DEVELOPING DIRECTIVES: STEPS AND SOUND PRACTICES

Development of directives is a legislative responsibility of a Ryan White HIV/AIDS Program (RWHAP) Part A Planning Council (PC). The PC is expected 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)]*

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

Directives are used to specify "how best to meet" the priorities established by the PC/PB. There is no requirement that a PC/PB develop directives every year, and there is no "appropriate" number of directives. Directives are indicated when your current system of care is not meeting identified service priorities, and you can identify actions that may enhance services and improve consumer engagement, retention, and outcomes.

Types of directives and their use are summarized in Training Guide Module 5, Priority Setting and Resource Allocation, and described in more detail in Quick Reference Handout 5.2: Directives. As explained in these resources, most directives relate to one or more of the following:

- **Geographic focus** to ensure service availability throughout the EMA/TGA or in a particular county or area
- **Population focus** to ensure services that are appropriate for particular subpopulations of people with HIV (PWH)
- Improvements in **access to care**
- Testing of new **service models** or expansion of effective strategies

This document offers suggested processes and steps for preparing directives. See pages 12-13 for a range of sample directives.

Responsibility for Developing Directives

Directives development can be coordinated by a single committee on the PC/PB or implemented by a Directives Task Force. If one committee takes responsibility, it can be:

- The committee responsible for improving service models and strategies (e.g., System of Care or Care Strategies Committee). Its members often review and update service standards and continuum of care or quality assurance data, and are informed about quality improvement efforts.
- The committee responsible for needs assessment. This committee's work involves identifying service barriers and gaps, as well as subpopulations not receiving appropriate services.
- The committee responsible for priority setting and resource allocation (PSRA). Directives are usually adopted as part of the PSRA process and may affect allocations.
- Some PC/PBs establish a Directives Task Force with representation from all these committees plus the consumer committee or caucus.

Timing of Directives Development

A PC/PB can develop a directive at any time. However, some directives require changes in subrecipient (service provider) scopes of work or increased costs, and the recipient may not be able to implement them immediately. For example, a directive for piloting a new peer Early Intervention Services (EIS) might need to wait until the next EIS grant cycle. A directive requiring outpatient ambulatory health services (OAHS) to be available in an outlying county might require an increase in OAHS resource allocations. Due to their financial and funding implications, directives are usually adopted as part of the PSRA process, when allocation requirements can be addressed. This means identifying the need for a directive several months earlier, before PSRA begins, to allow time for development and discussion with the recipient about costs and implementation – so the process of developing directives often begins in early spring.

Sound Practices for Directives Development

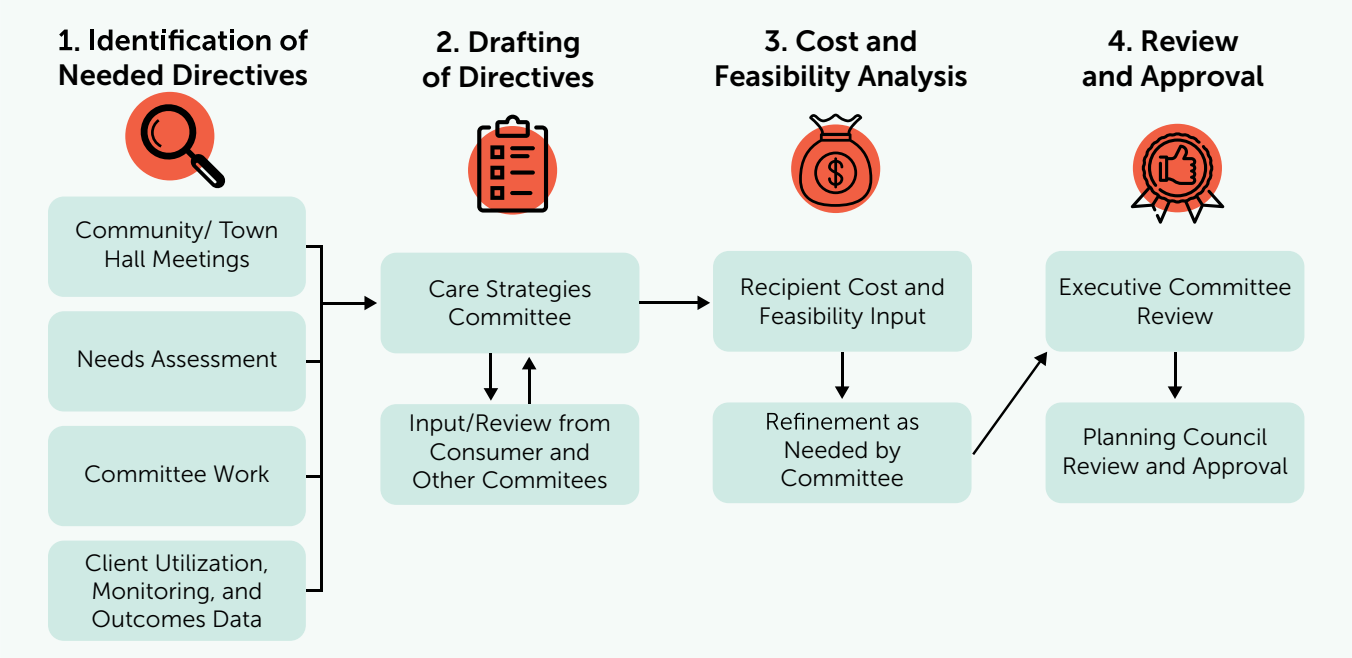
There are many different ways to develop directives. No single approach is best for every PC/PB. However, most effective processes have several sound practices in common:

- **Consumer and community input:** As the people using RWHAP Part A services, consumers often have the best understanding of what is and is not working, overall or for their own subpopulation. Planning Councils often develop directives based on needs assessment findings. Some also ask for consumer input at town hall meetings. Planning Council committees responsible for directives development often ask the Consumer Committee/ Caucus both to suggest directives and to review and provide input to draft directives.
- **Clear responsibilities:** Directives are too important to be an afterthought, but sometimes a busy PSRA Committee does not have adequate time to spend on them. Sound practice is to assign responsibility for directives development to a committee with both appropriate expertise and sufficient time to fulfill this responsibility. Often this is the committee responsible for service standards and other system of care issues, sometimes called the Care Strategies Committee. It usually does not have lead responsibility for either needs assessment or PSRA, so has the time to manage the process and bring proposed directives to the full planning council as part of PSRA.
- **Recipient involvement:** The planning council develops directives, but the recipient is responsible for implementing them. Recipient input on the cost of implementation of a proposed directive helps the planning council allocate additional funds when necessary as part of PSRA. The recipient can also provide advice on implementation feasibility and timing. For example, if a directive involves a new service model, implementation may be feasible only when the recipient releases a new Request for Proposals (RFP) for the relevant service category. Sometimes the recipient may suggest a modification to the directive that would make it easier or less expensive to implement.
- **The planning council is the decision maker about directives**, but the recipient can provide valuable technical input and should be engaged in directives development. Typically, the recipient will:
  - Provide some of the data used to identify issues to be addressed by directives (e.g., continuum of care and other outcomes data as well as Quality Management and client utilization data).
  - Offer technical advice to the responsible committee, since most committees have a recipient staff member assigned to them.
  - Formally review draft directives at the committee's request.
  - Be represented during Executive Committee and full planning council review and approval of directives.

Sample Process for Directives Development

The flow chart below shows a four-step approach for directives development:

1. Identification of needed directives
2. Drafting of directives
3. Cost and feasibility analysis
4. Review and approval



As described below, these steps involve multiple planning council committees, consumers and other community members, and the recipient. If the relevant committee has diverse membership including both consumers and providers, as well as regular, engaged recipient staff participation, a mutually acceptable approach to directives development can be established and used each year, with small refinements as needed.

STEP 1: IDENTIFICATION OF NEEDED DIRECTIVES

Ideas for directives come from many sources, including:

Needs assessment data, particularly information indicating persistent or commonly reported barriers to care, or services that are difficult to access for particular subpopulations of PWH – defined by characteristics such as race/ethnicity, gender/gender identity, sexual orientation, or age, or residents of particular counties or neighborhoods.

For example: You recently did focus groups with young Black MSM, young Latino MSM, older Black PWH (55+), and Black women with HIV. When asked about access to services, young Black and Latino MSM said that outpatient substance abuse treatment was very difficult to obtain. The Latino group said they found it hard to obtain medical case management, especially if they needed a Spanish-speaking case manager. Black PWH of all ages said they had trouble obtaining mental health services, and indicated that providers had few Black counselors.

Service utilization data showing client characteristics: A review of Ryan White HIV/AIDS Program Services Report (RSR) data can provide information about the characteristics of clients who use particular service categories. Quick review of tables or charts can help your PC/PB identify which service categories are especially likely or unlikely to be used by particular populations – and comparing this information with needs assessment data can be very informative.

Town hall or community meetings: Often consumers attending a community forum or town hall meeting are asked to identify service gaps and barriers to care that can suggest the need for a directive.

