care Act (ACA).

Part A

Planning – The Planning Council

Ryan White Part A Planning Council

Roles and Responsibilities:

- Develop and implement policies and procedures for planning council operations
- Assess needs
- Do comprehensive planning
- Set priorities and allocate resources to service categories, provide guidance (directives) to the grantee on how best to meet priorities

PC Roles and Responsibilities (continued)

- Help ensure coordination with other Ryan White and other HIV-related services
- Assess the administrative mechanism
- Develop standards of care

Eligible Part A and Part B Services

Core Medical Services:

- Outpatient/ambulatory medical care
- AIDS pharmaceutical assistance (local)
- Oral health care
- Early Intervention Services (EIS)
- Health insurance premium and cost sharing assistance
- Home health care

Core Medical Services (continued)

- Home and community based health services
- Hospice services
- Mental health services
- Medical nutrition therapy
- Medical case management
- Outpatient substance abuse services

Support Services

- Case management
- Child care services
- Emergency financial assistance
- Food bank
- Health education
- Housing services
- Legal services
- Linguistic services

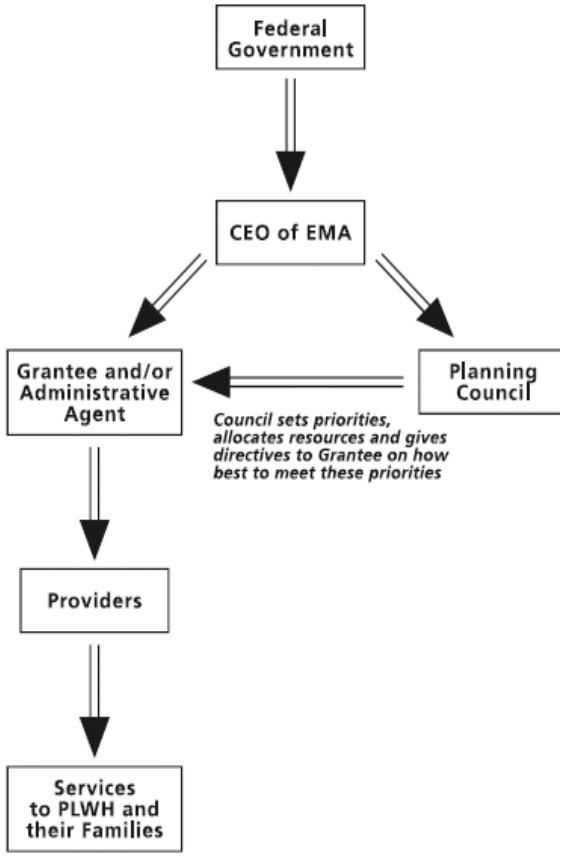
Support Services (continued)

- Medical transportation services
- Referral for healthcare/supportive services
- Rehabilitative services
- Respite services

Decision Making

Grantee and PC Roles

Summary: Flow of Part A Decision Making & Funds



Planning Council Roles in System of Care

Planning Council:

- Helps develop & improve a system of care through its planning tasks – needs assessment, comprehensive planning, PSRA
- Collaborates with Grantee on development of new & refined service models and approves models – PC must approve models
- Develops and approves of standards of care (SOC) for all funded service categories plus Universal Standards, working closely with the Grantee

Grantee Roles in System of Care

Grantee:

- Ensures that providers participate in a system of care
- Works with Planning Council to develop service models and SOC
- Uses SOC in preparing RFPs, contracting, monitoring, and Quality Management
- Implements service models approved by the Council, consistent with SOC
- Participates in comprehensive planning, which defines an "ideal" system of care and an action plan to work toward it

Planning Council Formation & Membership

- Chief Elected Official (CEO) establishes Planning Council (PC) – **Mayor appoints all members**
- Membership must meet legislated requirements & Bylaws – representative, reflective, 33% unaffiliated consumers
- Major focus on "vetting" and diverse membership because of legislatively prescribed roles
- Open nominations process required
- Grantee has no role in membership selection
- Planning Council may not be chaired solely by a Grantee employee &
  Government Co-Chair does not "outrank" Community Co-Chair
- Alternates no longer considered a sound practice

Planning Council Role: Revise Bylaws, Policies & Procedures

- **Bylaws:** consultant recommendations
- Review committee roles and membership
- Give Finance Committee responsibility for overseeing PC budget
- Clarify who assesses the efficiency of the administrative mechanism
- Eliminate alternates from membership
- Clarify that membership nominations go through PC and then directly to CEO
- Describe expectations of PC members
- Review PLWHA Advisory Board provisions – remove “advocacy for non-Part A issues”
- Remove all references to advocacy from Bylaws

