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

February 20, 2013
Cicatelli Associates, 505 Eighth Avenue
19th Floor Training Room
10:00 am – 12:00 pm

Members Present: Victor Benadava, Nancy Cataldi, Christopher Cunningham, Graham Harriman, Tracy Hatton, Daphne Hazel, Christopher Joseph, Peter Laqueur, Jun Matsuyoshi, Jan Carl Park, Andresa Person, Charles Shorter, Brenda Starks-Ross

Members Absent: Joan Edwards, Janet Goldberg, Deborah Greene, Sandy Guillaume, Terry Hamilton, Julie Lehane, PhD, Mary Poupon, Robin Wilder, Lisa Zullig

NYC DOHMH Staff Present: Amber Casey, Alison Jordan, Rafael Molina, Nina Rothschild, DrPH, Darryl Wong

Public Health Solutions Staff Present: Bettina Carroll

Others Present: Adrian Assing, Randall Bruce, Felicia Carroll, Billy Fields, John Hatchett, Zachariah Hennessey, Mallory Lowenstein, Terriell Peters, Donald Powell, Nilda Ricard, Guy Williams

Material Distributed:

- Agenda
- Rules for Respectful Engagement
- IOC Meeting Minutes from February 6, 2013
- HERR Positive Life Workshop Draft Guidance
- Presentation on non-Medical Case Management
- Planning Council Calendar for February 2013

Welcome/Introductions/Moment of Silence/Rules for Respectful Engagement/Review of the Meeting Packet/Review of the Minutes:

Committee Co-Chairs Nancy Cataldi and Charles Shorter welcomed meeting participants. Committee members introduced themselves. Meeting participants observed a moment of silence. Brenda Starks-Ross reviewed the rules for respectful engagement. Nina Rothschild reviewed the contents of the meeting packet. The minutes from the most recent IOC Committee meeting on February 6th were accepted for posting on the Planning Council website at nyhiv.org.

Public Comment: Zachariah Hennessey from the Center for Comprehensive Care stated that he had challenges with The Positive Life Workshop (TPLW) when it was initially offered by the New York City Department of Health and Mental Hygiene (NYC DOHMH) because his organization already provides patient education and had to re-direct clients away from the Center's own services and to TPLW. He expressed a preference for restructuring the Health Education/Risk Reduction (HE/RR) funding so that sites that have developed and implemented their own curricula can retain their autonomy and apply for City money to augment their own program. Sites should be able to use their own staff and resources with the goal of attaining improved self-efficacy for clients. He noted that organizations with an HIV prevention contract with DOHMH have to refer their clients to TPLW and that this arrangement undermines those organizations' own programs.

Mr. Hennessey also commented that the percentage of clients who would actually enroll in TPLW was very small because most clients were already enrolled in a medical home by the time they received the referral. Every patient in his program is assigned a social worker and a primary care provider, and the social worker makes referrals. Referrals through TPLW, therefore, are not necessary.

Donald Powell from Exponents stated that his organization has a peer-centered and peer-developed model with peer-delivered services for chronic disease self-management. The program is funded by the National Institute on Drug Abuse (NIDA). The curriculum focuses on treatment adherence and primary care engagement. Reports on primary care status measures are required every three months. Exponents just graduated its 10,000th graduate in December. Mr. Powell expressed his hope that the Planning Council would make awards to organizations that already have their own programs. Basically, he noted, Exponents/Arrive does the same thing as TPLW. He noted, too, that TPLW provides an overabundance of information for people who are newly diagnosed.

