INTEGRATION OF CARE COMMITTEE

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

M I N U T E S

Members Present: Christopher Joseph (Co-Chair), Lisa Zullig (Co-chair), Lauren Benyola (phone), Blaz Bush, Christopher Cunningham, Michael Ealy, Dorothy Farley, Janet Goldberg, Deborah Greene, Peter Laqueur, Jan Carl Park, Donald Powell (phone), Bobby Rallakis, John Schoepp, Claire Simon

Members Absent: Peter Campanelli, PsyD, Joan Edwards, Zach Hennessey, Julie Lehane, PhD, Brenda Starks-Ross

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

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

Others in Attendance: Mark Brown, Desirie Bundy, Vanessa Haney, Joshua Shelstad, Maria A. Rodriguez, Pierre Zemede

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 17th meeting were approved with minor corrections.

Agenda Item #2: Review of Meeting Packet

Ms. Lawrence introduced the meeting packet, including an updated draft of the service directive based on the discussion from the three previous meetings. The changes in the service directive were connected to the discussion notes (also distributed) with both documents highlighted to make clear what changes were made and why. The Pickers principles on patient centered care, the minutes and the July calendar were also included. Changes to the minutes were noted and the minutes were approved.

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

Mr. Joseph noted that the work of the meeting is to make our way through the updated draft of the service directive and reminded the committee that there is a tight deadline. *Mr. Park* explained the purpose of the service directive: to define the services included; define who is eligible to receive services; and to define agency eligibility. He noted that a column was missing – wherein the directive is linked to city, state and federally defined goals for ending the HIV epidemic. It is typically the second column of every directive, but was not included in the draft for CCP. *Mr. Park* suggested that the column be included in the next draft. He then introduced the committee to the concept of line-by-line editing, explaining that though

laborious, we read through to ensure that each line represents best practices, that needs are addressed and services are comprehensive.

In the interest of full disclosure with regard to potential conflicts of interest, committee members went around and declared if their agency had a CCP contract. *Mr. Joseph, Mr. Bush, Mr. Ealy* and *Ms. Greene* let us know that their institutions (Mount Sinai, Callen Lorde, Unique People Services and Elmhurst Hospital, respectively) have CCP contracts.

Line-by-line editing, starting from the first column, began. After the first column of entries was read aloud by *Ms. Zullig*, *Mr. Park* asked if the committee should include a standard to increase the proportion of individuals who enter care upon diagnosis. *Mr. Joseph* asked if that relates to the Integrated Plan's goals to increase it persons enrolled in care at diagnosis to 85% and noted that the second column with the stated goals would be useful in this instance. *Mr. Parks* asked where we are now - if the goal is 85% we need a better understanding of what standards we are using, and how we currently measure up. With looking at viral measures, the health department standard to define viral suppression is 200 viral copies, which is a 3rd generation measure, while 5th generation is 20 copies, and is the gold standard.

Ms. Lawrence asked to table the conversation about the second column until she could check in with Ms. Rothschild, the former Community Planner for the Integration of Care committee. *Mr. Joseph* noted that defining terms such as viral suppression, could be very useful. *Ms. Zullig* noted that defining terms may lock us into definitions that constantly require updating to stay current. *Ms. Aidarus* noted that if we are too stringent in the definition we may leave out agencies who do good work, but do not have the capacity yet to meet the numbers. *Mr. Park* asked that we aim for the most accurate measure and have the agencies move in this direction – and the only way to ensure movement is to define the standards. *Ms. Lawrence* asked that we choose an institution that makes recommendations current with the science. *Mr. Bruce* noted that we need consistency – does it make sense to get ahead of the CDC?

Mr. Joseph noted that if we are using the Integrated Care Goals – shouldn't it line up with that plan definitions. *Mr. Park* noted that the federal government, particularly in this moment, may not be the best guide for moving us forward. *Mr. Klotz* noted that purpose of the missing second column is for institutions like the health department to track progress through eShare. *Mr. Lacquer* asked that we table the discussion until we have more information on the standards. *Mr. Bush* agreed with idea that we be forward thinking, by finding an institution that holds up a standard that pushes us forward. According to eShare, anything under 200 is considered undetectable. *Mr. Park* wondered if we should be attaching our definitions to eShare. Ms. Goldberg noted that it is the lab that really decides if the viral count is undetectable, not eShare. It is the assays that make the determination – wherein agencies that are not able to work with a lab at that capacity will be left out. *Ms. Aidarus* noted that eShare is not the barrier. *Mr. Joseph* noted that the recommendation is to pull the language about how it is defined from the Integrated Plan.

