Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards: *A Los Angeles County Case Study*

Craig Vincent-Jones MHA
Los Angeles County Commission on HIV

Fariba Younai DDS
Los Angeles County Commission on HIV/
UCLA School of Dentistry

Coordination and Linkages: H-9
August 25, 2010

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

LEARNING OBJECTIVES

Learning Objective #1: The continuum of care/prevention should not be just a visual representation of services, but should show how services are planned and implemented and their outcomes. Workshop participants will learn to use the HIV continuum as a fully dynamic planning/implementation and quality management tool in which quantifiable data can be identified and inserted to forecast/predict linkages into care, patient/health outcomes and health and population impacts—information essential for developing and adapting standards and interventions and implementing, prioritizing, allocating and procuring service delivery.

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

LEARNING OBJECTIVES

Learning Objective #2: Audience members will leave with a better understanding of the impact and influence of standards of care, and what measures are being taken to ensure that they are kept up-to-date and continue to be shaped as services change and/or best practices are learned and incorporated. Examples of the procedures the planning council has put into place to maintain the standards and how the standards have changed service delivery in LA will be provided.

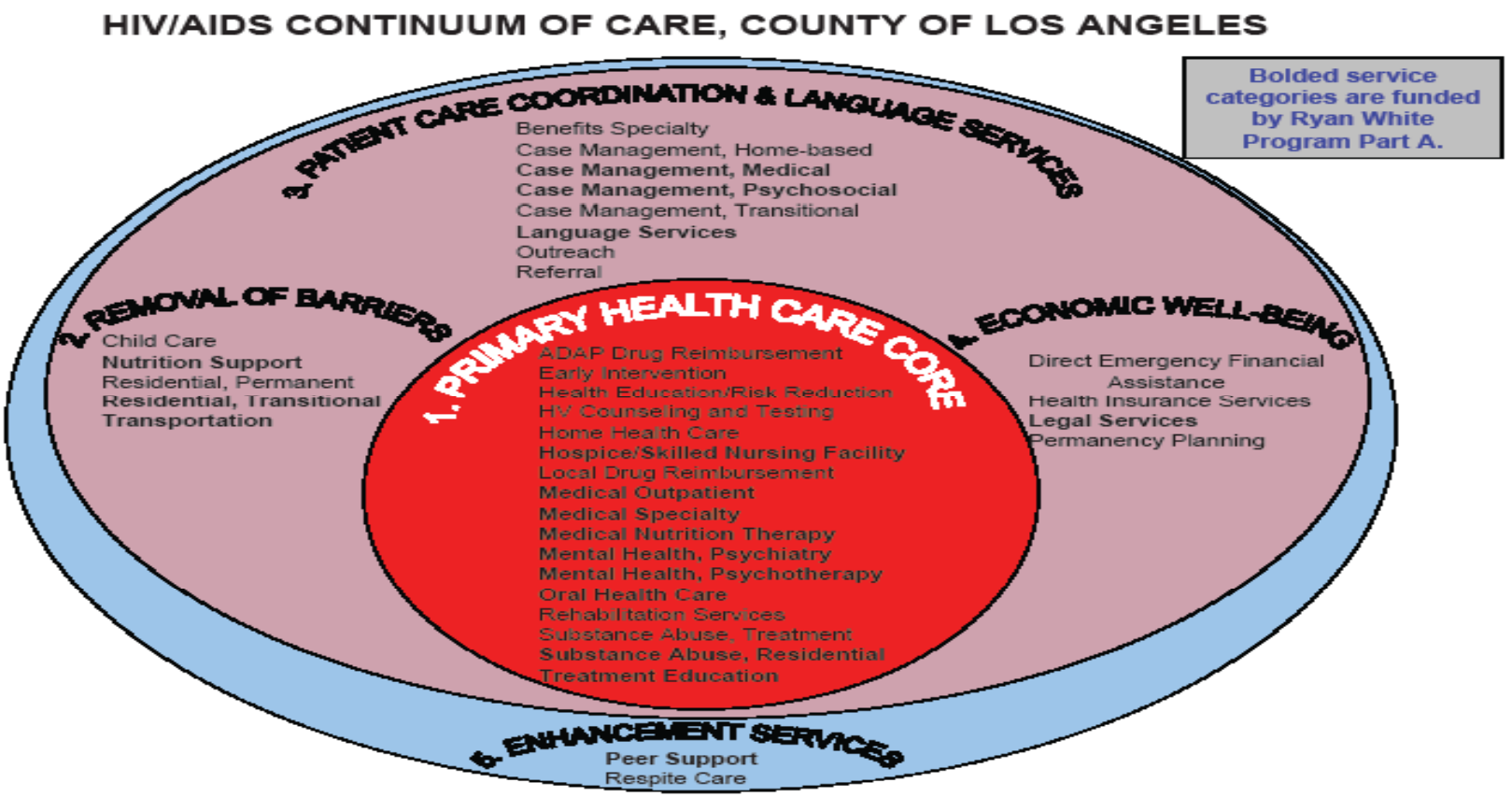
Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

LEARNING OBJECTIVES

Learning Objective #3: Guided by LA County's new continuum of care/prevention, workshop participants will learn how to quantitatively model and assess 1) services/interventions, 2) patient flow, and 3) outcomes/impacts and integrate the findings into local planning and service implementation by using 1) patient flow diagrams (to determine patient status, such a low risk, newly diagnosed, entering care, adhering to treatment plans), 2) systems mapping (to define factors and indicators, and show how they impact patient status and outcomes), and 3) evaluation scorecards (to show how to assess outcome effectiveness, cost-efficiency/effectiveness and best practices).

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

2005 Continuum of Care



Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Continuum of Care is not just a visual diagram . . .
  - It's pretty and all, but what does it do?
  - It's a nice pretty package of how services are supposed to interact, but is it really an accurate picture?
  - It's simple and concise, but are those really the characteristics we are seeking to depict a system of care with 20+ service categories serving 18,000 people?

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Continuum of Care is your guide to . . .
  - Plan
  - Do
  - Evaluate

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Starting with Standards of Care (2005) . . .
  - represent “minimum service delivery expectations” required in the provision of services,
  - describe the primary interventions used to improve patients’ health outcomes,
  - are the basic elements against which quality and effectiveness are measured,
  - provide coherent definitions of services used to help the planning council prioritize services and allocate resources,

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- form the basis for considering and integrating “best practices” into service delivery,
- empower consumers with the knowledge of what they can expect from their services,
- instruct agency administrators and providers as they develop and implement programs,
- identify gaps and disparities in service delivery, and respond to technical assistance needs, and
- help ensure consistency of services across diverse geographic, income and population spectrums.

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Standards of Care are the foundational building blocks for most of the primary health system management components:
  - Planning (continuum of care, comprehensive care plan),
  - Procurement (RFPs, solicitations, bids),
  - Service Delivery (service protocols, treatment guidelines, clinical procedures)
  - Contracting (contract monitoring, performance audits),
  - Quality Management (chart review and abstraction, grievances),
  - Evaluation (service effectiveness, cost efficiency, outcome evaluation),
  - Research (best practices, service, disease and population impact),
  - Financing (rate reimbursement structures, service unit costs).

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- The Commission prioritized standards of care development for the following reasons:
  - Promises to develop standards of care to HIV stakeholders for several years,
  - Increasing federal focus on quality management and its critical components,
  - Compliance with federally mandated responsibilities,
  - HRSA Project Officer directive to create standards of care,
  - Possible negative impact on the annual Ryan White Part A funding award,

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Significant variability in the same services that weakened consistent, effective and cost-efficient service delivery,
- Resulting service and quality gaps yielding a less responsive and reliable system of care,
- Multiple unspecified service variations led to inaccurate, irrelevant or inadequate planning decisions,
- Recognition that standards are continuum of care fundamentals essential for other decisions that would be needed in the future,
- Taking advantage of renewed community support/investment in the Commission, and
- Need to demonstrate new Commission effectiveness as an independent County entity.

