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

March 6, 2013
Cicatelli Associates, 505 Eighth Avenue at 35th Street
19th Floor Training Room
10:00 am – 12:00 pm

Members Present: Victor Benadava, Nancy Cataldi, Christopher Cunningham, Janet Goldberg, Deborah Greene, Graham Harriman, Christopher Joseph, Jun Matsuyoshi, Jan Carl Park, Andresa Person, Charles Shorter, Brenda Starks-Ross, Lisa Zullig

Members Absent: Joan Edwards, Sandy Guillaume, Terry Hamilton, Tracy Hatton, Daphne Hazel, Peter Laqueur, Julie Lehane, PhD, Mary Poupon, Robin Wilder

NYC DOHMH Staff Present: Amber Casey, Jacqueline Cruzado-Quinones, Alison Jordan, Rafael Molina, John Rojas, Nina Rothschild, DrPH, Darryl Wong

Public Health Solutions Staff Present: Bettina Carroll

Others Present: Michelle Bacon, Press Canady, Billy Fields, Yolanda Johnson Peterken, Ron Joyner, Shiane Lee, Mallory Lowenstein, Stefan McCullough, Nilda Ricard

Material Distributed:

- Agenda
- Planning Council Rules for Respectful Engagement
- Minutes from the February 20th, 2012 meeting
- Non-Medical Case Management: Service Category Overview and Data
- Presentation on the HIV Continuum of Care: Non-Medical Case Management Facilitates Jail Release Services
- Planning Council Calendar for March 2012

Welcome/Moment of Silence/Introductions/Rules for Respectful Engagement/Review of the Contents of the Meeting Packet/Review of the Minutes: Committee Co-Chair Charles Shorter welcomed meeting attendees. Everyone observed a moment of silence. Committee members introduced themselves. Victor Benadava reviewed the Rules for Respectful Engagement. Nina Rothschild reviewed the contents of the meeting packet. Consideration of the minutes from the previous meeting on February 20th was put on hold at the request of Committee member Graham Harriman.

Non-Medical Case Management: Amber Casey reviewed the timeline for examining non-medical case management (nMCM). She noted the HRSA service category definition: nMCM is the provision of services that include advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. Service elements may include: benefits and entitlement counseling, referral activities to help clients obtain access to public and private programs for which they may be eligible, and transitional case management for incarcerated persons as they prepare to exit the correctional system. nMCM does not involve coordination and follow-up of medical treatments. Today, the IOC Committee is dealing solely with nMCM in a corrections context. nMCM is a support service and is ranked 4th by the Planning Council.

nMCM on Rikers Island: Alison Jordan, the Executive Director of the Rikers Island Transitional Care Consortium, spoke about the Rikers system and about nMCM services. Two government entities are responsible for inmates – the Department of Health and Mental Hygiene (DOHMH) and the Department of Corrections. The Centers for Disease Control (CDC) has promoted the NYC model as used in Rikers as a model for other jurisdictions. A 24-hour drop-in center serves as a home for inmates who are being reintegrated into the community. Electronic health records are used in jail, making it easier to follow individuals who are sent to Rikers multiple times. The median length of stay is 8 days.

In 2006, Ms. Jordan came to the Planning Council and outlined the HIV continuum of care model as provided in the jail system, emphasizing the coordination of effort and attempts to reduce duplication of services. She and her colleagues applied for a HRSA SPNS (Special Projects of National Significance) grant for programs that have been able to do collaborative work and were one of ten sites selected for the award. Part of their success is attributable to Planning Council support for a population-based model: discharge data showed that their work had an impact on the community. Focusing on the Rikers population is particularly important because People Living with HIV/AIDS (PLWHAs) who have been discharged from jail return to areas of the City with high levels of morbidity and mortality from many causes, including HIV.

