INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th St., 7th floor
May 17, 2017, 9:30-11:30am

M I N U T E S

Members Present: Christopher Joseph (Co-Chair), Lisa Zullig (Co-chair), Lauren Benyola, Blaz Bush, Michael Ealy, Dorothy Farley (phone), Janet Goldberg, Deborah Greene, Zach Hennessey, Peter Laqueur, Jan Carl Park, John Schoepp, Brenda Starks-Ross

Members Absent: Peter Campanelli, PsyD, Christopher Cunningham, Joan Edwards, Julie Lehane, Donald Powell, David Price, Bobby Rallakis, Claire Simon

Other Council Members Present: Randall E. Bruce, Billy Fields, Saul Reyes

Staff Present: Nasra Aidarus, Jennifer Carmona, Bettina Carroll (Public Health Solutions), Kris Estem, Graham Harriman, David Klotz, Melanie Lawrence, Scarlett Macias, Cristina Rodriguez-Hart,

Others in Attendance: Shelly Blumenthal, Mark Brown, Desirie Bundy, Penelope Demas, Rachel Elzem, Elsa Gonzalez, Vanessa Haney, Yolande Makha, Maria A. Rodriguez, Elaine Ruscetta, Diane Tider,

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

Mr. Joseph opened the meeting and led introductions and the icebreaker. A moment of silence was held. The minutes from the May 3rd meeting were approved with minor corrections.

Agenda Item #2: Review of Meeting Packet

Ms. Lawrence introduced the meeting packet which included a draft of the service directive and the provider comments for DOT, Work Force & Supervision and Hiring Practices. *Mr. Laqueur* asked when we will put the notes to use in the directive, to which *Mr. Harriman* replied that at the following meeting an edited inclusive draft of the service directive would be presented for line-by-line editing.

Agenda Item #3: Medical Case Management (MCM) /Care Coordination Program (CCP) Service Directive: DOT, Work Force & Supervision, and Hiring Practices

Mr. Joseph re-introduced the visioning process, summarizing the discussion that happened over the last few months, i.e. case conferencing, and outreach/in-reach. *Mr. Bush* brought up the importance of looking at the process of intake and how that acts as a barrier; as well as when a patient leaves a program – and how this impedes their being able to get back into care. The rigidity of tracks is also an issue – the only two options at enrollment are DOT or a weekly track – it is too intense for some patients. Is this necessary.

Re-enrolled patients are noted as re-enrolled, but are treated as new patients (with regard to tracks). *Ms. Zullig* asked if it could be addressed in the service directive. It is actually a very complicated issue. *Mr. Harriman* noted that this committee cannot take on the e-share issues. Tracks and how tracks are implemented can be addressed. Mr. Bush asked if intake should really be a barrier - could we assert that that the client should be served regardless of intake. Where does e-share conversation live, since it cannot be addressed here.

1. Re-enrollment has a lot to do with E-Share – very difficult to make changes with creates a cascade of issues
    a. Intent was to provide data to our funders
    b. Is this a question for service directive?
    c. Is it possible to demand that services be provided to patient regardless of enrollment status?
    d. Is e-share setting up structural barriers and where is that conversation best placed?
    e. This conversation and necessary action steps will not be completed by end of June
    f. Providers have been presenting this issue to project officers – what happens next? Some issues have resolution, some are still being pushed
    g. It is possible for DOH to waive enrollment – possibly depends on project officer – there is flexibility but within a very fixed system
    h. Does payment for intake cover cost of engagement?
        1. There are no payment points for intake (as it exists right now)
        2. Only payments for services
        3. Maybe we need to change this structure
        4. Tracks – need to ensure that people are getting appropriate level of service
2. D.O.T.
    a. True DOT is watching every dose every day (some people have multiple doses); we provide modified DOT - only provided Mon-Fri, and only one dose per day.
        i. No guarantee they are taking second dose
    b. We should do a quick lit review to understand current info around Dot – directive is based on ten year old research (Grantee will conduct a lit review)
        i. Research shows this is most effective for people who need short term intensive treatment – long term support not so effective after about 3 months
        ii. Originally designed for TB patients
        iii. Great for Hepatitis C treatment
        iv. May be great for someone in recovery –
        v. According to lit does not really produce long term impact
        vi. Can create comfort while sick, but an irritant when well/capable – can take away choice
        vii. At some point during DOT people improve adherence and self-management
        viii. Once a day will have better outcomes, not as dependent on patient
            1. As dosage methods change how do you do DOT (i.e. injection, embedded in skin)
            2. How DOT is done is very important with regard to adherence
                a. Are you educating the patient and building self-efficacy?
            3. When a patient is rapidly decompensating DOT may play an important role – should not be taken out of toolkit
            4. DOT in current model is about developing a relationship with patient and teaching self-efficacy – but many don't achieve adherence/viral suppression
            5. Only 7% of CC patients receive this treatment
            6. If we just cut off DOT patients go back to old habits but tapering works when bolstered by reminders – helps with habit building
            7. Once healthy, patients can push back at meds – natural mental reaction
            8. Think about patients who go in and out of care vs those who are consistent
                a. Modified version is very helpful to providers
                b. Challenge changes when on multiple meds/doses
                c. No reimbursement beyond specified doses – patients can ask for more but unable to provide and question of actual help to patient
                d. How does behavior change happen? How to know if health promotion is effective
                e. Another approach is to use a "recovery" perspective, where patient's treatment adherence issues are looked at as something to overcome, and DOT is presented as a tool toward recovery.