Guy Williams and Terriell Peters of the AIDS Service Center of NYC stated that their organization has an 8 week peer recovery education program that transforms people's lives. When enrollees graduate, they go into the community and pass the information onward. Over 25% of AIDS Service

Center staff were peer educators. Mr. Williams noted that twelve years ago, he was living on the streets but is now an employee. ASC transforms the lives of people disconnected from their families. Mr. Peters stated that he was living in the South, where ADAP had a waiting list. He had family and friends up here who told him about the AIDS Service Center, and he came as a client. Within two days, he had a doctor and medicine; he graduated from the Prep program; became a trainer; then became a senior peer liaison; and interviewed for positions. Despite a history of incarceration and self-destructive thoughts, he took advantage of the opportunity for a healthy life. Jan Park noted that when he received his diagnosis in the early '80s, when nothing could be done for the infection, he appreciated having a place to go to open up.

John Hatchett stated that Cicatelli's Leadership Training Institute (LTI) began with funding from New York City and New York State. The training is still directed and delivered by HIV+ individuals. He urged the IOC Committee members to consider models other than The Positive Life Workshop. LTI has a three-day workshop focusing on treatment resistance, adherence, opportunistic infections, remaining healthy, and matches participants with a peer mentor. Four-hundred people have gone through the program in the last five years. Coming together with HIV-positive peers and trainers is meaningful. The atmosphere is not the same when programs aren't peer-delivered or peer-led. Mt. Hatchett stated that TPLW provides information overload without sufficient support and encouraged IOC Committee members to consider other models and offer choices. Self-management is a journey, he noted, not a destination.

Mr. Park noted that Mr. Hatchett's program was defunded by NYC DOHMH when TPLW was developed. Mr. Benadava stated that everyone felt that Dr. Fabienne Laraque took something away from PLWHAs when support for LTI ended.

HE/RR Discussion: Graham Harriman noted that members of IOC have spent five meetings going over the HE/RR Positive Life Workshop service directive. We have other issues to consider, including the Affordable Care Act and health homes. This kind of debate is not how we should use our time, he stated. This is just a very small piece of the much larger grant with which we will be working. He pointed to the timing of the process and the need for the IOC Committee to engage in proactive planning. Victor Benadava stated that instead of inviting peers from TPLW, the grantee should have invited the community to present at the first or second meeting. The community should not have had to wait until the fifth meeting in order to present programs. If the IOC wanted to look at other health education programs, this should have been included much earlier in the process.

Jan Park stated that the Committee is developing a health education service directive and that anyone in the community can apply for funding. This particular model was approved by the Planning Council, paid for with Ryan White Part A funds, and then designed through a community input process by DOHMH – i.e., it was a Department initiative – so the Department came here to persuade the community that this is a worthwhile undertaking. Jan Park noted that this won't replace other models and is just another option. Mr. Harriman noted that he sees the Planning Council and IOC members as his Board of Directors. If members want people from a variety of organizations providing patient education to come and present, he answers to the membership.

Ms. Hazel stated that there is no evidence that TPLW has had any impact, but that everyone except for her was voting in favor of it. Committee members should have asked for more information. Mr. Park stated that a service directive is for a whole service category, not for a specific program. He also noted that every Planning Council across the country does this differently but has to meet general guidelines. The Planning Council directs the grantee to put together an RFP specific to the wishes of the community, and our federal partners (HRSA) have questions about how this process has taken place in the NY EMA. We should review what our federal partners say. There are enough opinions about TPLW to put this initiative on hold. Mr. Benadava made a motion to postpone the conversation on HE/RR, Peter Laqueur seconded the motion, and the motion passed.

Non-Medical Case Management (non-MCM): Amber Casey opened the discussion of non-medical case management, noting that DOHMH currently funds services for people who are incarcerated and are about to be released. The waiver of the 75/25 core/non-core service allocation provides us with a unique opportunity to expand the NY EMA's offering of non-core services to meet people's needs. Mr. Park provided some context, noting that we funded non-medical case management prior to five years ago but have spent the last few years focusing on medical case management, which we fund at $25 million. In 2006, HRSA shifted its emphasis to MCM. Even within MCM, non-MCM still occurs when case workers focus on accessing benefits and entitlements.

