



LOS ANGELES COUNTY COMMISSION ON HIV

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STANDARDS AND BEST PRACTICES (SBP) COMMITTEE MEETING MINUTES February 19, 2015

Approved
3/19/2015

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Grissel Granados, MSW, <i>Co-Chair</i>	Suzette Flynn	None	Dawn McClendon
Fariba Younai, DDS, <i>Co-Chair</i>	David Giugni		Jane Nachazel
Raquel Cataldo	Kimler Gutierrez (<i>pending</i>)		
Kevin Donnelly	Mitchell Kushner, MD, MPH		
Dahlia Ferlito (<i>pending</i>)	Patsy Lawson		DHSP STAFF
Terry Goddard, MA	Angélica Palmeros, MSW		None
	Carlos Vega-Matos, MPA		

CONTENTS OF COMMITTEE PACKET

- 1) **Agenda:** Standards and Best Practices (SBP) Committee Agenda, 2/19/2015
- 2) **Minutes:** Standards and Best Practices (SBP) Committee Meeting Minutes, 1/15/2015
- 3) **Report:** SBP Work Group Report On "Client Choice" and "Health Outcomes," 2/19/2015
- 4) **Table:** Standards and Best Practices (SBP) Committee, 2014
- 5) **PowerPoint:** Medical Care Coordination Implementation Update, 1/27/2015
- 6) **PowerPoint:** Update on the Implementation of Ambulatory Outpatient, 1/27/2015

1. **CALL TO ORDER:** Dr. Younai called the meeting to order at 10:10 am.
2. **APPROVAL OF AGENDA:** Quorum was not achieved.
MOTION #1: Approve the Agenda Order, as presented or revised (**Postponed**).
3. **APPROVAL OF MEETING MINUTES:** Quorum was not achieved.
Motion 2: Approve minutes from the 1/15/2015 Standards and Best Practices (SBP) Committee meetings, as presented or revised (**Postponed**).
4. **PUBLIC COMMENT, (Non-Agendized or Follow-Up):** There were no comments.
5. **COMMITTEE COMMENT, (Non-Agendized or Follow-Up):** There were no comments.
6. **CO-CHAIRS' REPORT:** There was no report.
7. **STANDARDS OF CARE (SOC) WORK SCHEDULE:**
 - A. **SOC Work Activities:**
 - Dr. Younai presented the Work Plan for final review/revision. Aggregate Continuous Quality Improvement (CQI) data review is an ongoing responsibility, but has not been done recently. A service category should be selected for CQI data review. DHSP, the then OAPP, previously presented CQI data on a quarterly report form, but reports were intermittent.
 - She proposed Medical Care Coordination (MCC) as the first CQI review priority. MCC was meant to integrate Medical and Psychosocial Case Management, but reports indicate the latter aspect is being lost and services are unavailable to all in need. The multidisciplinary MCC Team was designed to ensure clients were accurately evaluated and served.

