INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th Street, NYC
October 26, 2016, 9:45-11:15am

M I N U T E S

Members Present: Lisa Zullig (Co-Chair), Lauren Benyola, Bláz Bush, Amber Casey (for Graham Harriman), Michael Ealy, Dorothy Farley, Janet Goldberg (by phone), Deborah Greene, Zach Hennessey, Peter Laqueur, Jan Carl Park, Donald Powell, Gina Quattrochi, Bobby Rallakis, John Schoepp, Claire Simon, Brenda Starks-Ross

Members Absent: Christopher Cunningham, Joan Edwards, Terry Hamilton, Christopher Joseph, David Price

Other Council Members Present: Matthew Lesieur

Staff Present: David Klotz, Nasra Aidarus, Jose Colón-Berdecía, Kris Estem, Kimbirley Mack (NYC DOHMH); Bettina Carroll (Public Health Solutions); Julie Lehane, PhD (WCDOH)

Agenda Item #1: Welcome/Introductions/Moment of Silence/Minutes

Ms. Zullig opened the meeting followed by introductions and a moment of silence. The minutes from the July 20th meeting were approved with no change.

Agenda Item #2: Public Comment

Steve Sacco (African Services Committee): We provide Ryan White legal services to immigrants to obtain PRUCOL status, which enables them to obtain Medicaid. We have heard that the Washington, DC EMA allows for a full range of immigration services to allow PLWHA to stay in the country and obtain optimal medical care. We would like to be able to do that here.

Ms. Casey noted that the Legal Services RFP is about to be released. The RFP, which is based on the Council's service directive, follows HRSA guidance that immigration legal work is limited to what is necessitated by the client's HIV status. The DC EMA (which includes Virginia, West Virginia and Maryland) may provide more extensive services because not all states provide PRUCOL that allows for Medicaid eligibility. Grantee staff will check with the DC EMA grantee to see what the situation is there, but given the timing of the RFP, any change

in the service directive would not affect the first year of newly contracted services, but can be included in the subsequent years' renewals.

Mr. Sacco added, in response to a question from Mr. Park, that the President's DAPA initiative to delay deportations is being held up in the courts.

Agenda Item #3: 2016-17 IOC Work Timeline

Mr. Klotz reviewed the timeline of work for the Committee over the coming planning cycle. Today's meeting will cover development of a template for standards of care (SOCs) for all service models. Next month, IOC will hold a joint meeting with the Needs Assessment Committee in order to get an update on the three recommendations developed by the committees last cycle concerning employment, Tri-County housing, and HIV/HCV coinfection.

In December, IOC will begin to develop a new service directive for Medical Case Management/ Care Coordination, in anticipation of the re-bid of this service category. IOC will approve a final care coordination directive, as well as final SOCs by the end of the cycle next summer.

Agenda Item #4: Standards of Care

Mr. Klotz discussed the role of the IOC, as spelled out in the Planning Council Bylaws, as well as the role of IOC in development of SOCs, as spelled out in the PC/Grantee Memorandum of Understanding (MOU). Standards of care are used to establish minimum expectations for the delivery of services. They help define how services are structured and delivered, and guide quality management and contracting. The EMA develops its own Service/Program Standards, and the Planning Council takes the lead in this effort, through the Integration of Care Committee, with extensive Grantee involvement.

Ms. Aidarus presented a draft template for developing the SOCs. Standards of Care will be informed by HRSA guidelines, service directives, RFPs and other documents based on research in best-practices, and patient experiences. SOCs fulfill a HRSA requirement so information is available for service models in one centralized place, and can be used for reference by DOHMH staff, Planning Council members, providers and consumers as an orientation tool or refresher. This tool will serve as a standardized template to be updated as models for delivery are updated.

A sample SOC template was shared with the IOC with the following sections: definition of services (from the HRSA monitoring standards); purpose of services (i.e., why the service is important); service goals (taken from the directives and RFP); client characteristics and needs; and service activities and standards.

The following is a summary of the ensuing discussion:

- SOCs do not inform procurement, but come after.
- HRSA requires us to link every service to a stage in the federally-approved care continuum (from diagnosed through virally suppressed).

- The mapping of the goals of services should be to the State's Integrated Care/Treatment Plan (which incorporates Ending the Epidemic goals), rather than the federal National HIV/AIDS Strategy. The grantee will prepare side-by-side goals.
- Client characteristics and needs will all include the basic RW eligibility (documentation of HIV status, residency in EMA, income at 435% of FPL). Most service models will include more as needed (e.g., Mental Health includes DSM V diagnosis).
- SOCs will change only if a category is rebid and a new service directive created. SOCs are meant to be core elements of the service, not the full description of everything in the scopes of services. SOCs will include items that are not payment points.
- SOCs do not further restrict how individual providers work. SOCs are broader, higher-level views of the service models with essential elements and do not supersede contracts.
- SOCs are meant to satisfy a HRSA requirement. The EMA had been telling HRSA that our service directives fulfill that requirement, but after this summer's Ryan White conference, HRSA said that they want the EMA to have SOCs. The grantee looked at models from a number of EMAs (which varied greatly), and this template is taken from the Oakland EMA, which closely matched our needs.
- The SOCs are a reference tool and will be particularly helpful to PSRA as they look at individual service categories. No new content will be created, but will be gleaned from existing sources (service directives, RFPs, etc.).
- There will be SOCs for every service model, which goes beyond the number of service categories (e.g., Medical Case Management has three service models – Care Coordination, Transitional Care Coordination, and the Tri-County Case Management model).

There was a consensus to use the template as presented (with the side-by-side goals from the Integrated Plan and NHAS).

There being no further business, the meeting was adjourned.