INTEGRATION OF CARE COMMITTEE

January 12, 2005
9:40-11:40am
GMHC, 119 W. 24th Street

MINUTES

Members Attending: J. Grimaldi, MD (Co-chair), D. Ng (Co-chair), P. Avitabile, R. Canosa, S. Elcock, S. Forlenza, MD, I. Gamble-Cobb, M. Gbur, MD, E. Greeley, C. Kazanas, E. Levine, L. Morrison, J. Omi, R. Quattrochi, A. Richardson, B. Starks-Ross, T. Troia, J. M. Garcia Orduña (ex-officio), S. Caba (ex-officio)

Staff Present: D. Klotz, I. Gonzalez, C. Silva, B. Barusek, M. Lesieur

Guest: D. Abramson (CHAIN)

I. Meeting Opening/Minutes

Mr. Ng reported that the Committee is looking to boost consumer participation (currently 21% of the membership is PLWHA). He has reached out to the chair of the Consumer Committee, and will recruit new members from the current solicitation process. Ms. Quattrochi noted that non-affiliated PLWHA should have priority. The minutes of the December 8, 2004 meeting were approved with one change from Ms. Levine, noting that testing *should* lead to engagement in care.

II. Draft Comprehensive System of Care Framework

The co-chairs prefaced the discussion by noting that this is the beginning of a three-year planning process, and that this Committee is charged with developing a broad framework for conceptualizing the care system. The sub-committees (ATC, MIC) will take this model and flesh it out with discrete services and service models. The Committee then reviewed the previously sent comments on the draft system model. The following is a summary of the comments in the subsequent discussion:

- Dr. Forlenza's model is a good refinement of the earlier draft.
- The entire system should be titled "HIV Care Continuum" and includes multiple funding sources.
- The system model should be as expansive as possible.

- The model should show more fluidity, especially between Access and Maintenance services.
- Services should be shown in a more circular pattern with system oversight connected to outcomes.
- The system should show multiple client pathways; not everyone needs every service.
- Bring Logistical Supportive Services unto the main square or show them as underpinning (nesting) the core services.
- Harm reduction needs to be specifically mentioned, not just drug treatment.
- Consider a grouping similar to the "Risk-related Services" in the Abramson model for services that eliminate barriers to care (e.g., homelessness, mental health issues).
- Care for PLWHA with disabilities should be included under specialty care.
- Housing is not a barrier to care but a critical component of care.
- Housing is important, but it is not primary care.
- The focus of the system should be in the center of the model – what gives the person an opportunity to improve their health status (i.e., primary care). Everything else is in concentric circles around that.
- Committee members should disclose conflicts of interest, but as providers in a certain field should bring their knowledge and expertise to the table. This is not necessarily "protecting" a service.
- System oversight includes capacity building as part of the underpinning of the system.
- Consumer feedback is an important part of evaluation.

The Committee came to a consensus on the following changes to the model:

- Title for overall model will be "Comprehensive HIV Care Continuum".
- Box with core services will not have a title.
- Eliminate the overarching "Access to Care" and "Maintenance in Care" titles.
- Keep housing as a separate and distinct broad category.
- Change "Case Management" to "Care Coordination and Case Management".
- Change "System Oversight" to "Oversight, Management, Quality Improvement and Capacity Development" and have it be an overarching umbrella over the core services.
- Take out sub-heading bullets. Instead, have a separate sheet identifying potential examples for each broad category, described as "may include, but not limited to".
- Change "Primary Care" to "Medical Care", limited to clinical and medical-related services, including Treatment Adherence.
- Create new, broad category, "Behavioral Health Management" to include risk-related services (e.g., mental health, substance use).
- Core services will be grouped into four broad categories: Medical Care, Behavioral Health Care, Care Coordination and Case Management, Housing. They will be visualized in overlapping circles with Medical Care at the center.

- Logistical Supportive Services will be represented as a “cradle” or “nest” underneath the core services.

The co-chairs will present this to the sub-committees at Data Day 1 on January 21st. Those committees will continue the work from here of assigning specific services to the overarching system model. Mr. Klotz noted that this is a planning tool, and will assist the Priority Setting & Resource Allocation Committee with its CARE Act-mandated task of annual priority setting (but not necessarily resource allocation).

III. Public Comment

R. Jones: The model should have consumer behavior at the center of a bulls-eye. Adherehce should be stressed.

P. Catapano: Integrate oral health care into medical care. It is best to stick to broad categories. This model will be helpful to the sub-committees.

IV. Other Business

Committee members were urged to attend Data Day 1 on January 21st, where the IOC chairs will present the model. The Maintenance in Care Committee’s proposed definition of “maintenance in care” was approved. Mr. Garcia Orduña announced an event in East Harlem.

The next meeting will be held on Wednesday, February 9th, 9:30-11:30am at GMHC.