Tools for Implementing the Care System Assessment Model

Richard Conviser, Ph.D.
Global Health Policy Partners
Missoula, MT

Acknowledgements

- Moses Pounds, Ph.D., ex-HRSA/HAB
- Christopher Bates, Office of HIV/AIDS Policy
- Barbara Aranda-Naranjo, Virginia Bourassa, Sonya Hunt-Gray, Alice Kroliczak, Katherine Marconi, Ledia Martinez, Jo Messore, Doug Morgan, Sam Ndubuisi, and Lorenzo Taylor, HRSA/HAB
- Leah Kedar, M.A., Miguel Vasquez, Ph.D., Luis Mejia, Ph.D., National Project Staff
- Karen Dodge, Ph.D., Miriam Potocky, Ph.D.; Mary M. Watson, Ph.D.; Joan Othieno, Ph.D.; Site Leadership

Outline of the Manual

- A. Introduction: Planning for Ryan White Funding Allocations
- B. The Care System Assessment (CSA) Model
- C. Rapid Assessment for Services Planning
- D. CSA Community Involvement
- E. Summarizing Study Findings for Community Forums and Developing Recommendations for System Change

A. Planning for Ryan White Funding Allocations

- Part A Planning Councils are required to develop a comprehensive plan for the provision of services that includes strategies for identifying HIV-positive persons not in care
- 75% of funds are for core medical services
  - outpatient and ambulatory health services, AIDS Drug Assistance Program treatments, AIDS pharmaceutical assistance, oral health care, early intervention services, health insurance premium and cost sharing assistance, home health care, medical nutrition therapy, hospice services, home and community-based health services, substance abuse outpatient care, and medical case management, including treatment adherence services (PL 109-415)
- 25% of funds are for ancillary services needed for PLWH to achieve medical outcomes
  - respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services (PL 109-415)

Intent of the CSA

- New tools to enhance typical needs assessments
- Key focus is on PLWH not in care, especially from selected minority communities, and
- the barriers to their care entry and retention
- Designed to inform planning and funding decisions to enhance or reshape local HIV care delivery systems to reduce barriers
- Prior to implementing the process, a community should determine the particular underserved ethnic/racial minority population(s) on which it plans to focus

CSA Pilot Test Sites and Target Minority Populations

- Palm Beach County, FL
  - Black women (including Haitian immigrants)
- Orange County, CA
  - Blacks and Latinos
- Twin Cities, MN
  - African immigrants and refugees

B. The CSA Model

- This model underlies and informs the whole process
- Four structural dimensions
  - 1. Comprehensiveness of the system of care
  - 2. Capacity for each type of service in the system
  - 3. Integration of the system
  - 4. Accessibility of services
- Three cultural/behavioral dimensions
  - 5. Acceptability of services
  - 6. Technical competencies of providers and PLWH
  - 7. Client health-seeking behaviors

1. Comprehensiveness

- This is the range of the types of health and ancillary support services offered in the care system. Are there any types of services that PLWH need that are absent from the care system?
- Methods: start with grantee reporting requirements
  - See table in next slide
  - Review public documents, speak with policymakers, planners, providers, PLWH in and out of care
- Most challenging to translate what PLWH out of care say

Ryan White Reporting Categories

CORE SERVICES	SUPPORT SERVICES
Outpatient/ambulatory care	Case management
AIDS Pharmaceutical Assistance	Child care services
Oral health care	Pediatric developmental assistance
Early intervention services	Emergency financial assistance
Health insurance premium assistance	Food bank/home delivered meals
Home health care	Health education/risk reduction
Home- and community-based services	Housing services
Hospice services	Legal services
Mental health services	Linguistics services
Medical nutrition therapy	Medical transportation services
Med. case mgmt. & treatment adherence	Outreach services
Substance abuse services--outpatient	Permanency planning
	Psychosocial support services
(SUPPORT SERVICES)	Referral for health/support services
Rehabilitation services	Respite care
Substance abuse services--residential	Treatment adherence counseling

2. Capacity

- This is the quantity (measurable in treatment slots, units, or doses) of each type of service that is available in the community. This information should be compared with estimates of the need or demand for the service. Are there any shortages?
- Methods: compare estimates of need with available service slots/units
  - Examine waiting lists/times at provider sites

3. Integration

- This is the ease with which clients, and information about them, can move about among providers of different types of services. Are there obstacles to people's getting services for which they have been referred? Are there any formal referral arrangements among providers?
- Methods: interviews, especially with case managers
  - Is there a system-wide client data system?
  - To what extent are there vertically integrated providers?

4. Accessibility

- This is the ease with which (potential) clients can get appointments with providers and get to those appointments. Elements of care accessibility include
  - whether appointment times are convenient,
  - whether service locations are convenient to where PLWH live or to public transportation routes,
  - whether various types of services are located under the same roof, and
  - whether potential clients are eligible for services and aware of their availability.
- Methods: interviews, focus groups

5. Acceptability

- This dimension concerns agency and provider cultural competency and client-centeredness.
  - Do providers engage in respectful interactions and transactions with potential clients, families, and the community?
  - Is the care that providers offer adapted to parts of clients' indigenous cultures?
  - Do the agency and the provider show an understanding of individuals' distinctive characteristics, preferences, circumstances, and needs?
- Methods: document reviews, interviews

