



INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th Street, NYC
December 22, 2016, 9:40-11:25am

MINUTES

Members Present: Christopher Joseph (Co-Chair), Lauren Benyola (by phone), Michael Ealy, Dorothy Farley, Janet Goldberg, Deborah Greene, Graham Harriman, Zach Hennessey, Jan Carl Park, Bobby Rallakis, John Schoepp, Claire Simon, Brenda Starks-Ross (by phone)

Members Absent: Bláz Bush, Christopher Cunningham, Joan Edwards, Terry Hamilton, Peter Laqueur, Donald Powell, David Price, Lisa Zullig

Other Council Members Present: Randall Bruce, Billy Fields

Staff Present: David Klotz, Nasra Aidarus, Jose Colón-Berdecía, Ashley Azor, Scarlett Macias, Jennifer Carmona, Kris Estem, Darryl Fields (NYC DOHMH); Bettina Carroll (Public Health Solutions); Julie Lehane, PhD (WCDOH)

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

Mr. Joseph opened the meeting followed by introductions. The minutes from the October 26th meeting were approved with no change.

A moment of silence was observed for long time IOC member Gina Quattrochi, CEO of Bailey House, who passed away last week after a long battle with multiple myeloma. IOC members and staff shared their memories of Gina, who was a leading light in the fight against HIV. Gina was instrumental in advocating around the link between housing and health care, and her contributions as a provider and advocate were enormous.

Agenda Item #2: Update: HCV DAAs

Mr. Park reported that the NYS AIDS Institute has added all of the directly acting anti-hepatitis C drugs to their formulary, with the exception of those made by Gilead. This was partly in response to the work done by the Council and its committees and community activists. Along with the work that DOHMH is doing to increase access through patient assistance programs, there will be greatly expanded access to these medications.

Agenda Item #3: Care Coordination Service Directive

The Committee began its discussion on a revised service directive for Medical Case Management/Care Coordination (CC).

Mr. Klotz reviewed the role of the IOC in development of service directives. The HRSA Part A Primer states that planning council has the right to provide directives to the grantee on how best to meet the service priorities it has identified, including service models and target populations, but cannot identify specific providers. This is elaborated in the Planning Council/Grantee Memorandum of Understanding. Elements of a service directive were outlined (goals, objectives, service models/elements, and client and agency eligibility). The master directive, approved last spring, details elements to be included in all future directives (e.g., Client centered, culturally appropriate, sensitive to disabilities, trauma informed, referrals and linkages, baseline eligibility). IOC does not weigh in on contracting elements (payment methodologies, reporting). CC providers are an important part of the discussion, providing insights on programs, client needs, service model successes and challenges, etc., but should not advocate for specific programs, rather helping to create best possible service model for future for service category as a whole. No service directive exists for the current category, and the current model, presented to the Council in 2009 in a PowerPoint by a former director of the Care & Treatment Program, was based on a model from the Boston EMA that incorporated elements of some pre-existing NY EMA service categories (e.g., Treatment Adherence Support, Treatment Education).

Mr. Harriman presented on the current CC program and the timeline for creating a new directive, with the goal of a finalized directive in May 2017. HRSA defines medical case management (MCM), including treatment adherence, as a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. MCM is a core medical service for purposes of Ryan White funding requirements. CC program objectives are: 1) support clients to manage their medical and social service needs; 2) provide linkage to care to clients in a coordinated manner; 3) work together with patients to support treatment adherence; and provide clients with home-based navigation, coordination or medical and social services, and support. CC currently funds 10 community based organizations and 17 hospital/clinical sites.

In FY 2016, the Council ranked MCM as its 5th highest ranked priority, with an allocation of \$24.5M (28% of program funds, compared to a range of 6% in Atlanta to 32% in Boston). MCM includes the following models: 1) Care Coordination (NYC contracts - \$21,272,362): Comprehensive program (based on CCP manual) that includes treatment adherence, health promotion, patient navigation, accompaniment, modified Directly Observed Therapy (m-DOT), and assistance with entitlement and benefits. 2) Transitional Care Coordination (NYC contracts - \$1,443,288): stabilizing case management for homeless and unstably housed individuals. 3) Case Management (Tri-County contracts - \$1,764,205): coordinate all levels of medical care and social services support through an initial patient assessment and periodic reassessments, the development of individualized care plans, and patient monitoring.

Other case management programs in NYC include: HIV/AIDS Service Administration (HASA), which offers case management and assistance in applying for public benefits and services; and

NYS Department of Health programs (Medicaid Health Homes, Medicaid Special needs plans (SNP) case management, Retention and adherence (RAP) programs, and Engagement and supportive services (ESS) initiative. Part A CC programs are specifically necessitated by HIV status, offer robust treatment adherence, and eligibility is based on medical need (unlike Health Homes and SNPs).

