



INTEGRATION OF CARE COMMITTEE

NYU McSilver Institute
41 E. 11th St., 7th floor
June 28, 2017, 9:30am-12:30pm

DRAFT MINUTES

Members Present: Christopher Joseph (Co-chair), Lauren Benyola (phone), Michael Ealy, Dorothy Farley, Deborah Greene, Graham Harriman, Zach Hennessey, Jan Carl Park, , John Schoepp, Brenda Starks-Ross (phone)

Members Absent: Lisa Zullig (Co-Chair), Peter Campanelli, PsyD, Christopher Cunningham, Joan Edwards, Janet Goldberg Peter Laqueur, Julie Lehane, PhD, Donald Powell, Bobby Rallakis, Claire Simon

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

Staff Present: Bettina Carroll (phone) (Public Health Solutions), David Klotz, Cristine Rodriguez-Hart

Others in Attendance: Gaines Blasdel, Mark Brown, Ishalaa Ortega, Abigail Skinner

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

Mr. Joseph opened the meeting and led introductions and a moment of silence.

Agenda Item #2: Review of Meeting Packet

Mr. Klotz 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 a lit review on person centered care, a policy on the use of incentives for adherence. *Mr. Klotz* asked everyone to bring the report on Trans Supportive Health Care.

Agenda Item #3: Stepping Up: A Consensus Statement by Trans Leaders

Mr. Joseph noted that the report, Stepping Up, is brand new, and thus the conversation in IOC is timely. The chairs contacted the Needs Assessment Committee (NAC) for input, but because the need around trans-supportive care is well established and documented, the NAC gave the go ahead, with the hope that the language IOC develops can then be integrated into the Master Directive. Stepping Up is divided into 3 sections: Best Practices for Clinical Care Providers, Best Practices for Funders and Best Practices for Social Service Providers. Medical Case Management largely falls onto social service providers.

Mr. Joseph asked how much the directive can be used to guide medical care providers. *Mr. Park* noted that the document has guidance with reference to providers that the committee should be aware of,

including the World Professional Association for Transgender Health (WPATH) standards of care¹ and Culturally and Linguistically Appropriate Standards (CLAS standards).² CLAS standards are already in the Master Directive and in every Request for Proposals and contract. *Mr. Park* asked if care coordination is a gate keeping or informed consent model, which also speaks to whether the model is based in person centered care.

Mr. Joseph feels like “person-centered care” does not achieve the kind of holistic orientation that the committee desires in the way that “patient-driven” or “client driven” does. Patient centered creates the dynamic of sick person who is being cared for, while person centered is more holistic – and looks at addressing the person as a whole. Patient/person driven is more about the person guiding and choosing the direction of their care. Gate keeping speaks to a legacy of providers controlling the decisions, and has been the historical/traditional model implemented in health care organizations.

Mr. Graham asked that the language model the service being provided in that something that applies to providers seems like it would apply to the state level and thus beyond the directive. We may not be able to direct the behavior of a clinical provider, but the agency level criteria can speak to that, and be required to meet certain standards – even if it pertains to other services provided at that agency. The ADA was brought up as a comparison point. *Mr. Park* asked if the directive could require agencies to have things like gender neutral bathrooms.

The question arose about what services the directive can influence. Ryan White (RW) is a drop in a larger bucket. We are assuming that care adheres to specific standards. *Mr. Blaz* noted that part of servicing the trans community means creating spaces that are welcoming and provide safety, and where they can see themselves reflected in the staff. Article 28 also applies.³ The clinical provider is the lead of the team – they can influence that space to a large degree. The agency is funded, but the clinicians are not funded by the award– how can they be forced to be adherent and attend training or comply in general. The grantee wanted to ensure that the goal of trans supportive care can be accomplished per the directive. Agency directives would apply to contract staff, not the whole agency. Can only recommend that the whole agency receives training.

The idea is that mandating this standard of care will eventually force the entire agency in that direction. The medical providers are very powerful, and are the team leaders – wherein no matter how well trained the staff is, it can all fall apart because of the leadership. We should be able to mandate that clinicians who serve these clients be appropriately trained in trans competent care. The directive does not pay for the doctors.

The grantee suggested that for those providers who are providing care, it is highly recommended that they are fluent in hormone treatment therapy, and that skill would give providers/agencies a leg up during the application process. *Mr. Reyes* noted that trans patients he knows have expressed that the experience they have at Manhattan agencies is uppity – so something is missing. Trans supportive care goes beyond pronouns – it is more about respect for people’s desire to be addressed by their chosen names. The directive should consider this, as well as who are the population served by RW. *Mr. Reyes* requested a line that patients be seen as someone specific – and does create a distance between provider and patient.

