CORE HIV MEDICAL SERVICES FOR PERSONS LIVING WITH HIV
RFP No. 2018-003

Successful Bidder's Conference

Los Angeles County, Department of Public Health
Division of HIV and STD Programs
June 19, 2019

Welcome

CORE HIV MEDICAL SERVICES FOR PERSONS LIVING WITH HIV RFP No. 2018-003 Successful Bidder's Conference

Terina T. Keresoma, Co-Manager
Contracted Community Services
Division of HIV & STD Programs
County of Los Angeles Department of Public Health

Agenda

- Director's Remarks
- Eligibility
- AOM Services
- MCC Services
- Clinical Quality Management
- Data & Reporting Requirements
- Financial Requirements
- Contract Monitoring
- Conclusion

Director's Remarks

Mario J. Perez, Director
Division of HIV and STD Programs

Los Angeles County HIV/AIDS Strategy

About Government Healthcare Professionals Community Health Districts Connect

There are currently **60,946** people living with HIV in LA County.

Welcome to LACounty.HIV

This is more than a website. It is the online home of a movement – the bold effort to significantly reduce the number of new HIV infections in Los Angeles County. Whether you work in government, are a healthcare professional, or are a community stakeholder, you have a role to play in bringing an end to the HIV/AIDS epidemic, once and for all.

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3 Goals of the Strategy

- Reduce annual infection to 500 by 2022
- Increase the proportion of PLWH who are diagnosed to at least 90% by 2022
- **Increase the proportion of diagnosed PLWH who are virally suppressed to 90% by 2022**

KB4

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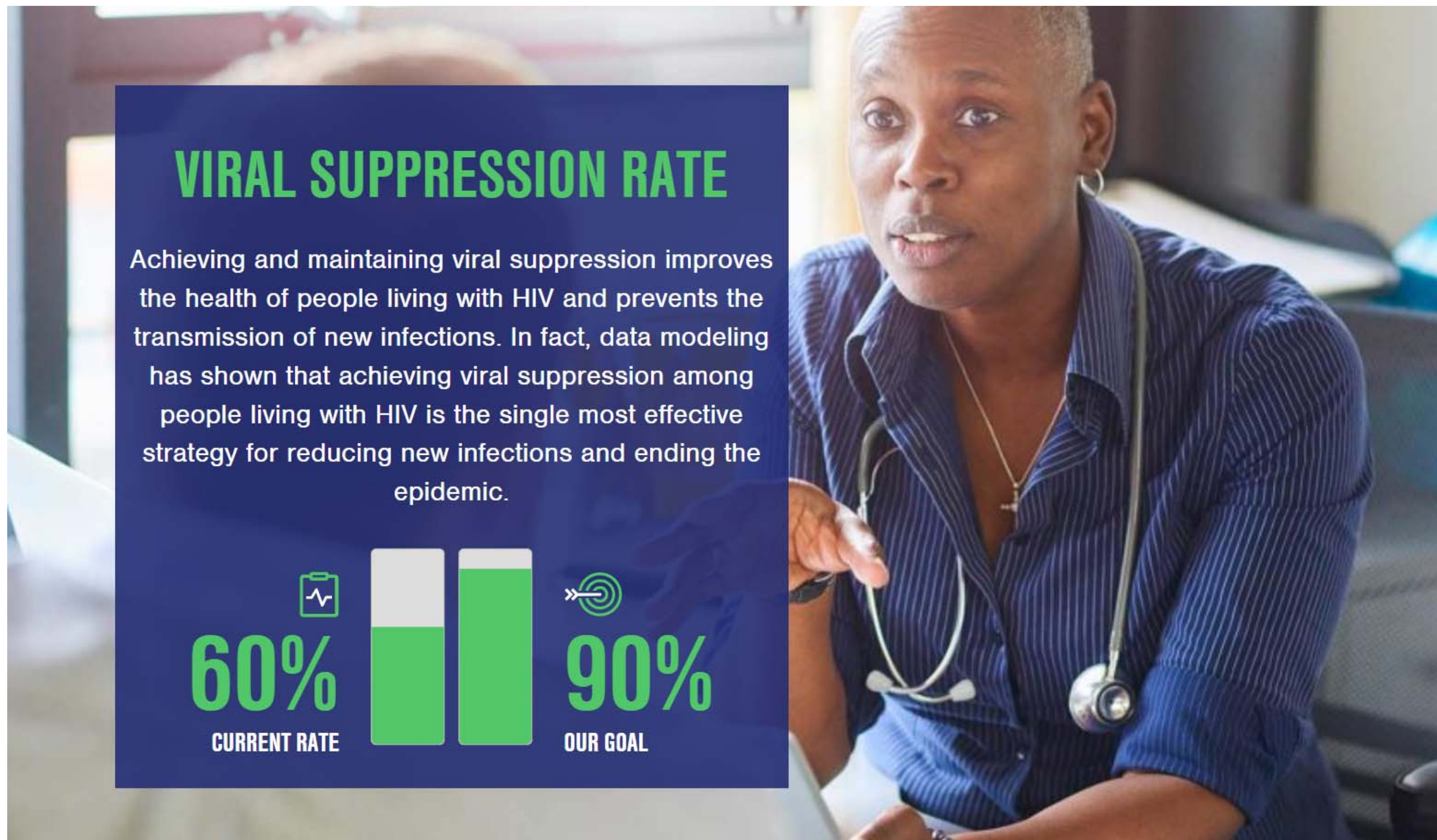
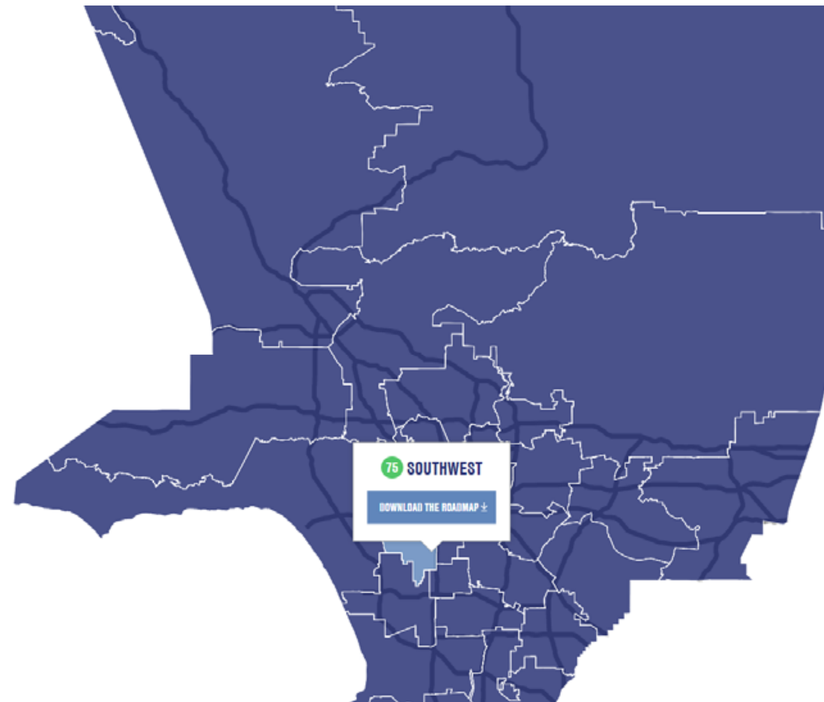
Performance Indicator – Viral Suppression Rate



Strategy Roadmap – Health Districts

You can view the goal for each performance indicator by Health District, allowing for a more tailored approach for your specific community needs.