When a client enters Rikers Island, he or she is seen by medical staff and asked about his/her HIV status within the first 24 hours. HIV tests are offered. Jail-based care is funded completely by New York City – Medicaid does not pay for care for inmates. From the electronic health record, staff who help inmates with HIV prepare for discharge find out the names of individuals on whom they need to focus. These staff members sit side-by-side with people who do treatment adherence counseling. Staff members engage with clients and terminate at the same time.

Committee member Christopher Cunningham asked how many days' worth of medication the inmates are given when they are discharged. Inmates are given a seven-day supply on release and a prescription for a 21-day supply. Ms. Jordan's staff members do joint case management with the providers who do mental health discharge planning.

The transitional care services model is to identify the population, engage the client, conduct an assessment, screen for benefits, and coordinate the post-release plan, including primary care, housing assistance, treatment for substance use and mental illness, social services, and dealing with the court system. Most clients being discharged from Rikers have some kind of addiction issue. The emphasis is on facilitating continuity of care. In 2012, almost 1,400 people were connected to care. Ninety days post-release is a very critical period. Victor Benadava asked Ms. Jordan if she knew why approximately 20% of clients were not linked to primary care in 2011. Ms. Jordan noted that staff members from the home visiting team are sent to find people who have not followed up on their discharge plan.

The Rikers Island Transitional Consortium (RITC) has had a positive impact on client health. Improvements are shown by increased CD4 count, more clients taking medication, fewer reporting hunger, and improved overall health and mental health. The program showed an impact in terms of enhanced treatment adherence, improved mean viral load, and an increased proportion of clients with undetectable viral load. The implications for the system include fewer homeless individuals in the prior month and fewer emergency department visits. This model has received national attention. In other efforts to integrate care, the Rikers Island Transitional Care Consortium has been working with NYS Links to enhance linkages to and engagement in care and is in preliminary discussions with the Special Needs Plans (SNPs) to improve access. The RITC has linkage agreements and/or MOUs with hundreds of community programs including all care coordination programs and is engaging in a SAMHSA ORP pilot collaboration. RITC focuses on getting people into the right level of care.

Approximately 10% of the Rikers Island population is female. Around 20% of the HIV+ population on Rikers consists of women, meaning that they are very

over-represented on the Island. The CBOs that work with the Rikers population have a high proportion of homeless and unstably housed clients. The average case load is 20-30 individuals. Other Ryan White programs that are involved with this population include harm reduction, housing, and medical case management. Non-Ryan White social service and medical providers that engage with the post-discharge population include HASA and Medicaid.

Several staff members who work on Rikers shared some of their experiences with IOC Committee members. Jackie Cruzado spoke about a particular patient. Michelle Bacon, who works for Corrections, noted that the correction officers support the work of the consortium management. In order to accomplish this kind of work, everyone has to collaborate as a team. The patient care coordinators look at where the clients are and help them to trust the staff. Their work also facilitates the creation of a client-centered discharge plan. As a whole, the RITC has many different moving parts. Staff members take the client to breakfast and to their offices and allow clients to call them and continue their work together.

Staff members from CBOs that are part of the Rikers Consortium shared stories of their work with clients, helping to link them to care, to education, and to their children. Sadly, women on Rikers who are incarcerated do not get visitors. The women are generally sicker than the men in jail. For men, the social supports help them to do better. For women, the social supports are a zero sum game. Generally, using peers is a helpful strategy. Christopher Joseph asked the staff members present whether they can identify the qualities that non-medical case management providers should offer in a non-criminal justice setting. Michelle Bacon responded that nothing that happens within the corrections arena works anywhere else. Mr. Joseph also noted that a lot of the work under discussion feels a lot like a medical case management model. The distinction between non-medical case management and medical case management is made by HRSA. None of these programs, noted the presenters, are solely Ryan White-funded. Committee members may have questions about the specific services for which Ryan White does and does not pay.

Public Comment: No members of the public commented.

Adjournment: The meeting was adjourned.