If the entire staff is not trained in trans competence, there will be gaps that break down the entire agency’s ability to provide a trans supportive environment. It makes no sense if a few people at the clinic gender patients and are insensitive. It is necessary to monitor trans standards with the patients – otherwise the

¹ A PDF of the standards of care can be found here:

http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926

² <https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>

³ https://www.emedny.org/providermanuals/clinic/pdfs/clinic_policy_guidelines.pdf

evaluation may not accurately reflect how the agency treats the trans community. Many organizations are fudging their numbers – gender non-confirming should not count as trans because it is not stigmatizing in the way that the trans experience is – also with regard to bathrooms, a gender neutral bathroom is not the issue – the place should be respectful of people choosing to use the bathroom of their choice. Trans people want more than a neutral bathroom. The experience should be normalizing, wherein people feel like they will be respected.

The front desk staff should be properly trained – and that should be reflected in the directive. The mandate should be clinic wide. A trans person should be treated with respect throughout the clinic, not just in some parts. The electronic medical record should include appropriate pronouns. Physicians are required to be part of case conferencing and should be required to be trained in trans sensitivity and affirming, respectful standards of care.

There is a need to employ more trans workers to help with training. We need to start looking at agency and organizational policies. They should want to know how to better serve their populations. Intentional policies should use language that is inclusive and not about “giving” rights to people when these rights are the standard. Trans people need to be on the staff or in consultation with the agency.

The grantee suggested that agencies providing care in line with WPATH standards will be prioritized or given preference. The directive is about the priority of the service, not the priority of the agency. Agencies should demonstrate competence with providing trans health care. But this could create a dynamic where agencies opt out of providing trans care. The question of mandating a trans advisory board was raised, but there has been great difficulty around creating HIV consumer advisory boards in general. How should the grantee evaluate agency ability to provide trans competent care?

Mr. Blaz asked about utilizing the goal of reducing disparities to push agencies to focus on diminishing those disparities. How can this be measured? A discussion on how to measure, and what components should be measured ensued. Can we ask that there be trans representation on the consumer advisory boards? We are asking agencies to devise a plan to demonstrate how they will move forward in holistically applying this standard.

The trans population should specifically be mentioned in the directive. The grantee suggested language where preference is given agencies that adhere to the WPATH standards of care. The grantee also suggested that agencies be encouraged to engage trans persons to help guide trans care. Because trans persons disparately suffer poorer health outcomes, they must be specified in the directive. Agencies should be concerned with populations that suffer poor epidemiological health outcomes. Basing it on epidemiology gives flexibility in identifying future populations that are suffering from disparities.

A should or must debate ensued, where using the word “should” allows agencies wiggle room, but “must” may exclude agencies and reduce access to care.

The role of the patient navigator is tasked with advocating for the patient needs, so if there is a breakdown with regard to respect/competence with a population in an agency, it is the role of the navigator to ensure these issues are addressed. Agencies have to show the funder how they currently are meeting the standards or how they are planning to demonstrate trans competent care with regard to care coordination. Agencies that do this across the agency should have preference. If providers are not forced to come on board, it is generally believed that they will not.

The committee must consider that not every program is co-located with a clinic – and a question on how to enforce standards at such sites. But as the agency providing the funding, it should be possible to leverage that resource towards the goal. Demonstrate should not mean just one thing – the directive is

asking agencies to illustrate what methods they are using to implement these trans supportive standards. Because care coordination is the premier program in the portfolio, it is critical for us to get it right. It also sets the standard for the entire country.

We need to give agencies time to build up their capacity – this has been a theme and common practice in other areas. This could mean asking for a plan – which creates inclusivity. In that plan we are asking for what they are doing throughout the institution and not just in the area of care coordination.

Mr. Brown noted that we need more consumer input and less provider input. The directive has been very clear to not include educational requirements in order to open positions to people with experience, but the directive cannot address hiring practices. There should be value placed on experiences such as incarceration, immigration, special populations, etc. How do union requirements impact the educational requirements of staff?

A debate ensued on how to ensure that hiring staff with life experience is encouraged by agencies. A Staffing Model objective was wordsmithed by Mr. Joseph at the very end of the meeting.

The minutes were approved.

Meeting Adjourned.