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 Minutes

INTEGRATION OF CARE COMMITTEE

Nancy Cataldi and Christopher Joseph, Co-Chairs

March 19, 2014
McSilver Institute at NYU
41 East 11th Street in Room 741
10:00 am – 12:00 pm

Members Present: Nancy Cataldi, Christopher Cunningham, Michael Ealy, Dorothy Farley, Janet Goldberg, Deborah Greene, Graham Harriman, Christopher Joseph, Peter Laqueur, Jun Matsuyoshi, Jan Carl Park, Andresa Person, David Price, Bobby Rallakis, Brenda Starks-Ross

Members Absent: Moya Brown, Peter Campanelli, PsyD, Joan Edwards, Sandy Guillaume, Terry Hamilton, Tracy Hatton, Daphne Hazel, Zach Hennessey, Julie Lehane, PhD, Mary Poupon, Gina Quattrochi, Robin Wilder, Lisa Zullig

NYC DOHMH Staff Present: Mary Kay Diakite, Katrina Estacio, MD, Rafael Molina, Nina Rothschild, DrPH, Wilbur Yen

Public Health Solutions Staff Present: Bettina Carroll, Stanley Zazula

Others Present: Johanna Breyer, Randall Bruce, Charlton Clay, Leah Dorman, Billy Fields, Elliott Gritz, MD, Karen Lerman, Mallory Lowenstein, Bart Majoor, Maxine Phillips, Karen Thompson, Gary Weiskopf

Material Distributed:

- Agenda
- Minutes from the March 5, 2014 Meeting of the IOC Committee
- Presentation by Elliott Gritz, MD and Stanley Zazula on the Assessment and Referral Team (ART)
- Presentation by Gary Weiskopf on Implementing Medicaid Behavioral Health Reform in New York
- Geographic Distribution of OMH-Funded Outpatient Clinic Treatment Programs and HIV Prevalence

- Draft Mental Health Service Directive
- Planning Council Calendar for March 2014

Welcome/Introductions/Work of the Planning Council/Review of the Meeting Packet/Review of the Minutes/Moment of Silence: Committee Co-Chairs Nancy Cataldi and Christopher Joseph welcomed meeting participants. Attendees introduced themselves. Jan Carl Park explained the work of the Planning Council in general and the IOC Committee in particular. Nina Rothschild reviewed the contents of the meeting packet. The minutes from the IOC meeting on March 5th were approved for posting on the Planning Council website at nyhiv.org. Randall Bruce led the moment of silence.

Assessment and Referral Team: Dr. Elliott Gritz, a psychiatrist and the Deputy Medical Director of the New York City Human Resources Administration, and Stanley Zazula, who manages the Assessment and Referral Team (ART) contract, spoke about the ART program linking HASA clients with serious mental illness to treatment and care services. A copy of their presentation is available on the Planning Council website at nyhiv.org. Public Health Solutions has been managing the contract under which assessment and referral services are provided since 1994.

Preliminary statistics for 2013 show a total enrollment in ART of 159 clients, of whom 151 are first direct contacts. As of October 12, 2013, HASA was serving almost 44,000 individuals. This contract has two components: home-based visits and crisis management. Field staff members conduct evaluations in clients' homes, provide crisis services, and take clients to the hospital if necessary. Clients must have at least one unmet service need and no duplication of services. This is a difficult population with clients who are resistant to treatment. Services include:

- Weekly home visits with intensive case management
- Promotion of treatment adherence
- Accompaniment to and from appointments
- Ongoing coordination with HASA
- Crisis intervention
- Referral to long-term services
- Linkage
- Follow-up

Without these services, clients would be unengaged. ART is time-limited and does not deal with directly observed therapy (DOT). Staff members only have the ability to transport people, not to hospitalize them. Occasionally, clients are referred to assisted outpatient treatment.

Role of the IOC Committee: Jan Carl Park and Graham Harriman discussed the role and responsibilities of the IOC Committee and the grantee in the development and implementation of the mental health service directive. Currently, the Planning Council allocates approximately $5 million to mental health services, including two carve-out programs: one – the ART Program -- for HASA clients with serious mental illness (monitored by Public Health Solutions) and one for mental health programs offered in syringe exchange programs (monitored by the NYS AIDS Institute). Mr. Park stated that the IOC Committee (and the Planning Council) should examine the entire portfolio of mental health services, including the two carve-outs. The Planning Council is the steward of public funds and has the right to know whether a contract or set of contracts are sole-sourced.

