

**PROPOSED LIHP HIV TRANSITION PLAN**  
**February 10, 2012**

***Introduction***

California has proposed a Section 1115 Demonstration amendment to assure that persons with HIV make the transitions of coverage from Ryan White to California's Low Income Health Programs (LIHPs) with continuity of quality care, without loss of either core medical or other critical services, and wherever possible with minimal disruption to critical patient/provider relationships. The proposal would establish a separate HIV Transition Incentive Program within the safety net care pool (SNCP) that is made available for the development of programs of activity that support the LIHP systems' efforts to address the following components of care concerning LIHP enrollees with HIV, particularly those individuals who previously received services under the Ryan White program:

- Continuity of quality care,
- Care coordination, and
- Coverage transition issues.

As a core element of the HIV Transition Incentive Program, participating LIHPs would develop individualized HIV Transition Plans that are specifically designed to strengthen the capabilities of their health care delivery systems to meet the unique health care needs of persons with HIV who are enrolled in the LIHP, with a particular focus on outpatient medical services. These Transition Plans would highlight the infrastructure, programs, and services that each participating LIHP must put in place to ensure that persons with HIV can be cared for in an integrated and coordinated system of care.

The purpose of this document is to provide a preliminary description of the HIV Transition Incentive Program within LIHPs and additional insight into how plans in California could be structured.

***Plan Descriptions***

Under the Demonstration amendment, each LIHP would submit a plan oriented to meet the goals of quality care, care continuity, care coordination and seamless coverage transition. Plans would include appropriate projects with milestones for each Demonstration year for their individual HIV Transition Plan. Milestones could help to build physical and IT infrastructure, promote innovation in the way care is delivered and improve the quality of care delivered across broad populations. Based on the progress made toward achieving the milestones, LIHPs would receive HIV Transition Incentive Program payments associated with that particular metric. Because each LIHP has distinct local needs and resources, plans would vary from program to program and identified milestones would likely differ.

Each plan would include projects and milestones for the following categories:

1. **Improvements in infrastructure and program design:** Each plan would include projects and milestones that are able to improve how care is delivered to HIV patients.
2. **Improvements in clinical and operational outcomes:** Each plan would also include projects and milestones that measure HIV patients' health and health care.

Additionally, each plan would include milestones related to **shared learning**, such as participating in learning collaboratives/initiatives, training and education, and identifying and communicating best practices so that effective interventions and models can be more rapidly and broadly disseminated.

Below is a description of these categories and examples of projects and associated milestones that may be selected within each category. These sample projects and milestones are not meant to be adopted by every County, but rather the example milestones serve to demonstrate a comprehensive array of potential improvement activities and metrics through which progress can be measured. In designing their HIV Transition Plans, Counties may select from the milestones included here or may propose other similar milestones that accomplish the aims of the HIV Transition Plan and are better suited to meet the particular needs of the individual County. However, it is important to note that the overall undergirding of the projects (i.e., the models and constructs) would be similar across the Counties in that each County's plan must include both categories as well as shared learning.

Each County's individualized plan would be subject to approval by CMS and DHCS. Incentive funding would be allocated to each project and its associated milestone. Together, these plans, and the important transition work they describe, would better promote a seamless and continuous transition of coverage and care coordination for patients with HIV.

### ***Category 1: Infrastructure & Program Design***

This category is foundational to the success of Category 2: the infrastructure and programmatic efforts proposed below will enhance the ability of County LIHPs to provide care within patient-centered medical homes, an essential building block to ensuring delivery of high-quality medical care for patients with HIV. Sample projects detailed here include:

1. Empanel patients into medical homes with HIV expertise
2. Implement an ambulatory Electronic Health Record
3. Roll-out a Disease Management Registry module suitable for managing patients with HIV
4. Build clinical decision support tools to allow for more effective management of patients with HIV
5. Develop Retention Programs for patients with HIV who inconsistently access care
6. Enhance data sharing between LIHP providers and County Departments of Public Health (DPH) to allow for systematic monitoring of quality of care, disease progression, and patient and population level health outcomes

Further detail and milestones of each of these proposed **Infrastructure and Program Design** projects is provided below.

