Quick Reference Handout 5.2: Directives

RWHAP Legislative Requirements

One of the duties of a Ryan White HIV/AIDS program (RWHAP) Part A planning council (PC)* is to

> *"...establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a recipient should consider in allocating funds" [Legislation, Section 2602(b)(4)(C)]*

Directives address *how best to meet* the priorities established by the planning council.

**Planning bodies provide recommendations rather than serving as decision makers, but sound practice is for both PCs and PBs to develop directives.*

Purpose and Focus of Directives

Directives help strengthen the system of care. They provide written guidance to the recipient from the PC/PB regarding how best to meet specific service priorities established as part of the priority setting and resource allocation (PSRA) process, and other factors the recipient should consider in arranging for services. Often, directives address identified barriers to care or disappointing health care system performance on measures and clinical outcomes such as linkage to care, retention in care, adherence to medications, and viral suppression, overall or for particular PLWH populations or geographic areas.

Most directives focus on one or more of the following:

1. **Geographic targeting:** ensuring availability of services in all parts of the EMA/TGA or in a particular county or area

   Examples of directives:
   - *RWHAP-funded outpatient ambulatory health services (HIV-related medical care) must be available within each county in the EMA/TGA, either through facilities located in the county or through other methods such as use of mobile vans or out-stationing of personnel.*
   - *Oral health care must be accessible to PLWH in the EMA/TGA regardless of where they live.*
   - *Mental health and outpatient substance abuse treatment services must be available to PLWH within County X at least 2 days a week.*

2. **Population targeting:** ensuring services appropriate for specific target PLWH populations

   Examples of directives:
   - *Core medical service providers must have bilingual Spanish-English staff in positions with direct client contact, including clinical staff.*
   - *Each of the three counties in the EMA/TGA must have at least one service provider qualified to provide culturally appropriate services to young MSM of color.*
   - *At least one outpatient substance abuse treatment provider must offer services appropriate for and accessible to women, including women who are pregnant or have small children.*

3. **Access to care:** overcoming barriers that reduce access to care

   Examples of directives:
   - *Every funded outpatient ambulatory health services (OAHS) provider and every medical case management provider must offer services at least one evening a week and/or one weekend day a month.*
   - *Transportation must be made available to PLWH who are unwilling to seek care in their own communities due to fear of exposure and stigma, and who require such assistance so they can access care in another location within the EMA or TGA.*
   - *PLWH with a history of unmet need must have access to peer navigator services or other targeted assistance for at least the first six months after they return to care.*

4. **Service models:** requiring the testing or broader use of a particular service model

   Examples of directives:
   - *At least two medical providers will receive funds to test the use of a Rapid Response linkage to care model, designed to ensure that newly diagnosed clients have their first medical visit within 72 hours after receiving a positive test result.*
   - *All medical case management providers will ensure that at least one case manager completes recipient-approved geriatric training on a refined case management model for older PLWH.*
   - *The EMA/TGA will pilot test an Early Intervention Services (EIS) model designed to reach young MSM of color who are newly diagnosed or out of care, link them to care, and help ensure that they become fully connected to medical care.*

Directives are one way of strengthening the system of care. There are other ways, as well, such as adding requirements to universal or service category-specific Service Standards. Sometimes a directive will call for testing a new service model or approach. If it proves successful in addressing the identified need, it may be added to Service Standards and implemented throughout the system of care.

Identifying the Need for a Directive

The PC/PB may identify needs and issues leading to directives at any time of the year through many sources, among them review and discussion of data from the following sources:

- **Needs assessment**—service gaps, barriers to care, or issues identified by consumers, service providers, or PLWH who are out of care, or through a review of epidemiologic data trends
- **Town hall meetings or public hearings** that are part of the PSRA process—identified service needs, gaps, services strengths or weaknesses
- **HIV care continuum**—disparities in linkage to care, retention, and/or viral suppression among specific PLWH populations
- **Service utilization**—disparities in use of particular service categories by different PLWH populations based on such characteristics as race/ethnicity, age, gender/gender identity, sexual orientation, risk factor, or place of residence
- **Clinical Quality Management (CQM)**—identified performance issues or changes in service models that improve patient care, health outcomes, and patient satisfaction

Often, review of such information will help to identify issues such as the following:

- ***Poor service access,*** limited use of services, poor retention, or low rates of viral suppression for PLWH populations, especially those who are traditionally marginalized and/or have co-morbidities
- ***Lack of culturally and linguistically appropriate services*** overall or in particular locations or specific service categories
- ***Too few providers in outlying areas*** of the EMA or TGA
- ***A need for new models or strategies*** to better address the changing local epidemic

HRSA/HAB Expectations

PC/PBs have a great deal of flexibility in the development and use of directives. Directives can be developed whenever available data indicate the need for action to provide parity in access to high quality care for all PLWH, regardless of who they are or where they live within the service area.

HRSA/HAB expects directives to be:

- **Based on an identified need,** determined through review of data from needs assessment, town hall or other community meetings, service utilization data, CQM activities, or other sources
- **Explored and developed as needed throughout the year**—often with the involvement of several committees, such as the following (Committee structures and names vary by jurisdiction):
  - *Needs Assessment and Planning*
  - *Care Strategy/System of Care*
  - *Consumer/Community Access*
  - *Priority Setting and Resource Allocation*
- **Presented in relation to the PSRA process,** since they often have financial implications and may require changes in how services are delivered—and are best addressed through discussion with the recipient before allocations have been made
- **Approved by the full PC/PB,** along with or separate from resource allocation
- **Consistent with an open procurement process.** Directives should not have the effect of limiting open procurement by making only 1-2 providers eligible, since the PC/PB should have no involvement in the selection of specific entities to serve as subrecipients.