- 3 Alhambra
- 5 Antelope Valley
- 6 Bellflower
- 9 Central
- 12 Compton
- 16 East LA
- 19 East Valley
- 23 El Monte
- 25 Foothill
- 27 Glendale
- 31 Harbor
- 34 Hollywood
- 37 Inglewood
- 40 Long Beach
- 47 Northeast
- 50 Pasadena
- 54 Pomona
- 58 San Antonio
- 62 San Fernando
- 69 South
- 72 Southeast
- **75 Southwest**
- 79 Torrance
- 84 West
- 86 West Valley
- 91 Whittier



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Strategy Roadmap – Health Districts

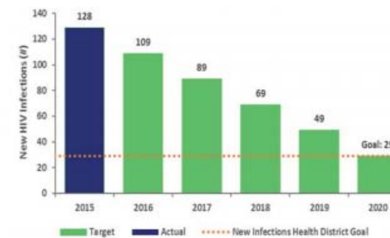
SOUTHWEST HEALTH DISTRICT PROFILE

STRATEGY GOALS

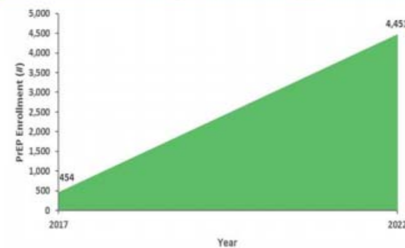
The Los Angeles County Department of Public Health's Division of HIV and STD Programs (DHSP) is undertaking an ambitious strategy to significantly reduce the number of HIV infections in LA County. The goals of the strategy are:

- Reduce annual new HIV infections to 500
- Increase proportion of Persons Living with HIV (PLWH) who are diagnosed to at least 90%
- Increase viral suppression of PLWH to at least 90%

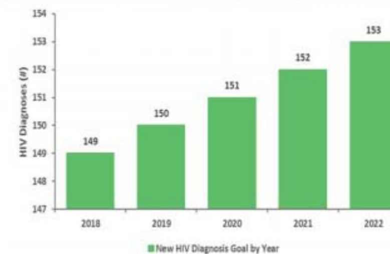
HIV INFECTION REDUCTION GOAL



PrEP ENROLLMENT GOAL



HIV DIAGNOSIS GOAL



HIV VIRAL SUPPRESSION GOAL

KEY FOCUS AREAS

- Increase PrEP enrollment
- Increase targeted HIV testing
- Increase viral suppression rates among males and females
- Increase viral suppression rates among 18-29 and 30-49 year olds
- Increase viral suppression rates among African-American, Latino, American Indian and multi-racial persons

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Strategy Goals - AOM and MCC Services

- **Moving forward, all AOM/MCC providers will be relied upon to help meet the goal of increasing the proportion of diagnosed PLWH who are virally suppressed to 90% by 2022**

Eligibility Requirements

Michael Green, PhD, Chief
Planning, Development and Research

Eligibility Requirements

- HIV+ Diagnosis
- Income level at or below 500% Federal Poverty Level
- Resident of Los Angeles County
- Uninsured or Underinsured

Eligibility Requirements

- Annual Certification
  - Verification documentation required
  - Current or recent proof of income and residency
- 6-Month Recertification
  - Self-Attestation Forms
  - Telephone Attestations
- First 30 - days of Eligibility

Ambulatory Outpatient Medical Services

Becca Cohen, MD, MPH
Clinical Quality Management

Ambulatory Outpatient Medical Services

- Past successes and areas of improvement
- New performance measures
- Expected clinical practice updates
- Participation in the Medical Advisory Committee

Review of AOM YR 27 program successes and areas for improvement

- Onsite Review Process – Conducted in 2018
- Review Period – 1/1/2017 to 12/31/2017
- Sampling Methodology
  - Sample 1 – Included patients who had 2 or more visits with a provider (MD, PA, NP); used for Eligibility, Core & Supplemental Part A measures
  - Sample 2 – Included patients who had 1 or more visits with a provider (MD, NP, PA); used for Supplemental Part B measures

- Total Number of Providers in The Sample – 18 (Including 6 Providers With Multiple Clinical Sites)
- Total Number of Clinics in The Sample – 38

Excellent system-wide performance for the following:

- Screening for Hepatitis B & C, syphilis, and urogenital chlamydia & gonorrhea
- Viral load suppression
- Adherence counseling
- Pneumococcal vaccination
- Documenting HIV status in the medical records
- Obtaining consents & Casewatch release
- Providing information on limits of confidentiality

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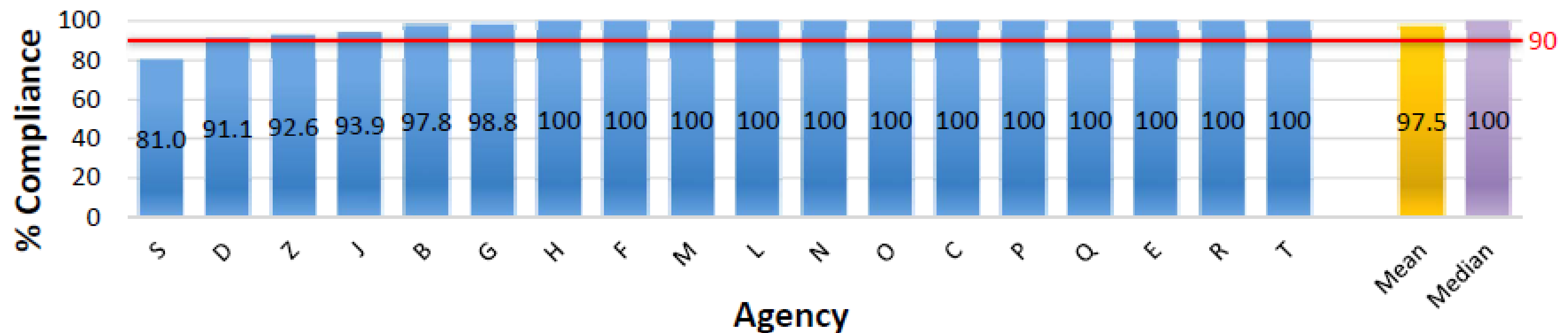
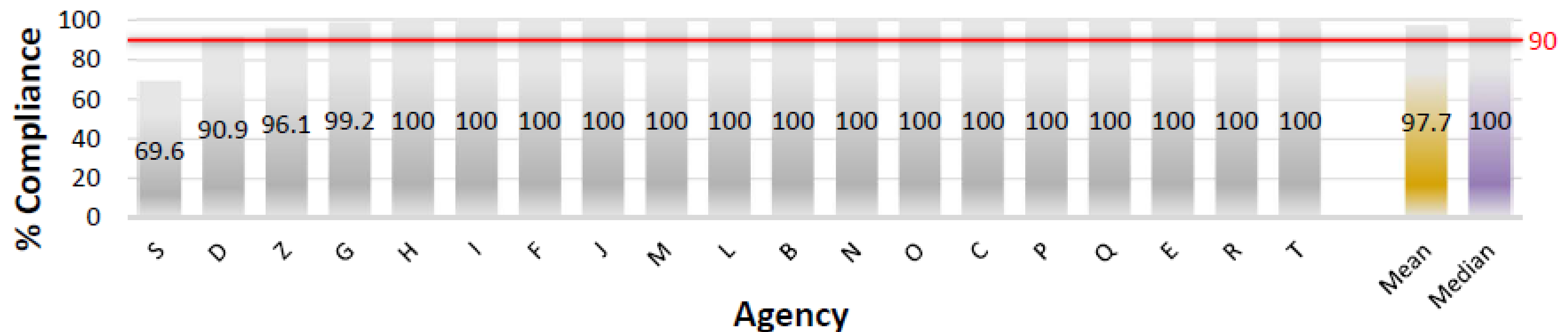
Chlamydia Screen

