



Meeting Minutes
INTEGRATION OF CARE COMMITTEE
Nancy Cataldi and Charles Shorter, Co-Chairs

December 19, 2012
Cicatelli Associates, 505 Eighth Avenue
20th Floor, Yellow Room
10:00 am – 12:00 pm

Members Present: Victor Benadava, Christopher Cunningham, Joan Edwards, Janet Goldberg, Graham Harriman, Tracy Hatton, Daphne Hazel, Christopher Joseph, Jan Carl Park, Andresa Person, Charles Shorter, Brenda Starks-Ross

Members Absent: Nancy Cataldi, Hans Desnoyers, Deborah Greene, Sandy Guillaume, Terry Hamilton, Peter Laqueur, Julie Lehane, PhD, Jun Matsuyoshi, Mary Poupon, Robin Wilder, Lisa Zullig

NYC DOHMH Staff Present: Amber Casey, Mary Irvine, DrPH, Rafael Molina, Amanda Raker, Nina Rothschild, DrPH, Chris Williams

Public Health Solutions Staff Present: Bettina Carroll

Others Present: Randall Bruce, Felicia Carroll, Billy Fields

Material Distributed:

- Agenda
- Minutes from the December 5th IOC Committee Meeting
- Presentation on The Positive Life Workshop by Amanda Raker
- Positive Life Workshop Flow Chart
- Draft Health Education/Risk Reduction Services Directive
- Draft Planning Council Calendar for January 2013

Welcome/Introductions/Moment of Silence/Review of the Meeting Packet/Review of the Minutes: Charles Shorter welcomed meeting participants. Committee members introduced themselves and observed a moment of silence. Nina Rothschild reviewed the contents of the meeting

packet. The minutes from the IOC Committee meeting on December 5th were accepted for posting on the Planning Council website at nyhiv.org.

Care and Treatment's Response to Issues Raised at December 19th IOC Committee Meeting: Amanda Raker of the Care and Treatment Program addressed a number of evaluation questions concerning The Positive Life Workshop (TPLW). The logic model for TPLW was created by the curriculum developer and presents the intended immediate effects of participation in the workshop, including an increase in knowledge, attitudes, and skills, along with the opportunity to meet other PLWHA. After the full 20 hours of the workshop, participants should have more understanding of personal health, the self-manager role, life course development, self-monitoring, and the importance of support. Medium-term outcomes include increased engagement in healthcare, improved treatment adherence, a reduction in risk behavior, and addressing biological, psychosocial, and social life issues as co-factors in HIV illness.

Participants in TPLW take a pre- and post-test survey and a three-month follow-up survey. The survey contains four knowledge item questions and assesses attitudes toward HIV and behaviors. The survey was piloted in March of 2012 and showed no significant improvement in knowledge – but the survey only asked four questions and was distributed to participants who had a high level of knowledge before even enrolling in the workshop. Over 85% of participants responded correctly on the pre-test, indicating substantial awareness of the subject matter. The survey did, however, reveal significant increases in participant understanding that having a high CD4 count is desirable. Limitations include the small sample size, the fact that the training did not take place under the more controlled circumstances of a laboratory setting, the fact that some people arrived late, and the fact that wooing participants to come back for a three-month follow-up visit is challenging.

Next steps include using data from the pilot study to update the survey tool and expanding knowledge items. Evaluators will continue to assess the reliability and validity of the evaluation survey. They also plan to match the workshop data with the HIV surveillance registry data to assess medical care engagement and viral load suppression over time in workshop participants.

Daphne Hazel asked whether the survey and workshop captured the population for whom the intervention was intended – namely, individuals at high risk of not remaining in care. Amanda Raker noted that NYC DOHMH staff are moving The Positive Life Workshop program to agencies in order to reach the intended population. Graham Harriman stated that we are changing the model to better reach people who are marginally in care. The language of the survey is at a fifth-grade literacy level, and building in the use of peers should also help to attract relatively marginalized populations. Christopher

Cunningham asked about the data on one participant who appeared to have less knowledge after participating in the workshop than he did when entering the workshop. Dr. Mary Irvine responded that the incorrect response might have been related to the wording of the question and that in any case the difference is not significant.

Victor Benadava stated that the information provided in the workshop is really good but is a lot to digest and might be too much for people who have issues on their mind such as feeding their kids. Mr. Harriman noted that he took several years to come to grips with his illness but that the curriculum is very client-centered. The best way to encourage behavioral change is to help people identify the changes that they want to make. Reaching people not in care is challenging, and we want to find candidates for the program who have a variety of challenges – for example, with adherence to medications.

