

Continuum of Care

Administrative Overview Training

Ryan White Part B

June 7, 2011

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Overview of Presentation

- What is a Continuum of Care?
- Characteristics of a Continuum of Care
- Standards of Care and Your Continuum
- Basic Continuum of Care Services
- Continuum of Care and Points of Entry
- Continuum of Care Strategy and Implementation
- Barriers and Challenges



Overview (continued)

- Building a Continuum of Care
- Benefits and Costs
- Consequences of a Failed Continuum of Care



What is a 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.



Continuum of Care

Continuum Engagement in Care

Not in Care



Fully Engaged

Unaware of HIV status (not tested or never received results)

Aware of HIV status (not referred to care; didn't keep referral)

May be receiving other medical care but not HIV care

Entered HIV primary medical care but dropped out (lost to follow-up)

In and out of HIV care or infrequent user

Fully engaged in HIV primary medical care



Characteristics of a Continuum of Care

*Coordination
Among Provider
Treatment
Activities*

*Seamless
Transitions
Across Levels of
Care*

*Coordination of
Present and Past
Treatment*



The Key Component - Continuity

Informational Continuity

- Documentation is the thread linking care from one provider to another

Management Continuity

- Real time communications between multiple provider disciplines

Relational Continuity

- Emphasizes communication between the patient and each provider within the continuum



Relational Continuity

Example #1:

Sophie was born HIV positive, and has been quite ill in her seven years of life. Her parents spent most of the last four years at the hospital visiting her. As a consequence, the parents got to know the clinicians quite well and were kept well informed of Sophie's various treatments and overall prognosis. It was not uncommon for the parents to ask how one particular treatment related to another.



Informational Continuity

Example #2:

Dan was diagnosed with HIV 10 years ago in New York City. He currently resides in Maryland and his physical and mental health condition has significantly deteriorated since his relocation. His new case manager at the Prince George's County DOH immediately contacts NYC DOH and requests the appropriate medical records in order to allow medical history to guide current clinical decisions.



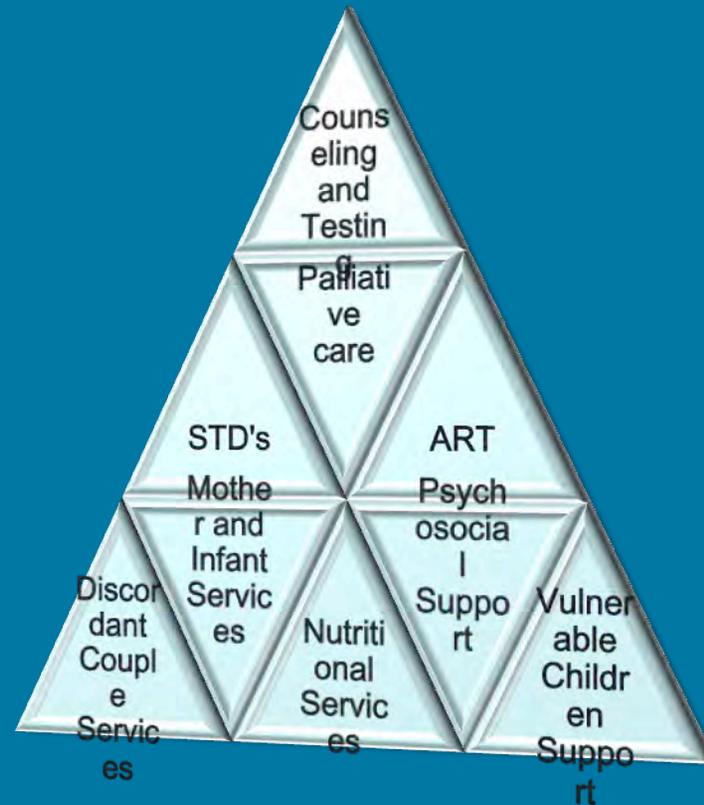
Management Continuity

Example #3:

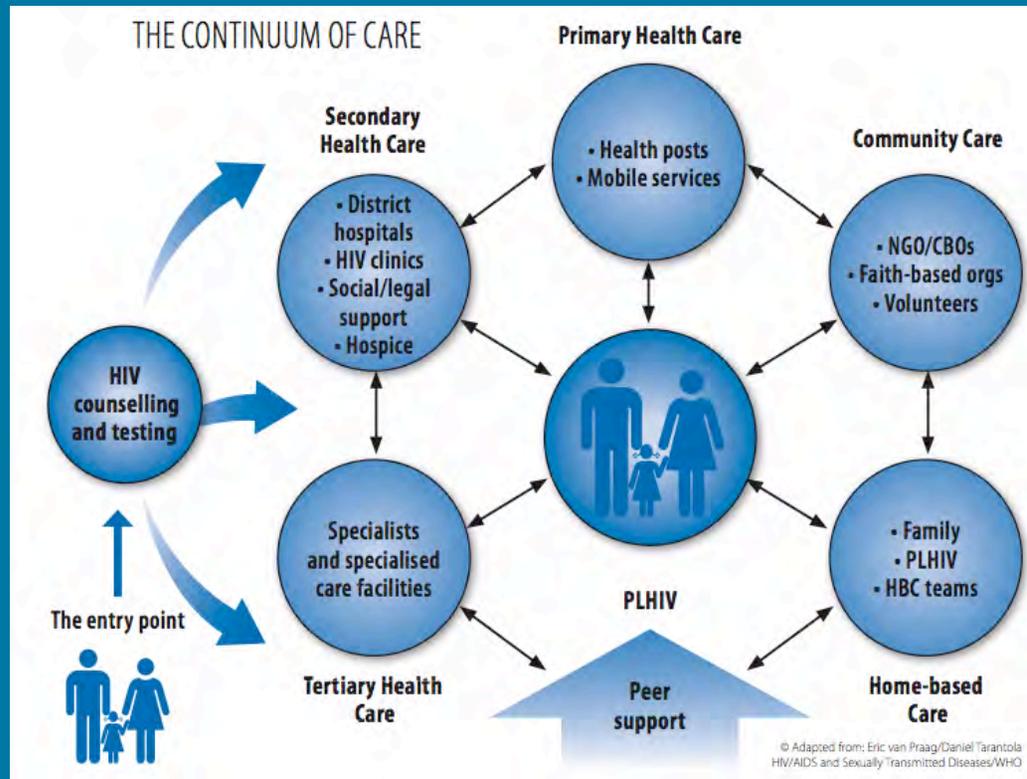
Alex lives in DC and has been HIV positive for 1 year. He was being followed primarily by a local Infectious Disease Specialist who has recently retired. All Alex can remember is that there was an orthopedist who read his x-rays and recommended he talk to an internist. He went to the internist who referred him to a rheumatologist. And the rheumatologist recommended that he return to his Infectious Disease doctor. Alex is confused and frustrated, and wonders why these people just can't talk to one another.



