INTEGRATION OF CARE COMMITTEE

December 8, 2004
9:40-11:00am
GMHC, 119 W. 24th Street

M I N U T E S

Members Attending: J. Grimaldi, MD (Co-chair), D. Ng (Co-chair), S. Abramowitz, PhD, P. Avitabile, R. Canosa, S. Forlenza, MD, I. Gamble-Cobb, M. Gbur, MD, E. Greeley, J. Lehane, PhD, E. Levine, L. Morrison, R. Quattrochi, A. Richardson, T. Troia, G. Edwards (ex-officio), J. M. Garcia Orduña (ex-officio), R. Ortiz (ex-officio), M. Villacis (ex-officio),

Staff Present: D. Klotz, I. Gonzalez

Guest: D. Abramson (CHAIN)

I. Meeting Opening/Minutes

After introductions, the minutes of the November 10th meeting were approved with one change from Ms. Quattrochi, noting that there were additional data requests made.

II. Draft Comprehensive System of Care Framework/Charge to Sub-committees

Mr. Ng framed the discussion of the draft comprehensive system of care model as the framework which the sub-committees (Access to Care, Maintenance in Care) will use to identify programs that promote access to and maintenance in care.

Mr. Abramson described the draft comprehensive system of care model, derived from the ten-year CHAIN prospective cohort study. The model begins with prompts to enter the system, such as a critical event (illness, jail), public health campaign, outreach, and medical and/or social service advocacy. This should lead to testing (e.g. CBO, DOHMH site, hospital, jail), which leads to entry into primary medical care, either directly or through a range of services bundled into four large groupings: client engagement (e.g., outreach), risk-related supportive services (e.g., mental health, substance abuse), case management, and logistical supportive services (e.g., child care, transportation). People may move in multiple directions between groupings of services, with the end result hopefully being improved health outcomes (as measured by viral load) and lower HIV transmission. The entire system is supported by oversight through evaluation and TA. All Title I services can fit into the model (as listed in an addendum), as well

as the range of services provided through other funding streams. Mr. Abramson also presented a model of how a client moves through the system.

Mr. Abramson presented four areas with questions for further consideration for this Committee and ATC/MIC: the system model, service models, client pathways, and policy and evaluation.

There was a lengthy and detailed discussion on the draft model. The following is a summary of the main points:

- The diagram attempts to balance being general and specific. For example, an additional critical event is homelessness.
- Housing should be either a separate category or part of a package of comprehensive care services.
- Mental health and substance abuse services are integral parts of primary care.
- We need to think strategically, particularly regarding HRSA's emphasis on primary medical care and meeting unmet need (i.e., getting people into care who know their HIV status but are not in care). Be strategic about what we label as primary care and what we label a supportive service.
- Outcomes should be measurable across the population, e.g., lower viral load. HIV transmission can be measured by using STD rates as a proxy.
- The next step is looking at the basket of services that fits into this model. E.g., ATC and MIC will describe how the primary care setting will look (e.g. co-located mental health services).
- Label different sections of the model "access to care" and "maintenance in care".
- Entry to care is actually two stages: identification of need (i.e., testing), and actual entry into care.
- The model is a global concept and ATC and MIC can further define it, impose more detail on it, and carve Title I out of it.
- All arrows from the Primary Care box should be bi-directional.
- Include consumer input in oversight and evaluation.
- This model will also function as a policy document.
- Think about including process indicators.

Rev. Troia presented a draft revised version of the chart, based on the ideas discussed above. The chart splits the prompts and creates a circular pathway of care, with key services bundled into a "comprehensive" or "integrated" set of care services leading to improved health outcomes.

There was some discussion of Rev. Troia's model. There was a consensus to further refine this model. Mr. Klotz will circulate a new draft and the Committee will comment on it by e-mail, with a revised draft going to the sub-committees for their December 20th and 21st meetings, in order for them to start their work. This Committee will finalize the model at the January meeting.

In addition, Committee members will be asked to add questions for consideration that IOC, ATC and MIC will have to answer as part of their charge (i.e., the system model, service models, client pathways).

III. Public Comment

J. Livigni: Mental health programs have special requirements. The system model needs to be fine tuned and evaluated.

R. Jones: This Committee needs more PLWHA input. As an example, I entered the care system through mental health and substance use programs.

Ms. Quattrochi: I agree that the Committee needs more consumer representation.

The next meeting will be held on Wednesday, January 12th, 9:30-11:30am at GMHC.