% of Patients Who Were Screened For Chlamydia at Least Once in The Measurement Year



Source: 2017 AOM Monitoring

Benchmark

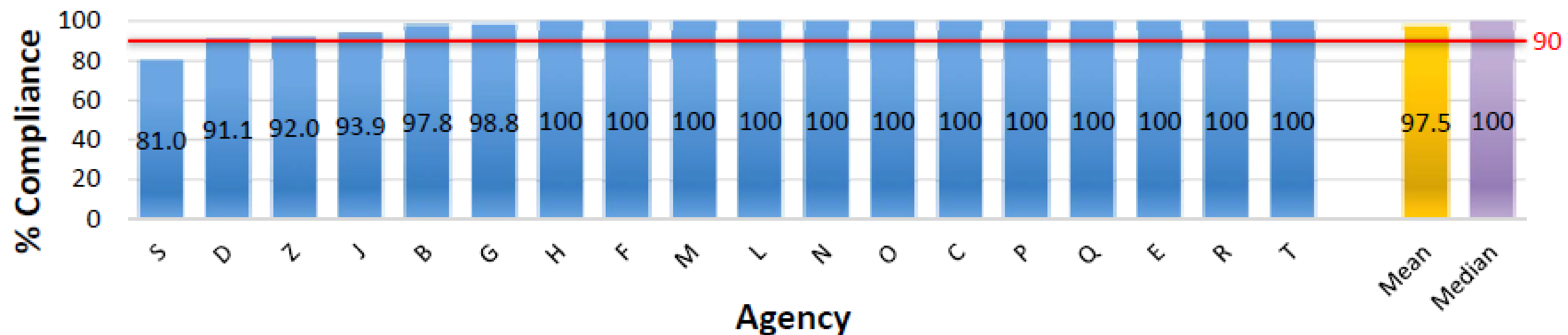


Source: 2016 AOM Monitoring

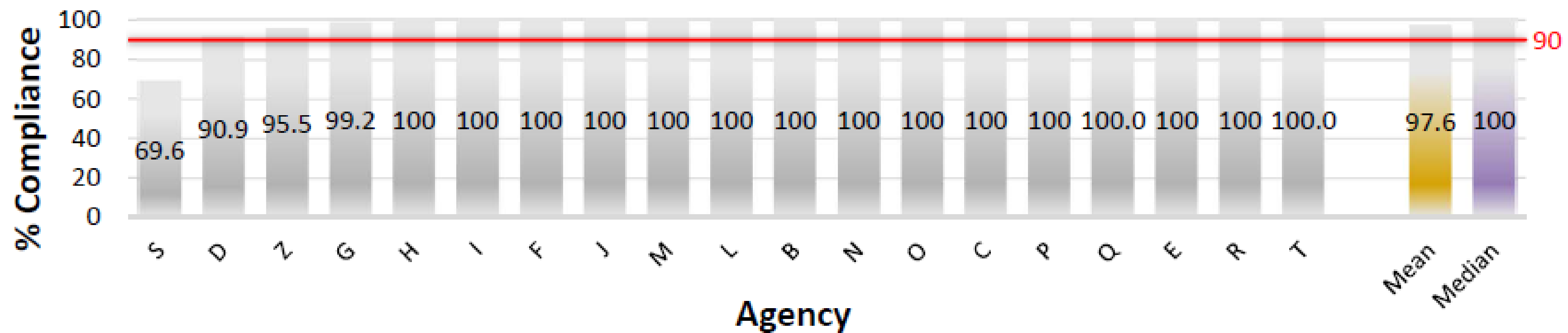
Benchmark

Gonorrhea Screen

% of Adult Patients Who Were Screened For Gonorrhea at Least Once in The Measurement Year



