INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th St., 7th floor
April 19, 2017, 9:30-11:30am

M I N U T E S

Members Present: Christopher Joseph (Co-Chair) , Lisa Zullig (Co-chair), Lauren Benyola, Michael Ealy, Dorothy Farley, Deborah Greene, Graham Harriman, Zach Hennessey (phone), Peter Laqueur, Donald Powell (phone), Bobby Rallakis ,John Schoepp, Claire Simon, Brenda Starks-Ross

Members Absent: Bláz Bush, Christopher Cunningham, Janet Goldberg, Peter Laqueur, Julie Lehane

Other Council Members Present: Randall Bruce, Paul Carr, Sharen Duke, Billy Fields, Saul Reyes

Staff Present: Ashley Azor, Jose Colon-Berdecia, David Klotz, Melanie Lawrence, Nasra Aidarus, Christina Rodriguez-Hart; Bettina Carroll (Public Health Solutions)

Others in Attendance: Shelly Blumenthal (NYC Health & Hospitals, Bellevue), Mark Brown, Maria Rodriguez (Argus Community, Inc), Migdalia Vientos (NYU Lutheran), Pierre Zemde (Bellevue MCM),

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

Mr. Joseph and *Ms. Zullig* opened the meeting followed by introductions. A moment of silence followed. The minutes from the March meeting were not approved because they had not been included in the packet. [The minutes were sent out over email, and with no objections beyond one minor correction, have been approved since]. An ice breaker, "What is your favorite thing about spring?" was conducted.

Agenda Item #2: Review of Packet

The April 25th from 9-1, at CUNY Baruch's Newman Conference Center, the 2nd Community Briefing: Housing for People Living with HIV/AIDS flyer was introduced by *Ms. Lawrence*
Package also contained a consolidated side by side comparison of eligibility and outcomes for Health Homes, including HARP, Ryan White Care Coordination and Retention and Adherence programs. Care Coordination Provider Comments and a Recap of Care Coordination Service Eligibility were included. The draft service directive for Care Coordination as it now stands was also included.

Agenda Item #3: Medical Case Management (MCM) /Care Coordination Program (CCP) Service Directive

Mr. Joseph introduced the concept of visioning and suggested we use the projector to track comments and concerns before quickly passing the floor to Mr. Harriman.

Mr. Harriman asked how comfortable the committee is with the documents developed by the grantee (included in packet: (**1**) *CCP Care Completion and Health Home (HH) Enrollment Status*; (**2**) *Eligibility and Outcomes for Ryan White Part A (RWPA) CCP vs HH vs Retention and Adherence Program (RAP) vs Health and Recovery Plans (HARP)*; (**3**) *CCP Provider Recommendations*; (**4**) *Service Element Comparison- RWPA CCP vs HH vs RAP*). Approximately half of the room agreed that they were comfortable.

Mr. Harriman then reviewed document (**1**) with the group. Document (**1**) was originally developed 4 years ago to better understand the role of HH and their impact on the Payer of Last Resort (POLR) and the CCP. Persons who are not covered by any programs/resources (and are eligible) – should receive full CCP benefits with Ryan White reimbursement. Persons who may need some assistance in accessing entitlements and services – that are not treatment adherence specific are not eligible for CCP, are meant to receive Health Homes (HH) only. The focus of HH has been to reduce ER visits/reduce costs; not target HIV+ persons. Health Homes PLUS CCP are for people who need care coordination to address treatment adherence, etc., but also need assistance accessing other entitlements/services. In HH PLUS CCP, persons receive partial Ryan White reimbursement.

In Document (**2**), *Mr. Harriman* asked that we note that RAP is reimbursed by state and has same weight as POLR. Although RAP is similar to CCP – the model is of a shorter time with smaller awards, though the two programs do similar things. To be enrolled in a HARP, a person *must* be enrolled in an HH – enrolling in the HARP is a complicated and cumbersome process. Few people are currently being served by HARPS – but this may change over time. HARPs have a behavioral health focus, and does not focus on HIV health outcomes.

Ms. Duke commented that there are a number of care coordination programs funded by Ryan White. Transitional Care Coordination (TCC) – funded by Ryan White, is for people who are homeless or unstably housed. The four are: CCP, the current service directive the committee is revising, TCC, Non-Medical Case Management, and a 4th care coordination program just for the re-entry population (Rikers). Priority Setting and Resource Allocation (PSRA) Committee wants to know why IOC is looking at CCP in a vacuum and not considering the other programs, what with potential cuts to funding. *Ms., Duk*e recommended the IOC look at all of the models to find redundancy in the portfolio – should there be distinct models for different populations? PSRA is asking if IOC can expand its purview and look at all of the care coordination models funded by Ryan White.

Mr. Joseph reminded us that there is also an CCP program in the tri-county region that we are not looking at, and that the IOC's specific directive is to specifically revise the CCP that is on the table, and for which we have a draft of what currently makes up the model.

Ms. Duke said that DOHMH has said that one of the models may be redundant and asked if we should be looking at who is served, case load ratios, etc. She suggested that PSRA and IOC could jointly look at the various models.

Mr. Harriman said that PSRA had not made a formal recommendation. The DOHMH sees TCC as potentially redundant – clients can be served in different ways and the model does not truly address what needs to be addressed. The grantee brought the TCC to the attention of the PSRA as a potential place to look if funding cuts dictated the elimination of services. TCC is a $1.4m program while CCP is $22m. *Mr. Harriman* commented that there is no point in considering TCC if it is going to be eliminated. He then asked the IOC to continue revising the current draft of the CCP service directive.

Ms. Duke suggested that understanding all the models would better inform allocation of resources.