Empanel patients into medical homes with HIV expertise: Empanelment into medical homes specifically equipped to care for patients with HIV is a critical component of care provision for this population. Panel management by care teams enables medical homes to conduct population-based management of chronic conditions that affect individuals with HIV. To adequately prepare for implementation of medical homes able to care for HIV patients, clinics must determine the optimal staffing model for provision of multi-disciplinary team-based care, including care management services, to optimize access, retention, and treatment adherence and improve health outcomes and self-management. Counties must also develop panel weighting / patient risk-adjustment methodologies for building patient panels. For example, patients may be weighted according to consideration of factors such as: 1) prior utilization patterns of HIV care services; 2) prior history of difficulty in adhering to treatment plans; 3) time since HIV diagnosis; and 4) persistently poor health status. *Specific milestones* related to this project include:

- Select/develop optimal staffing model(s) for use in medical homes that care for patients with HIV
- Define the roles and responsibilities of team members
- Implement a staffing model appropriate for LIHP patients empaneled in a medical home with HIV expertise, including pharmacy and medication adherence services for patients with advanced disease and co-morbidities
- Develop patient weighting/ risk-adjustment algorithms for assigning patients with HIV to medical homes
- Empanel patients into medical homes

Implement an ambulatory Electronic Health Record: Ambulatory Electronic Health Records (EHR) provide medical home teams with the critical information needed to promote health and improve patient outcomes. EHRs should be contiguous or seamlessly interface with hospital-based EHRs / clinical repositories to facilitate information sharing across the care continuum. *Specific milestones* related to this project include:

- Assess and supplement, as needed, IT staffing and equipment inventory, including workstations, printers, internet capability, etc.
- Standardize/refine workflow processes prior to EHR roll-out
- Train staff on necessary skills for using an EHR
- Roll out EHR to medical homes

Roll-out a Disease Management Registry module suitable for managing patients with HIV: Disease Management Registries (DMR) are able to track clinical quality and health outcomes for patients empaneled in medical homes. Many DMRs have optional HIV modules. These specialized clinical modules will allow HIV providers to effectively monitor and deliver key aspects of HIV care that are known to be associated with improved health outcomes among HIV-positive populations. HIV modules can be configured with the ability to track clinical performance measures that allow the HIV provider team to identify and focus intensive clinical

services and interventions on those patients who are not meeting treatment goals. *Specific milestones* related to this project include:

- Identify/develop HIV DMR module
- Pilot use of HIV DMR module in clinics
- Roll-out HIV DMR module in all clinics that serve as a medical home for HIV-positive patients
- Document ongoing evaluation of clinical performance measures and use of data for performance improvement activities

Build clinical decision support tools to allow for more effective management of patients with HIV: Clinical decision support tools allow clinicians to better manage HIV patient panels through the use of disease-specific rules and queries that allow providers to identify patients in the medical home who are not meeting a prioritized set of HIV care goals consistent with national treatment guidelines and standards of care. Rules will allow providers and the care team to identify patients who, for example, (1) are out of care or inconsistently/sub-optimally accessing care, (2) qualify for antiretroviral therapy (ART) but are not receiving it, (3) are on ART but not achieving viral suppression and full benefit of therapy, and (4) are in need of screening or treatment for other co-morbidities or preventive health services. After relevant patient populations are identified, specific tools will help guide the patient toward proper diagnostic or therapeutic decisions. Tools may be built into the DMR to facilitate appointment planning, reminders, and outreach services or care coordination. The use of these tools will result in achieving more timely, patient-responsive, and efficient delivery of care to empaneled HIV patients. *Specific Milestones* related to this project include:

- Define full set of clinical decision support tools that will be available
- Deploy Information Technology (IT) programming and resources to develop clinical decision support tools
- Pilot, refine, and fully implement clinical decision support tools within medical homes that care for patients with HIV
- Establish protocols and procedures for tracking use of clinical decision support tools and evaluating impact on disease management, service provision, and clinical health outcomes

Develop Retention Programs for patients with HIV who inconsistently access care: Patients with HIV must regularly access and engage with their medical homes in order to enjoy optimal health outcomes. Failure to engage in consistent HIV care is a significant challenge for many Counties and is associated with suboptimal adherence to ART, virologic treatment failure, increased rate of community viral resistance, increased secondary HIV transmission, and poorer survival rates. To address the need to successfully re-engage patients lost to HIV care and improve subsequent retention in consistent HIV care, Counties may implement clinic-based Retention Programs. Patients identified as being out of regular medical care will be referred to the Program which will utilize investigative techniques to locate lost-to-care patients and offer them client-centered interventions to improve their linkage and retention in HIV medical care. *Specific Milestones* related to this project include:

- Define criteria for enrolling patients in Retention Program
- Identify staffing models for implementation of Retention Program
- Implement Retention Program in medical homes for patients with HIV
- Track effectiveness of Retention Program along pre-defined outcome metrics

Enhance data sharing between LIHP providers and the County Departments of Public Health (DPH):

Improved health information exchange will allow for more systematic monitoring of quality of care, disease progression, and patient and population level health outcomes among HIV cohorts. This includes developing an electronic data interface (EDI) between the LIHP and DPH data systems in order to facilitate collection of standardized performance measures and key utilization and health outcome data (e.g., HIV viral load, CD4 cell counts) across the population of individuals living with HIV in each County. As HIV patients transition from Ryan White to the LIHP and ultimately to Medicaid in 2014 under the ACA, robust data sharing and exchange are critical to ensuring that access and high-quality care remains uninterrupted and that all patients, regardless of payer, are cared for according to the same high standards and goals of care. Improved data sharing will also enhance Counties' efforts to track and improve population health, reduce morbidity and mortality, and reduce forward transmission in order to stem the local HIV epidemic. *Specific Milestones* related to this project include:

- Identify and map domains for data exchange
- Develop and implement Electronic Data Interface
- Establish protocols and procedures for ongoing monitoring and use of data to improve quality of care and population health

**Category 2: Clinical and Operational Outcomes**

The milestones outlined below will drive County LIHPs to select and commit to achieving discrete patient outcomes across several clinical domains. In doing so, CMS can ensure that Counties are making concrete gains in patient quality and operational effectiveness.

Milestones will be considered across six projects:

1. Access to Care
2. Health Screening – Identify Treatment/Service needs
3. Preventive Health Measures
4. HIV-Specific Clinical Outcomes
5. Care Management
6. Client Satisfaction

Sample milestones for each of these proposed **Clinical and Operational Outcomes** projects are provided below.

Access to Care

- xx% of clients who have not seen an HIV provider in the prior 6 months will receive outreach to re-engage in care
- xx% of clients who have had at least 2 HIV primary medical care visits in the prior 12 months, at least 3 months apart

- % of clients diagnosed with HIV in the prior 12 months who are linked to HIV medical care within 3 months of diagnosis

#### Health Screening – Identify Treatment/Service needs

- xx% of clients screened for an active psychiatric illness in the prior 12 months
- xx% of clients screened for active substance abuse and dependency problems using outpatient substance use indicators in the prior 12 months
- xx% of clients are pre-screened for barriers to treatment adherence in the prior 12 months
- xx% of clients who are at risk for syphilis based on clinical indication have had a serologic test performed at least once in the prior 12 months
- xx% of female clients who were tested for cervical cancer at least once in the prior 12 months
- xx% of clients who were tested for Hepatitis C at least once upon entering care, and every 12 months if at ongoing risk
- xx% of clients have been screened for Hepatitis B at least once since entering care
- xx% of clients who had lipid testing performed at least once in the prior 12 months when on ART
- xx% of clients who were tested for tuberculosis based on clinical indication at least once in the prior 12 months
- xx% of clients who were tested for chlamydia based on clinical indication at least once in the prior 12 months
- xx% of clients who were tested for gonorrhea based on clinical indication at least once in the prior 12 months
- xx% of clients using tobacco who have received tobacco cessation counseling at least once in the prior 12 months