Planning Council Operations

Planning Council:

- Must develop bylaws, policies and procedures to ensure fair, efficient operations
- Must have grievance procedures
- Must manage conflict of interest (COI)
- Should give major attention to new member recruitment, orientation and training
- Ensures that most work is done by committees and that they report through the Executive Committee to the full Planning Council
- Is assisted by Planning Council support staff

Planning Council Meetings

- Equal leadership from two Co-Chairs
- PC decisions based on work & recommendations from working committees through Executive Committee
- Rules of respectful engagement enforced
- Public Comment period
  - Essential
  - Managed to allow reasonable/equitable time
  - Code of Conduct required from public as from PC members
  - Care taken to address only issues within PC's scope of responsibility – receive and refer others appropriately

Coordination of Services

- **Shared responsibility of Grantee and Planning Council**
- Coordination in planning, funding, and service delivery
- Part A funds should fill gaps, not duplicate other services, and make Ryan White the payer of last resort
- Emphasis on coordination with Part B, given budget challenges and ADAP waiting lists
- Emphasis on coordination with prevention, given new EIIHA requirements
- Council reviews other funding streams as input to resource allocation
- Grantee ensures that providers have linkage agreements and use other funding where possible – for example, ensure eligible clients apply for Medicaid

Needs Assessment

- **Planning Council has primary responsibility and "ownership"** – design, direct work or oversight of consultants or volunteers; Committee should include non-PC members
- **Grantee provides support** – data, procurement if a consultant is needed, staff assistance
- Need active community involvement – especially consumers & providers
- **Need multi-year plan** for assessing needs of PLWH in and out of care
- Findings go in user-friendly formats as input to decision making, especially priority setting & resource allocation

Needs Assessment Components

- Epidemiologic Profile
- Assessment of Service Needs and Gaps (surveys, focus groups, special studies, town halls, etc.)
- Resource Inventory
- Profiles of Provider Capacity and Capability
- Estimation and Assessment of Unmet Need and HIV+/unaware

Comprehensive Planning

- **Shared task, with Planning Council as lead**
- Roadmap or vision for HIV service delivery system in the EMA, usually for 3 years *(next one due in spring 2012)*
- **Key focus:** strengthening the continuum of care to address disparities & bring people into care
- Must be consistent with Statewide Coordinated Statement of Need (SCSN)
- Must emphasize collaboration
- Council develops planning process, plays primary role in consultant selection, oversees process through committee that includes consumers, non-PC members
- **Grantee participates actively, provides data support**
- Both suggest goals in their areas of responsibility
- Council monitors progress; Grantee provides data to monitor progress, such as QM, cost & utilization, EIIHA and unmet need data

Priority Setting and Resource Allocations: Overview

- **Most important legislative responsibility of Planning Councils –** should actively involve the whole PC and be done by vetted PC members
- **Includes:**
  - **Priority setting:** deciding what services and program support categories are most important for PLWH in the EMA
  - **Resource allocations:** deciding how much Part A funding to provide for each service priority
  - **Directives to the Grantee** on how best to meet these priorities – e.g., what service models for what populations in what geographic areas
  - **Reallocation of funds** across service categories during the program year, as needed

Priority Setting

Planning Council Responsibility:

- Means determining what service categories are most important for PLWH in the EMA – *unrelated to who provides the funding for these services*
- Grantee provides information – especially service utilization data – and advice, but has no decision-making role
- Council needs a fair process for priority setting that ensures decisions are data based