For example: Your PC/PB arranges a virtual or face-to-face community meeting with PWH in one of the EMA or TGA's outlying counties. A focus for public input and discussion is what, if any, needed services are hard to access, and what are the main barriers to care. A number of consumers say they have great difficulty accessing mental health services and oral health care. The main barriers identified relate to distance and service hours. These services are provided only in the central city of the EMA/TGA, and transportation is a problem. In addition, the providers have no evening hours, and employed PWH find it very hard to take time off during the workday. Getting such care usually means losing a whole day of work, especially if they must use public transportation, which is very limited outside the city.

Consumer committee or caucus: PC/PBs sometimes ask their consumer committee or caucus to devote one meeting to reviewing needs assessment, service utilization, and town hall or community meeting data and identify the need for directives based on those data and their own collective experience.

For example: Your PC/PB always asks for consumer committee input about potential directives and help in framing them. This year the consumers discuss the focus group data and utilization data on mental health and outpatient substance abuse treatment, and agree on the need for more information about possible barriers such as insufficient funding and waiting lists, extent of staff diversity, and availability of services on evenings and weekends. They discuss distance, office hours, and transportation issues as an access issue for PWH from outside the central city, and suggest the need for a directive to address this issue, perhaps by requiring subrecipients to outstation staff several days a week in an outer county.

Ongoing committee work: Sometimes a committee receives information as a part of its work that suggests the need for a directive. This might involve insights from reviewing the system of care for updating an integrated prevention/care plan, looking at data on unmet need by race/ethnicity, exploring HIV continuum of care data by subpopulation, or receiving data from the recipient on waiting lists for specific services in considering reallocations.

For example: The PSRA Committee might be informed that there is a 4-month waiting period for mental health services due to limited resources and high demand, and that outpatient substance abuse service providers are operating at reduced capacity due to difficulties in filling staff vacancies that occurred during the worst of the COVID-19 pandemic.

As these examples suggest, the idea for a directive typically arises as a way to address an identified service gap or barrier or data indicating that a current service model is not working well overall or for some PWH subpopulations.

STEP 2: DRAFTING OF DIRECTIVES

Once the possible need for a directive is identified, the assigned lead committee needs to further explore the need and agree on whether a directive is an appropriate response, and if so, what it should say.

Often the responsible committee will ask for input from other committees during this process. In developing directives, the committee often considers questions and issues like the following:

How significant is the need for action? Directives are intended to provide guidance to the recipient on how best to meet identified priorities, and sound practice is to develop a small, manageable number of directives that address important service gaps, barriers, or weaknesses.

Do we need to better understand the situation before trying to address it? For example, if a problem is identified in a focus group, your committee may want to review client utilization data, performance measures, or other existing information, or to consult with the consumer committee/caucus to better understand what is happening and why. Sometimes a "roundtable" meeting with providers, consumers, and other experts is helpful. If the situation appears complex, the committee responsible for needs assessment might be asked to do a "special study" before action is taken.

Is a directive the right way to address this issue? Sometimes another approach may be quicker, more efficient, or more appropriate. Alternatives might include changes in service priorities or allocations for Part A or Minority AIDS Initiative (MAI) funds, modified service standards that strengthen or clarify requirements, or other options explored with the recipient.

For example: A PWH survey as part of needs assessment finds that more than 30% of consumers who say they need mental health services are not receiving them. Some say they have been waiting for more than 9 months. A provider survey finds that funded subrecipients have very limited funds and cannot meet demand. Few non-RWHAP options exist, none of them accessible to PWH who live outside the central city. The PC/PB ultimately decides that this problem can best be resolved not by a directive but by increasing the Part A allocation for mental health services.

Does the committee have a good idea of what the solution should be? If you have identified the problem but are unclear about an appropriate solution, you may need some brainstorming or consultation with consumers, providers, recipient staff, and other experts. Or you may want to define the problem clearly but give the recipient considerable flexibility in choosing an approach.

For example: The committee agrees that something must be done to provide better access to OAHS services for PWH who live outside the county where the central city of the EMA/TGA is located. All Part A OAHS services are currently provided at clinics in the central city, and public transportation from the PC/PB's two outer counties is very limited. The PC/PB identifies several possible solutions:

- Require current OAHS subrecipients to open a facility or outstation clinical personnel in an outer county at least a specified number of hours per month.
- Fund a mobile clinic.
- Require a subrecipient to partner with a clinic located in one of the outer counties.
- Require that at least one OAHS provider be a clinic located in an outer county.
- Provide improved transportation assistance.

