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

May 15, 2013
Cicatelli Associates, 505 Eighth Avenue at 35th Street
20th Floor in the Lavender Room
9:30 am – 12:30 pm

Members Present: Victor Benadava, Peter Campanelli, PsyD, Christopher Cunningham, Michael Ealy, Janet Goldberg, Deborah Greene, Graham Harriman, Tracy Hatton, Daphne Hazel, Zack Hennessey, Peter Laqueur, Jun Matsuyoshi, Mary Poupon, David Price, Charles Shorter, Brenda Starks-Ross, Lisa Zullig

Members Absent: Matt Baney, Moya Brown, Nancy Cataldi, Joan Edwards, Sandy Guillaume, Terry Hamilton, Christopher Joseph, Julie Lehane, PhD, Jan Carl Park, Andresa Person, Gina Quattrochi, Alexandra Russo, Robin Wilder

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

Public Health Solutions Staff Present: Bettina Carroll

Others Present: Randall Bruce, Billy Fields, Mallory Lowenstein

Material Distributed:

- Agenda
- Rules for Respectful Engagement
- Minutes from the May 1, 2013 IOC Committee Meeting
- One-Pager on Rikers Island Transitional Consortium
- Draft Non-Medical Case Management (nMCM) Service Directive
- nMCM Service Directive Showing Track Changes
- Draft Health Education/Risk Reduction (HE/RR) Service Directive
- HE/RR Service Directive Showing Track Changes
- One-Pager on Peer Based HIV Patient Education Programs
- Planning Council Calendar for May 2013

Welcome/Introductions/Moment of Silence/Rules for Respectful Engagement/Review of the Meeting Packet/Review of the Minutes: Committee Co-Chair Charles Shorter welcomed meeting participants. Attendees introduced themselves. Zack Hennessey led the moment of silence. Christopher Cunningham read the Rules for Respectful Engagement. Nina Rothschild reviewed the contents of the meeting packet. The minutes from the IOC Committee meeting on May 1st were accepted with two changes regarding attendance for posting on the Planning Council website.

Non-Medical Case Management (nMCM): Nina Rothschild noted that this is a working meeting to discuss the nMCM and Health Education/Risk Reduction (HE/RR) service directives. No votes are scheduled. At the end of the May 1st meeting, we were discussing the role of the Rikers Island Transitional Consortium (RITC) in nMCM. Attendees had some questions about RITC, and Care and Treatment staff members have invited Alison Jordan, Executive Director of the RITC, to address these questions.

Ms. Jordan stated that DOHMH considers all organizations that receive HIV+ patients from Rikers as partners. We have a consortium that functions as a bridge between jail and community providers. This consortium specifically addresses the needs of patients who are not already engaged in care in the community. The RITC partners work with the jail staff to develop a plan for when the patient leaves jail, ensuring that the patient will have a primary care provider, housing, and wraparound social services.

Daphne Hazel asked for the names of the partners, noting that she does not have an entry for RITC in her linkage book. Ms. Jordan noted that over 200 medical and mental health organizations participate in the Consortium. Graham Harriman reminded Committee members that the IOC Committee (and all Planning Council Committees) is provider-blind: we do not share names of providers. We need a coordinating body to figure out how to transition inmates back into the community but do not talk about specific funded agencies.

Victor Benadava asked how an organization could become part of the consortium. Ms. Jordan responded that anyone awarded a contract to work on Rikers is part of the RITC because we cannot coordinate services without it. An organization does not have to be a member of the RITC in order to apply to provide services but has to become a member if awarded funding. The RITC ensures that each client has only one case manager, that the client consents to services, and that the agencies agree on policies and procedures and provide services consistently. The RITC is funded by Part A, has existed for a long time, and is a practical mechanism to coordinate the work.

Describing the work of the RITC, Ms. Jordan noted that she and her staff lead the group and that decisions about which agency will work with each client are made on a case-by-case basis. Technical assistance is provided to the Consortium members. The Department of Corrections is an active participant: officers are dedicated to working with the RITC and enable participants to move clients around. Dr. Peter Campanelli asked whether anyone keeps track of client outcomes. Ms. Casey responded that we track the plan, release, and connection with care. A SPNS (Special Projects of National Significance) initiative shows a positive outcome.

IOC Committee members resume discussing the nMCM directive, examining the agency eligibility criteria. Ms. Hazel noted that consumers will go to different programs in their neighborhoods and across the boroughs to obtain services. Janet Goldberg asked whether an agency can be penalized if a client is receiving the same service at two agencies. Mr. Harriman noted that this question goes into contracting. He encouraged Committee members to keep the discussion broad and specific to the population served.

Dr. Rothschild agreed to incorporate all tweaks to the nMCM directive and send the directive to the grantee for double-checking. IOC will vote on the revised directive at the June 5th meeting. If IOC votes to accept the directive, it will go to the Executive Committee and to the full Planning Council. Dr. Rothschild also informed IOC Committee members about how to read the version of the directive included in the meeting packet with tracking to indicate changes agreed on by members at the May 1st meeting.

Health Education/Risk Reduction: Patti Abshier, Director of the Training and Technical Assistance Program in the Bureau of HIV/AIDS Prevention and Control, reviewed a sheet she prepared with information on peer based HIV patient education programs. The sheet includes goal/objectives/desired outcomes, target population, substantiating evidence, length of intervention, and published curriculum/licensed/adapted for original agency. Included on the list are all the organizations that provided testimony during the IOC meeting on February 20th and all programs reviewed as part of the background literature for developing The Positive Life Project.

Most programs on Ms. Abshier's list state improved quality of life as a goal, but many programs don't define QOL. Some programs are not generalizable across populations. Output refers to number of clients served, and outcome refers to measures such as satisfaction – e.g., 95% of participants were satisfied with the program – but there is no way to detect the impact of most programs. The majority of interventions are long. Dr. Campanelli noted that some programs, including Stanford and Shanti, are evidence-based. Stanford is the most frequently cited in the HIV patient education literature. Mr. Benadava asked about the criteria that patient education programs should

demonstrate. Mr. Harriman cautioned Committee members that we cannot do everything with this service category – we don't have enough money for a much larger allocation, and we need to think about what is fundable, trainable, and scalable. The current funding is $460,000.

Committee members discussed whether organizations already funded to provide evidence-based patient education programs could apply for this funding and whether only the curricula in Ms. Abshier's list would be eligible for use. Mr. Harriman stated that group would define the terms "evidence-based" and "best practices" at the next meeting.

Public Comment: Billy Fields spoke about the issue of accessibility for disabled persons. Some programs are not accessible to people in wheelchairs. Ms. Casey volunteered to find the HRSA language concerning accessibility for the disabled. She noted that Ryan White funds cannot be used for construction.

Adjournment: The meeting was adjourned.