HIV Health & Human Services
PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting of the

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE

Monday, June 23, 2014
AIDS Service Center of NYC, 85 University Pl., 5th Floor
3:10 – 4:50 pm

MINUTES

Members Present: Sharen Duke (Co-Chair), Matthew Baney, Randall Bruce, Nancy Cataldi, Robert Cordero, Graham Harriman, Amanda Lugg, Peter Laqueur, Deb Marcano, L. Freddy Molano, M.D., Jan Carl Park, Tom Petro, Allan Vergara (by phone), Leonardo Vicente III

Members Absent: Felicia Carroll, Joan Edwards, Jan Hudis, Daniel Pichinson, Sam Rivera

Staff Present: David Klotz, Nina Rothschild, Rafael Molina, Anna Thomas, (DOHMH); Rachel Miller (Public Health Solutions)

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

Ms. Duke opened the meeting followed by introductions. *Mr. Park* led a moment of silence. The draft minutes of the May 12, 2014 meeting were approved with no changes. Mr. Klotz reviewed the meeting packet. Ms. Duke announced that ASCNYC will be moving its offices in the fall to Midtown Manhattan.

Agenda Item #2: Mental Health Services Directive

Ms. Cataldi and *Dr. Rothschild* presented on the revised Mental Health (MH) services directive approved by the Integration of Care Committee (IOC) after extensive data review, presentations and review of current services. The goals of Part A MH services are: to provide treatment and care to PLWHA with mental illness, with or without substance use disorders; to improve quality of life and mental health functioning; to overcome barriers to mental health care; to facilitate ongoing involvement in bio-psychosocial care and treatment, including adherence to ART and/or psychotropic meds; and to reduce use of emergency care. These goals map to a number of objectives in the EMA's Comprehensive Strategic Plan, including reducing health disparities.

The philosophy behind the new directive is: client-centered; non-judgmental; guided by harm reduction principles; trauma-informed (understanding the impact of trauma and paths for healing); culturally appropriate; and tailored to populations served. Specific targeted populations include (but are not limited to): individuals with diagnosed mental illness or in need of mental health services; persons with co-occurring mental health, substance use, and other medical

conditions; chronically homeless, homeless, and unstably housed PLWHA; home-bound clients; gay, bisexual, other MSM, lesbian; transgender men and transgender women; and immigrants.

Required components of the service include: referral to medical care, MCM, housing, substance use treatment, independent living skills, food and nutrition, and legal services; individual and/or group treatment adherence counseling (includes discussion about PCSM, appointment adherence, ART and psychotropics adherence) and coordination with client's providers; mental health intake assessment, diagnosis, and treatment; crisis intervention; and individual and/or couple/family and/or group mental health counseling services.

Optional components include: psychiatric evaluations and follow-up visits; psychiatric re-evaluation; psychotropic medication monitoring and management, and linkage with inpatient psychiatric care when indicated; individual, group, and family services for clients with a history of or currently using alcohol or other drugs; client engagement activities (scheduling appointments and coordinating services); outreach for client re-engagement to monitor scheduled appointments and follow-up on missed appointments; wellness individual or support groups to educate and monitor clients on key issues related to the client's current MH needs and potential barriers to MH treatment; and interpersonal violence assessment/intervention. Special considerations include accompaniment services as appropriate to external agencies and within the mental health program's facility, and home-based services for clinical purposes including services listed above as appropriate and necessary.

Client eligibility is individual and family units with one or more HIV+ persons and in which the HIV+ person has a DSM-5 diagnosis. Active substance use does not preclude eligibility for and maintenance in services. Also, client must have a household income less than 435% of FPL and live within the NY EMA.

Agency eligibility is: Licensed Article 31 or Article 28 mental health providers currently certified to deliver outpatient MH services or CBOs with an MOU with an Article 31 provider who has added the CBO site to its licensure. Organizations should have multi-disciplinary MH programs including counseling, psychiatric care and/or pharmacological management, and alcohol and substance use services, should use multiple, evidence-based therapeutic modalities and/or best practices including harm reduction approach, should have experience with HIV+ persons and active substance users, and should have experience with persons who are out of care or sporadically in care, transitioning from institutional care, or needing self-management support. Agencies must be co-located or have linkages with programs providing medical and psychosocial support services, Medicaid, Medicare, and NYS Health Insurance Exchange Systems, and health homes, must ensure that staff have HIV knowledge, training, cultural sensitivity and must be able to provide services in languages of populations served, and must be accessible to clients from throughout the NY EMA.

The new directive is very similar to the core elements of the current services, but there are refinements, such as to the philosophy and targeted populations, as well as inclusion of linkages with Health Homes and Health and Recovery Plans (HARPs), which did not previously exist, so that Medicaid and other payers can be billed when possible. The link with medical services is also more explicit.

The directive does not include a targeted allocation of $834,060 to provide wrap-around low threshold (non-DSM) counseling services in State-funded syringe exchange programs, which IOC recommends retaining and reclassifying as part of the Supportive Counseling and Family Stabilization (SCF) category, as it fits better in the SCF definition. There is also a targeted allocation for MH services in HASA housing, which would be included in the new MH service directive.

The following is a summary of the ensuing discussion:

- Reclassifying the wrap-around services in syringe exchange programs is an excellent idea, as it lifts the onerous requirement that the services be provided by licensed MH professionals. This will allow programs to stabilize clients in crisis and link them to professional MH services. Also, this service is not Medicaid reimbursable.
- IOC's development of service directives in a silo with no direction on the cost of services is a flaw in the planning process. PSRA needs to be brought in to the discussions so that it can better understand the directive, the need for the service and the cost.
- Unit cost and the allocation are separate issues. Allocations are the overall amount for the service, based on need, which can be informed by the Needs Assessment Committee.
- PSRA has always used the carrying cost of programs as the basis for allocations, because if a category needs more funds, then it must be taken from somewhere else. A zero-based budget could be done, but it would be destabilizing to the portfolio.
- The PSRA and IOC chairs and staff will discuss involving PSRA earlier during the development of the next service directive, Home and Community-based Services.
- PSRA, at a minimum, must approve a list of ranked categories and a spending plan for the application by the end of July's meetings. Given the large-scale changes in the ranking from the previous year and the limited time, it would be more practical for PSRA to rank new service directives, and reaffirm rankings of continuing services.
- PSRA should review the ranking tool, and get updates from Christine Rivera on the affect of the insurance exchanges on ADAP enrollment, in addition to the Medical Case Management update planned for this meeting.

An additional PSRA meeting was set for Wed., July 9th, 2-5pm, followed by a final meeting on Monday, July 21st, 2-5pm.

There being no further business, the meeting was adjourned.