Mr. Park stated that the Rikers Island Transitional Health Care Consortium is a Department of Health and Mental Hygiene program. He noted that we should make sure that we don't make the same mistake here as we did with HE/RR, focusing exclusively on DOHMH programs, and clarified that what we are discussing today is non-MCM specific to Rikers Island. He asked where the opportunity is to bring the community in and inquired whether the current approach seems reasonable. Brenda Starks-Ross commented that she feels as though she is being rushed. Nancy Cataldi noted that Ms. Casey is trying to

present the definition of non-medical case management and that Committee members should let her finish.

Non-medical case management consists of services providing advice and assistance with benefits and entitlements counseling, referrals, and transitional case management for incarcerated persons as they prepare to exit the correctional system. It does not involve coordination and follow-up of medical treatment. Non-medical case management (n-MCM) is ranked high on our grant application to HRSA and is non-Medicaid billable. It is similar to health homes. nMCM is ranked so high because there is no other payer for these services. The allocation to Rikers is 4.8% or $5.2 million for services for the incarcerated and formerly incarcerated. This includes transitional services and a drop-in center for recent releasees. Los Angeles calls this service category case management, psychosocial and allocates 7.6% of its budget (including local county funds) to it.

The CHAIN research team members, who are following cohorts of individuals living with HIV/AIDS over the course of many years, have created a proxy for case management. Individuals in need of case management possess one or more of several characteristics, including poor mental health functioning, recent emergency room use, impatient care, or mobile unit visit for psychiatric or mental health reasons, recent drug or drinking problem, or recent housing instability. Adequate utilization, according to CHAIN, requires one or more of the following services in the past six months among those in need: development or revision of a care plan or referral for social services or assistance in completing an application for benefits or entitlements.

Potential opportunities include refining service delivery for individuals who are currently or were recently incarcerated, providing low-threshold, time-limited case management benefits and entitlements counseling, providing low threshold, non-medical case management for undocumented individuals, and providing case management services that are removed from primary care sites – e.g., for mental health case management or substance use treatment case management. Ms. Casey encouraged IOC Committee members to think of questions they'd like providers to address. Thus far, invited providers for future IOC meetings include providers we already fund.

Non-Medical Case Management on Rikers Island: Alison Jordan, the Executive Director of the Transitional Health Care Consortium on Rikers, stated that the average daily census on Rikers is approximately 12,500. About 100,000 admissions take place annually. Approximately 70% of the people released from New York City jails return to areas with the greatest socioeconomic disparities. Rikers is 100% funded by City Tax Levy. All the jails on Rikers use Electronic Health Records (EHRs), making it easier to see inmates' health records from their previous admissions.

The Rikers population is aging. Short stays are the norm. More than half of inmates leave within a week, giving staff limited time in which to diagnose, start treatment, and maintain care. During the intake interview, staff members take a history and offer a physical exam with universal voluntary testing less than 24 hours following admission. Testing is offered on an ongoing basis thereafter. If a client self-reports that he/she is infected, staff members work from the self-report. In order to promote access to care, staff do case conferencing pre-release, provide a medical summary, offer accompaniment and transportation, and connect PLWHA with a community case manager. The goal is to help PLWHAs to feel supported. Rikers Island staff use evidence-based models and tools and ultimately try to transfer the key elements of what works from jail staff to community providers. More than 200 community partners exist, and Rikers staff members do a lot of education with those partners.

Asked about use of condoms in jail, Ms. Jordan responded that carrying an open condom in jail is illegal. The Department of Corrections permits the distribution of three condoms during an inmate's stay, and inmates are again given condoms when they are released. Approximately 1,300 people are linked back to care within the community. Client level outcomes for 249 individuals with 6-month post-release jail linkages include increased CD4 counts, more individuals taking their medications, fewer reports of hunger, improved overall health and mental health, improved treatment adherence, improved viral load, lower numbers of homeless individuals, and fewer emergency department visits.

Adjournment: The meeting was adjourned.