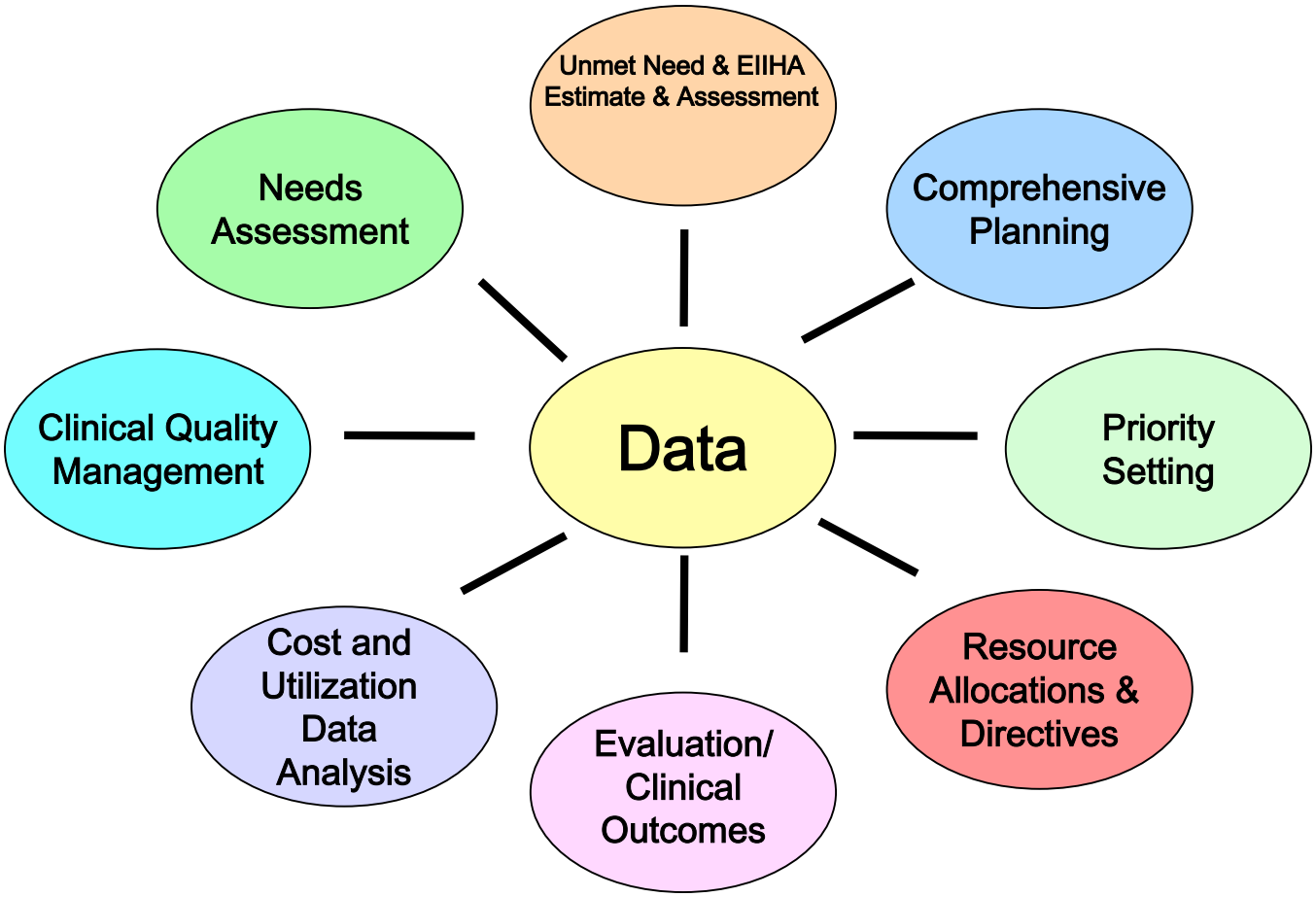
Resource Allocation

- **Planning Council responsibility – should involve entire Planning Council**
- Process of deciding how much funding to allocate to each priority service category
- ≥75% of service dollars must go to core medical-related services; ≤ 25% may go to support services contributing to positive clinical outcomes
- Grantee provides extensive data & advice, but has no decision-making role
- Only PC members (appointed by the Mayor) participate in resource allocation
- Best practice: include presentation & discussion with Part B & ADAP about State continuum of care
- Good decisions require cost data including cost per client per year for each service category

Resource Allocation (continued)

- Must use a fair, data-based process
- Conflict of interest must be managed
- Process should protect against "impassioned pleas"
- Must consider strategies for EIIHA and bringing people into care
- Must consider other funding streams – *so some highly ranked service categories may receive little or no Part A funding*
- Calls for use of all the knowledge & skills developed through PC membership

Data-Based Planning and Decision Making



HRSA Expectations for Committees

- Do groundwork for PC decision making
- Explore issues, obtain and analyze data, and provide input and recommendations to full PC through Executive Committee
- Focus on Part A legislative responsibilities
- Receive content and logistical support from PC staff
- Receive information/reports from Grantee on regular schedule, with a defined process for requesting data
- Work closely with Grantee:
  - Every committee should have regularly assigned Grantee staff to support its work and participate actively
  - Grantee staff has no vote in committees

HRSA Expectations for Committees (continued)

- Ensure diverse membership, in terms of professional & personal backgrounds
- Ensure strong consumer participation on *all* committees
- Include non-PC members in committees that link to the community – like Needs Assessment, Consumer, Integration of Care – but not PSRA, Membership/Rules
- Require regular attendance, COI disclosure and management, and adherence to Code of Conduct from *all* members
- Provide committee-specific training

Consumer and Community Input

- Consumer input through:
  - Unaffiliated consumer members of PC
  - Consumer Committee
  - PLWHA Advisory Board
  - Needs assessment efforts
  - Public comment
- Challenges:
  - Obtaining broad-based input, not just “impassioned pleas”
  - Ensuring Ryan White funds are used only for Ryan White related activities
  - Using resources efficiently
  - Ensuring that Codes of Conduct are followed and personal attacks not tolerated