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- Ms. Nachazel noted DHSP presented on MCC to the Planning, Priorities and Allocations (PP&A) Committee. DHSP reported only two years of data are available due to newness of the service. Three years of data are considered necessary for reliability so DHSP considers MCC data preliminary.
- Mr. Goddard supported an in-depth MCC review. MCC appears to be primarily based on a Medical Case Management model. For example, the Commission received HUD funding for a SPNS grant for planning and demonstration projects to bring into care PLWH who were out of care and unstably housed or homeless. One element was to immediately assign clients to an MCC Team for comprehensive Psychosocial Case Management.
- Glenda Pinney wrote the proposal six months prior to MCC implementation, but participated in the then Standards of Care Committee and contributed to MCC standard development. Nevertheless, the SPNS client to staff ratio exploded from approximately 50 to 1 to 400 to 1. Resources were insufficient and many clients were assessed self-managed.
- Ms. Cataldo said her nurse and social worker report many patients are deemed ineligible because the acuity level is not assessed subjectively but, instead, generated by Casewatch from a 30-page psychosocial assessment.
- Dr. Younai said the standard defined acuity levels. Only patients with absolutely no need were assessed self-managed, i.e., patients successfully engaged in medical care, with housing and other such needs met and no psychological issues. Even they were to receive a social worker check-in periodically by phone and all others were to receive MCC services.
- There was general agreement screening and assessment/acuity determination were not working as intended.
- Currently, screenings for referral to the MCC Team for assessment/acuity determination may be done at various patient flow points, e.g., at intake or during a Primary Care Provider (PCP) appointment. Patients are referred if they: were diagnosed in past six months; had no HIV medical appointment in past seven months; are not on ART despite meeting clinical treatment guidelines; are on ART, but have Viral Load greater than 200 copies/mL or are referred by their PCP. There were 8,947 patients screened from January 2013 to June 2014 with 39% referred for active MCC.
- Dr. Younai recalled the original standard provided for a brief, initial screening leading to assessment as needed. She felt 61% of screened patients classified as not in need of active MCC very high. The process should be reviewed.
- Mr. Goddard urged MCC standard review to assess the need for revision to meet current circumstances, e.g., impact of ACA implementation and/or resource issues. Client to staff ratios seem high indicating DHSP may be overwhelmed by current client need. Internal agency communication has also been an issue, especially at larger agencies, with lower level staff unaware their agencies were MCC sites. Ms. Nachazel noted DHSP reported not all MCC Teams had been rolled out at the start of the reporting period, but had since been established.
- Ms. Ferlito said Linkage To Care (LTC) staff originally thought patients could be referred directly to MCC, but DHSP said patients should be referred to the care site which will screen them for MCC Team referral. Screening standards may differ depending on an agency's funding, e.g., an agency directly funded by CDC may have a different screening standard from one funded by DHSP. That has led to considerable confusion about screening and what MCC is.
- There will be a TLC+ Roundtable 3/13/2015, 10:00 am to 4:00 pm, at St. Anne's Maternity Home. DHSP was invited to present, but declined. Another presenter has been invited. The group has been meeting for some two years.
- Dr. Younai said SBP will need to re-group standards as existing ones are finalized and released. LTC will house many of the services reflected in the earlier set so it is important to be informed, e.g., in developing Expert Review Panels.
- A final review of current standards includes cutting boilerplate from individual standards and placing one copy at the front of the set. A list of Committee participants will be added to each standard. They can then be published online.
- After that, SBP needs to re-categorize standards in light of prevention integration. Mr. Goddard felt strategic planning should have been done when the Commission first integrated and would benefit this work now, e.g., perhaps SBP might benefit from a Prevention Subcommittee to ensure prevention is not lost in the discussion.
- Ms. McClendon reported the Comprehensive HIV Planning Task Force just submitted its report to the Executive Committee. One of its recommendations is a Commission capacity assessment utilizing an outside consultant.
- Mr. Goddard noted the Commission is applying to HRSA for approval to waive the requirement to use a minimum 75% of funding for core medical services if needed in light of continuing migration from Ryan White (RW) to other payer sources since ACA implementation. RW is funding of last resort. Financial screening assesses client eligibility for other insurers. Most remaining RW patients will be undocumented individuals or those pending enrollment elsewhere.
- RW can pay for wrap-around services, i.e., a patient may be enrolled in another payer source for medical care which does not cover other needed services. Such services will become an increasingly major part of RW so he felt it would be valuable to review who funds various services in order to judiciously strengthen wrap-around service provision.
- Dr. Younai questioned whether standards needed to be fundamentally different when services are offered as wrap-around rather than as part of full RW. Mr. Goddard agreed in principal, but noted mental health issues are becoming a

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much more prominent so may need to be a larger standard component. Most housing contracts now require long-term psychosocial case management, but RW funding has dried up and services such as harm reduction are not addressed.