The directive can call for a specific solution (as indicated above) or several options, or it can be stated to define the required level of access rather than the specific solution, for example:

Directive: "No RWHAP Part A consumer will have to travel more than one 1½ hours from their home to obtain OAHS, whether by car or public transportation."

Directive: "RWHAP Part A consumers will have access to OAHS services within each of the three counties of the EMA/TGA at least two days a week, and transportation assistance will be provided for any consumer who lives more than 5 miles from the OAHS location."

If a new service model or strategy is needed, how specific and detailed should the directive be? If current services are not leading to acceptable results like retention in care or viral suppression, overall or for particular subpopulations, a new service model or strategy may seem necessary. If you have only a general idea of the desired approach, you can prepare a flexible directive that asks the recipient to develop the model. If you have done the work necessary to choose or develop a desired model (ideally in consultation with the recipient), it helps to be as specific as possible in identifying desired outcomes and approaches to consider. If you want the recipient to develop the model, your directive might look something like this:

Directive: "The recipient will develop and arrange for three-year pilot implementation of a peer-based Early Intervention Services (EIS) Program designed to ensure that young MSM of color who are newly diagnosed, out of care, or loosely connected to care become fully engaged in care, adhere to treatment, and reach viral suppression."

If the PC/PB wants greater involvement in development of the model, the directive might look more like this:

> ***Directive:*** "The recipient will work with the Planning Council on development of a peer-based Early Intervention Services (EIS) Program and then arrange for it to be implemented as a 3-year pilot effort. The program model will be developed by the Care Strategy Committee in consultation with the recipient and must be approved by both parties."

If the PC/PB wants a specific model implemented, the directive might be more detailed and include an attachment:

> ***Directive:*** "The recipient will implement a three-year peer-based Early Intervention Services (EIS) Program targeting young Black and Latino MSM, based on the model tested and documented through the 20XX RWHAP Special Projects of National Significance (SPNS) grant entitled "XXX." Key components are outlined in the attached summary [Provide an outline of the model from the committee]. The program model will be refined as needed by the recipient in consultation with the Care Strategies Committee and must be approved by both parties before implementation."

Once these and other questions have been answered and the committee is at the stage of drafting directives, it may want to do any or all of the following:

- Consult with the consumer committee/caucus or another committee.
- Report progress to, and receive feedback from, the Executive Committee.
- Provide an update and request input at a full PC/PB meeting.

Draft directives can be prepared, and then further reviewed and refined based on further consultation.

STEP 3: COST AND FEASIBILITY ANALYSIS

Once the committee has drafted a directive, it needs to explore its financial and practical feasibility.

The directive may well affect allocations, and the amount needs to be known before annual allocations are made or reallocations are considered during the program year. Typically this process includes several steps:

Obtaining cost estimates for implementing the directive, and considering revisions if costs are too high. This may be a complex process if the directive calls for a pilot project involving a new service model. It may be simpler if the intent is to increase or refine existing services. The committee may be able to obtain cost data from other sources. For example, budget information may be available for a SPNS project or a model that has been used in another location. Service providers on the committee may be able to offer useful information on the costs of extending clinic hours based on their own experience. If the PC/PB receives data on unit costs for particular services, it may be able to use this to estimate additional costs for increasing those services. However, the recipient is usually an essential source for cost estimates. Comparing projected costs for several possible approaches may help the committee choose or eliminate options before finalizing the directive. For example, consider a directive that calls for increasing access to OAHS for residents of an outlying county and offers multiple options. The recipient might project additional costs for each approach. The PC/PB can then make appropriate allocations, and future RFPs for OAHS providers can offer applicants these options.

Reviewing the directive to ensure that the proposed solution is a practical, feasible way to address the need, considering factors like provider capacity and timing as well as current service standards. This usually involves consultation with recipient staff and other knowledgeable advisors, including provider personnel, consumers, and other experts. Among the issues to consider:

- *Does the recipient feel the directive can be implemented with current subrecipients, or does it require new contracting* – which could delay implementation? For example, a pilot project may require a new competitive procurement, but extended service hours might be possible through the annual revision in a statement of work or even an amendment during a program year if funds are available for reallocation. It is helpful for a recipient to inform the PC/PB well in advance when RFPs for particular service categories are going to be released, so directives related to those services are prepared and ready for inclusion in the RFP.
- *Do providers have needed capacity and interest?* Some directives are never implemented because no provider submits a proposal in response to a recipient RFP, or current subrecipients are unable to implement the desired strategy. Consider this situation: a PC/PB in a jurisdiction with a large Latino immigrant population develops a directive requiring at least one mental health provider to offer individual and group therapy in Spanish. The recipient attempts to implement the directive through a competitive RFP using MAI funds, but no applications are received. Providers explain to the recipient that they have been unsuccessful in recruiting bilingual mental health counselors because their salaries are not competitive. The recipient suggests that to the PC/PB increase the MAI mental health allocation to allow for higher salaries. The RFP might then be re-competed successfully.
- *Are the service standards for the relevant service category(ies) flexible enough to permit a pilot?* Sometimes service standards are so specific and detailed that they must be changed to permit testing of a new model or strategy.