Role of Planning Council Support Staff

- **Assist the Planning Council to carry out its legislative responsibilities and to operate effectively as an independent planning body**
- Staff committees and Planning Council meetings
- Provide expert advice on Ryan White legislative requirements and HRSA/HAB regulations and expectations
- Oversee a training program for members
- Encourage member involvement and retention, with special focus on consumers
- Serve as liaison with the Grantee
- Help the PC manage its budget
- Are involved *only* with supporting Part A-related activities

Planning Council Operations: HRSA/HAB Expectations

Cost-Effectiveness and Outcomes Evaluation

- Planning Council has the legislative option of assessing the effectiveness of services offered – usually best done in coordination with QM and use of performance standards
- Grantee monitors cost effectiveness of services as part of QM
- Grantees now measuring clinical outcomes
- Findings used by Grantee in selecting and monitoring providers
- Findings used by Planning Council in priority setting, resource allocation, and development of directives on service models

Assessment of the Administrative Mechanism

- **Planning Council responsibility**
- Done annually – directly or through a consultant
- Involves:
  - Assessing how quickly and efficiently the Grantee contracts with service providers and how long the Grantee takes to pay the contracted providers
  - Determining whether the Grantee used service funds as specified in the Council's priorities & allocations/ reallocations and followed Council directives
- Grantee provides needed data and access to providers
- Written report goes to Grantee, which indicates what action it will take to address identified problem areas
- PC Co-Chairs prepare a letter for application stating whether PC priorities & allocations were followed

Clinical Quality Management

- Grantee role
- Involves ensuring that:
  - Services meet Public Health Service and clinical guidelines and local standards of care
  - Supportive services are linked to positive medical outcomes
  - Demographic, clinical, and utilization data are used to understand and address the local epidemic
- Grantee requires providers to develop QM plans, monitors providers based on quality standards, and recommends improvements
- PC's only related role: development of SOC
- Council receives QM findings from grantee or subcontractor by service category and across categories for use in decision making

Developing Standards of Care

- Integration of Care Committee usually takes lead
- Process generally involves consultation with providers, AIDS Education and Training Center (AETC), and academicians as well as Planning Council member involvement
- Grantee participates in PC-led process
- PC approves SOC
- PC reviews and updates SOCs when the Ryan White legislation or HRSA/HAB guidance changes service category definitions or requirements

Typical Components of Universal Standards of Care

- Policies and Procedures
- Program Staff
- Access to Services
- Eligibility Determination/Intake/ Screening
- Service Coordination/Treatment/Referral
- Client Rights and Responsibilities

Developing Service Models

- Model should specify:
  - Service category and definition
  - Need for a new model and rationale for adopting/testing this one
  - Components and description
  - Projected costs, including $ per client per year
  - Staff qualifications
  - Client eligibility
  - Provider eligibility and capacity
  - Implications for system of care
  - Any inconsistencies with existing SOC
- PC must approve detailed model
- Grantee responsible for RFP

HRSA/HAB Expectations

- PC staff are hired and supervised according to local procedures, but work for the Planning Council
- PC Executive Committee participates along with supervisor in evaluation of PC Director
- To ensure an independent Planning Council, PC staff must be independent of the Grantee
- PC staff ensure that all PC members receive appropriate training and support
- PC staff assist consumer members of the PC to play active, informed roles

Grantee Staff Roles with Planning Council

- Attend and make a Grantee report at Planning Council meetings
- Regularly provide agreed-upon reports (e.g., cost and service utilization data)
- Provide advice on areas of expertise without unduly influencing discussions or decisions
- Assign staff to attend committees except where Grantee participation is not requested
- Collaborate on shared roles
- Carry out joint efforts such as task forces and special analyses consistent with roles and resources

Non-Service Funds

- Grantee may take 10% for administrative costs and up to 5% or $3 million (whichever is less) for clinical quality management (QM) activities
- Planning Council support budget comes out of 10% administrative costs – *amount must be negotiated with the Grantee*
- Planning Council has no say in the amount or use of other administrative or QM funds – Grantee decides whether to share budget information

Procurement

- **Grantee role**
- **No** Planning Council involvement
- Involves:
  - Publicizing the availability of funds
  - Writing Requests for Proposals (RFPs)
  - Using a fair and impartial review process to choose providers
  - Contracting with providers – and requiring that they follow standards of care (SOC) and meet reporting and quality management (QM) requirements
- Contract amounts by service category or sub-category must be consistent with Planning Council allocations and directives

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