



INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th St., 7th floor
June 21, 2017, 9:30-12:30am

DRAFT MINUTES

Members Present: Lisa Zullig (Co-chair), Lauren Benyola (phone), Blaz Bush, Michael Ealy, Dorothy Farley, Janet Goldberg, Deborah Greene, Graham Harriman, Zach Hennessey (phone), Jan Carl Park, Donald Powell (phone), John Schoepp, Claire Simon, Brenda Starks-Ross (phone)

Members Absent: Christopher Joseph (Co-Chair), Peter Campanelli, PsyD, Christopher Cunningham, Joan Edwards, Peter Laqueur, Julie Lehane, PhD, Bobby Rallakis

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

Staff Present: Nasra Aidarus, Nadine Alexander, Jennifer Carmona, Bettina Carroll (Public Health Solutions), Kris Estem, Sarah Kazlowski, David Klotz, Melanie Lawrence, Scarlett Macias,

Others in Attendance: Maria A., Mark Brown, Penelope Demas, Maria A. Rodriguez

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

Ms. Zullig opened the meeting and led introductions and the icebreaker. The minutes from the June 7th meeting were approved with minor corrections.

Agenda Item #2: Review of Meeting Packet

Ms. Lawrence introduced the meeting packet, which included the most updated draft of line-by-line edits to the service directive. Also included in the packet was the summary of client vs person centered articles prepared by Mr. Joseph and one of the articles he identified, and Stepping Up, a guide to care for HIV+ Trans patients. The minutes were accepted but one change was noted later in the meeting (which will be changed). The minutes were accepted.

Agenda Item #3: Directly Observed Therapy (DOT) Presentation

Ms. Aidarus noted that the DOT was developed in response to a committee question on what the most recent literature and evidence around DOT says. The presentation began with an overview. DOT began in the field of Tuberculosis treatment. A health worker directly observes a patient take each dose of TB medication. The aim is to ensure adherence, but also provides support and a resource for patients. DOT for TB is finite – it is a 9 month regimen, while HIV meds are for life – this impacts the DOT approach for both groups. In rural areas as well as places without mass transit, DOT is very difficult.

Ms. Aidarus' presentation reviewed different studies and meta-analyses to look at the efficacy of DOT among different groups as well as pill counting, adherence and viral suppression. *Ms. Aidarus'*

conclusions from a review of the literature, as presented in her PowerPoint was that DOT was most effective when programs built rapport with the clients and when vulnerable/at-risk groups received the intervention. Video and text based DOT showed feasibility across all studies. Positive outcomes were also found with self-reported adherence, in the form of lower viral loads. The greatest impact that has been seen with DOT is when used with groups most at risk for non-adherence.

Mr. Park asked what data we have on DOT among our Ryan White consumers. *Mr. Bush* helped organize a learning collaborative to improve DOT outcomes at his and similar agencies. He noted that it has been challenging to enroll people in DOT, but that engaging providers in the conversation to recommend DOT has been shown effective. Giving people flexibility around how long they committed to DOT also worked. Travel time is a huge barrier – over the phone or video DOT would help immensely in removing this barrier. It has also been helpful to meet clients where they are –doing DOT 3 times a week instead of five. Lunch was a great incentive to getting patients into the agency to eat and take their medication. People who have success with DOT, frequently experience a drop in adherence, but when they become virally unsuppressed they are unlikely to re-enroll.

The committee discussed that DOT should focus on building rapport with the patient, and that modifications for how DOT is administered should be made to better convenience the client and improve enrollment and engagement in DOT.

Before starting the line by line editing, *Ms. Zullig* led the committee in a moment of silence.

Ms. Zullig noted that the patient assessment needs to drive the care plan and asked the committee to review the new language developed to ensure that it does. *Mr. Bush* asked we include language that allowed patients to access services before they were fully enrolled or had completed the intake, because the intake is a huge barrier. Intake is always a challenge, but especially so when a patient is in crisis. This grace period should be noted as allowed, but cannot be mandated because the agency may be on the hook if the full intake is not done. *Ms. Carroll* asked how an agency would retroactively bill for service and the grantee responded that they would figure it out. *Ms. Carroll* asked how reimbursement would work for services outside of non-medical case management (referrals). *Mr. Park* asked us to consider these issues when we discuss patient vs person centered care.

Mr. Bruce wanted to understand why intakes must be done repeatedly in the same agency for different services. *Mr. Bush* noted that it would be great if most of the intake were allowed to be pulled from the patient's medical record. *Ms. Greene* asked if the care plan must be developed at the first meeting. There was a question of what should happen at the first meeting, when a care plan should be developed, and how frequently it should be updated. The grantee wanted to be sure that the language covered the fact that unless the intake is done, services will not be reimbursed.

The grantee asked that phone and text check-ins be placed under treatment adherence and not as a part of DOT. The language was modified to reflect that.

With regard to outreach and case finding – the grantee wanted to ensure that patients were not encouraged to switch their provider when they were in fact satisfied with their care. It is ideal to minimize competition between agencies for patients. But it is critical that agencies know that clients are receiving services, even if they are no longer at their agency.

Mr. Parks asked how case finding is actualized. *Mr. Bush* responded that funding could be used to intensify patient engagement and interactions when patients are not virally suppressed/undetectable.

Inviting pharmacists to be part of the case conference brought up question of on-site vs patient pharmacist and how to identify that difference in the directive. This would be an adaptation to the model. *Ms. Farley* asked that patient consent be necessary for pharmacist inclusion. Individual consent is not necessary for information sharing inside of the patient's team within the agency. Consents already indicate who has access to which part of your medical record – there is a question of how aware the patient is of what is contained in the release.

Inclusion of the patient is dependent on many factors: readiness and capacity of the patient to be in the room during a case conference, but *Ms. Lawrence* noted that the patient should always be informed of decisions around their care. The program agreement does inform the patient about case conferencing and what is shared.

Mr. Harriman let us know that Nasra Aidarus will be leaving for a new job in Toronto and thanked her for her outstanding work for IOC and the Council.

Meeting Adjourned.