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Local political and partnership dynamics at the time
  - New Commission reporting relationship to the LAC Board of Supervisors
  - Commission previously reported to the Office of AIDS Programs and Policy (OAPP), Part A administrative agency (Grantee)
  - OAPP responsible for quality management, procurement, contracting; Commission previously not involved in service design or delivery structure/implementation
  - No existing Memorandum of Understanding (MOU) between PC and Grantee
  - Main source of service design guidance for providers comes from contracts, established at the provider level in earlier stages of the epidemic
  - Lack of service model uniformity creates intense provider-level ownership and investment in individually designed services

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis		
Assessing Local Readiness to Develop Standards of Care in 2004-2005	**STRENGTHS** ▪ New reporting authority to Board of Supervisors ▪ Renewed community support for Commission	**WEAKNESSES** ▪ No relationship definition between Grantee/PC ▪ Limited guidance about PC's standards authority
OPPORTUNITIES ▪ Stakeholders acknowledge need for service uniformity ▪ Consumers demand more service accountability	**Future** ▪ Standards improve client/ patient outcomes ▪ Standards underscore PC relationship to services	**Internal** ▪ Adopt standards at a fast pace to reduce anxiety ▪ Ensure standards have "real-world" applications
THREATS ▪ Grantee/providers resist greater PC role in services ▪ Grantee/providers refuse to incorporate standards	**External** ▪ Educate stakeholders on importance of standards ▪ Provide stakeholders opportunity to participate	**Present** ▪ Develop standards using existing contracts/models ▪ Define how standards should be used/applied

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

Standards of Care Approval Process (*followed for each Standard of Care*)		
Steps:	**Activity(ies)**	**Time Needed**:
Step #1:	Draft the standard, using: ▪ existing contracts schedule, ▪ HIV standards from other jurisdictions, and ▪ existing, relevant literature and clinical/service guidelines	**(two months)**
Step #2:	Convene an Expert Review Panel (ERP) to review and modify the draft standard	**(one month)**
Step #3:	Incorporate ERP interests into the standard and send second draft of the standard to the ERP for final input	**(one month)**
Step #4:	Incorporate ERP final input, when appropriate, into the standard and forward to the SOC Committee for review and edits	**(one month)**
Step #5:	Incorporate SOC interests into the standard and forward second draft to the full Commission	**(one month)**
Step #6:	Present the draft standard to the full Commission and open public comment until the next SOC meeting	**(one month)**
Step #7:	SOC determines what, if any, public comment to incorporate into the final draft	**(one month)**
Step #8:	Present changes resulting from SOC's review of public comment to Commission, and adoption of the standard, with or without additional revisions/modifications	**(final adoption)**

Steps #1 and #2, combined, took no longer than two months;
Steps #3 - #5, combined, took no longer than two months;
Steps #6 - #8, combined, took no longer than one month (*unless extended due to months in which the Commission did not meet/held special meetings—meaning four standards presented at the subsequent Commission meeting*)
Step #8, allowed to be extended one month depending on extent of Commission input at the meeting

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- **Standards of Care Development Process Summary:**

⇨ **6,000+ hours of total time dedicated**

- Contracted/staff work: 5,000+ hours
- Volunteer/expert contributions: 3,000+ hours
- 250+ participants

⇨ **33 service standards**

- Nine (9) new service categories
- 15 Special Population Guidelines
- New Continuum of Care

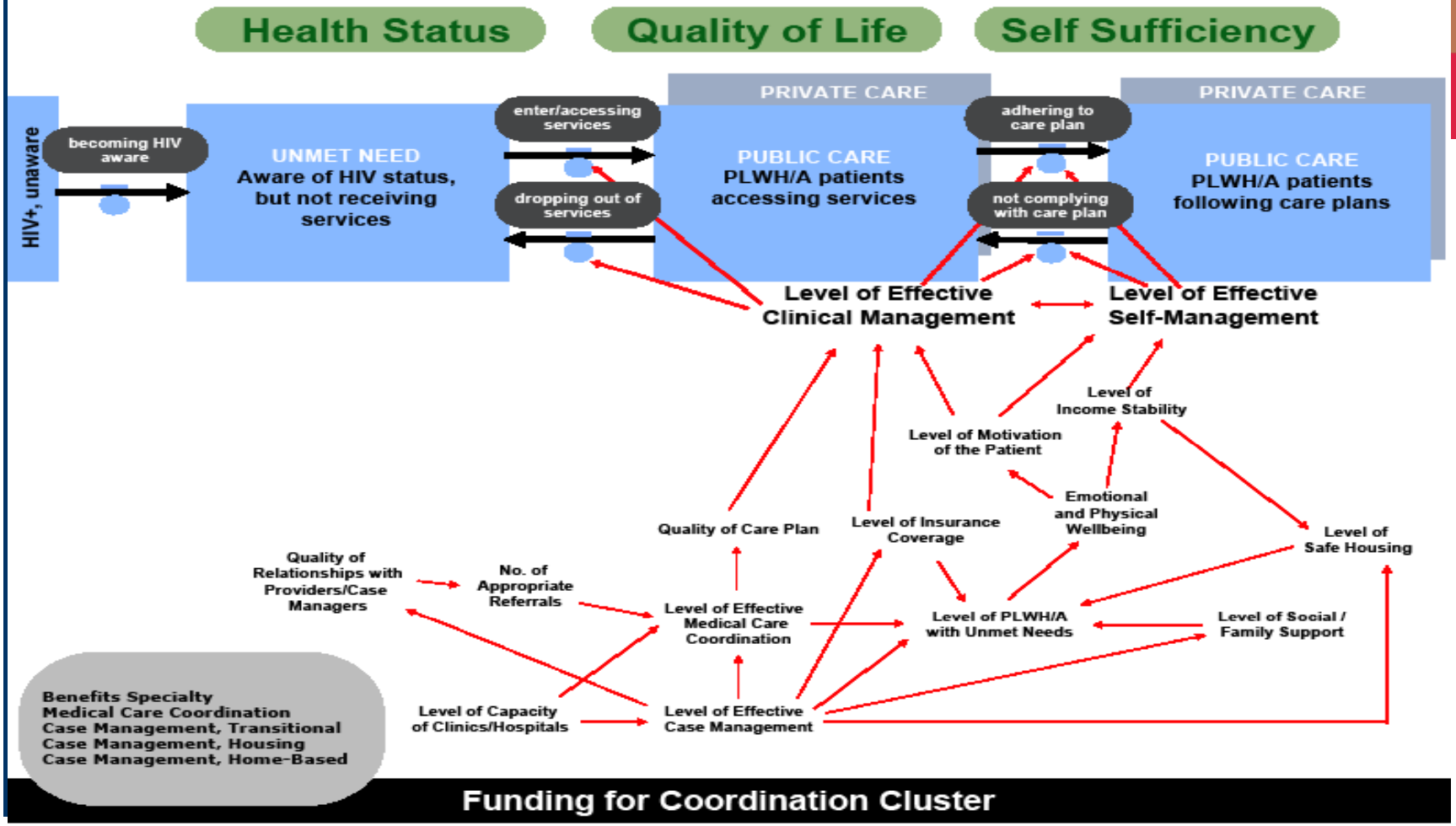
Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- **Policy on Standards of Care Development and Oversight**:
  - The Commission recently adopted a policy regulating how often formal updates to the standards will be performed (every four years in alternating years), under what circumstances and when revisions can be performed, and the Commission's process to ensure Grantee compliance with the standards in its annual contracting and procurement processes.

