Meeting Minutes

INTEGRATION OF CARE COMMITTEE

Nancy Cataldi and Christopher Joseph, Co-Chairs

February 5, 2014
McSilver Institute at NYU
41 East 11th Street in Room 741
10:00 am – 12:00 pm

Members Present: Michael Ealy, Dorothy Farley, Janet Goldberg, Deborah Greene, Graham Harriman, Tracy Hatton, Daphne Hazel, Zach Hennessey, Christopher Joseph, Jan Carl Park, David Price, Gina Quattrochi, Bobby Rallakis, Lisa Zullig

Members Absent: Moya Brown, Peter Campanelli, PsyD, Nancy Cataldi, Joan Edwards, Sandy Guillaume, Terry Hamilton, Peter Laqueur, Julie Lehane, PhD, Jun Matsuyoshi, Andresa Person, Mary Poupon, Brenda Starks-Ross, Robin Wilder

NYC DOHMH Staff Present: Mary Kay Diakite, Katrina Estacio, Nina Rothschild, DrPH

Public Health Solutions Staff Present: Bettina Carroll, Rachel Miller

Others Present: Diana Arias, Yvette Ayala-Burnstin, Elainee Ayzman, Velia Hernandez (for Brenda Starks-Ross), Steven Hornsby, Natalie Humphrey, PhD, Donald Lee, Mallory Lowenstein, Andre Peck, MD, Lorraine Pirro

Material Distributed:

- Agenda
- Minutes from the January 15th Meeting of the IOC Committee
- Presentation on NYC Ryan White Part A Mental Health Service Category
- Mental Health Service Category Development Provider Questions
- Ryan White Part A Mental Health Service Category Provider Responses to Survey
- PSRA Scorecard on Mental Health Services
- Payer of Last Resort Tool – Providers of Mental Health Services

- Planning Council Calendar for February 2014

Review of the Meeting Packet/Review of the Minutes: Committee Co-Chair Christopher Joseph welcomed meeting participants. Committee members introduced themselves. Graham Harriman led the moment of silence. Nina Rothschild reviewed the contents of the meeting packet. The minutes from the January 15th IOC meeting were accepted for posting on the Planning Council website at nyhiv.org.

Survey of Ryan White Part A Mental Health Service Providers: The Care and Treatment Program sent a survey to the providers of mental health services with which it has contracts, and 17 out of 21 providers (81%) completed the survey. One provider noted that most of the mental health clients are not Medicaid-eligible, and most are uninsured or underinsured. Providers can offer wraparound services and effectively link clients to care. The system is flexible and provides various contact points, and Ryan White enables the funding of culturally competent staff. The spirit of the services is collaborative, affirming, and non-judgmental.

One-third of service providers said that the Medicaid certification requirement has had no impact on service delivery. Other providers cited positive aspects of the certification requirement including improved capacity and facilitated access to psychiatric evaluation and medications. Negative features include a potential reduction in the number of mental health visits and more administrative monitoring. Other challenges for providers include continuity of care and staffing issues: only credentialed staff can bill Medicaid. Committee member Gina Quattrochi noted that her organization can provide a higher level of care now that it is an Article 31 facility.

Zach Hennessey mentioned the possibility of channeling resources to provide mental health services in unconventional environments. Because of stigma, many clients don't want mental health services, but embedding them in other might be a helpful approach.

Gaps and challenges include eligibility verification, incentives, staffing, billing and documentation, and lack of services.

> Incentives: Clients receive different incentives from various agencies, and some offer non-Ryan White incentives. Dr. Natalie Humphrey, Planning Council member and clinical psychologist at Harlem Hospital Center, noted that incentives help with HIV treatment adherence. Mary Kay Diakite of the Care and Treatment Program suggested that providers email her with ideas about incentives for patients, and the incentives could be embedded in the mental health service directive.

Staffing: Agencies do not have enough staff for data entry, and clinicians often feel burdened by the amount of data entry

Billing and Documentation: Staff members spend a great deal of time on billing and on documentation. Dr. Humphrey noted that if a client sees a psychiatrist for medication and then sees her for therapy, lots of notes are required. A more flexible approach and more funding to support documentation would be helpful. E-Share is very burdensome, requiring about 300 hours per year or 7 hours per week per worker to enter documentation. Each month, agencies have to report on their yearly target but are not paid separately for providing this documentation.

Lack of Services: Service provision would be enhanced by options such as videoconferencing for maintaining appointments, affordable housing, and urgent care.

Successes include client satisfaction, enhanced health outcomes, and achievement of intermediate program outcomes.

Client Satisfaction: Clients report improved well-being and quality of life and are satisfied with quality and services provided.

Improved Health Outcomes: Clients report improvement in symptoms, suppressed viral load, greater adherence to medications, and reduced use of ERs and crisis interventions.

Intermediate Program Outcomes: Clients are retained in care, and programs show increased demand for services, engagement, and linkage to care, and better communication between providers.

Provider Panel: Current providers of Ryan White Part A mental health services from Harlem Hospital Center, the Salvation Army, Harlem United, the Haitian Centers Council, Public Health Solutions' Assessment and Referral Team, and Project Hospitality identified specific components of the mental health service category that should be considered for enhancements/reductions. Some of the points they raised, and comments made by Committee members, included the following:

- Treatment adherence is limited to two sessions per month and should be enhanced. Service providers out perform their targets.
- Care coordination with service providers is limited to one session per month and could be enhanced. Clients have multiple needs, including homelessness, and meeting these needs requires work beyond the single episode per month for which providers can be reimbursed.

- We need to look at systemic models of mental health care, including mental health case management.
- The Planning Council should increase funds for services that are not Medicaid-billable.
- Mental health advocacy works well.
- The therapeutic alliance is powerful.
- The IOC Committee should consider a carve-out pilot program that would provide all services for mental health patients.
- IOC should consider placing these services in locations capable of providing a more comprehensive program – otherwise, you're just applying a bandaid.
- One-stop shopping is helpful. In response to a suggestion that organizations partner with other organizations in their area, one panel member noted that his organization has tried that arrangement but that requiring clients to go to a different sites is a burden. Seriously and persistently mentally ill (SPMI) patients have more trouble accessing services. The current model is designed to capture people who have become lost to care and help them to access resources.
- Examining the different funding streams and using them appropriately and without duplicating services is important.
- IOC might consider reducing the use of family interventions because attendance is sporadic.

Public Comment: No members of the public commented.

Adjournment: The meeting was adjourned.