6. Technical Competencies

- This applies to both providers and clients (which is why it is in the plural).
  - On the provider side, aspects of competency include clinicians' experience in managing therapies, opportunistic infections, and comorbidities, as well as their ability to communicate clearly.
  - On the client side are health literacy and self-management skills.
  - Clients may have theories of disease that link it to moral conduct and spirituality, and they may be reluctant to submit to medical management of HIV disease, which rests on a different worldview.
- Methods: review of provider information, interviews

7. Client health-seeking behaviors

- These are the patterns, preferences, and beliefs associated with the things people do to promote, protect, or restore their health.
  - People prefer providers who respect their culturally-based attitudes, beliefs, and practices.
- Methods: focus groups and interviews
  - with providers, cultural experts, PLWH in and out of care

C. Rapid Assessment for Services Planning

- Adapted from Rapid Assessment, Response, and Evaluation (RARE) techniques used for HIV prevention planning
- Used in more than 30 U.S. cities starting in the late 1990s
- Observational and ethnographic techniques help to understand the worldviews and experiences of populations examined
- Used to gather information from and about PLWH not in care

Sites at which PLWH not in Care and Those Newly in Care May Be Found

- Emergency rooms
- Clinics for sexually transmitted infections
- Primary care provider sites
- Mental health clinics
- Substance abuse treatment programs (including detoxification programs)
- Adult and juvenile detention facilities
- Ancillary service delivery sites/activities
  - Homeless shelters
  - Food programs
- Centers for Disease Control prevention sites/activities
  - HIV testing and counseling sites
- Community and social locations
  - Churches, clubs, bars, organizations, agencies

Rapid Assessment Techniques

1. Interviews with cultural experts
2. Direct observation
3. Focus groups
4. Rapid survey interviews
5. Geo-mapping
6. Cultural consensus surveys
7. Free lists and sorts

D. CSA Community Involvement

- Leadership team: Site Coordinator, Site Assistant, Field Team Coordinator
- Field Team: matched closely to target population(s)
- Planning Council and grantee involvement
- Diverse steering committee (advisory group) for project
- Community meetings to introduce project at beginning, generate recommendations for system change at end
  - Process needs to be transparent to build legitimacy

Leadership Team Roles, Skills

- Site Coordinator
  - Project leader: oversight for planning, design, implementation
  - Community-based public health research background
  - Analyzes data, summarizes and presents findings
- Site Assistant
  - Helps with document reviews, system assessment
- Field Team Coordinator
  - Guides rapid assessment process
  - Oversees Field Team
  - Needs knowledge of project target population(s)

Training for Project Staff, Advisors

- Outside trainer, via TA contract from HAB
- Needs to present the CSA model clearly
  - All project findings are to be understood in terms of the model's seven dimensions
- Introduce and give practice on use of all rapid assessment techniques
  - Role playing as administrators, recipients of techniques
  - Content of interview, focus group, survey instruments may be adjusted as Field Team gains experience in their use

E. Summarizing Study Findings & Developing Recommendations

- Examples of barriers to care found at pilot test sites
  - Stigma and fear of disclosure (limit service acceptability)
  - Bureaucracy (accessibility), fears of medicines and side effects (acceptability), mental health and drug use comorbidities (client health-seeking behaviors), limited skills of providers outside of the Ryan White care system (technical competencies)
  - Special issues for immigrants
    - Fear of detainment, deportation, loss of employment
    - Lack of knowledge of entitlement to HIV care
    - Discomfort with western providers, lack of knowledge of health care system

Summarizing Study Findings for Community Forums

- Compare findings from document reviews; care system assessment with policymakers, providers, and PLWH in care; and rapid assessment with PLWH not or newly in care
  - Differences in perspectives may be important
    - Providers may prioritize medical care while PLWH prioritize support services
    - Document reviews may acknowledge fewer barriers than other methods
- Look at consistency of information from
  - different methods
  - different sources using the same methods
  - different analysts examining the study findings
- Summarize care system strengths and challenges on each dimension
- Group responses into thematic areas that may cut across dimensions

Structuring Community Meetings

- The Site Coordinator should prepare a report that is publicly available in advance of community meetings
  - This should form the basis for the Coordinator's presentation at the meetings
  - The meetings should be well publicized and open to the public
- Both the report and the presentation should summarize the study's findings without making recommendations
- Attendees at the community meetings should be given the opportunity to generate recommendations based on their discussion and interpretation of study findings
  - Break-out groups may be configured by theme, dimension, or representation of interested parties
  - Ground rules should assure respectful consideration of everyone's input

Final Steps in the CSA Process

- Within groups and the community meeting as a whole, there should be opportunities to identify goals, objectives and strategies for care system change or enhancement
- The final recommendations are to be turned over to the Planning Council and grantee for action
- The community should track its progress relative to the recommendations

Examples of Recommendations from Pilot Test Sites

- Improve provider staff cultural competency
  - Offer trainings and provide oversight to assure their success
- Develop a client-centered approach to care
  - Create a single point of entry and eligibility verification
- Provide community HIV education
  - Use mass media and be present at community events
- Develop outreach mechanisms to bring at-risk populations into care
  - Collaborate with minority communities to reduce knowledge and attitude barriers to care entry

For Further Information

- See the August 2007 supplement to Journal of Health Care for the Poor and Uninsured
  - Available online at http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu18.3A.html
- Contact me at pitchfixer@mac.com or (406) 251-3010