INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th Street, NYC
February 15, 2017, 9:40-11:30am

M I N U T E S

Members Present: Christopher Joseph (Co-Chair) , Lisa Zullig (Co-chair), Lauren Benyola (by phone), Bláz Bush, Amber Casey (for Graham Harriman), Michael Ealy, Dorothy Farley, Deborah Greene (by phone), Zach Hennessey, Peter Laqueur (by phone), John Schoepp, Bobby Rallakis, Claire Simon

Members Absent: Christopher Cunningham, Janet Goldberg, David Price, Jan Carl Park, Donald Powell, Brenda Starks-Ross

Other Council Members Present: Randall Bruce, Billy Fields (by phone)

Staff Present: David Klotz, Jennifer Carmona, Jose Colón-Berdecía, Kris Estem, Darryl Fields, Scarlett Macias (NYC DOHMH); Bettina Carroll (Public Health Solutions)

Guests Present: Timothy Au (APICHA), Shelly Blumenthal, Pierre Zemele (Bellevue Hospital), Diane Tider (Mt. Sinai), Tiffany Jules (Services for the Underserved); Deborah Mitchell (Interfaith Medical Center); Lori Hurley (RFSUNY); Judi Brenner (HHC Elmhurst Hospital)

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

Mr. Joseph and *Ms. Zullig* opened the meeting followed by introductions and a moment of silence. The minutes from the January 25th meeting were approved with no changes.

Agenda Item #2: Medical Case Management/Care Coordination Service Directive: Provider Survey

Ms. Carmona, who oversees the Care Coordination Program (CCP) project officers at DOHMH, presented the results of a survey of all CCP providers. The survey is part of the process of developing a new service directive and was meant to get input on challenges and successes on different components of the model, and to provide insight on what works and what doesn't to inform the new service directive. Survey questions were drafted by DOHMH/BHIV Care & Treatment staff. A near-final draft was provided to Planning Council staff and the IOC co-chairs for feedback. The survey was distributed electronically to CCP program directors and was designed to be anonymous to ensure honest feedback and input to program model would be provided. Instructions noted that providers are welcome to attend IOC meetings to provide feedback to the review process directly, if desired. Participants were instructed

to submit one survey per agency. There was an 89% response rate - 24 of 27 programs (10 community-based and 17 clinic or hospital-based).

Twenty-six percent of providers said that they get referrals (not enrolled) to the programs who are not medically eligible (89% of those have other medical conditions such as co-morbidities, or have social/behavioral issues). PLWH are referred to CCPs from a primary care provider (PCPs stay involved throughout program participation, as per the protocol), other clinic staff, or from a testing program at their agency. Twenty-nine percent are mental health referrals. Fourteen percent are from outreach/case finding or lateral transfer (from another CCP or Health Home or other program who might decide that more intensive services are needed). Seven percent are external referrals (e.g., DOHMH Field Services Unit). Twenty-one percent are walk-in (e.g., the client might have seen the service listed on the clinic's website). Ninety-three percent of CCPs engage in case finding through outreach, PCP support, STD clinics, and linkages from testing or medical clinics. The 7% who do not engage in case finding cited the time intensity and lack of reimbursement.

Eighty-seven percent of CCPs can always take new clients (the survey did not delve into how), and 8.7% say it is difficult but they manage. CCPs determine when a client is ready to move to a less intensive track through case conferencing (34%), adherence measures (29%), improved viral load (29%), health status (6%), or health promotion understanding (3%). The top three barriers to moving a client to a less intensive track are: client's need for psychosocial support; concern from the PCP; and client's cognitive impairment. Additional barriers include: co-morbidities, lack of basic needs, non-adherence, reliance on CCP, readiness along stages of change.

The average percent of clients who will be able to self-manage without CCP is about 40%, but this varied widely and may be because the survey question was not specific enough (post-graduation?, only HIV care?). Top reasons that clients may not be able to achieve self-management are: client's substance use, client's mental illness, client's needs for psychosocial support, and cognitive impairment. Additional common barriers are: lack basic needs (e.g., housing, 60%), stigma (10%), difficulty managing health care (10%), and denial (10%). Other case management that CCPs refer clients to are: other support services (83%), Health Homes (61%), and Ryan White Part A non-Medical Case Management (31%).