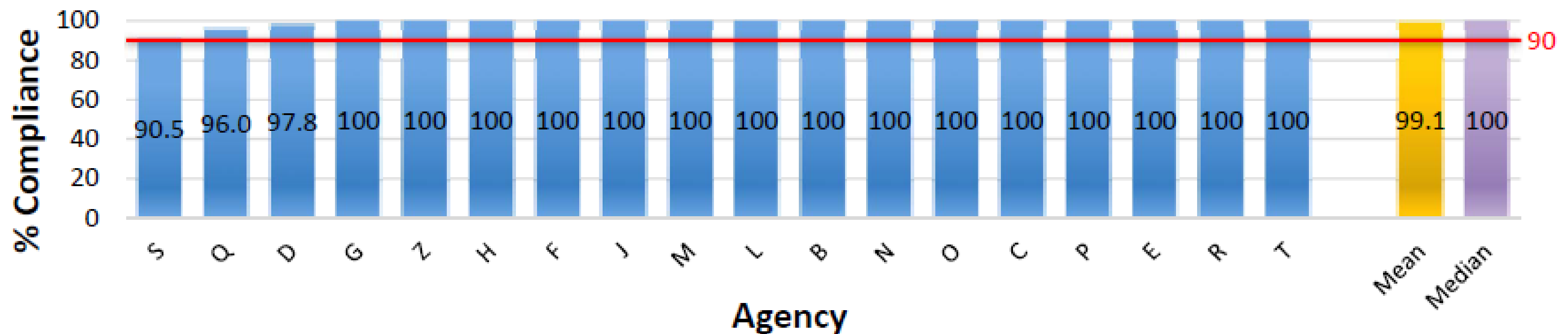
Source: 2017 AOM Monitoring



Source: 2016 AOM Monitoring

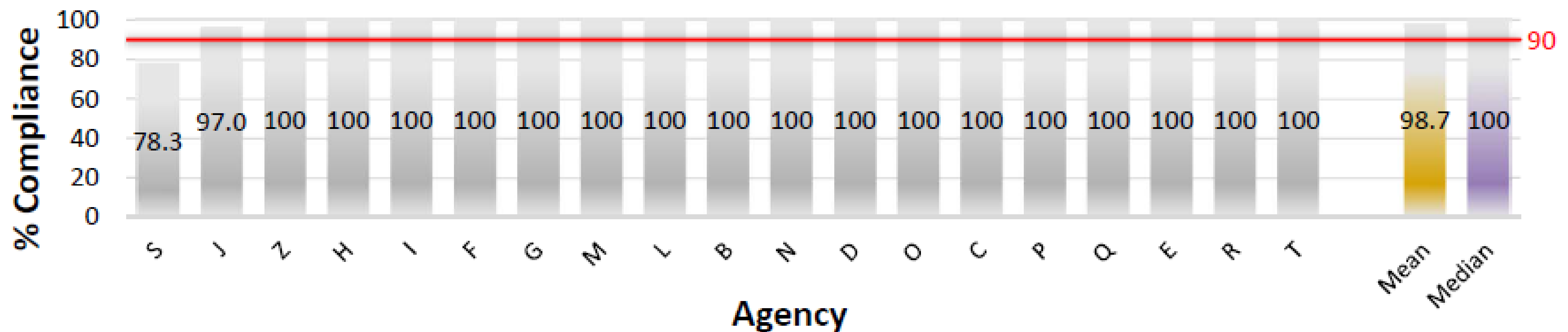
Syphilis Screen

% of Patients Who Were Tested For Syphilis at Least Once in The Measurement Year



Source: 2017 AOM Monitoring

Benchmark

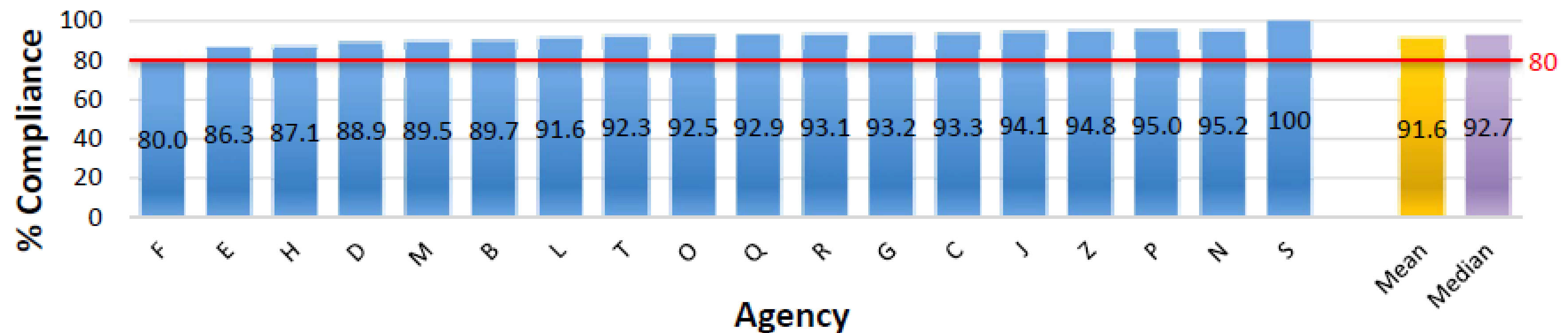


Source: 2016 AOM Monitoring

Benchmark

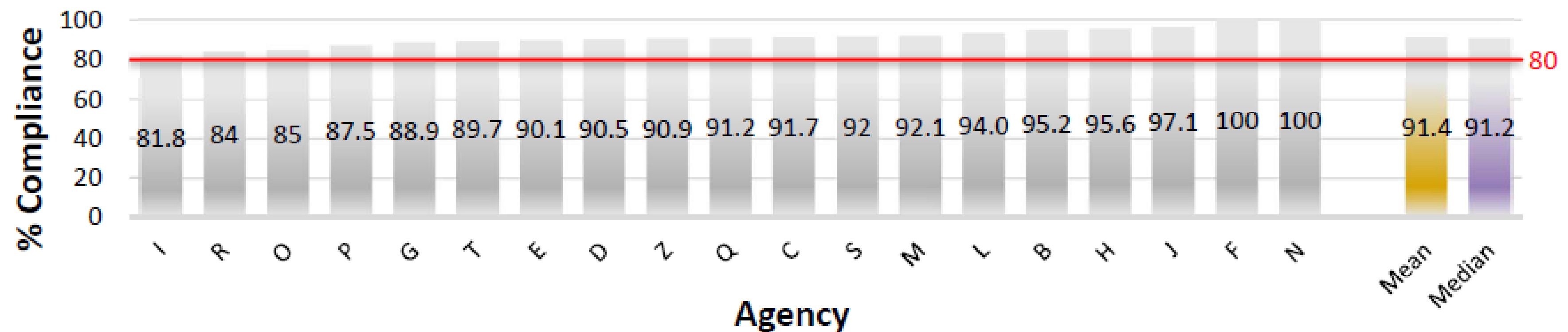
Viral Load Suppression

% of Patients on ARV Therapy (≥ 12 Weeks) Who Were Virally Suppressed (<200 Copies/ml) on Their Last Viral Load Test