The Council must now work with the State, not the City, to get feedback on progress. To make a determination on how we should frame virally suppressed/undetectable, it is important to know where we are now. The committee does not want to exclude agencies based on the lab they are working with. *Mr. Park* asked that our recommendations be based on science, and that we push agencies and labs to the gold standard. *Ms. Goldberg* proposed that we redefine suppression as un-detectability as a solution to the question of definition.

Mr. Joseph noted that mortality reduction had not previously been a goal. *Ms. Aidarus* noted that people are dying from co-morbidities, and while some clients may be accessing care in emergency scenarios, they are not continuously engaged in care. It is important to be conscientious of who is dying of HIV

related deaths. The question of how CCP patients' other medical issues are handled, such as cancer, etc. Patient interventions may not fall under CCP, but can possibly addressed in another service directive.

Ms. Zullig finished reading through the first column. The committee debated where the language about referral linkage belongs to ensure that agencies are not just handing the patient a sheet of paper with a referral and sending them off. Committee agreed to include language that says referral and linkage to social service support.

Mr. Joseph asked the committee about the use of Picker's Principles to define client centered, and how the committee felt about that choice. *Mr. Park* asked us to look at the difference between client oriented vs. client centered and recommended that we consider other choices, and that theme should apply to the entire CCP program. *Ms. Farley* asked if we should leave non-judgmental out as it should be covered under client centered. *Mr. Park* asked the committee to look into alternate models to our care coordination program.

Mr. Reyes asked that we remember that the consumers in the room should be the ultimate guides on how client centered is defined in the document - how would a provider interpret the list of Picker's Principles. The grantee figures out how to interpret the directive for the agencies to ensure that it is implemented appropriately. The roll out of trauma informed care has probably had the most impact on the all services in the portfolio. Trauma informed care has been integrated into all parts of portfolio, through trainings and evaluation that ensured it was being integrated into agency work. That model of care highlights the importance of carefully defining client centered. As we go through the directive, we have to ask: do these principles align well with what we want for patients. The principles would only apply to the CCP service directive, unless it was decided to add them into the master directive.

The committee was asked to bring/send in client centered/oriented definitions that they like or that their agencies use. *Mr. Joseph* asked that the peer recommendation (to utilize peers as often as possible) be moved from the boiler plate language. The committee did not feel comfortable with moving the peer recommendation to the agency eligibility section as not all agencies have the capacity to run a peer program/hire peer workers.

The committee asked how "logistics coordination" is defined, as it felt unclear. Different language was proposed. *Mr. Powell* asked for appointment preparation, and client re-engagement, beyond outreach, to be included. *Mr. Reyes* noted that appointment support should already include logistics coordination – and that there is confusion around specifics vs umbrellas. *Mr. Bruce* noted that umbrellas are necessary, because it can be too much to list, but some specifics must be noted because the umbrella may not typically include them. *Mr. Bruce* asked how to include an evaluation of client capacity to get to appointment.

Mr. Lacquer asked that we use consistent language throughout the document, and that housing specifically be mentioned. *Mr. Joseph* noted that the specifics of appointment support would benefit from a specific definition. The committee agreed that medical and non-medical services should be separated. CCP should provide medical services with referrals for all other services. The committee agreed to re-define Care Navigation as Clinical Care Navigation. *Ms. Carroll* noted that the service directive document is for the grantee – and it needs to stay more general to avoid leaving things out – emphasizing the difference between a Request for Proposals (RFP) and the service directive. *Mr. Park* noted that certain specifics, even if in the footnotes, are important, such as ensuring that text messages be used for appointment reminders – and that it is a fine line between the RFP and the directive. Ms. Zullig noted that we should table that question due to the time.

Meeting Adjourned.