In answers to open-ended questions about how CCPs meet client needs, respondents cited: 1) client-centered care individualized and tailored support from a dedicated navigator and Care Coordinator); 2) health promotion (education which helps them to understand their diagnosis)l 3) adherence support (facilitates self-management process, viral load suppression and retention in care); 4) social support (A number of clients are alone and/or do not have any kind of support system at home and CCP becomes that support for them); 5) holistic care (a one stop shopping where client is able to get all the services, from medical to social needs); and 6) benefits navigation.

CCPs identified the following as one aspect of the model that they would change: reduce paperwork (30%); revise tracks (20%); health promotion revision (10%); case finding reimbursement (10%); POLR issues (5%); improved program specific DOH involvement (5%); better patient feedback mechanism (5%), and additional support services (5%). CCPs cited the following resources from DOHMH that would improve services: trainings; revised tracks; eShare improvement; client incentives; equipment; multilingual materials; marketing; and technical assistance.

The following is a summary of the ensuing discussion:

- The model does not pay for outreach, which is very labor intensive.
- Bellevue has an influx of monolingual French-speaking high-need clients because they had French-speaking staff.

- CCPs get many referrals of those lost to care.
- Potential clients have opted out during the intake process once they realize how intensive it is, and they may not be able to make the commitment at the beginning for weekly visits. In those cases, the CCPs will offer other options. Eventually, they may move to a less intensive track.
- Programs should be client-centered and empower the client.
- The model may seem rigid, but programs learn to work around it for flexibility. Bellevue will try their best to engage the client, and will keep the case open even if they disappear for a while, bringing them back into the program when they return. Eventually, a CCP may have to close the case.
- Some clients do not want to leave the program, even if they have met the CCP goals.
- The average time to self-management is about 2 years.
- Even if HIV-related medical goals are reached, but the client is not taking their psych or diabetes meds, then the CCP will continue to work with them.
- There is a need for more finely graded tracks (e.g., something in between daily DOT and weekly visits).

Agenda Item #3: Medical Case Management/Care Coordination Service Directive: Provider Perspectives

A representative sample of CCP providers was invited to discuss issues concerning the successes and barriers of the service. The following is a summary of the discussion:

- The CCP has been crucial since its inception, bringing treatment adherence, case management, entitlements and health education together and helping the clients at Bellevue attain a 93% VLS rate.
- Services for the Underserved uses CCP as a transition from the Transitional Care Coordination program. CCP needs to be more flexible, as SUS does not have a patient navigator onsite, and so it is a challenge to conduct case conferencing.
- APICHA has a co-located clinic, which helps to have one team for the client. Most APICHA clients are only covered by ADAP, and so CCP is POLR for them, as they cannot graduate to Medicaid of any other programs.
- Hospital-based programs have the advantage of being able to delay discharge for a client for whom housing could not be secured in time.
- Interfaith Medical Center uses CCP to provide a holistic view of the client, beyond just medical needs. Communication is key to developing a relationship with the client.
- It would help to translate the manual to meet the client where they are and try to ease the burden on clients.
- Staff is cross-trained and is always real-time the clients' experience through both formal and informal channels (e.g., QI measures, CAB feedback, satisfaction surveys). The HRSA-mandated DOHMH portfolio-wide client satisfaction survey is not specific enough to assess the individual CCPs.
- The quality track (once every three months) is the least helpful, as a lot can happen in that time.
- DOT has the biggest impact. For a program with clients from all over the City, it is hard to do DOT, e.g., if the provider is in Manhattan and the client in Coney Island. The model should, like TB-based DOT, allow for video DOT.
- The way services and payments are tied together is a constraint on tailoring the service to the client's specific needs. There needs to be a track that is something between DOT and a weekly visit.
- It is important to keep contact with the client, especially if they are socially isolated.

- It can be a difficult issues to get clients to move on if they have become dependent on the CCP. Some need more psycho-social support and linkages to other programs. Also, a less intensive model would allow the CCP to keep them engaged while giving the extra support they need to keep them from hospitalization.
- It would be good to introduce the goal of graduation from the CCP at enrolment, so that client know they are expected to move to complete self-management, although if someone cannot graduate for some reason, they are kept in the program.
- Clients are a diverse group from across the treatment cascade with differing needs. For some, the CCP is the first program that works for them, after having failed COBRA and others. However, long-term clients take up spaces that can be used for new clients. Clients should be evaluated on a case-by-case basis with a checklist on goals toward graduation (similar to the way Part D grantees move young clients into adult care).
- There needs to be more data from DOHMH on effectiveness, including after graduation (via surveillance data). (The CHORDS study shows that clients with the most needs benefit the most from CCP services).
- Quality of care must be kept first in mind above payability issues.

There being no further business, the meeting was adjourned.