Source: 2017 AOM Monitoring

Benchmark



Source: 2016 AOM Monitoring

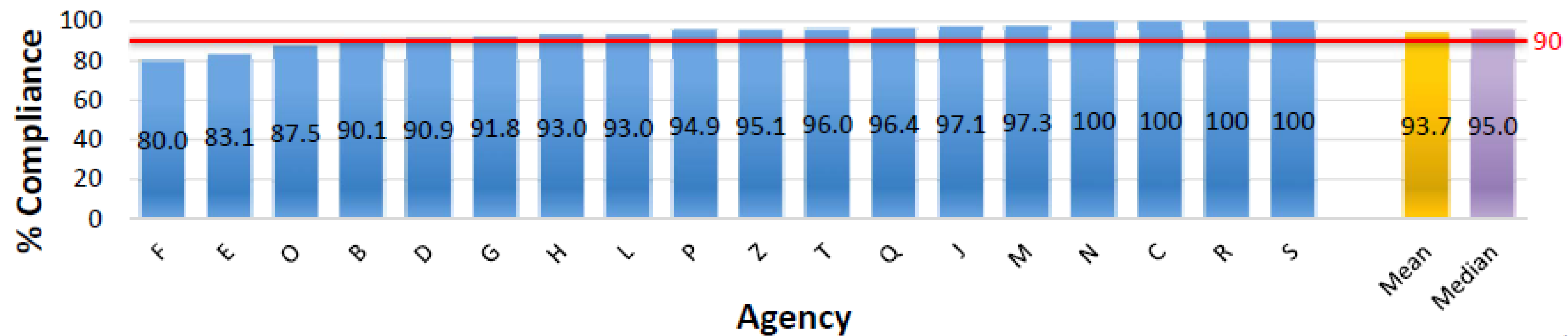
Benchmark

Did well with room for improvement

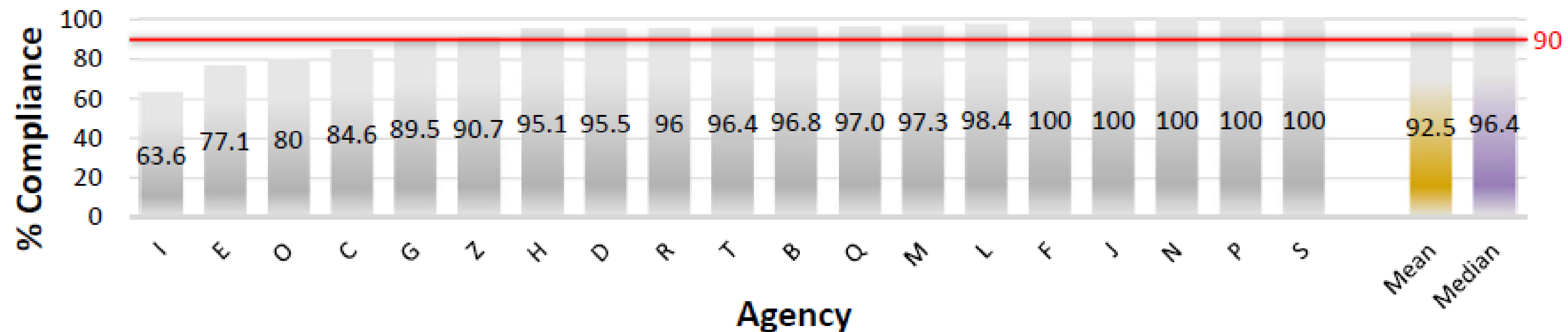
- Medical Visits/Retention in care – 2 or more medical visits at least 3 months apart
- Pharyngeal and rectal GC/CT for males
- Assessment for substance use, mental health
- Referral to oral health
- Patient satisfaction survey
- Screening for LTBI

Medical Visits

% of Patients Who Had a Medical Visit With an HIV Provider 2 or More Times at Least 3 Months Apart in The Measurement Year