To fulfill HRSA policy and to assess the administrative mechanism, the Council has the right to ask specific questions about a sole-sourced contract or group of sole-sourced contracts: how did they come into existence, what procurement process was used, and was it a fair and open bidding process. The future mental health service directive will build upon all mental health services provided in the current portfolio. When the service directive is delivered to the grantee, the grantee will issue an RFP and will follow City procurement policy, competitively bidding the services identified in the service directive. IOC Committee members need to know what is so unique about sole-sourced programs like ART and the NYS AIDS Institute's mental health programs that are part of syringe exchanges. Why can they not be competitively bid and why can no other organizations in the EMA provide such services?

Mr. Harriman stated that procurement of services is done by the grantee. If a provider is in a unique position to offer specific services (as is the case with these two carve-outs), the Planning Council does not need to engage in an in-depth examination of these services; rather, current contracts can be maintained. The ART has a unique relationship with clients in HASA. No other agency has that relationship or is in a position to offer equivalent services. Public Health Solutions, HASA, and the HRA have close working relationships that would be difficult to replicate.

Committee members asked several questions and received some answers:

- How is ART different from ACT? ART is time-limited and is not about providing treatment but, rather, is just about linking clients to care. ACT, by contrast, provides services.
- How does the ART program measure success and what is the recidivism rate? This seems to be a very tiny group of people being served. Is this program really addressing the issue? Recidivism: 7 out of 159 recent clients were repeats, or 4.4%.

- What is the cost per client? ART staff did not have information available on cost per client.
- What gaps are staff finding? Are in-home psychiatric services really needed? HASA is not the only place where you could locate this kind of system. Finding providers who will do home-based psychiatric services is challenging.
- How does this program fit with requirements for Medicaid billing?

New York State-Funded Mental Health Services: Gary Weiskopf of the New York State Office of Mental Health spoke about moving Medicaid-funded mental health services into managed care. A copy of his presentation is available on the Planning Council website at nyhiv.org. This is a major change from how business was done in the past. The initiative also involves moving substance use services into managed care, but IOC is focusing on mental health. The goal is to improve quality by transforming the system from inpatient-based to community-based and recovery-oriented.

The redesigned mental health service system developed out of the work of the Medicaid Redesign Team's behavioral health work group. Fee-for-service populations and services will be moved into managed care with the goal of improving quality of care, improving health outcomes, and reducing cost and right-sizing the system. On Friday, March 21 an RFQ will be released for determining managed care plans' qualifications for participating in the program.

Currently, the system spends $2600 per person per month on hospitalization and medications. People are frequently readmitted for physical health problems, often because their behavioral health needs are not being met. The new system, assuming that it is approved by the Federal government, will include home and community-based services so that people can stay out of hospitals. The State will provide training for behavioral health providers to help them learn how to bill managed care.

Behavioral health will be managed by Qualified Health Plans meeting rigorous standards and Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs. Enrolling in a HARP will not be mandatory. All HARPs will have dedicated psychiatric staff, crisis lines, and a process for a warm handoff to social workers. If a person is not engaged in the system but is enrolled in Medicaid, Medicaid can pay for off-site services. The system will offer habilitation (giving the patient the skills to go where he/she needs to go) and rehabilitation and is trying to build up peer supports. The down side: person-centered caps of approximately $7,000 per person per year.

Concerns about Medicaid managed care include:

- What do managed care companies know about these mental health populations?
- What are the staffing requirements?
- There are approximately 80,000 HARP-eligible individuals in NYC. Will the health homes be able to handle the significant increase in the number of patients? The health plans will be held accountable for the care they provide, but we need to ensure that they have the capacity to succeed.
- Will the networks be culturally competent?

Public Comment: Johanna Breyer from New York Harm Reduction Educators stated that her organization offers mental health services provided by social work trainees. NYHRE is not an Article 31 but does a lot of pre-engagement work with patients who are triple- or quadruple-diagnosed to help them to access and remain in care. Leah Dorman from the After Hours Project stated that there aren't a lot of providers who can handle the clients seen by her organization. The clients mistrust medical providers, suffer relapses as part of their serious mental illness, and often have a history of trauma. Linkage to and retention in care is very tricky. The cap on services is potentially problematic. These clients need services for a long time and may lose out with managed care. Mr. Park assured the representatives from the city's syringe exchange programs, present in the audience, that there were committee members sitting at today's table who themselves were in recovery, who had accessed syringe exchange programs or knew of friends who use their services and that they, along with other committee members, would guarantee continued support and funding for these vital services.

Adjournment: The meeting was adjourned.

Items for Follow-Up:

- How does the ART program measure success?
- What is the cost per client of ART?
- What gaps are staff finding in ART?
- Are in-home psychiatric services really needed for clients who are currently enrolled in ART?
- How does this program fit with requirements for Medicaid billing?
- What do Article 28s and Article 31s cover?