- Dr. Younai noted SBP can make minor revisions, but major revisions require the full process of approximately five months for Expert Review Panel(s), writing, SBP review and 30 days public comment prior to Commission approval. Availability was unknown for Phil Meyer, prior writer; Kathleen Clannon, prior facilitator, or Lise Ransdell.
- DHSP contracts are based on the standards. DHSP normatively provides an RFP schedule to use in prioritizing revision of existing or creation of new standards. An SBP calendar is then developed to address the standards with two or three at various process stages at any given time. Special Population Guidelines follow the same basic process.
- Ms. Ferlito questioned if everything on the Work Plan was useful. Dr. Younai replied, e.g., the Continuum of HIV Services developed by SBP was valuable for long-term planning. It can be cumbersome as a whole so need not be discussed overall, but discrete aspects can be used for planning purposes, as needed.
- Dr. Younai suggested a work group to develop a strategy to publicize the current set of standards once finalized. A one page overview for consumers is done, but a separate provider document was needed.
- Mr. Goddard felt it too early for a dissemination strategy. Provider input on Home for Good, Standards of Excellence showed cost-saving was their priority. That differs from the Commission's priority so it may be better now to publish the standards and request health plan feedback. In terms of SBP resources, strategy work may not be essential now.
- It is in everyone's best interests for health plans to adopt good standards. To accomplish that, SBP needs to take resources into consideration. That would be a fundamental shift in standards development requiring significant work. Health plans want to save/make money so standards should ensure needed services at an acceptable cost.
- Dr. Younai replied HIV services are coming to be seen as specialty care so quality should be defined. It could be argued quality care averts costs by improving health outcomes. Mr. Goddard noted, conversely, positioning quality HIV care as specialty care could backfire if health plans charge a premium for it as Kaiser recently did for HIV medications.
- Ms. Cataldo noted Hepatitis C medications are already available only as part of a treatment plan by a GI or Infectious Disease physician specialist. Mr. Donnelly added his RN Practitioner cannot prescribe some of his required medications.
- Dr. Younai said this long-range planning discussion pertains to broader strategy on how to ensure quality care for those unable to afford, e.g., higher co-payments. SBP can frame such issues for referral to the Executive Committee as part of the strategic planning discussion related to the Commission's charge as advisor to the Board on HIV-related matters.
- Meanwhile, Mr. Goddard urged a laser focus on identified work even with as simple a tool as identifying a prioritized list of projects. Ms. Ferlito appreciated this full SBP involvement in rebuilding the work plan.
- Dr. Younai noted SBP authorized the Patient Choice Work Group to develop a report to the Executive Committee on the patient choice aspect of the City of Long Beach issue. A literature search revealed very little evidence that providing greater choice in itself improves efficiency or quality of care. Health-Related Quality of Life studies among PLWH used scientifically proven measures, e.g., satisfaction data, in qualitative assessments of health care services. The Work Group recommended use of such metrics rather than the hard to define or measure patient/client choice.
- ➡ Request DHSP revise MCC PowerPoint for CQI review with expanded information on assessment including the screening tool, assessment form and how acuity levels are defined.
- ➡ Ms. Ferlito will report back on highlights of the 3/13/2015 TLC+ Roundtable.
- ➡ All standards in the existing set will undergo a final review with Dr. Fariba Younai reviewing Oral Health and Michael Johnson reviewing Ambulatory Outpatient Medical. Boilerplate sections will be pulled from each standard and placed at the start of the set. A single list of everyone who participated in the Committee during standards development, with Committee Co-Chairs noted, will be placed at the end of each standard to recognize their contributions.
- ➡ Mr. Vega-Matos will provide an updated RFP schedule and information on what payer sources fund which services to inform SBP in prioritizing standards for revision or development.
- ➡ Dawn McClendon will email the PowerPoint developed by Craig Vincent-Jones on the Continuum of HIV Services as well as Committee training materials to Dr. Younai for review.
- ➡ March meeting agenda: final Population Specific Guidelines format and Social Determinants Framework review to prepare for Commission presentation; review SBP basic processes, e.g., developing a standards development calendar.
- ➡ Move: Standards to Work Plan Item II; Continuum of HIV Services to Item III with discrete aspects discussed, as needed.
- ➡ April meeting agenda: Approve list of allowable services/interventions - Identify and define care and prevention into discreet activities and definitions; and Determine which activities require specific standards and which are encompassed by other standards.

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- May meeting agenda: Approve list of allowable services/interventions - Review and modify, if necessary, list of allowable care service categories/definitions; and Specify additional prevention service/intervention categories/definitions necessitating standards.
- June meeting agenda: Determine how to integrate prevention and care services into uniform standards; Define uniform format for all standards in the Continuum of HV Services; and Finalize calendar for standards development.
- Initiate new Service Definition Work Group with: Mr. Goddard, care/treatment; Ms. Granados, prevention; and Mr. Donnelly, consumer. Ms. McClendon will request Angela Boger to represent DHSP. She will also forward the current HRSA and CDC definitions of services to the Work Group.
- Confirm SBP Patient Choice Work Group Report on "Client Choice" and "Health Outcomes" and forward to Executive. The Work Group has completed its assignment and has sunset.

8. NEXT STEPS: There was no additional discussion.

9. ANNOUNCEMENTS: There were no announcements.

10. ADJOURNMENT: The meeting adjourned at 12:15 pm.