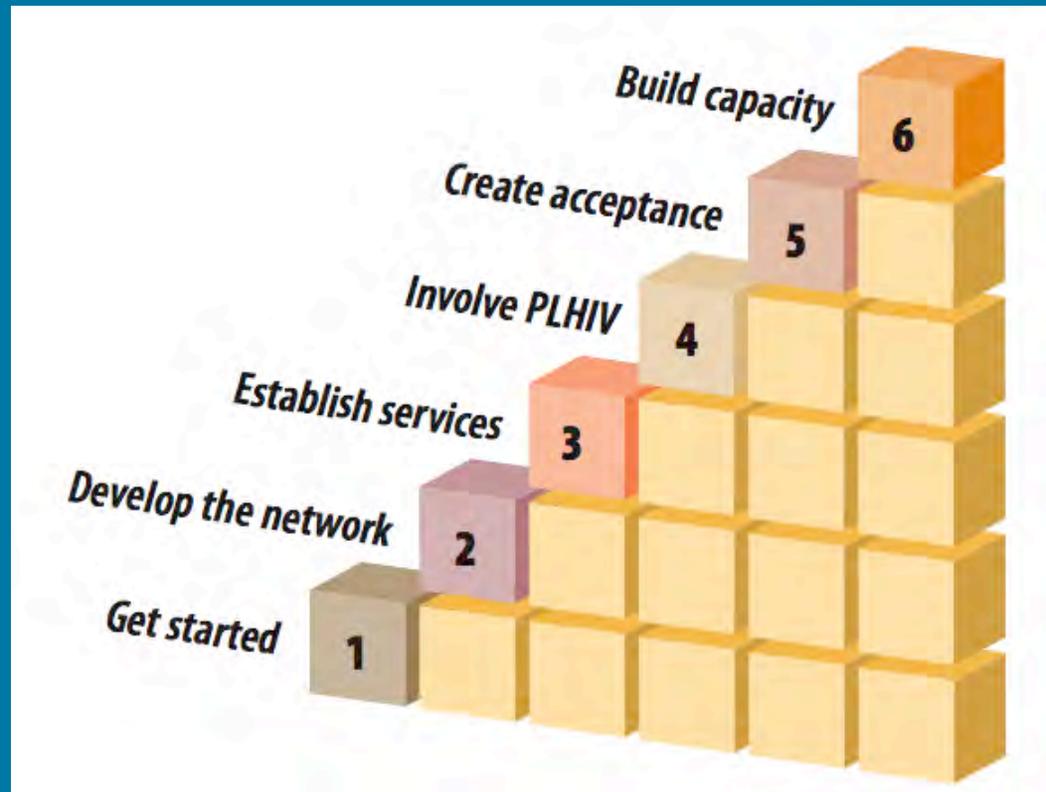
Basic Continuum of Care



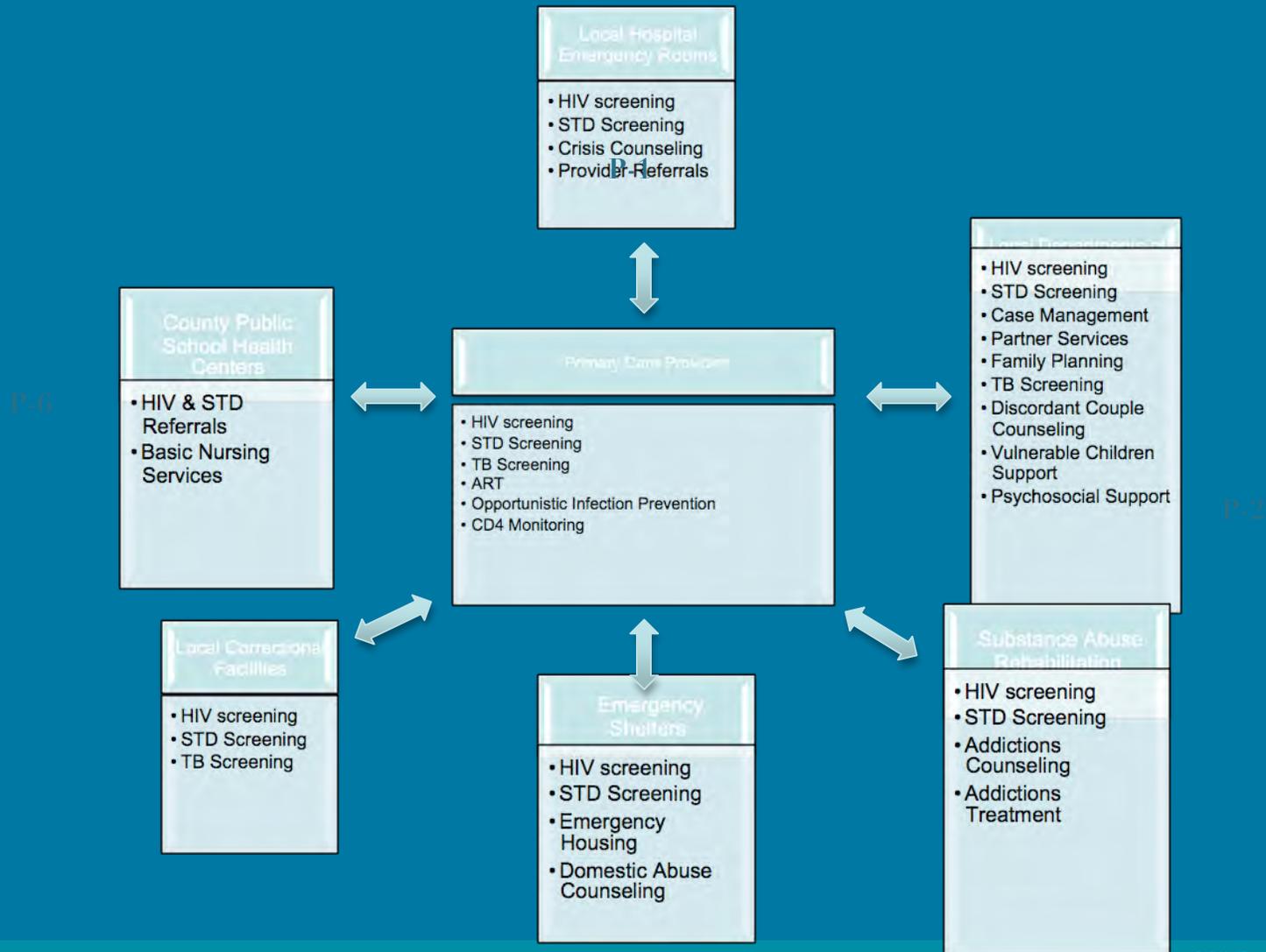
Continuum of Care Points of Entry



Building a Continuum of Care



Continuum of Care: Flow Chart



Common Barriers/Challenges



Costs vs Benefits of Continuum of Care



Consequences of a Failed Continuum of Care



Recap

An effective Continuum of Care should account for:

Chronic Care Model

- Matriculation through care e.g. from diagnosis until that person longer requires care
- Loss to care and/or follow-up



Recap (Continued)

Continuum Engagement in Care

**Not in
Care**



**Fully
Engaged**

Unaware of
HIV status
(not tested or
never
received
results)

Aware of HIV
status
(not referred
to care; didn't
keep referral)

May be
receiving
other medical
care but not
HIV care

Entered HIV
primary
medical care
but dropped
out
(lost to
follow-up)

In and out of
HIV care or
infrequent
user

Fully
engaged in
HIV primary
medical care



Recap (cont'd)

- Overall importance of Ryan White services is to improve health outcomes of PLWHA.
- Recall the intent of Ryan White Legislation:
 - Primary Care and Support Services for PLWHA.
 - Provision of Life-extending HIV/AIDS Drug Tx
 - Provision of Health Insurance and Financial Resources towards care



Planning

Administrative Overview ~ Ryan White Part B

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Overview of Presentation

- Legislative overview
- Needs Assessment
- Statewide Coordinated Statement of Need
- Comprehensive Plan
- Implementation Plan
- Monitoring/Evaluating/Updating



Legislative Language ~ Consortia and Planning

- Consortia – “agrees to use such assistance for the planning, development and delivery, through the direct provision of services or through entering into agreements with other entities for the provision of such services.....
- Assurances – “the service plan established under subsection (c)(2) by such consortium is consistent with the comprehensive plan....
- Application – demonstrates that the consortium has carried out an assessment of service needs within the geographic area to be served



Consortia and Planning (continued)

- *(C) demonstrates that adequate planning has occurred to meet the special needs of families with HIV/AIDS including family centered and youth centered care;*
- *(D) demonstrates that the consortium has created a mechanism to evaluate periodically –*
 - *(i) the success of the consortium in responding to identified needs; and*
 - *(ii) the cost-effectiveness of the mechanisms employed by the consortium to delivery comprehensive care*
- *(E) demonstrates that the consortium will report to the State the results of the evaluations*
- *(F) demonstrates that adequate planning occurred to address disparities in access and services and historically underserved communities.*



Planning and The State Part B Program

- “The application submitted under subsection (a) shall contain:
- (3) a determination of the needs of such population, with particular attention to
 - Individuals with HIV/AIDS who know their status and are not receiving HIV-related services, and
 - Disparities in access and services among affected subpopulations and historically underserved communities.



Planning and The State Part B Program (continued)

- “the designation of a lead State agency that shall:
 - (A) administer all assistance under this part;
 - (B) conduct the needs assessment and prepare the State plan under paragraph (3);
- (5) a comprehensive plan that describes the organization and delivery of HIV health care and support services to be funded



Planning and The State Part B Program (continued)

- (F) provides a description of how the allocation and utilization of resources are consistent with the statewide coordinated statement of need (including traditionally underserved populations and subpopulations) developed in partnership with other grantees in the state that receive funding under this title;....



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.



State-wide Coordinated Statement of Need

- The SCSN is a collaborative process of identifying and addressing significant HIV care issues related to the needs of individuals living with HIV/AIDS
- The SCSN should maximize coordination, integration and effective linkages across the Ryan White HIV/AIDS Programs in the State
- Part B Programs are responsible for convening a meeting for the purpose of developing the SCSN and for the submission of the document to HRSA



State-wide Coordinated Statement of Need

- The SCSN can be a statewide meeting or can be some other locally developed process.
- It is HRSA's expectation that all Ryan White Program grantees within your jurisdiction participate in the process.



State-wide Coordinated Statement of Need ~ What's New?

- 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.



What's New (continued)

- The EIIHA initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals:
 - 1) Reducing the number of people who become infected with HIV
 - 2) Increasing access to care and optimizing health outcomes for people living with HIV
 - 3) Reducing HIV-related health disparities



Planning

- Planning is imperative to the Ryan White HIV/AIDS Program's focus on local and State decision making in developing HIV/AIDS care systems.
- Each grant year designated planning bodies establish service and resource-allocation priorities and implementation plans to address those priorities.
- Comprehensive HIV services planning goes beyond this annual process. It provides an opportunity for the planning bodies to step back from short-term tasks to examine the current system of care and envision an "ideal" system of care and develop a three-year plan for achieving this vision.
- This is accomplished by the review of needs assessment data, existing resources to meet those needs, and barriers to care.
- This planning process includes the consultation and collaboration with the community to obtain diverse perspectives regarding the system of care.