Source: 2017 AOM Monitoring



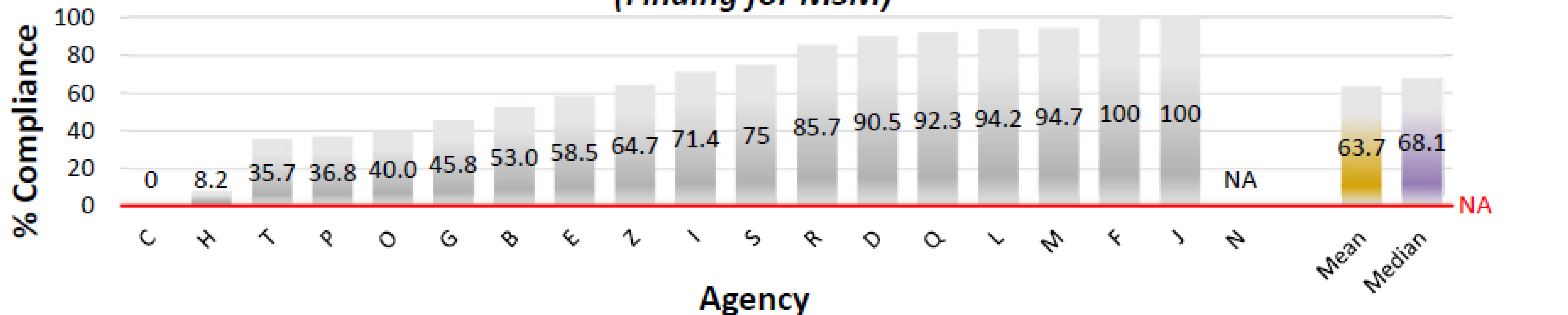
Source: 2016 AOM Monitoring

GC Pharyngeal Screen For All Males

% of Male Patients Who Were Screened for Pharyngeal GC in The Measurement Year

Source: 2017 AOM Monitoring

Benchmark

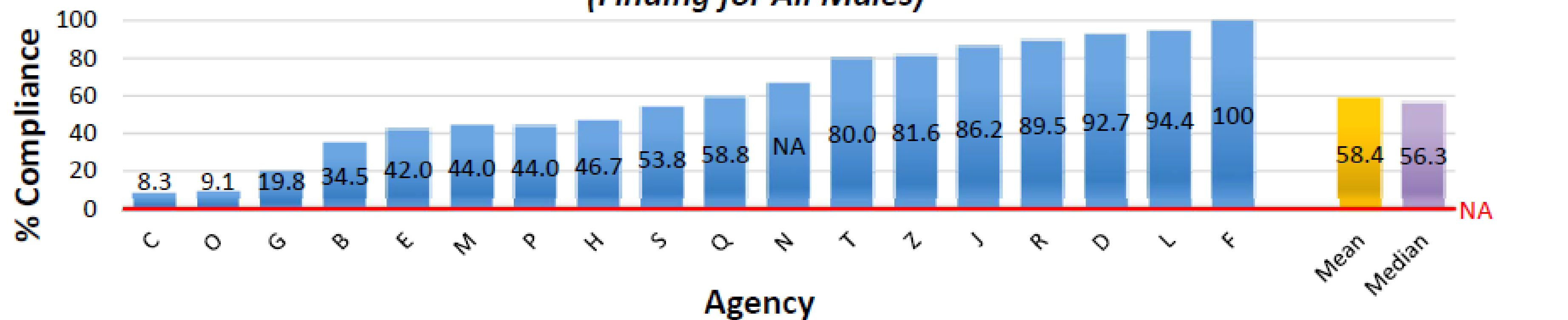


Source: 2016 AOM Monitoring

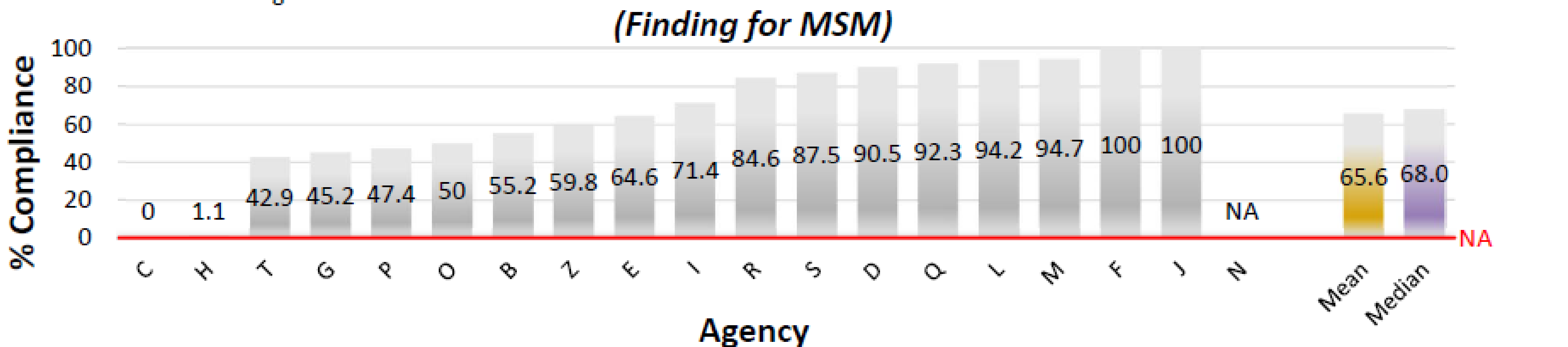
Benchmark

GC/CT Rectal Screen For All Males

% of Male Patients Who Were Screened For Rectal GC/CT in The Measurement Year



Source: 2017 AOM Monitoring



Source: 2016 AOM Monitoring

AOM: Payment Structure & Pay-for-Performance Model

- New contracts build upon success of PFP model with updates to reimbursement rates and performance measures
  - Reduced number of core and supplemental measures
    - Focus on areas for improvement
    - Input from the Medical Advisory Committee
    - 22 → 12
  - Base Rate: $312.40 per patient visit for CY 1-2
  - If core measures are met, additional incentives available based on performance of supplemental measures starting in CY 3
    - New rate in CY 3 could be as high as $375.40 per patient visit

Core Measures

	Core Performance Measures	Performance Threshold		
1.1	HIV Viral Load Suppression – all clients	CY 1-2 80%	CY 3 85%	CY 4-5 90%
1.2	HIV Medical Visits – all clients	80%		

Supplemental Measures

	Supplemental Performance Measures	Performance Threshold	Complexity Score	Additional Incentive
2.1	PCV13 Pneumococcal Vaccination – All Clients	80%	1	$3.00
2.2	MCV4 Meningococcal Vaccination – All Clients	80%	1	$3.00
2.3	Annual Hepatitis C Screening – Males Only	80%	1	$3.00
2.4	Annual Urogenital GC/CT Screening – All Clients	80%	2	$6.00
2.5	Annual Pharyngeal GC Screening – Males Only	80%	2	$6.00
2.6	Annual Rectal GC/CT Screening – Males Only	80%	2	$6.00
2.7	Annual HIV Risk Assessment – All Clients	80%	3	$9.00
2.8	Bi-annual Syphilis Screening – All Clients	80%	3	$9.00
2.9	Annual Substance Use Screening – All Clients	80%	3	$9.00
2.10	Annual Depression Screening – All Clients	80%	3	$9.00

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Expected Practices - Highlights

- Annual HIV Risk Assessment
  - Demonstrate that **EACH** of the following four (4) HIV risk reduction strategies was addressed:
    - Benefit of HIV disclosure to partner(s);
    - Treatment as prevention;
    - Use of condoms;
    - Availability of post and pre-exposure prophylaxis for partner(s).

Expected Practices - Highlights

- Annual Depression Screening
  - Was the client screened for depression using a standardized, validated depression screening tool at least once within the measurement period? (Y/N)
    - Patient Health Questionnaire (PHQ9)
    - Beck Depression Inventory (BDI or BDI-II)
    - Center for Epidemiologic Studies Depression Scale (CES-D)
    - Depression Scale (DEPS)
    - Duke Anxiety-Depression Scale (DADS)
    - Geriatric Depression Scale (SDS)
    - Cornell Scale Screening and PRIME MD-PHQ2

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Expected Practices - Highlights

- Annual Substance Use Screening
  - Demonstrate that the client was assessed for use/misuse of **EACH** of the following substances:
    - Alcohol
    - Illicit drug(s)
    - Tobacco/Tobacco product(s)

- Screening for tuberculosis (TB)
  - After initial screen at entry into care, annual screening is risk assessment with serum/skin testing only when indicated

Expected Practices - Highlights

- Ensure timely linkage to medical provider for new and out of care clients
  - Seen by a medical provider within (2) business days of the request for an appointment
- Rapid initiation of ART for newly diagnosed patients at first visit (even before genotype returns)
- Retention in care
  - Reduce clinic specific factors/policies and client-level barriers that impede retention in HIV medical care.
  - Maintain a broken appointment policy and procedure

Expected Practices - Highlights

- Ensure referral to Oral Health Care Services annually
- Deliver reproductive counseling and ensure that HIV-positive pregnant persons are referred to an HIV Perinatal Specialty Center
- Provide gender affirming care
  - Ensure that clinic environment and staff are inclusive and affirming of all LGBTQ+ people
  - Provide care for gender-health related needs (medications, referrals, etc)

Medical Advisory Committee

- Comprised of the Medical Directors/Lead Physician of HIV programs at each AOM agency
- 3-4 x per year
- Opportunity for program leaders to exchange best practices and to have direct dialogue with DHSP regarding clinical practices, policy and programs

Support for Surveillance Activities

Wendy Garland, Chief Epidemiologist
Planning, Development and Research

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Support for Surveillance Activities

- HIV Case Reporting
- Participation in the Medical Monitoring Project (MMP)

Medical Care Coordination Services

Wendy Garland, Chief Epidemiologist
Planning, Development and Research

Medical Care Coordination Services

- Background of MCC Services
- MCC Program Evaluation
- MCC Enhancements

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Medical Care Coordination (MCC) History

2008-09
COH establishes MCC service standards

2010-11
DHSP Pilots "Blended" CM Model

2010-11
DHSP Pilots "Blended" CM Model

2011-12
DHSP develops MCC Program

Dec. 2012
-MCC added to AOM contracts
-MCC launched

2015
Year 1 evaluation of MCC

2016
-Expansion to non-RWP clinics
-Addition of retention specialist

2019
AOM/MCC integrated solicitation

MCC: Integrated Support Services to Improve Health Outcomes

- MCC integrates medical and non-medical case management services to increase engagement in HIV care and improve health outcomes
  - Delivered by multidisciplinary teams located at a RW funded medical home (RN, Master’s –level social worker, and Retention Outreach Specialist, and a Case Worker)
- The goals of MCC are to:
  - Increase access to care
  - Reduce HIV-related health disparities
- Implemented at 20 agencies representing 35 Ryan White HIV medical homes in LAC

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Approach to MCC

Protocol

- Grounded in COH MCC Standards of Care
- Informed by evidence-based interventions and best practices
- Supports standardized service delivery

Assessment

- Surveyed validated tools to develop
- Measure patients' needs in an objective manner

Acuity

- Identified key questions in assessment related to level of need
- Assigned acuity level responses to those questions
- Guides service intensity and care planning

MCC Implementation

- Service Guidelines
  - Evidence-based and best practices
- Training
  - 4-day programmatic training
- Screening and assessment tools
- Monthly reporting
- Monitoring/TA

GUIDELINES FOR THE PROVISION OF HIV/AIDS MEDICAL CARE COORDINATION SERVICES IN LOS ANGELES COUNTY

Revised September 14, 2017

Los Angeles County Department of Public Health, Division of HIV and STD Programs

Who is being served through MCC?