Mr. Joseph reminded us that CCP has a specific eligibility criteria. Case finding is uncredited/not reimbursed. The initial steps taken to get someone into care is not part of care coordination in a formal way. *Mr. Reyes* noted that when thinking of care, as a consumer you don't know the structures that guide what services are received when. The end result should be focused on making the consumer comfortable. *Mr. Klotz* noted that we are not all on same page about terminology. There is a broad service category called Medical Case Management (MCM); it has two distinct and separate service model programs: CCP (with tracks, treatment adherence, etc.) and TCC which targets the homeless and unstably housed. As a committee, the IOC is to look specifically at CPP. There is a separate line in the spending plan – called Non-Medical Case Management, which has two components: a general population broad case management program (which was recently developed), and a program for people leaving the jail at Rikers. Essentially, there are four separate service models defined under two broad category names in the spending plan.

Ms. Duke noted that Ms. Azor (a part of the grantee team) is working on a grid for PSRA that compares all care coordination/case management programs. *Mr. Harriman* let the committee know that when the grid is ready it will be shared with the IOC. In answer to a question about the possibility of combining all of the care coordination programs, *Mr. Harriman* noted that would take a many years, and that because HRSA has different definitions for non-medical case management (consumer initiated/asking for help with food stamps, etc.) and medical case management (active engagement, provider initiates, can help with things like food stamps but are medically engaged with consumer) then the council, there would be significant hurdles, and in the end may not be the best idea.

Mr. Joseph noted that CCP is rigid and not client centered. There are issues– i.e., what is graduation's significance? The CCP requires medical eligibility and requires consumer to trust provider on program selection. The process of program eligibility is complicated and non-transparent.
The committee then agreed to move forward with visioning the new service directive to guide CCP.

Below are the notes about provider recommendations as reviewed during the discussion:

Provider Recommendations

More patient centered care.

Should we be more specific in defining "newly diagnosed"?

Better flexibility of tracks.

1. Paperwork
    a. DOHMH has been responsive to this request
    b. There are too many forms that a patient has to sign and the Dr. has to sign – these are required during audits – why does the Dr. need to be involved
    c. Dr.'s often sign off on forms without reading them
    d. The directive should focus on what is possible, such as improved access and efficient delivery of paperwork
    e. Some regimentation is needed, but we should look at where the processes can be smoother
    f. Is it possible for some of the paperwork to be signed by support staff

2. Tracks

a. This is under investigation by DOHMH – they are looking at how to replace tracks with alternative methods of reimbursement
b. The tracks in the model are meant to match the level of need with level of service – but the way it is operationalized does not always make sense
c. Improved ongoing assessment can ensure that the determination of a clients' level of need is appropriately addressed to ensure optimal health outcomes
d. Shift to *gradations* vs tracks is encouraged, which would allow for the development of in-between steps that better focus on client needs
e. Must be client centered – sometimes agencies force services on clients in order to comply with tracks and ensure reimbursement
f. DOT by phone using facetime, etc. would better use technology to meet clients' needs. Other programs have more flexibility in how an encounter is defined, which benefits the client.
g. There is a need to maintain tension and balance to appropriately engage and serve clients.
h. If a certain level of care is not provided, how can we be sure the client getting what they need?
i. Reassessments do not necessarily capture client need or client capacity (i.e. where is client in ensuring their own care? Hoe effectively can they self-manage)

3. Improve Assessment
    a. Consumers assume that check-ins are assessments – but it in a clinical sense, not with regard to self-management. There is not an explicit enough connection between self-management and clinical outcomes/assessments.
    b. Self-reports on the part of the consumer can be unreliable. Home visits help providers confirm testimony.
    c. It is necessary for providers to build and maintain trust with patient while ensuring appropriate care
    d. Self-assessment vs self-management. – if patients cannot name their own meds they need continued assistance
    e. Assessments should be evidence based. Not everything in the directive is rooted in evidence.
    f. The payment methodology is built on top of evidence – but is not necessarily informed by evidence.
    g. Actual conversations about goals and consumer buy-in is critical. How can the committee ensure and encourage more substantive conversations

4. Health Promotion
    a. Curriculum covers 18 topics, i.e. how to talk to your provider, etc.
    b. The curriculum is not implemented in same way and integrity is difficult to measure
    c. Limited assessment can both impact and limit health promotion
    d. There should be a built in motivational aspect as well as required training on motivation

e. The program is required to train patient navigators – i.e. train the trainers – but the training, including the schedule implemented inconsistently

f. How can technology be better incorporated? Could online modules, or phone apps be developed?

g. Emotional stimuli are helpful. An emotional connection is necessary to make change

h. The focus on education can cause the emotional piece to be overlooked. A stronger emphasis on health counseling, motivational listening would improve engagement.

(1) Frequently health workers and peer workers are not highly trained. Some of this has to do with an insufficient schedule of trainings.

(2) Does the make-up of the workforce need to change?

i. Trainings should incorporate and explain health education principles

j. Flip the framework/point of view to help navigators see that they are learning as well

k. Better training needed – infrequent training hurts programs

l. The train the trainer curriculum does not touch on motivational counseling

m. The service directive should be more specific on how training is developed and conducted.

5. Focus on Directive
    a. The committee needs to weed out what recommendations actually belong in the directive. We can raise points and issues, but not everything can be addressed or changed, i.e. eShare
    b. It is good to be clear about what is in our purview vs what is not.
    c. It would be helpful if materials came in more than the 5 languages provided: can this happen?

6. For Next Discussion:
    a. We will discuss **OUTREACH, CASE CONFERENCING, DOT, AND THE WORK FORCE (INCLUDE SUPERVISION) i.e. HOW DOES HIRING WORK ACROSS AGENCIES**, on May 3rd