STEP 4: REVIEW AND APPROVAL

Usually the directive undergoes at least the following levels of approval: the responsible committee, the Executive Committee, and the full PC/PB.

Before sending a proposed directive forward, the responsible committee often consults with, and asks for approval from, other committees, most often the consumer committee/caucus and the committee responsible for reviewing financial data and managing allocations and reallocations. Some PC/PBs ask for preliminary review by these entities before they ask the recipient to spend the time to project the costs of implementation. Ideally, consumers and providers serve on the committee, and the recipient is represented at committee meetings as directives are being developed and can provide valuable advice throughout the process. Often the committee's chair provides updates to the Executive Committee and full PC/PB at their meetings. This means they are already familiar with the directive and can offer input before formal approval is requested.

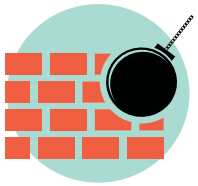
SAMPLE DIRECTIVES

Directives to Help Increase Access to Services

- **Oral Health Services:** All oral health care providers must provide for some evening and/or weekend appointments.
- **Linguistic Services:** All RWHAP Part A-funded providers shall have access to trained medical interpreters and/or a language line, for use as needed.

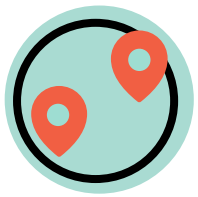
Directives to Help Remove Barriers to Care

- **Linguistic Services:** All RWHAP Part A-funded providers shall have access to a language line for use as needed.
- **Culturally Appropriate Services:** Since over 40% of RWHAP Part A clients are Latino, all OAHS and Medical Case Management subrecipients shall have at least one Spanish/English bilingual/bicultural clinical staff member.



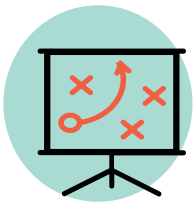
- **Services for Young Adults:** At least one subrecipient shall offer services with a specific focus on retaining young adults ages 18-25 in care, and helping them adhere to treatment and reach and maintain viral suppression.
- **Services for Older PWH:** Over the next 12 months, all case managers funded partially or fully through RWHAP Part A shall participate in geriatric case management training arranged by the recipient, or equivalent training arranged by their organization.

Directives to Help Reduce Geographic Disparities



- **Psychosocial Services:** Support groups, professional and/or peer led, shall be provided in all three counties of the TGA, with locations, transportation assistance, and/or use of remote technology to ensure access to all consumers, regardless of where they live or work.
- **Access to Care throughout the Service Area:** Minority AIDS Initiative (MAI) funding for Medical Case Management will be divided equitably among the EMA's five regions based on their proportion of RWHAP-eligible minority populations.

Directives to Test or Adopt New or Refined Service Strategies



- **Consistent Mental Health Screening and Referral:** By the end of the next program year, all Medical and Non-Medical Case Managers must ensure that all their RWHAP Part A clients receive mental health screening using the TGA-approved screening tool, and that those with mental health service needs receive follow-up to link them to mental health services.
- **Piloting a Peer-based Model Linked to Non-Medical Case Management:** The recipient will work with the Planning Council on development of a peer-based model pairing peers with case managers, and then arrange for it to be implemented as a 3-year pilot effort. The program model will be developed by the Care Strategy Committee in consultation with the recipient and must be approved by both parties. The model must use peers: individuals with HIV who are in care and from priority racial/ethnic/cultural communities. The pilot must involve a central agency that is responsible for training, oversight, and evaluation, with peers assigned to and serving as staff of at least three subrecipients.

This resource was prepared by JSI Research & Training Institute, Inc. and EGM Consulting, LLC, and supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U69HA30795: Ryan White HIV/AIDS Program Planning Council and Transitional Grant Area Planning Body Technical Assistance Cooperative Agreement. This information or content and conclusions are those of the author(s) and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.