  For example, consider the following possible directives:

  > *Mental health services must be provided by clinicians that can demonstrate expertise in serving people living with HIV*
  >
  > *Mental health services must be provided by organizations with prior RWHAP experience*

  The first is an acceptable directive, requiring that mental health clinicians have appropriate expertise to serve PLWH—which can be obtained through training and/or prior experience, regardless of funding source. The second suggested directive is not acceptable, because it limits possible subrecipients to those that have received RWHAP funding in the past. There might be only one or two entities that meet that requirement, which would prevent an open procurement process.

Tips for Preparing Sound Directives

The following approaches support the development of sound directives:

1. **Provide a limited number of carefully thought-out directives.** If the PC/PB proposes too many directives, they may not receive the individual attention or resources needed for successful implementation.
2. **Review current directives,** to retire those that no longer apply and to avoid duplication where appropriate by refining an existing directive rather than developing a new one. Directives only rarely need to be maintained over many years. If the approach in the directive proves effective, it can be made permanent through other means, such as inclusion in Service Standards.
3. **Base directives on data and be prepared to present the underlying data** when proposing a new or revised directive to the PC/PB.
4. **Identify and research possible directives throughout the year,** as part of your ongoing efforts to improve the continuum of care. This provides time to explore service models used by other jurisdictions, determine costs, and have a well-considered directive to present as part of PSRA —and ensure allocation of resources needed for implementation.
5. **Refer to but don't duplicate requirements in existing Service Standards.** If aggregate monitoring or CQM data show that Service Standards are not being met, the PC/PB should explore with the recipient why this is happening—and may want to consider a directive that offers a refined approach.
6. **Use plain, direct language** so that the directive is easy to understand and implement.

Role of the Recipient

The recipient is *responsible for implementing* directives. Beyond that, the PC/PB should collaborate with the recipient as it formulates directives, particularly with regard to assessing the costs, feasibility, and timing of implementing a potential directive.

COSTS

Suppose the PC/PB has developed the following proposed directive to improve retention in care for employed PLWH:

> *All RWHAP Part A-funded OAHS and medical case management providers must provide services at least one evening a week or one weekend day a month .*

Adding evening or weekend hours may improve care, access and retention, but it also adds costs for staff and for keeping the facility open longer. Before time for resource allocation, the PC/PB needs to ask the recipient to estimate the added costs per year for evening hours and for weekend hours. That will allow the PC/PB to refine the directive if necessary. For example, if it would be much less expensive to use evening rather than weekend hours, it might remove the weekend option. That will also give the PC/PB the information needed to add dollars to the OAHS and medical case management allocation to permit implementation of this directive—unless it is willing to serve fewer PLWH in these service categories.

FEASIBILITY

The PC/PB should consult with the recipient regarding such issues as whether a similar strategy or service model has been tried before, and if so, with what results; and whether the directive can be implemented or perhaps needs to be revised or restated. For example, a directive that calls for use of telemedicine in providing mental health services is feasible only if state law allows such use of telemedicine. Strategies must be

consistent with RWHAP service definitions and other HHS guidance. Incentives for keeping medical appointments must meet federal guidelines or be funded out of non-federal funds.

TIMING

It is not always possible for a directive to be implemented quickly. While some jurisdictions may be able to modify the scope of work for a multi-year subrecipient contract, others will not be able to change requirements or specify a new service model until the service category goes out for competitive bid, which may happen only every 2-4 years. It is sometimes possible to state a directive so that parts can be implemented immediately. For example, the directive below will probably be implemented only after these service categories go out for bid, since it is likely to require hiring of staff with specific skills and experience:

> *All OAHS and medical case management providers must ensure transgender PLWH and African immigrants receive services only from clinicians and case managers with both training and experience in serving these populations.*

As an interim measure, the following directive could be implemented quickly, with assistance from the recipient, or the PC/PB could instead decide to add it as a requirement in its Service Standards:

> *All OAHS and medical case management staff serving transgender PLWH and African immigrants must first complete in-depth, recipient-approved cultural competence training to prepare them to serve these populations.*

Discussion with the recipient can help in addressing these cost, feasibility and timing challenges.

Assessing Implementation and Results

Directives are generally implemented by the recipient through procurement and contracting, and/or program monitoring and clinical quality management (CQM) efforts, including quality improvement projects. The recipient must follow directives in procurement and contracting but cannot always guarantee full success. For example, the recipient might put out a request for proposals (RFP) to implement a new service model but receive no qualified responses. The recipient may want to suggest revisions in the directive to make responses more likely.

Once a directive has become a requirement for subrecipients, its implementation can be followed through program monitoring, reviewed as part of CQM, or assessed in terms of changes in performance measures or clinical outcomes for affected PLWH. The recipient should always be asked to provide updates on implementation of directives, ideally at least quarterly. The PC/PB and recipient should work together to assess the results of directives and to decide when a pilot project should be expanded, refined, or ended.