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

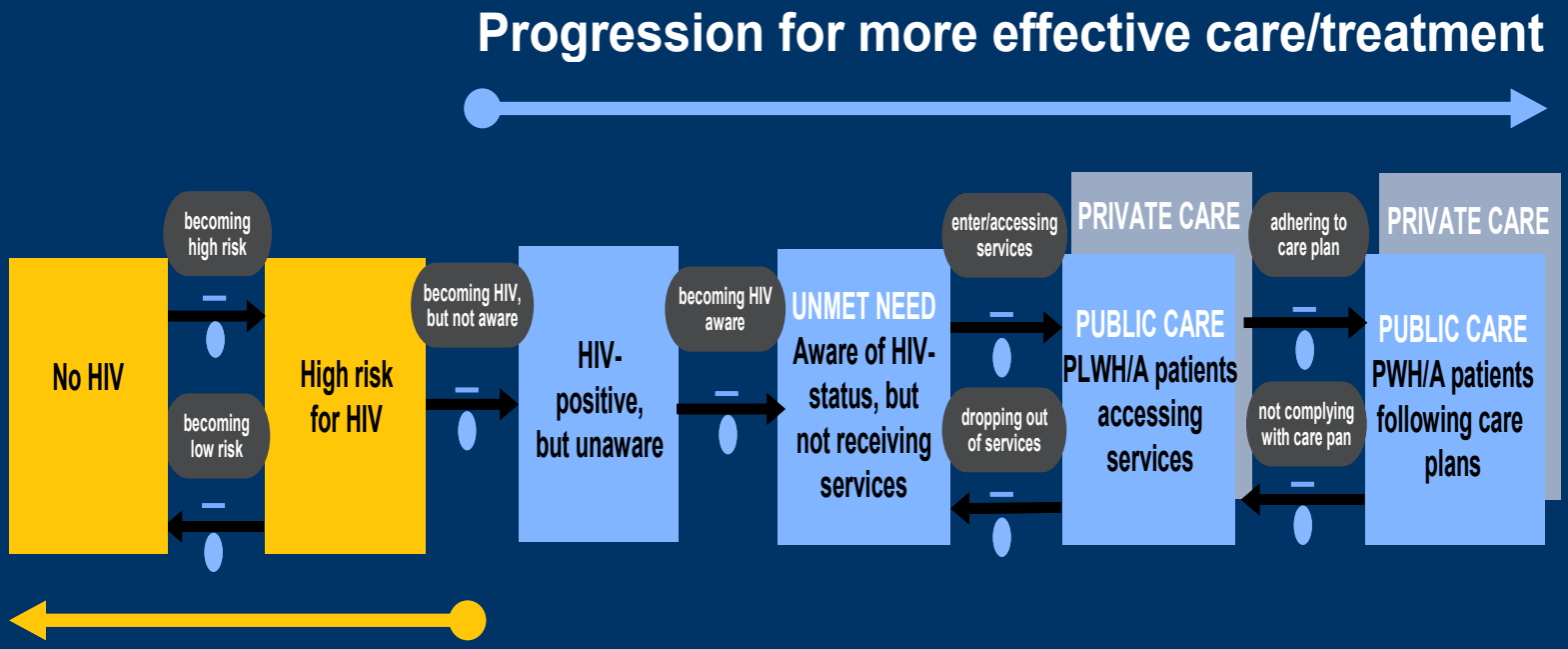
- **Continuum of Care**:
  - The development of the Los Angeles County's HIV Standards of Care led the Commission on HIV to begin reviewing the relationships between services through a systems mapping process. Systems mapping led to a patient flow diagram that showed where and how patients engage various levels of care and treatment, and the systems maps identified how services link to stages in the patients' progression through care and treatment. From those relationships, health and patient outcomes were revealed and indicators identified demonstrating whether or not patients and services were achieving those outcomes.