- Most patients are Latino and African American (75%) and male (85%)
- Majority are aged 40-59 years (45%)
- 60% are living at or below the federal poverty level
- Approximately 12% were homeless in the past six months
- One-third (35%) had a history of incarceration
- 29% percent had symptoms of a depressive disorder, 26% had symptoms of an anxiety disorder, 20% had symptoms of an substance addiction disorder
- Most patients were moderate acuity (53%), followed by high (27%) , self-managed (low, 19%) and severe acuity (1%)

MCC Evaluation - Implementation

- A total of 8,580 patients enrolled from January 2013-Feb 2019
  - Clinic-level screening identifies patients at greatest need for MCC
  - Intensity of service delivery is guided by patient acuity level –higher acuity patients receive more hours
  - The majority of patients identified as needing brief interventions to support engagement in care, ART adherence and risk behavior domains received them

MCC Evaluation – Service Effectiveness

On average, viral suppression improved by 80% in the 12 months after enrollment in MCC

	12 Months Pre-MCC	12 Months Post-MCC
2013 (n=1,300)	34%	71%
2014 (n=1,195)	36%	70%
2015 (n=1,781)	45%	76%
2016 (n=1,576)	47%	76%
2017 (n=1,708)	47%	79%

.Source: Ryan White Program Data (HIV Casewatch 2013-2019), HIV Surveillance Data (eHARS as of April 2019).

MCC Evaluation – Service Effectiveness

On average, retention in care improved by 34% in the 12 months after enrollment in MCC

	12 Months Pre-MCC	12 Months Post-MCC
2013 (n=1,300)	62%	84%
2014 (n=1,195)	59%	81%
2015 (n=1,781)	62%	80%
2016 (n=1,576)	56%	80%
2017 (n=1,708)	54%	70%

Source: Ryan White Program Data (HIV Casewatch 2013-2019), HIV Surveillance Data (eHARS as of April 2019).

Best Practices

- **MCC teams have a critical role to reach the 90% viral suppression goal by continuing to:**
  - Prioritize patients with or at risk of poor health outcomes for MCC
  - Provide patient-centered clinical and support services based on patient acuity
  - Re-engage patients in care who were lost to follow-up from MCC and the clinic
  - Maintain robust communication and conferencing with the patients' medical team and support service providers

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Recommendations

- **In order to reach the the 90% viral suppression, goal improvements are needed to:**
  - Strengthen communication and connection with MCC teams
    - Testing providers
    - Linkage and Re-engagement program
  - Increase retention in care to ensure that these complex patients are receiving needed medical and support services
  - Improve communication between MCC teams and DHSP to understand what is happening "on the ground" to support the implementation of best practices
  - Strategies to ensure consistent monitoring and follow-up to keep patients engaged

Clinical Quality Management Program

Lisa Klein, RN, MSN, CPHQ
Quality Improvement & Privacy Officer

Objectives

- Briefly review HRSA/HAB PCN #15-02
- Discuss the DHSP CQM contract requirements

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Policy Clarification Notice #15-02

- Required by Title XXVI
- Applies to all RWHAP Parts (A – D)
- DHSP required to ensure agency CQM program

Policy Clarification Notice #15-02

- What is a Clinical Quality Management Program?

"The coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction."

Policy Clarification Notice #15-02

- Three components [of a CQM program]
  - – Infrastructure
  - – Performance Measurement
  - – Quality Improvement
- Each has distinct role but all are necessary to meet requirements

Policy Clarification Notice #15-02

- Infrastructure
  - Leadership
  - Committee
  - Dedicated staffing and resources
  - Written plan
  - Consumer and stakeholder involvement
  - Evaluation

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Policy Clarification Notice #15-02

- Performance Measurement
  - STRONGLY encouraged to use HAB & NHAS measures
  - Number of measures varies per service
  - Data collected and analyzed at least quarterly
  - Data used to inform quality improvement activities

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Policy Clarification Notice #15-02

- Quality Improvement
  - Focused on patient care, outcomes or satisfaction
  - Using defined approach / methodology
  - Documented
  - Continuous & ongoing

DHSP CQM CONTRACT REQUIREMENTS

DHSP CQM Contract Language

- Implement CQM program aligned PCN 15-02
  - – Maintain CQM program infrastructure & plan
  - – Collect, analyze & report performance measure data
  - – Involve HIV consumers in QI activities
  - – Assess client perception of care/satisfaction with services
  - – Conduct quality improvement activities
  - – Evaluate effectiveness of CQM program annually

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CQM Program - Plan

- Implement CQM program based on written CQM plan
  - Single, agency-wide plan encompassing all HIV services
  - Submitted to DHSP within 60 days of contract execution and updated as needed
  - Signed by Executive and/or Medical Director

CQM Program – CQM Plan

- Plan shall describe the CQM program's infrastructure including:
  - Goals, objectives
  - CQM committee
  - Selection of a QI approach
  - Performance measures, data collection & analysis
  - Improvement projects and activities based on data
  - Client feedback process (frequency, methods, reporting)

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CQM Program – Performance Measurement

- Collect, analyze & report data to assess:
  - Patient care
  - Health outcomes
  - Patient satisfaction
- Number of measures required varies per PCN 15-02
- Defined sampling and collection methods
- Analyzed at least quarterly and used to inform QI activities

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CQM Program – Quality Improvement

- Routinely conduct QI activities, document & report
- Involve consumers in QI; use feedback to drive improvements
- Evaluate CQM program annually
- Participate in EMA-wide QI initiatives & QI capacity building
- Annual report of CQM activities to DHSP

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CQM Program – Agency CQM Contact

- Identify CQM contact for your agency
  - Serve as point of contact for all CQM related activities
  - Participate in quarterly Regional Quality Group meetings
  - Lead/participate in agency CQM activities

Grievance Management

- Agency responsibilities:
  - Grievance Policy and Procedure
  - Track, trend and report grievance data
  - Post DHSP Grievance Poster in patient areas
  - Grievance procedures acknowledgement (at intake)
- DHSP responsibilities
  - Assist clients in resolving complaints/concerns
  - Report via warmline, email, in person, etc.
  - Goal: resolve within 60 days