Jan Park noted that the Committee's task is to construct a service directive and move the program into the community. Brenda Starks-Ross asked about having a precursor program for people who are really not in the system and not functioning. Ms. Hazel commented that TPLW provides a lot of information at one time and suggested that we look at spreading it out over time and also reinforcing the information provided at other encounters, such as visits to doctors and hospitals. She suggested an alternative implementation plan with less time per session and a larger number of sessions. Felicia Carroll also stated that TPLW provides too much information for someone who is newly diagnosed. When she took the workshop, one man was rocking in his chair and crying, and no one on the DOHMH staff reached out to him. Ms. Raker noted that she has seen people cry at workshops. The program's purpose is to help people to take first steps, offer support, and open the door.

Mr. Harriman noted that by changing the model, we can better address these concerns – and a hospital or clinic or CBO is better positioned to do this than DOHMH is. DOHMH is not a direct service provider. Joan Edwards asked whether the program could be offered at higher and lower thresholds. Charles Shorter noted the importance of community support and involvement at intake. Janet Goldberg commented that her expectation – and the expectation of others in the community – is to link the person to care when the door is opened.

Christopher Joseph asked whether the program uses techniques such as motivational interviewing and stages of change and whether we can tailor it for people with higher and lower levels of knowledge. Mr. Harriman responded that the program, especially the peer component and breakfast sessions, is client-centered, and the health journal is client-centered and stages-of-change-centered. Mr. Benadava argued that the clients wouldn't use the journal. Ms. Hazel asked about what happens to the peer educators

after they have been trained. Mr. Harriman noted that we have worked with these peers for two years and don't want to abandon them. Mr. Benadava asked why Planning Council money should pay DOHMH staff to conduct the training. Why can't peers do the training? Mr. Harriman responded that we want to train the peers and provide them with support to make sure that they present the curriculum as intended.

Jan Park noted that this is not a peer reviewed intervention – the Committee is being asked to support a work in progress that has implementation challenges and has probably not had much of an effect – and we have already invested \$1.5 million dollars. Will implementation through CBOs fill in what's missing? Do we have to accept this package as is, or can we break it apart? Mr. Harriman noted that DOHMH conducted focus groups with consumers and providers, and they identified important areas to cover in the workshop.

Randall Bruce stated that he took the course already and sat in a room with people who were out of care. Some understood half of what was being said but were not really interested. He stated that the newly diagnosed are not engaged in a program such as this and that the program should be developed for people who have lived with HIV for three or four years. He needed four years to get his T-cell count up to fifty. Mr. Harriman noted that only 9% of people who have gone through the workshop are newly diagnosed. DOHMH does not pretend to address every person's issues with this twenty-hour program, but he does believe that this is an important part of our portfolio to help PLWHA manage their health.

Christopher Cunningham stated that no one is ready for twenty hours of presentation. Such a program has utility, but it has to meet the needs of the participants. If we bring this program to the community, we should have two or three workshops targeted to different stages of dealing with HIV. Daphne Hazel noted that if the program is given to the CBOs, DOHMH will require rigorous monitoring and evaluation. Mr. Harriman stated that we need to locate the intervention in the community. We are doing limited partnerships and want to do more. Outcomes so far are premature – seeing an impact takes several years. Janet Goldberg expressed interest in bringing the program into the community sooner and noted that she would like a quick screening, not a lengthy screening. Ms. Raker noted that the program facilitates connections with peers.

Dr. Mary Irvine noted that if different groups (e.g., at various CBOs) were to conduct different versions of TPLW, evaluation would be difficult. The evaluation tool is already being revised. Unlike the situation with our other programs, there is no six-month reassessment. The data from TPLW can be matched to data in DOHMH's HIV surveillance registry so that we can look at outcomes in the group as a whole – we are allowed by law to use data in the

aggregate to measure program impact -- but there is a 9-12 month lag before surveillance data becomes available. Jan Park stated that IOC's next step would be to start examining the service directive itself.

Committee members examined some estimates of program cost. Ms. Hazel commented that \$480,000 has been allocated to the workshop, at a cost of roughly \$43 per person just for the intake interview, and the cost for someone who completes the program is around \$2,000. Mr. Harriman stated that he would provide precise information on cost per participant to IOC members. Mr. Cunningham reminded the group that you cannot assess need just by looking at participants in the course. Bettina Carroll noted that starting up a program takes approximately six months. Ms. Hazel asked whether the program is worth the investment and said that she cannot vote until she sees more precise figures on the cost. The group was reminded that the Planning Council cannot deal with procurement issues (cost per service).

Janet Goldberg noted that having a peer program in the community can work really well. This is community education and should work better in the community. She made a motion to move forward with moving the program into the community, given that CBOs are better positioned to connect people to services. Mr. Harriman reminded IOC members that what we are spending with our current portfolio is different from what we will be spending with changes in the health care system. IOC Committee members voted to move forward with developing a service directive.

Adjournment: The meeting was adjourned.