INTEGRATION OF CARE COMMITTEE

February 10, 2006
10:15am-12:00pm
GMHC, 119 W. 24th Street

MINUTES

Members Attending: J. Grimaldi, MD (Co-chair), T. Troia (Co-chair), R. Canosa, M. Gbur, MD, E. Greeley, K. Huang-Cruz, P. Lacqueur, E. Levine, J. Matsuyoshi, R. Quattrochi, A. Richardson, J. Shields, D. Williams

Staff Present: D. Klotz, I. Gonzalez, S. Bailous, C. Silva, D. Wong

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I. Meeting Opening/Minutes

Dr. Grimaldi and Rev. Troia opened the meeting. After introductions, the minutes of the January 11, 2006 meeting were approved with no changes.

II. Discussion: Presentation on Housing and Care/Prevention

The chairs asked for a discussion of Dr. Aidala's presentation at the previous meeting, noting that Dr. Aidala was proposing a paradigm shift to include thinking about care and prevention in the context of structural elements, rather than population characteristics alone. The context includes factors like homelessness, poverty, low literacy, immigration status, multiple diagnoses (substance use, mental illness), lack of integrated services. Points of the discussion included:

- The lack of access/maintenance in care is a system failure (e.g., prison releasees with no discharge planning or follow-up)
- The old model "blames the victims"; we should brainstorm what puts people into a risky situation, rather than boil down people into endless small special populations
- "Special populations" are inter-related, but all have base issues of substance use, mental illness, unstable housing and other triggers to "risky behavior"
- Systems are insulated from each other (e.g., medical doctors will not coordinate with social services agencies; multiple systems with different funding sources)
- Housing and food are keys to entering the system
- The presentation supports the contention that support services underpin access to/maintenance in care

- Our strategic planning includes policy advocacy to make systems more responsive
- Providers need to do continuous outreach, especially to engage people with multiple diagnoses
- Medical and support services need to be simultaneous and integrated
- SNPs are making an attempt to integrate care; when medical care is provided onsite at a CBO, people are staying in care (but SNPs are economically driven and go for the "easy patient" – providers need to engage the "difficult" client)
- ESAPs are good at integrating medical and low threshold services (DACs should participate in them)
- Multiple systems asking for data and onerous requirements can drive systems apart (e.g., CBOs requiring doctors to certify that a person is in care in writing every 90 days)
- There is a lack of accountability (reporting units of service is not enough)
- Linkage agreements as currently conceived are meaningless; true co-location and integration of services is needed
- The Needs Assessment Committee (NAC) and full Council should hear Dr. Aidala's presentation and start looking at special populations from a new perspective
- Primary care and coordinated housing referral in the shelter system is needed

III. CHAIN Report on Service Gaps for Special Populations

Ms. Silva presented data from a CHAIN report on service gaps among six special populations, which was presented to NAC the previous week. There is little variation in the percentage with a gap in a particular service across populations. There are, however, certain services for which the gaps are particularly high (e.g., mental health and substance use services). The following are the main points of the ensuing discussion:

- We need to focus on areas of high gaps across populations
- The gap for transportation is high (albeit a small number are in need of the service); we need to know the whys (e.g., people not getting half fare cards, problems with Access-a-Ride)
- HIV Quality Management data will give a fuller picture of need
- The study shows the overlap with mental health and substance use and the service gaps for both
- There are two kinds of mental health service, but we have separated them out (professional psychiatric services, and lower threshold counseling); we should consider both how to integrate them as well as which populations are better served by each kind of service
- Such a shift could be implemented through an RFP (e.g., primary care, mental health and substance use services in homeless shelters)
- The AIDS Institute mental health model allows for more comprehensive services (not just Article 31 licensed providers); they can provide psychiatric services in harm reduction settings. This model acknowledges the usefulness of mental health services in settings other than just Article 31 facilities; for example, in harm reduction settings

III. Program Guidance for Service Categories

The above discussion led into a consideration of the program guidance in the service categories to be considered. The first considered was Emergency Rental Assistance. Points of the discussion were:

- The program works well (gets out rapidly to those in high need), but there is not enough money
- The goals can be strengthened and linked to risk reduction and connection to care
- The current guidance calling for linkage to primary care is acceptable, as it is not too prescriptive
- It should be incumbent on the agency making the referral to connect the client with care and verify it; the connection must be sustained
- Ms. Quattrochi will draft new wording on service goals

The next meeting will continue this discussion on other service categories. IOC has until the June meeting to complete its review of the service categories. Rev. Troia also proposed discussing two additional topics at the next meeting: new restrictions on Title I legal services, and opening mental health services beyond Article 31 providers to CBOs with onsite primary and mental health care.

IV. New Business/Public Comment

Rev. Troia presented Ms. Gonzalez with flowers in gratitude for her work for the Council. She starts next week at the East Harlem District Public Health Office.

Ms. Quattrochi reported that the President's proposed budget includes an increase for HOPWA.

M. Gold thanked Ms. Gonzalez and reported that the state legislature is considering a bill that would allow Medicaid to fully pay for prescriptions for Medicaid/Medicare dual eligibles. Also, the grace period for Medicaid to provide medication coverage for dual eligibles has been extended from 1 to 3 months. Sen. Clinton is also working on a federal bill to correct problems with Medicare part D.

The next meeting is Fri., March 17 (third Friday of the month), 10am-12pm at GMHC, room 405. Subsequent meetings will be the second Friday of each month.

There being no further business, the meeting was adjourned.