The MCM model covers PLWHA on the care continuum at all points after initial diagnosis. The target population is RW-eligible individuals at risk for suboptimal care outcomes, such as: newly diagnosed, irregularly in care, lost to care, never in care, starting new ART regimen, and incomplete adherence/response to ART. There are four components of the CC model that work together for the client: 1) Patient Navigation to accompany clients to appointments helping them navigate the health care system; 2) Health Promotion to address risk reduction behaviors through a 16 module curriculum (developed with PACT) delivered in the client's home; 3) Treatment Adherence to teach clients the importance of adherence to both medical appointments and medical regimens and help them do so by monitoring pill boxes and providing Directly Observed Therapy (DOT) if appropriate; and 4) Benefits and Services Coordination to ensure clients' traditional case management needs are met, e.g. housing. In addition, there are three aspects of the Care Coordination model that are shared across all four components: 1) Assessment and Planning is shared by all relevant parties (from the provider to the client) to ensure client's needs are met; 2) Information is also shared by all relevant parties. One way is through formal and informal case conferences; and 3) Outreach is conducted to return clients to care when they have been lost as well as actively re-engage current clients when appointments are missed. Clients are enrolled in different tracks depending on the level of intensity of service they need, from health education through directly observed DOT. There was a comparison of services in CC and Health Homes (e.g., both provide case conferencing and DOT, but only CC provides accompaniment and assistance with benefits).

In FY 2015, there were 4,225 client actively enrolled with a median of 363 days enrolled. 4% were dually enrolled in CC and Health Homes. The majority of clients were enrolled in tracks C1 and C2 (higher intensity tracks that include monthly or weekly health education and treatment adherence). All clients are enrolled in track C2 in the induction phase (first 60 days). Outcomes data from the DOHMH CHORDS study show that significant viral load suppression (VLS) increases are apparent in all subgroups, including all demographic, clinical and psychosocial subgroups we could measure. VLS increases were seen in even those with housing, mental health and/or substance-related barriers at the time of enrollment. A significant positive program effect is demonstrated for both newly diagnosed individuals and individuals who were unsuppressed for the full year prior to enrollment. In short, the CC program shows evidence of effectiveness for those at the highest risk of suboptimal health outcomes, even when controlled for citywide improvements in VLS. In the next few months, DOHMH will be reviewing components of the CC program and developing draft guidance for a new, updated service directive.

The following is a summary of the discussion:

- IOC and PSRA can address questions of cost of providing services (e.g., general cost by intensity of service), without prescribing reimbursement methodologies. CC has the most complex reimbursement strategy of any RW Part A service.
- Health Homes do not have nearly the level of structured intensity as CC programs.
- DSRIP (part of Medicaid) provides health coaching, patient navigation and case transition between hospital and home.
- The presentation of CC tracks should be more intuitive, showing them from lowest to highest intensity.
- For clients in track A (not prescribed ART), providers build a relationship to move them onto treatment, but can only be reimbursed for a meeting every three months.
- Clients not on ART may have a variety of reasons (on a drug holiday, not ready to start treatment) and CC programs should be client-centered and meet them where they are, although there is a benefit for the client to be virally suppressed, both for the client's health outcomes and for public health benefits.
- Where there is overlap in services between CC and Health Homes (e.g., accompaniment), if a client is getting the service in Health Homes, then they cannot receive that service in their CC program.
- While the median length of enrolment is about one year, the average can be as much as two, as the average is skewed by some clients who stay enrolled for a long time.
- There are no clients who are only enrolled for one day, as the intensive intake process screens out those who cannot commit to the program.
- Tri-County has a board case management program, but the Steering Committee has not identified CC as a service. Also, there is no access to epi data for TC to measure outcomes.
- Usage of DOT (at around 5% of clients) is lower than what was originally anticipated (around 10%).
- The VLS data does not account for blips and variations in data points (e.g., a one-time spike in VL).
- For the non-CC control group, it is not known if they are getting similar services through Health Homes or RAP.
- People who are inconsistently suppressed usually have ongoing issues, and even if they are not consistently suppressed, the CC program may still be addressing some of their other issues (e.g., access to benefits).
- The current CC model is meant to be short-term, but some people may need longer to become stable and virally suppressed.
- IOC should invite clients for their perspective (e.g., is the model overbearing). The process of developing a new directive needs all points of view.

There being no further business, the meeting was adjourned.