Incident Reporting

- Reportable Incident:
  - any unusual/sentinel event threatening the physical/emotional health or safety of client or staff (i.e., suicide, medication error, treatment delay, etc.)
- Written report to licensing AND DHSP
  - Within 1 business day

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Recap

- Maintain CQM program infrastructure and plan
- Collect, analyze and use performance measure data to implement QI activities
- Track client feedback and involve HIV consumers
- Identify CQM contact and report program progress
- Participate in DHSP QI activities and learning opportunities
- Track client complaints & report incidents

CQM Technical Assistance

- Quality Improvement and Program Support unit
  - DPH-QMProgram@ph.lacounty.gov

Lisa Klein, RN, MSN, CPHQ
lklein@ph.lacounty.gov
213-351-8350

Financial Requirements

Dave Young, Chief
Financial Services

Financial Services

- Invoice Instructions
  – AOM Fee For Service
    - Schedule 1: AOM Medical Visits
    - Schedule 2: AOM Other
  – MCC Cost Reimbursement

- Budget Modification Guidelines
  - Timeline Table

Deadlines for the RECEIPT of Budget Modification Requests:

Funding Term	Unrestricted Modification*	Restricted Modification**
January - December	August 31	October 31
March - February	October 31	December 31
April - March	November 30	January 31
July - June	February 28	April 30
September - August	April 30	June 30
October - September	May 31	July 31
Seven - Eleven Months	Last day of the month that is 2 months prior to the end of contract term.	Not Accepted
Six Months or Less	Last day of the month that is 1 month prior to the end of contract term.	Not Accepted

*Unrestricted Modifications

- An unrestricted budget modification allows the Contractor to request to reallocate budgeted monies from line items in one budget category to line items in another budget category within the same budget.
- **Budget Categories** are the major classifications of expenses shown on the Budget Summary page: Salaries, Employee Benefits, Travel, Equipment, Supplies, Other, Consultant/Contractual and Indirect Costs.

**Restricted Modifications

- Restricted budget modifications limit the Contractor's ability to reallocate budgeted monies. In restricted modifications the Contractor **CANNOT** reallocate budget monies across categories and can only request to reallocate to line items WITHIN budget categories.
- **Budget Line Items** are the individual cost items within each budget category. For the Salaries category, for example, budget line items are the individual staff positions to be funded. The "Other" category may include such items as office or facility rent, postage and telephone.

Financial Services

- Cost Reports
- Fiscal Audits

Contract Monitoring

Terina Keresoma, Co-Manager
Contracted Community Services

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Contracted Monitoring

- Program Manager Role
  - First point of contact with DHSP
  - Clarify contract expectations & goals
- Monthly Monitoring
  - Review monthly reports for programmatic updates
  - Review monthly invoices for expenditures
- Annual Monitoring
  - LA County & HRSA requirement
  - Programmatic review

MCC Teams

- Tier 1 Clinics
  - Client census population of 150 clients or more
  - Medical Care Manager, Patient Care Manager, Retention Outreach Specialist (previously called Patient Retention Specialist), and a Case Worker
- Tier 2 Clinics
  - Client census population of 149 clients or fewer
  - Medical Care Manager and a Patient Care Manager

MCC Teams

- Patient Care Manager (PCM)
  - Assesses a client's psychosocial needs, particularly in relation to behavioral health and addiction issues
  - Conducts brief interventions addressing client's barriers
  - Works in conjunction with the MCM
  - Does NOT perform psychotherapy or mental health counseling

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MCC Teams

- Medical Care Manager (MCM)
  - Ensures the client's biomedical needs are met and that their care is coordinated
  - Conducts brief interventions addressing difficulties with medical and/or medication adherence; changes in HIV health status; and other related issues
  - Does NOT perform clinical nursing duties and works in conjunction with the PCM

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MCC Teams

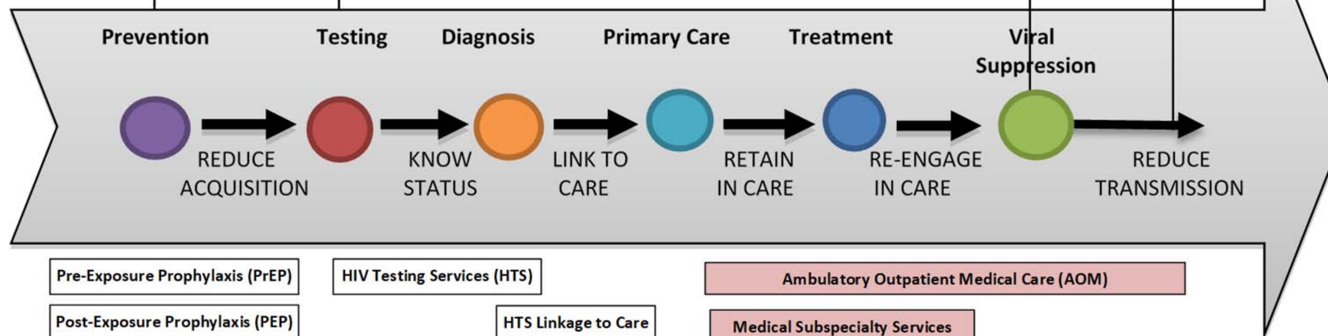
- Retention Outreach Specialist (ROS)
  - Previously called Patient Retention Specialist
  - Conducts field outreach to locate clinic clients that are deemed to be “out of care”
  - Provides mobile services to clients in need

MCC Teams

- Case Worker
  - Assists the MCM and PCM with client monitoring, linkage to services, updating care plan results, following up with clients and tracking outcomes
  - Acts as the liaison between HIV Counseling and Testing sites and the medical clinic to ensure new clients are enrolled into care seamlessly and timely

DHSP Programs and Services

LACHAS 2022 GOALS



Pre-Exposure Prophylaxis (PrEP)

Post-Exposure Prophylaxis (PEP)

Health Education/ Harm Reduction (HE/RR)

HIV Testing Services (HTS)

HTS Linkage to Care

HIV Partner Services

Ambulatory Outpatient Medical Care (AOM)

Medical Subspecialty Services

Oral Health Care

Medical Care Coordination (MCC) (HRSA – Medical CM)

Mental Health: Psychotherapy and Psychiatric

Medical Nutrition Therapy

Home-Based Case Management

Language/ Interpretation Services

Residential Care (includes Transitional Facilities and Facilities for Chronically Ill)

Benefits Specialty

Transitional Case Management (Incarcerated and Youth)

Substance Abuse Residential Services: Residential Detox, Residential Rehabilitation, and Transitional Housing

Medical Transportation

Food/Nutrition Support

Legal Services

Linkage and Re-engagement

Housing Assistance

DHSP SERVICES AND PROGRAMS

= Ryan White Core

=Ryan White Support Services

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Conclusion

- Please ensure that each agency representative has signed in.
- For more information, please visit: http://publichealth.lacounty.gov/dhsp/InfoForContractors.htm

Thank you!