f. DOT is only M-F 9- 5: Skips weekends - how does this impact adherence?
    i. Rapport is integral to success of DOT. Talking to patient about what it means to want to be healthy… *inspiring* them with will to survive.
    ii. Need to operationalize flexibility
    iii. DOT should be client centered and based on client needs – video recording for weekend and second doses –
    iv. Staff training is foundation of effective DOT
    v. How to ensure that people doing DOT are "right" kind of people?
    vi. Has peer-to peer/buddy system been tried for weekends?
    vii. Can be compensated for building peer- to peer into program
    viii. Not everyone has a smartphone/video chat… and if you need DOT what are chances you have a smart phone/video chat?
        1. How do you address these challenges?
        2. Many people have smart phones – even subsidized phones are frequently video capable.
        3. It's always supposed to be optional.
    ix. DOT/CC is always voluntary - if patient does not want it, will try to find another program for them
    x. Write into directive that video tech can be done
    xi. Adherence is a bigger problem than HIV treatment
g. There is a need to redefine "modified" DOT

3. Staff Training, Supervision & Qualifications
    a. Patient Navigator are front line staff; programs decide how many patients each navigator will work with; care coordinator supervises navigators – ratio depends on program and track
        i. All are required to go through DOH training
        ii. Refresher course and advanced training (incl. for advanced skills, e.g., motivational interviewing) tailored to specific staff (navigator, coordinator). This raises supervision issues.
    b. Health promotion training – must happen on a regular basis
    c. Monthly health promo training is a boon to staff (Callen-Lorde)
        i. Speaks to what staff are seeing with patients, i.e. Hepatitis C
        ii. Staff don't want to go back to basic training – desire to keep learning/advancing
    d. Clinical supervision of patient navigators is required, on top of additional training and must be documented. Led by LCSW – provides ongoing support.
    e. Can (higher threshold) peers be added to staff?
        i. If included – maybe they could handle the weekend virtual DOT
        ii. What does it take to incorporate staff – to do stipended work
        iii. No preclusion of peers being staff – must just meet levels of qualification/experience
        iv. Only prescriptive staffing – center based nurse, and a supervisor
    f. Staff who can take training
        i. Staff are required to take training but others are welcome to the training. Slots are reserved for agencies that conduct care coordination
        ii. Training is 12 days – very intense.
        iii. Would have to invest to create more spaces in DOH training
    g. Alliance does a very good job of training people
        i. Motivating, peers can be inspired to go back to school
        ii. Model utilized is very important
    h. Leadership Training Institute
        i. Can this be brought back?
    i. Are peers being fairly compensated for work? What is balance between getting compensated and losing benefits? Peers are often asked to work for free

i. Peers can work 15 h a week and wont impact benefits – allowed to make $6000 a year without disrupting benefits.
ii. Work to transition people to full time

j. Care Coordination has not really been focused on peers – are now more focused
k. Have made additional efforts to have trainings count for peer certification
i. Because model is very intensive – this may not be the best fit for inclusion of peers
l. Program is over 9 years old in inception, development and practice
m. PACT model – what is its efficacy today vs 9 years ago- how does it stack up against alternate models?
i. We need to develop a model based on current research
ii. DOT is a small segment but very important – what about incorporating pharmacists to facilitate treatment adherence?
n. How has training changed and adapted? How much does training cost? Is this effective?
o. Build a cutting edge model that eliminates what no longer makes sense.
p. Care Coordination is the most studied model in USA.
i. Shown effective in viral suppression among many vulnerable groups
ii. Necessary to continue to study it and study the fine tuning we are doing
q. What about online training?
i. It would have to be developed – and be specific to Care Coordination
ii. There may be elements of online training possible – but group training is important
r. Do we want peers to be patient navigators

4. Peer certified patient navigators are encouraged – this already exists
i. Typically peers serve as enhancement to team – i.e. outreach texting; appointment escorts;
ii. Not necessary to say how peers should be used in program
iii. Don't want to develop a role for them that is not feasible or useful
b. Nothing says peer cannot be navigators, but if they need to limit the amount of work that they have – and there is no room for a part time navigator – is there a way to incorporate part time roles into the structure
c. DOH has recently said that a certain level of funding is required to compensate peers
d. Objection to this being a requirement (having a peer program) – running a peer program is very difficult – may rule out CBOs who cannot do that well, and possibly impact large bureaucratic institutions and barriers associated
e. Need to consider consistency and best practices
f. Consider difference between requiring and recommending
g. Can roles for peers be easily integrated into Care Coordination? Groups facilitated by peers, health promotion led by peers have been incredibly effective.
h. Not cost effective to send peers out to do DOT (10-15 hour max work hours)
i. Staying connected over weekend could be very helpful
j. Think about rapport peers can bring
k. Vulnerable groups exhibit huge drop off with viral suppression – how can we address those needs in client and agency eligibility
l. Directive must be broad enough in directive to ensure that DOH can do what they need to do
m. Social support building – involving family and community – very important
i. This can provide support for weekend doses
1. Builds self-management, can normalize taking medications
2. Hiring someone else is not better than people already in a client's life