Comprehensive Plan

- Ryan White Part A and B grantees are required to submit an updated Comprehensive Plan every three years.
- The purpose of this multi-year plan is to assist in the development of a comprehensive and responsive system of care that addresses needs and challenges as they change over time.
- It is a **living document** that serves as a roadmap for the grantee and should be continually updated as needed.
- It 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.



Comprehensive Plan (continued)

- The Comprehensive Plan must be compatible with existing State and local service plans including the Statewide Coordinated Statement of Need (SCSN).



What's New for the 2012 Plan?

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.



What's New for the 2012 Plan? (continued)

- **The National HIV/AIDS Strategy**
- The National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.
- The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce the potential of transmitting the virus to others.
- The 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.



What's New for the 2012 Plan? (continued)

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.

Affordable Care Act:

- The intent of the Patient Protection and Affordable Care Act (P.L. 111-148) is to expand health insurance coverage while also reforming the health care delivery system to improve quality and value. It also includes provisions to eliminate disparities in health care, strengthen public health and health care access, invest in the expansion and improvement of the health care workforce, and encourage consumer and patient wellness in both the community and the workplace.



What's New for the 2012 Plan? (Continued)

- 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).
- **Healthy People 2020**
- Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. Healthy People 2020 establishes new 10-year national objectives for improving the health of all Americans. The initiative has two major goals: (1) to increase the quality and years of a healthy life; and (2) eliminate our country's health disparities. The program consists of 28 topic areas and 467 objectives. One of the topic areas is HIV which includes specific objectives.
- The Comprehensive Plan should discuss how the Healthy People 2020 objectives will be addressed.





Part B Program Components

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Program Components

ADAP

Health Insurance Premium and Cost Sharing Assistance

Home and Community-based Health Services

Consortia

State Direct Services



ADAP

Provides HIV/AIDS related prescription drugs to uninsured and underinsured PLWHA

Provide medications to:

- Treat HIV disease
- Prevent the serious deterioration of health
- Prevent and treat opportunistic infections



Health Insurance Premium & Cost Sharing Assistance

Health Insurance Premium:

Financial assistance for insurance premiums, deductibles, and co-payments

Cost Sharing Assistance:

Provides assistance for PLWHA dually eligible for Medicare Part D and Ryan White Services

- Monthly Premiums
- Deductibles
- Co-Pay
- Coverage Gap
- Catastrophic Coverage



Home and Community-Based Health Services

Home and Community-Based Care is defined as follows: Therapeutic, nursing, supportive and/or compensatory, health services provided by a license/certified home health agency in a home/residential setting in accordance with a written, individualize plan of care established by a case management team that includes appropriate health care professionals.

- Provides services to clients in their homes or in a community based setting
- May reduce costly stays in hospitals and nursing homes
- Offers clients the benefit of being treated in a more comfortable or familiar environment



Consortia

Consortia are groups comprised of providers, consumers, and others who perform a planning and advisory function to regions or the entire State in determining needs and delivering essential health and support services

Consortium: A planning entity established by State grantees under Part B of the Ryan White Treatment Modernization Act to plan and sometimes administer Part B services as lead agency.

Grantee: recipient of Ryan White funds

First-line entities: those entities receiving funds directly from the Part B grantee

Lead Agency (Also known as a fiscal agent): this agency is responsible for contract administration for Part B funds within a consortium region



State Direct Services

State Direct Services are services provided by the grantee or consortia

Core Medical Services

- Outpatient and ambulatory health services
- AIDS Drug Assistance Program (ADAP)
- Pharmaceutical assistance
- Oral health care
- Early intervention services (EIS)
- Substance abuse services – outpatient
- Mental health services
- Medical case management including treatment adherence
- Health insurance premium & cost sharing assistance
- Home health care
- Home & community-based health services
- Medical nutrition therapy
- Hospice services

Support Services

- Case Management
- Child Care Services
- Emergency Financial Assistance
- Food Bank- Home Delivered Meals
- Health Education/Outreach
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation Services
- Outreach Services
- Psychosocial Support Services
- Referral for health care/supportive services
- Rehabilitation Services
- Respite Care
- Substance Abuse – Residential
- Treatment Adherence counseling



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