INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th St., 7th floor
May 3, 2017, 9:30-11:30am

M I N U T E S

Members Present: Christopher Joseph (Co-Chair), Lauren Benyola, Blaz Bush, Dorothy Farley, Janet Goldberg, Graham Harriman, Peter Laqueur, Jan Carl Park, John Schoepp, Claire Simon, Brenda Starks-Ross

Members Absent: Christopher Cunningham, Michael Ealy, Deborah Greene, Janet Goldberg, Zach Hennessey, Julie Lehane, Donald Powell, David Price, Bobby Rallakis, Brenda Starks-Ross, Lisa Zullig (Co-chair)

Other Council Members Present: Randall E. Bruce, Billy Fields, Ron Joyner, Matthew Lesieur, Saul Reyes

Staff Present: Jennifer Carmona, Kris Estem, David Klotz, Melanie Lawrence, Cristina Rodriguez-Hart, Bettina Carroll (Public Health Solutions)

Others in Attendance: Mark Brown, Lauren Estby (Bailey House), Lloyd Goulbourne, Wilbert Robins (UPS), Diane Tidar (Mount Sinai), Jin Xy (UPS), Pierre Zemele (Bellevue MCM),

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

Mr. Joseph opened the meeting and led introductions and the naming your favorite candy bar. A moment of silence was held in honor of council member Daphne Hazel. The minutes from the April 19th meeting were approved after the notation of a minor correction.

Agenda Item #2: Review of Minutes/Review of Meeting Packet

The draft of the service directive for Care Coordination was introduced. Provider Recommendations were included, and the place where we left off was noted. Additional documents that had not been included in the folder were available on the table. Upcoming meeting times were noted.

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

Mr. Joseph re-introduced the visioning process, and noted that we are focusing on CCP specifically, because 1. That is the task at hand, and 2. Transitional Care Coordination (TCC) is a very different, smaller and

targeted program to people with unstable housing or who are homeless. Other care coordination programs in the Ryan White Part A (RWPA) fold are very specific as well, and look very different from CCP.

During the previous meeting we began going through the Provider Recommendations to determine what we want to include in the revised service directive for CCP.

We began where we left off last meeting: Outreach. *Mr. Joseph* read a concern from providers regarding the lack of remuneration for time spent doing case finding. The DOH is trying to find a better way to do this. *Mr. Harriman* brought up the issue of in-reach vs outreach.

Case finding is a set of services that happens prior to enrollment/to facilitate enrollment. There is no reimbursement for these services. These are people who have fallen out of service, as well as new patients who may be eligible but have not been enrolled.

What follows are the on board notes from the previous meeting (Paperwork, Tracks, Improve Assessment, Health Promotion, Focus on Directive) as well as the themes discussed during the May 3rd meeting: Outreach, Case Conferencing and Other Directives. This information will be mapped onto the draft service directive. The following themes will be discussed at the upcoming meeting: **DOT, Work Force & Supervision, and Hiring Practices**

Service Directive Care Coordination Program

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 is 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. Outreach
    a. In-reach vs outreach: client engagement vs re-engagement
        i. Is in-reach comprehensive enough?
    b. Need language that includes engaging people in the field (but have a previous relationship with) = in/outreach
    c. Amount of time figuring out eligibility is complicated
    d. Case finding vs outreach
        i. Enrolling someone compared to re-engaging someone who is in program but has disappeared- DO NOT GET CREDIT/REIMBURSEMENT FOR RE-ENGAGEMENT IF THEY ARE DUAL ENROLLED – this is a Payer of Last Resort (POLR) issue. Medicaid does pay this (HH) but if HH isn't doing the work does not get reimbursed – some HH do this service, but do all??
    e. If you have not seen a patient for 3 months they are not engaged
    f. Case finding and outreach once enrolled is not reimbursed.
    g. Needs to be accountability somehow – how can this be better designed? How to assess?
    h. Documented phone calls/home visits/etc. If not payable, less emphasis – so hardest to reach patients stay out of care. CCP does this work but does not get paid for it – difficult to staff this when staff are needed in other areas.
    i. How can this be formally incorporated into the model? Should it be?
    j. Can add language about coordination with the HH – but how do we want to define the service?
    k. Should we include peers in the directive – they are frequently taught to do engagement and outreach (let's bring this up when we get to staffing)
    l. With patients it is a progressive outreach over time: starts with a letter, phone calls, outreach to the home, but you have to give the patient a break at points.
    m. Sometimes a patients HH status is unknown – and it is possible the details of HH services are not available, i.e. Community Healthcare Network HH is not clear – no data available.
    n. Define a very clear protocol on what a CCP should do (w/ regard to outreach) – then there would not be inconsistent service delivery
    o. Want to ensure client is re/engaged and in appropriate care. And that appropriate reimbursement is occurring for that care. Now we just need to find the language.
    p. How realistic is it to coordinate with a HH? Don't want to see stuff loaded into CCP that is not going to/ be paid for…
    q. Most Medicaid patients are enrolled in HH.
    r. The longer patient is unfound, the harder/less likely they will be found. What are the time limits for attempts? What defines due diligence?
    s. Is duplication of services is largely unknown?
    t. Are HH and CCP's competitors? Some say yes. Viral suppression is supported by CCP in ways HH do not.