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

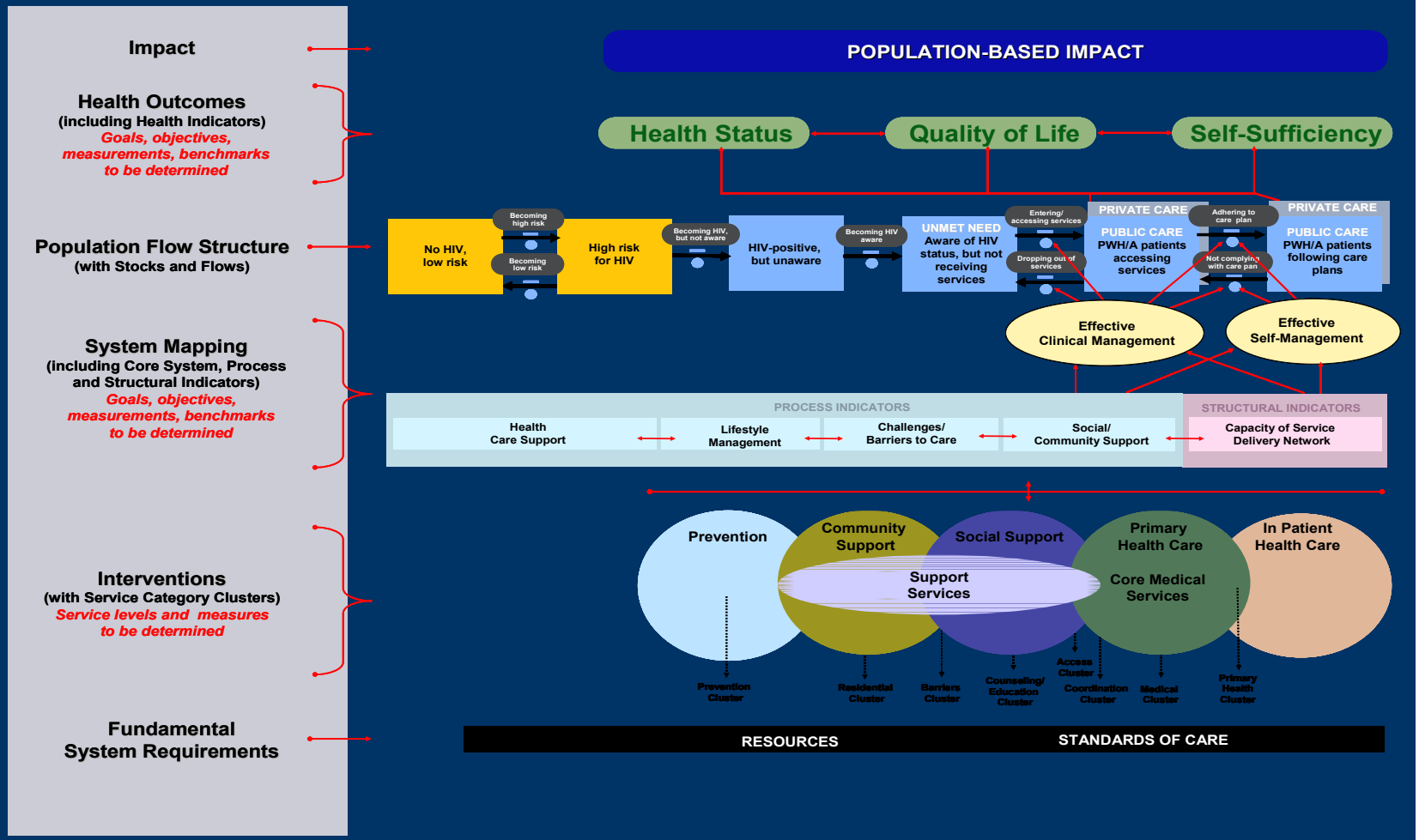


20 Years of Leadership
A LEGACY OF CARE

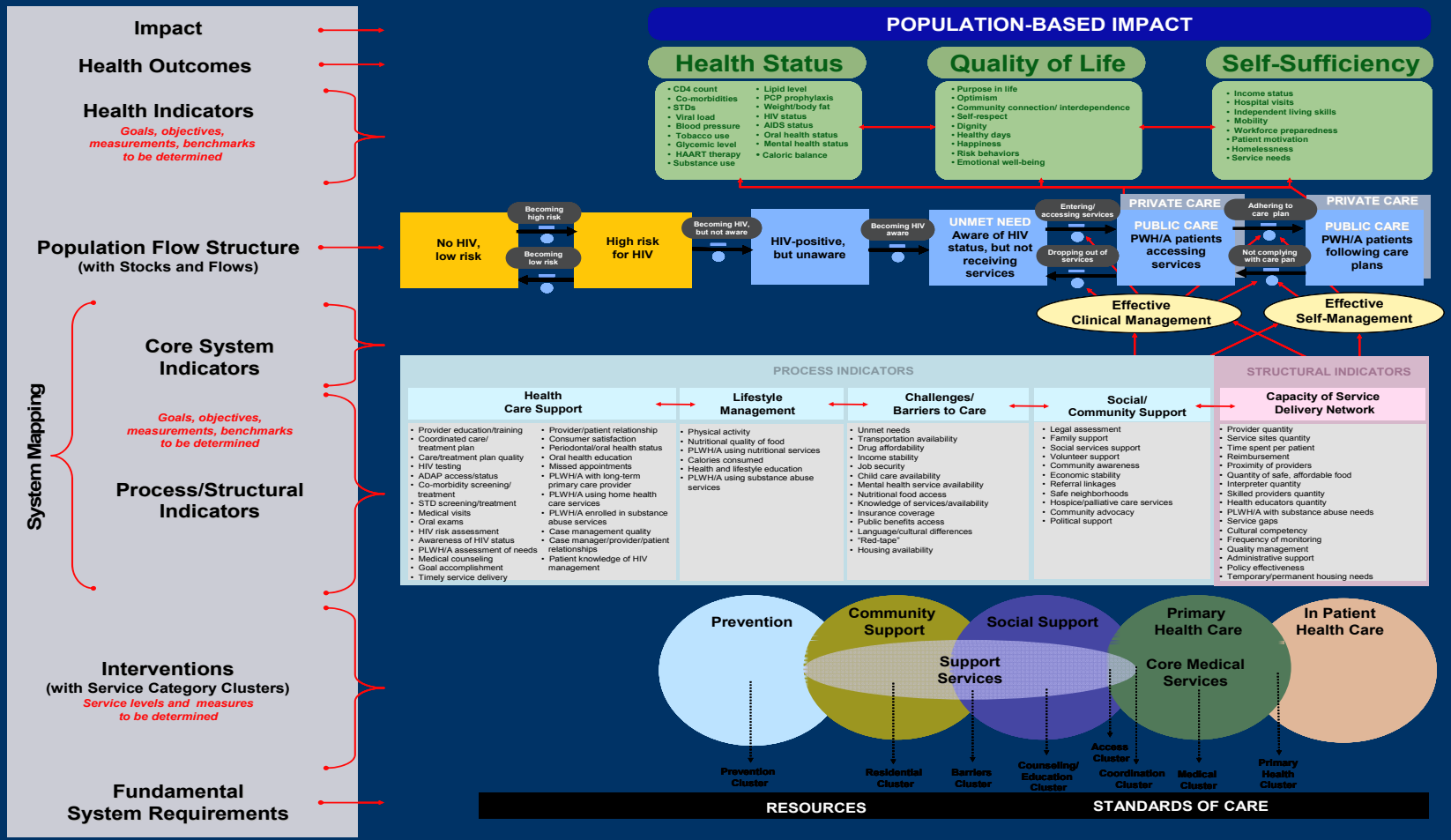
Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards



Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

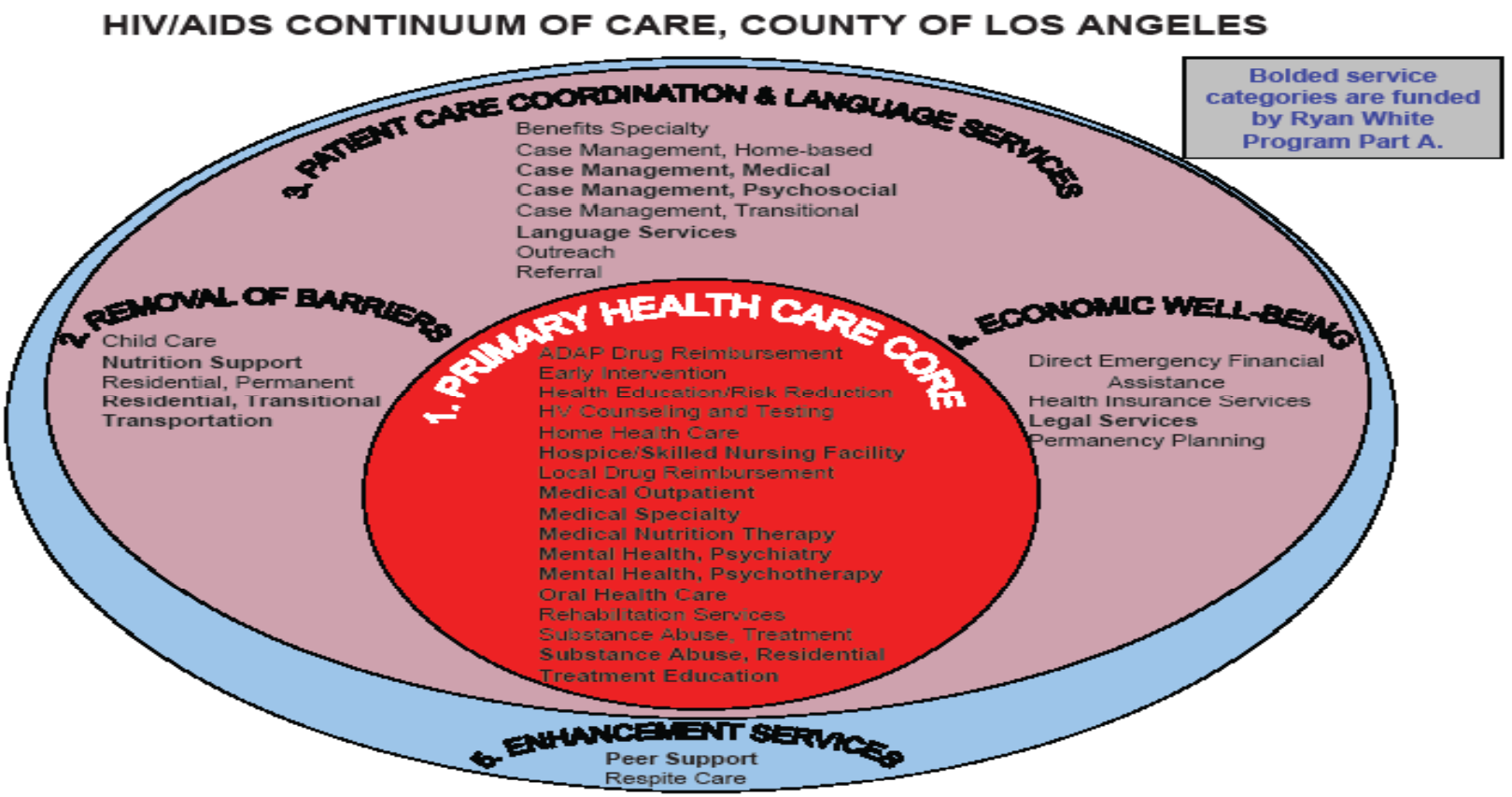


Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

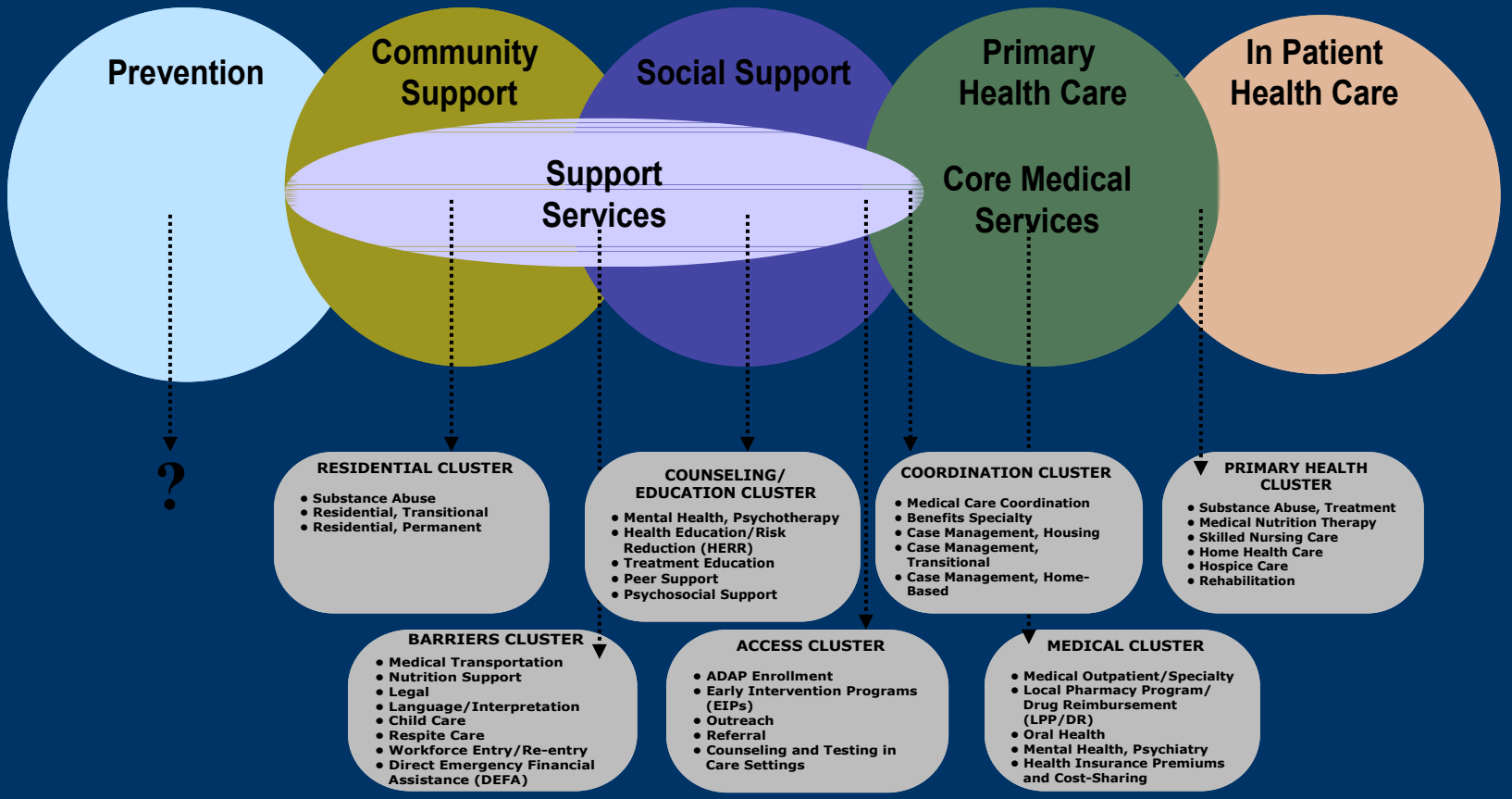


Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

2005 Continuum of Care



Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards



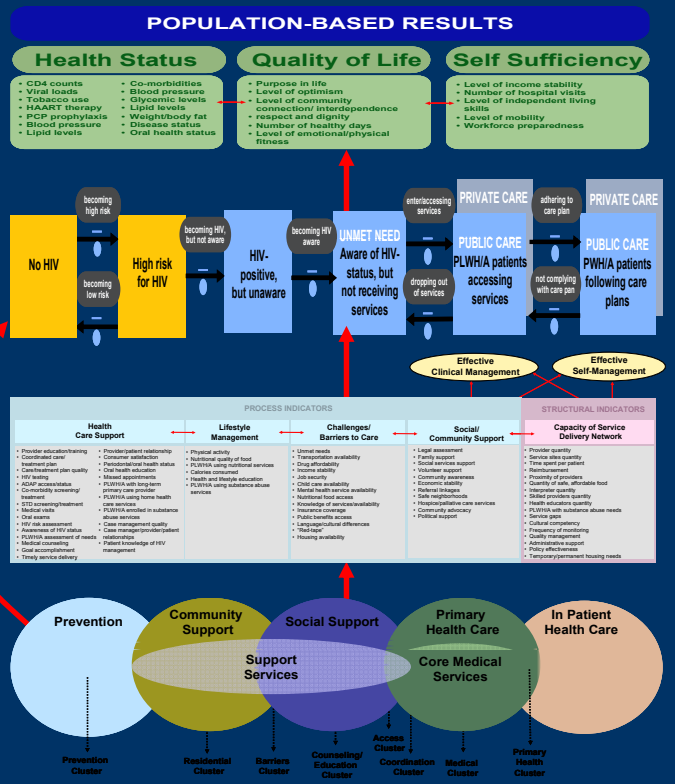
Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

④ How our services improve individual/overall health

② How we help patients/clients optimize their care/treatment

③ How our services actually help PWH/A maximize health care benefits

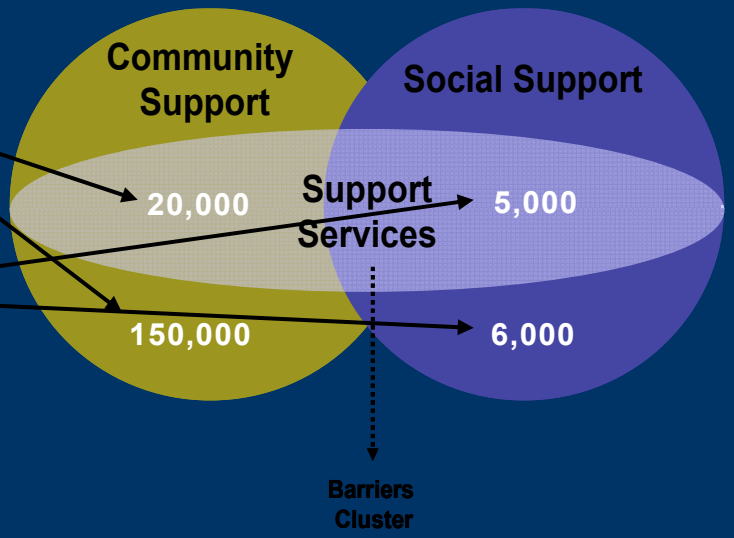
① What the services are and how they integrate with other community support systems



Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

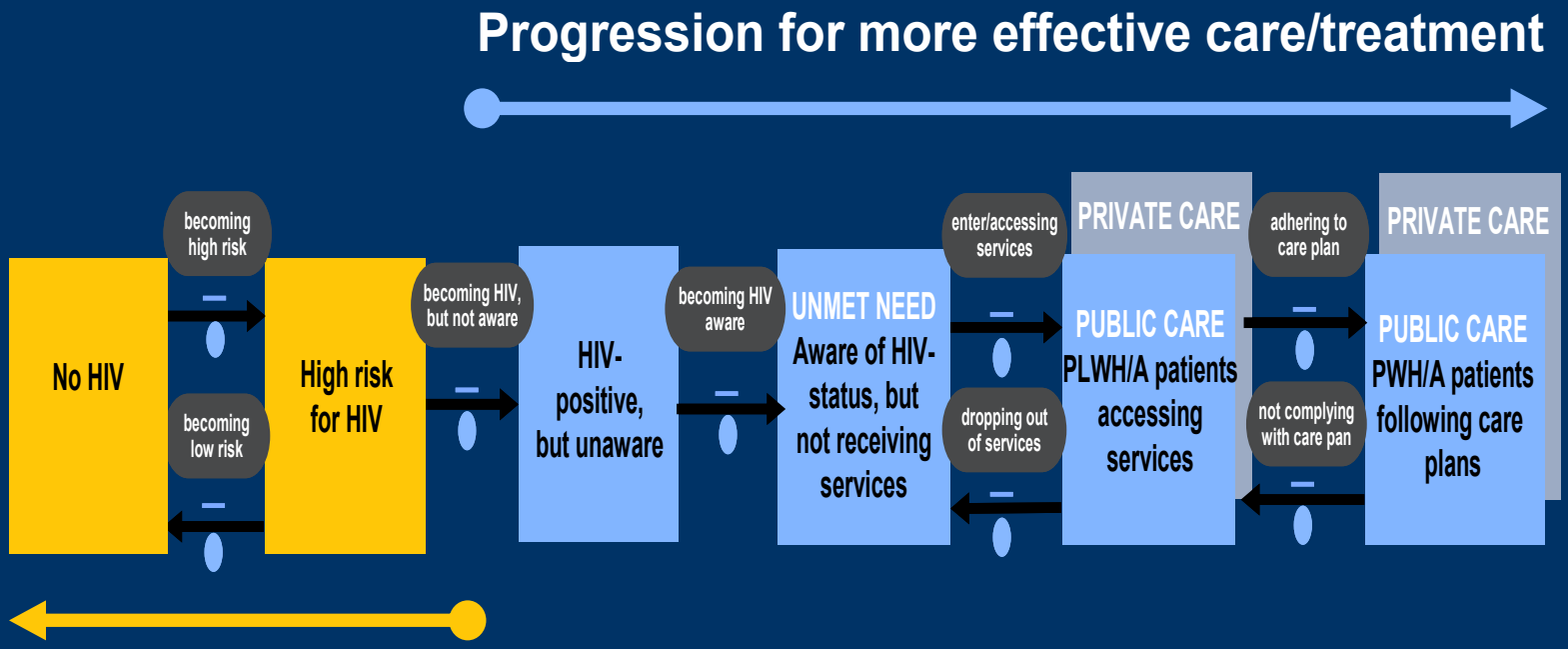
EXAMPLE: CHILD CARE RESOURCE INVENTORY

- 170,000 child care service units available in community; 150,000 from DCFS, OAPP contracts another 20,000 from DCFS.
- 11,000 service units from ASOs; OAPP contracts for 5,000.
- OAPP contracts for 25,000 service units total; need is 35,000.
- Do we allocate for an additional 10,000, or assume that clients can access services in the community?
- How do we allocate?

