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

July 10, 2013
Ryan/Chelsea Clinton Community Health Center
645 Tenth Avenue at 45th Street
9:30 am – 12:00 pm

Members Present: Matt Baney, Amber Casey (alternate for Graham Harriman), Nancy Cataldi, Michael Ealy, Deborah Greene, Peter Laqueur, Mary Poupon, David Price, Gina Quattrochi, Alexandra Russo, Charles Shorter, Lisa Zullig

Members Absent: Moya Brown, Peter Campanelli, PsyD, Christopher Cunningham, Joan Edwards, Janet Goldberg, Sandy Guillaume, Terry Hamilton, Tracy Hatton, Daphne Hazel, Zach Hennessey, Christopher Joseph, Peter Laqueur, Julie Lehane, PhD, Jun Matsuyoshi, Jan Carl Park, Andresa Person, Brenda Starks-Ross, Robin Wilder

NYC DOHMH Staff Present: Mary Kay Diakite, Rafael Molina, Nina Rothschild, DrPH, Anna Thomas

Public Health Solutions Staff Present: Bettina Carroll

Others Present: John Barbiero, Joann Buttaro, Steven Hornsby, Jan Hudis, Mallory Lowenstein, Anne Lyster, Yvonne Mbewe- Palmer

Material Distributed:

- Agenda
- Minutes from the June 19th IOC Meeting
- Non-Medical Case Management Service Directive
- Non-Medical Case Management Service Directive with Track Changes
- Presentation on Supportive Counseling and Family Stabilization Services
- Planning Council Calendar for July 2013

Welcome/Introductions/Moment of Silence/Review of the Meeting Packet/Review of the Minutes: Committee Co-Chairs Nancy Cataldi and Charles Shorter welcomed Committee members and guests. Participants introduced themselves and observed a moment of silence. Nina Rothschild reviewed the contents of the meeting packet. The minutes from the Integration of Care Committee meeting on June 19th were accepted for posting on the Planning Council website at nyhiv.org.

Non-Medical Case Management (nMCM) Service Directive: Committee members had no further questions on the nMCM service directive. The grantee announced that it was fundable. Committee members voted 11 to 1 to accept the nMCM directive and forward it to the Executive Committee for discussion at its next meeting.

Supportive Counseling and Family Stabilization Services (SCFSS): Anna Thomas from the Care and Treatment Program delivered Part II of a presentation on SCFSS. SCF focuses on families and is for individuals without a DSM V diagnosis. Services are not billable to Medicaid and will not be directly impacted by the Affordable Care Act or by Medicaid expansion in New York State. In addition to undocumented immigrants, potential clients who are not Medicaid-eligible include immigrants who are legally in this country but have not yet been here for five years, individuals who do not fall within the income guidelines for Medicaid, and other populations.

Although we don't have literature about the effectiveness of supportive counseling and family stabilization services, we do have access to literature about its various components and we know that psychosocial interventions increase drug adherence and have a positive effect on immune system functioning. A place definitely exists for these complementary services.

Staff from the Care and Treatment Program made site visits to SCFSS providers and learned more about some of the important features of the service model, including its flexibility, low-threshold nature, loose definition of family, and the fact that it is not based on EBIs (Evidence Based Interventions). The SCFSS programs have a quality improvement component, and providers are required to collect primary care status measures (e.g., adherence, t-cell count, etc.) – and in fact these providers are among the best reporters of these measures. Services include family counseling, support groups, peer counseling, individual counseling, language services (particularly helpful for immigrants), and accompaniment to appointments. Successes include linking clients to primary care and addressing the concerns that inhibit adherence. Some of the facilities that offer these services are licensed under Article 28.

Q & A with SCFSS Providers: The Care and Treatment Program currently contracts with African Services Committee, CAMBA, The Family Center, the NY Coalition on Adoptable Children, SUNY Downstate, and Project Hospitality to provide SCFSS. Representatives of these agencies joined the Committee for Q & A, making many points:

- One agency noted that clients benefit most from the individual, group, and family component.
- Agencies have a lot of choice in the variety of services they can provide.
- None of the agencies is connected with an Article 31 facility. They do not have to be part of an Article 31 facility unless they are offering a Medicaid-billable service.
- If a client has a severe mental illness, he or she can be referred and linked to a provider of mental health services. Clients receive an evaluation and are referred if necessary.
- For clients who need someone who is culturally competent (particularly clients from African Services Committee), escort services are helpful to allay fear of being in a hospital or clinic.
- Bidirectional MOUs are worthless.
- Low-threshold mental health services, not necessarily based on a medical model, are needed. Not every client is severely mentally ill, and some have been pushed away from the mental health system.
- Supportive counseling consists of a wide range of services. Some concerns of clients – namely, that they will be rejected because of their HIV diagnosis – may not be severe enough to qualify as anxiety and to warrant psychiatric attention – but SCFSS providers can work with them on ways to overcome stressors.
- African Services Committee staff can coordinate with housing and legal services.
- This is a social work model and is about connecting people to services and motivating clients to engage with providers. The providers can gauge where the client is in terms of readiness to access care. People come in and are thoroughly assessed. If they need intensive services, they can be referred for mental health attention.
- Tighter linkages with other providers would be helpful so that, for example, clients in crisis could be stabilized and then referred to SCFSS providers for care.
- This is a community-based model, and providers can do home-based work. Providers can also employ former clients to go out and look for people who have disengaged from care.
- Criteria for receipt of services are the same as for other Ryan White services: someone must be HIV+, live in New York City, and fall within Ryan White income levels. HIV-negative caregivers of HIV+ children

can be served – for example, a provider might deal with issues concerning the stabilization of the family.

- Staff members don't have to be mental health-licensed but they can be if an agency chooses. Staff can include, for example, LCSWs, LMHCs, LMSWs, and peer workers who are former clients.
- Peers can be trained, for example, in facilitating support groups. One CBO has a peer who has been on staff for 7-8 years. She doesn't provide counseling but does a lot of supportive work. Peers can also provide accompaniment.
- All of these programs should be connected to an HIV medical clinic.
- A typical mental health program doesn't have the ability to track down patients who have dropped out of care, but that is an important feature of these programs.
- Many patients do suffer from depression and the after effects of trauma. Providers can do a bio-psychosocial assessment.
- SCFSS are non-core.
- Challenges include dealing with clients who don't always have high motivation. They may attend services during a crisis and then drop out. Other challenges include languages.
- Clients can remain in services for as long as they want. For many of them, their group members are like family.

Next Steps: Planning Council and grantee staff will draft a service directive for SCFSS, and Committee members will discuss it at their next meeting on July 17th.

Adjournment: The meeting was adjourned.