        i. Can be considered business competitors? Maybe in early stages when identifying clients – but then separates. Slight duplication in early stages. Need to put in template an expectation of delivered services.
    u. HH contact can be overwhelming: HH don't want to hear that you are not interested – need a strategy.
        i. Do consumers know difference between HH and CCP? NO. Can be overwhelming to patients
    v. Clients=money so programs hire people that are going to be aggressive about bringing those clients into the program?-
    w. Can there be guidance around expectations: how much is reimbursement? What is burden to provider?
    x. Is this a negotiation on who gets case finding money?
7. Case Conferencing
    a. How can technology be better used to accomplish the goals of case conferencing.
    b. Defined as formal and informal – formal includes primary care provider.
    c. Are we creating a definition of case conferencing? With FIDA – everyone had to be in the same room to solve the issue of dual services – way too rigid – doctors and staff do not want to be dragged away from office hours to do case conferencing. Providers asked patients to dis-enroll. Requires flexibility
    d. Can we include skype/facetime?
    e. How well are physicians and providers engaged in the process? Seems like it is happening
    f. Every 3 months a formal case conference is required.
        i. No time for case conferencing.
        ii. Dr./PA in charge and the team coming together – not outside folks who touch the client. Only outside person is the CBO that has a formal relationship with the medical site
    g. Are there models where the CBO is not out stationed at the medical center?
        i. YES and case conferencing is difficult. When person is not engaged or in in track 4 – no monthly appointments – they go as long as 4-6 months – creates difficulty – not able to do case conferencing with these patients
    h. We do send a lot of emails to keep everyone on same page (no credit for this) providers prefer email because it saves time. Informal meetings do happen. But quarterly case conference meeting can be very difficult to achieve
    i. Formal case conference must happen in house with provider, patient does not have to be there.
    j. If you have a conversation with anyone that isn't medical provider – there is no guidance on how often that should happen – but it happens as needed. There is reimbursement for informal case conferencing (it counts toward threshold). We should include that informal case conferencing is delivered on an "as needed" basis in the directive.
    k. What is purpose of case conferencing: discuss missed appointments, hospitalizations, meds, viral count, CD4s
    l. But what really happens is that everyone on the care team has a different picture of you and your issues – they are not on same page – shouldn't case conferencing address this.
        i. Not enough awareness of specific patients and their cases
    m. What are limitations of this service? i.e. consider timing of visits as a patient moves through the track
    n. What is supposed to happen in case conferencing?

i. Yes the medication brings the viral load down – but the wrap around services – which provide support to the client – make that possible – reduce fear of meds and of care and of providers. That team approach makes viral suppression accessible to people.
ii. Case conferencing brings social determinants to light for provider and helps educate the patient. Without care coordination – less people would be ready to take the steps that result in viral suppression.

o. Case conferencing should allow phone calls – will better involve clients.
p. When Dr.'s think you are doing well – until the point where you are critically ill – Dr.'s are not trying to hear it.
q. How are we defining what care is when it comes to the patient?
r. If we could better involve the patient – can help improve outcomes.
s. Doesn't make sense to have a patient be in the room for case conferencing - BUT "nothing about us without us" – patients should be in the room.
t. Needs to be greater flexibility with regard to case conferencing. Can we come up with better use of tech?
u. Patients advocating for themselves - idea that providers know it all is at odds with client centered medicine Dr.'s need to respect patient. Dr.'s don't have to deal with side effects – we need to have more open minded providers – providers must listen to patients and adapt.
v. Priorities should be made regarding including the patient.
w. How can we include other key people in "formal" case conferencing? i.e. member of care team
    i. Maybe this needs to be in the guiding documents
x. There should be a notification to the primary care provider in advance of the case conference – going to see the Dr. doesn't mean client is healthy or have problems that are more paramount.
y. How to draft this so that other kinds of communication can constitute a case conference.
z. Must differentiate whether it is personal or a group – most case conferencing happen individually. We will follow up discussion of services with a conversation about holistic patient centered care
aa. Will it be intimidating for patient to be in a conference with all the different people who provide care to the patient?
bb. Where is email for the patient so that patient can be on same page?
cc. What does client centered mean?? This needs to be defined – it is fuzzy = define this in the directive as what is required at minimum.
dd. Can be intimidating when patient doesn't know what a patient is being called for

8. Other Directives
    a. We should make sure to include tech in other directives (sidebar)
    b. Track system may have been devised to "graduate" people to less support because of better adherence
        i. But does not fit all cases.
        ii. If you leave it up to the provider, it is the client that suffers.
    c. Necessary to define "client centered" because it does not always result in the client being put first
    d. Case conferencing, outreach and client centered – we will look at the language.