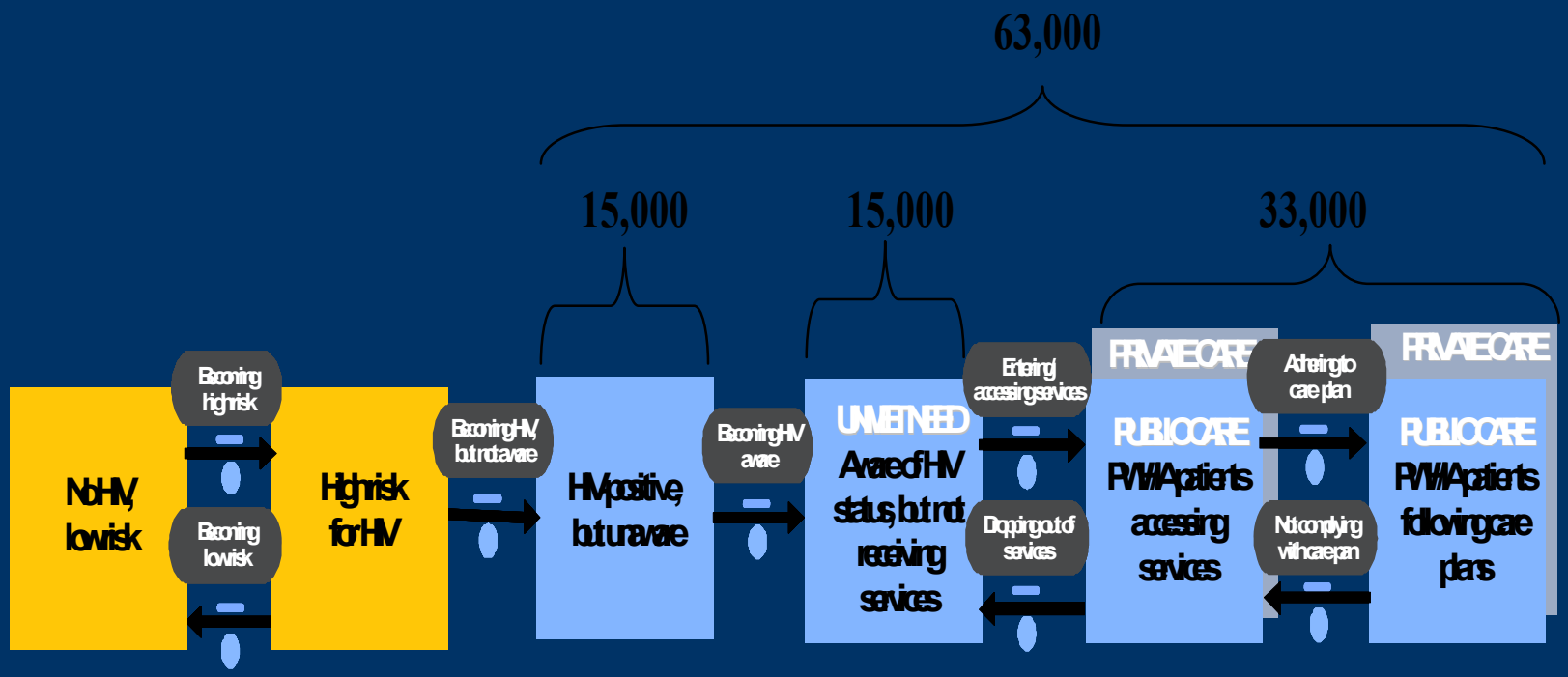


Data Is NOT Real

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

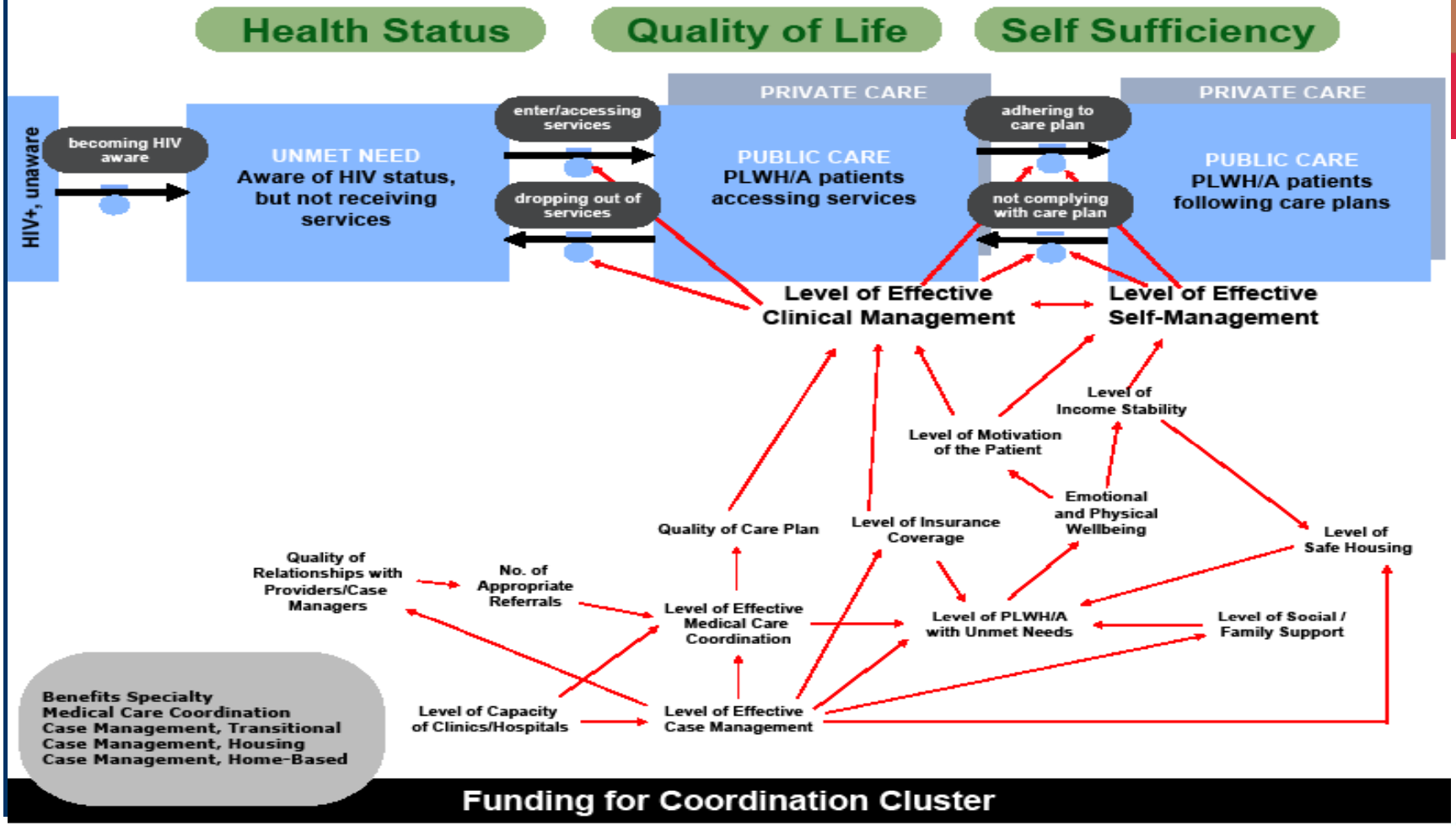


Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards



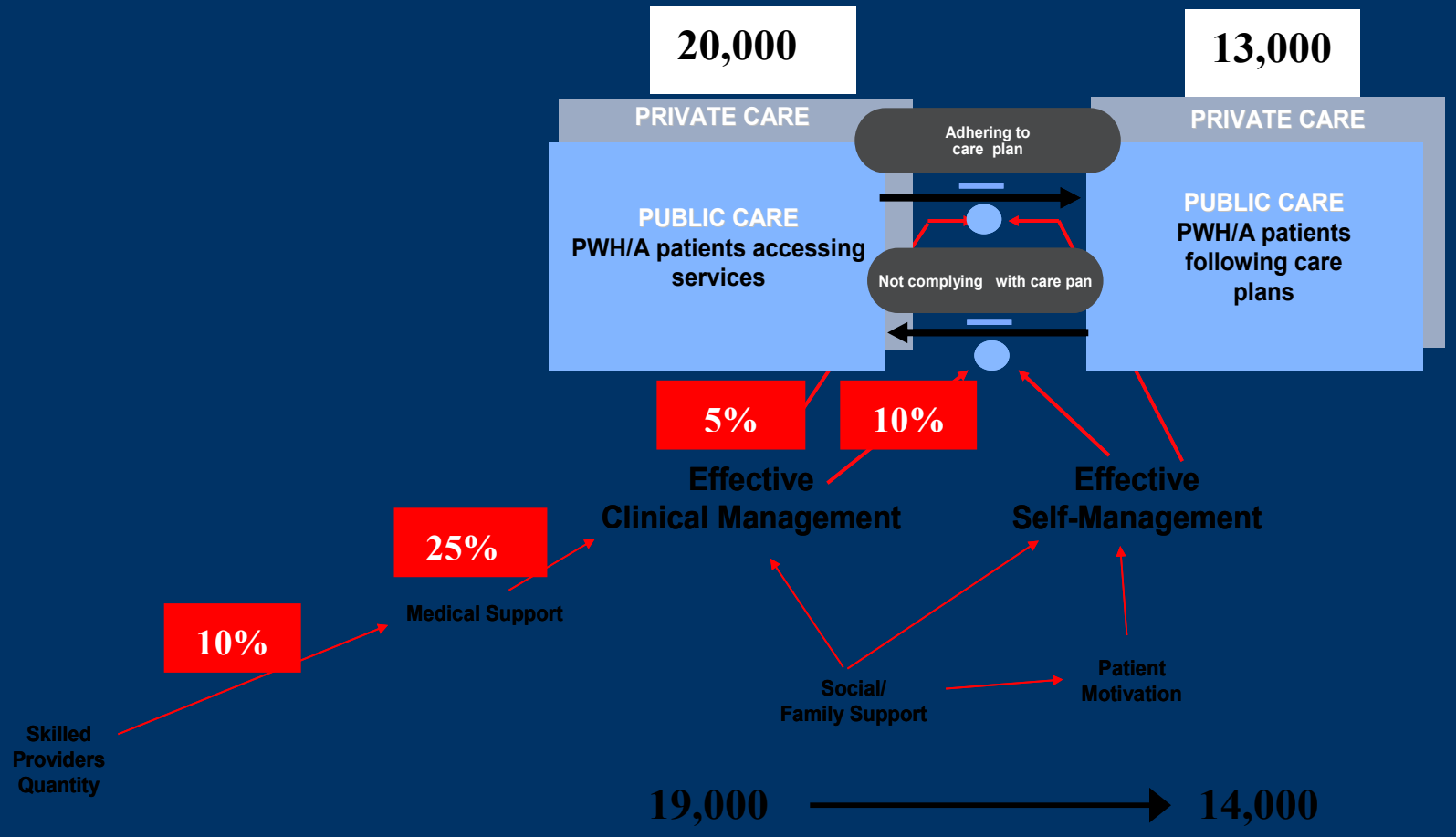
20 Years of Leadership
A LEGACY OF CARE

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards



20 Years of Leadership
A LEGACY OF CARE

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards



Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Commission on HIV:
  - created standards of care in 33 service categories (2006)
  - significantly revised its Continuum of Care (2008)
  - Introduced and integrated Medical Care Coordination into the Continuum of Care (2009)
- Next step is to evaluate service effectiveness

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

① Is the system of care effective?

② Are services provided effectively?

③ Are services provided cost-efficiently?

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

SERVICE EFFECTIVENESS DATA:

① is useful information in the annual priority- and allocation-setting process, and can help rank priorities and steer allocations;

② identifies targets for needed technical assistance;

③ focuses additional and enhanced quality assurance and management efforts and activities;

④ detects areas of concern/comfort for increased/decreased management emphasis;

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

⑤ ascertains where best practice attention can be more effectively addressed;

⑥ assesses how successfully the local jurisdiction is investing federal and other revenues in service delivery; and

⑦ reports to consumers and the community the strengths and weaknesses of the current service delivery system, and where improvements are needed.

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- ESE may indicate where QM or best practices focus is needed
- ESE is not a continuous measurement; QM is continuous measurement
- ESE measures service categories, service delivery; QM measures provider- and patient-level performance
- ESE is only a snapshot of the effectiveness of services within a specific period of time; QM measures over time

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- ESE requires re-assessment/re-measurement and comparability—all elements built into a standard QM process;
- ESE may have a moral hazard effect: biasing overall improvement and re-measurement when consumers respond to “scorecard” results; QM aims for continuous improvement
- Both are needed to for different pictures of the service delivery system

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

① **System Effectiveness**: **Are services (the system of care) effective?**

Does the continuum of care achieve its health outcomes: maintenance or improvement in health status, quality of life and self-sufficiency?

② **Service Effectiveness**: **Are services (the interventions) provided effectively?**

Do interventions (services) in the continuum of care achieve patient outcomes: entry into care, retention in care, and adherence to care/treatment?

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

③ **Cost Effectiveness**: **Are services delivered in a cost-efficient manner?**

Are interventions delivered in a manner that optimizes health and patient outcomes while maximizing available resources (funding)?