#### Preventive Health Measures

- xx% of clients with CD4 T-cell count < 200 cells/mm<sup>3</sup> who were prescribed PCP prophylaxis
- xx% of patients with CD4+count below 50 cells/mm<sup>3</sup> who were prescribed MAC prophylaxis
- xx% of clients who are not immune to or chronically infected with Hepatitis B who have received the Hepatitis B vaccination series
- xx% of clients who have received the Hepatitis A vaccination series
- xx% of clients who have received the pneumococcal vaccination series within the last five years
- xx% of clients who have received the influenza vaccination in the prior 12 months
- xx% of clients who are sexually active and received risk reduction assessment and if appropriate risk reduction counseling at least once in the prior 12 months

#### HIV-Specific Clinical Outcomes

- xx% of clients who had two or more viral load tests performed at least three months apart in the prior 12 months
- xx% clients with unsuppressed viral load who are on ART that receive at least one treatment adherence intervention in the prior 12 months
- xx% of pregnant clients who are on ART
- xx% of HIV-infected patients who had two or more CD4 T-cell counts performed at least three months apart in the prior 12 months
- xx% of HIV-infected patients with CD4 T-cell counts <500 cells/mm<sup>3</sup> or an AIDS-defining condition who were prescribed an ART regimen in the prior 12 months
- xx% of clients taking HIV medications will have a suppressed viral load 6 months after enrollment (or if not on treatment at the time of enrollment, 6 months after initiation of treatment)

#### Care Management (CM)

- xx% of clients identified as in need of CM services who engage in and receive these services to assist with treatment adherence
- xx% clients who remain engaged in primary medical care while receiving CM services
- xx% of clients actively enrolled in CM who had a medical visit at least every 4 months in the prior 12 months
- xx% of clients receiving CM who had an assessment documented and updated once every 6 months in the prior 12 months

#### Client Satisfaction

- xx% of clients receive a patient satisfaction survey in their medical home once every 12 months
- xx% clients who report satisfaction with care provided

#### ***Required Plan Elements***

Each LIHP would include projects, and associated milestones, from both categories for each demonstration year. The projects and milestones may come from the set of examples provided above, or Counties may propose other similar projects and milestones that are better suited to their resources and needs. For each specific milestone, Counties would specify the metrics to be used to measure progress in each demonstration year in table format. While milestones may apply to more than one demonstration year, Counties must uniquely specify the particular progressive improvement (and metric) for that year.

Each Transition Plan should include milestones that promote shared learning. These may include the following actions by Counties:

- Participate in a collaborative
- Share learnings from implementing process improvements, e.g., through presentations and reporting

- Share data, promising practices, and/or findings with peer groups and/or a quality improvement entity to foster shared learning and/or to conduct benchmarking activities

Participating LIHPs would submit an explanation and rationale for their HIV Transition Plan that includes the following:

- Specific challenge(s) the Plan is seeking to address
- Solution(s) identified to address the challenge(s), including an explanation of how the project would work to fill the gap/need or solve the issue
- Starting point for each County related to the project, such as a benchmark or baseline, if one exists
- Overall goal and the significance of that goal to the HIV patients and the LIHP; this would include reasons for selecting the milestones, metrics, improvements and targeted goals based on relevancy to the HIV population and circumstances, community need and priority and LIHP starting point
- Expected results of the plan and how those align with the Plan's goals