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Balanced Scorecard® is widely used as a framework for evaluating effectiveness in health care and hospital systems
- Using the Balanced Scorecard methodology, the system/institution measures a limited number of indicators in four critical domains—
  - Customer
  - Internal
  - Financial
  - Innovation/Learning and Growth

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Balanced Scorecard® links domains/elements to the organization's strategic plan (in EMAs, comprehensive care plan)
- Commission on HIV interpreted domains as follows:
  - **Customer**: *Consumer Satisfaction*
  - **Internal**:
    - ***Productivity*** **(Health Outcomes)**
    - ***Engagement*** **(Patient Outcomes)**
    - ***Unmet Need***
  - **Financial**: ***Cost Efficiency***
  - **Innovation/Learning and Growth**: ***Best Practices***

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Balanced Scorecard® links domains/elements to the organization's strategic plan (in EMAs, comprehensive care plan)
- Commission on HIV interpreted domains as follows:
  - **Customer**: *Consumer Satisfaction*
  - **Internal**:
    - ***Productivity*** **(Health Outcomes)**
    - ***Engagement*** **(Patient Outcomes)**
    - ***Unmet Need***
  - **Financial**: ***Cost Efficiency***
  - **Innovation/Learning and Growth**: ***Best Practices***

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

Balanced Scorecard®: CUSTOMER PERSPECTIVE		
① **Consumer Satisfaction**	**Needs Assessment**	
▪ Are consumers satisfied with the services they received? ▪ Do consumers feel that services meet their needs? ▪ Do consumers feel that services accessible? ▪ What do consumers feel are their greatest barriers? ▪ Why are consumers staying in care? ▪ Why are consumers falling out of care?	*LACHNA service effectiveness survey*	*Survey to be developed during Fall 2008; survey runs through February – June 2009.*

Evaluating Service Effectiveness:
Developing Methodology *(cont.)*

Balanced Scorecard®: INTERNAL PERSPECTIVE		
② **Productivity**	**Health Outcomes**	
▪ Are we achieving health and process outcomes?	*Systems of care/data system*	*Driven by systems mapping process; outcomes finished by Summer 2008; data to be collected and compiled by December 2008.*
▪ Have our current models of care maximized outcomes?	*Comparing providers' models of care*	
▪ Are services meeting established performance goals?	*OAPP to develop criteria*	
③ **Engagement**	**Patient Outcomes**	
▪ How many people are we getting into care?	*Service utilization data*	*Driven by goals and objectives in the Comprehensive Care Plan; corresponding to fulfillment of those goals.* *Commission and OAPP to form work group to develop goals/objectives for CCP, to define service delivery criteria and to quantify measures.*
▪ Are we meeting service objectives?	*CCP goals and objectives*	
▪ Are we meeting the need?	*LACHNA needs assessment survey*	
▪ Are services accessible?		
▪ How do barriers impact service access?		
▪ How seamless is our service delivery system?	*Population flows and\ service system mapping*	
▪ Where are there service gaps?		
▪ Is there adequate infrastructure to support services?		
④ **Unmet Need**	**Surveillance System**	
▪ How much are we reducing "unmet need"?	*Only relevant for overall system evaluation*	

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

Balanced Scorecard®: FINANCIAL PERSPECTIVE		
⑤ **Efficiency**	**Financial/Service Modeling**	
▪ Are models of care cost effective? ▪ How cost effective is service delivery between models? ▪ Are we providing services at optimal levels? ▪ What is "system capacity"? ▪ Are we operating at capacity?	*Various financial models*	*Begin developing the financial modeling in Fall 2008; compiling data by June 2009*

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

Balanced Scorecard®: INNOVATION and LEARNING/GROWTH PERSPECTIVE		
⑥ **Innovation**	**Literature Review/Surveys**	
▪ Are we maximizing the best service delivery practices? ▪ Are we meeting the standards' minimum expectations? ▪ How effectively are we achieving outcomes?	*Based on feedback during best practice conferences; OAPP input prior to implementation of conferences.*	*Start best practice conferences in January 2009.*

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

- Generate an “annual service effectiveness” scorecard
- Scorecards will entail “scores” for each of the services evaluated, and for the service cluster overall
- Begin with Medical Cluster of Services
  - Core service categories and most data available
- Medical Cluster of Services
  - Medical Outpatient/Specialty
  - Oral Health
  - Mental Health Psychiatry
  - Pharmaceutical Assistance Programs

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

Overall Score							Sum (1:5)
Balanced Scorecard: CUSTOMER PERSPECTIVE							
1. Consumer Satisfaction				Sum (1a:1f)	tbd %	E x F	
a. Services received	tbd %	tbd %	B x C				
b. Meeting consumers' perceived needs	tbd %	tbd %	B x C				
c. Perceived service accessibility	tbd %	tbd %	B x C				
d. Perceived barriers	tbd %	tbd %	B x C				
e. Staying in care	tbd %	tbd %	B x C				
f. Falling out of care	tbd %	tbd %	B x C				
Balanced Scorecard: INTERNAL PERSPECTIVE							
2. Productivity				Sum (2a:2c)	tbd %	E x F	
a. Achieving outcomes	tbd %	tbd %	B x C				
b. Maximizing outcomes	tbd %	tbd %	B x C				
c. Meeting performance goals	tbd %	tbd %	B x C				
3. Engagement				Sum (3a:3h)	tbd %	E x F	
a. Entering care	tbd %	tbd %	B x C				
b. Service objectives	tbd %	tbd %	B x C				
c. Meeting needs	tbd %	tbd %	B x C				
d. Service accessibility	tbd %	tbd %	B x C				
e. Barriers	tbd %	tbd %	B x C				
f. Service seamlessness	tbd %	tbd %	B x C				
g. Service gaps	tbd %	tbd %	B x C				
h. Infrastructure support	tbd %	tbd %	B x C				
4. Unmet Need				Sum (6a)	tbd %	E x F	
a. Unmet need	tbd %	tbd %	B x C				
Balanced Scorecard: FINANCIAL PERSPECTIVE							
5. Efficiency				Sum (4a:4e)	tbd %	E x F	
a. Cost effectiveness	tbd %	tbd %	B x C				

Evolving a Fully Comprehensive Care/ Prevention Continuum and Standards

A Domain/Dimension/Indicator	B Measure	C Sum and Weight	D Weight	E Adjust Score	F Weight	G Adjust Score	H Weight	I Adjust Score
A. Balanced Scorecard®: CUSTOMER PERSPECTIVE *(cont.)*								
1. Consumer Satisfaction *(cont.)*								
c. *Oral Health*	**76.33%**		**x 15 %**					
1) Satisfied with care received	**75%**							
2) Services meet clients' needs	**74%**							
3) Never encountered barriers to care	**80%**							
d. *Mental Health, Psychiatry*	**76.67%**		**x 15 %**					
1) Satisfied with care received	**74%**	x **33%**						
2) Services meet clients' needs	**73%**	x **33%**						
3) Never encountered barriers to care	**83%**	x **33%**						
B. Balanced Scorecard®: INTERNAL PERSPECTIVE						E x F	**x 50%**	
2. Productivity (Health/Clinical Outcomes)				C x D	**x 40%**			
a. *Medical Outpatient/Specialty*	**Sum (2a)**		**x 40%**	***Responsibility (method): indicator(s) (% formula)***				
1) CD4s	**xx%**	x **40%**	OAPP (Casewatch): CD4 data *(ratio: % </> 400)*					
2) Viral loads	**xx%**	x **15%**	OAPP (Casewatch): Viral load suppression *(% undetectable; ratio to ARV)*					
3) Opportunistic Infections (OIs)	**xx%**	x **15%**	OAPP (Casewatch): proportion on PCP prophylaxis *(% of total patients)*					
4) Physical pain related to HIV	**xx%**	x **15%**	OAPP (Audit Sample): SF 1-10/neuropathy *(% global pain scale panel)*					
5) Resistance	**xx%**	x **15%**	Commission (Survey): #s of genotypes/results *(vs. baseline resistance testing)*					
b. *Pharm./Med. Access Programs*	**Sum (2b)**		**x 30%**	***Responsibility (method): indicator(s) (% formula)***				
1) Adherence	**xx%**	x **100%**	OAPP (Audit Sample): patients report 95% or better adherence *(% of total)* HIV/Epi (MMP): ARV adherence from RW sites *(from total client population)*					
c. *Oral Health*	**Sum (2c)**		**x 15%**	***Responsibility (method): indicator(s) (% formula)***				
1) Pocket depth	**xx%**	x **30%**	OAPP (Audit Sample): average pocket depth *(% of pocket depth range)*					
2) Decayed teeth	**xx%**	x **15%**	OAPP (Audit Sample): # of patients getting fillings/extractions *(% of total)*					
3) Discomfort when eating	**xx%**	x **15%**	OAPP (Audit Sample): pain assessment *(% of total)*					
4) Presence of symptoms	**xx%**	x **40%**	OAPP (Casewatch): # of patients' tooth replacements *(% of 50% progress)*