HIV Health & Human Services
PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting Minutes
INTEGRATION OF CARE COMMITTEE
Damian Bird and Charles Shorter, Co-Chairs

February 11, 2011
Cicatelli Associates, 505 Eighth Avenue, 20th Floor
10:00 am – 12:00 pm

Members Present: Rosemary Cabrera, Nancy Cataldi, Jose Colon-Berdecia, Christopher Cunningham, Janet Goldberg, Steven Gordon, Elaine Greeley, Deborah Greene, Tracy Hatton, Fabienne Laraque, MD, MPH, Jun Matsuyoshi, Carline Numa, Jan Carl Park, Charles Shorter, Kimberleigh Smith, Brenda Starks-Ross, Steven Varnadore, Lisa Zullig

Members Absent: Brent Backofen, Damian Bird, John Anthony Eddie, Joan Edwards, Sarah Gonzalez, Terry Hamilton, Peter Laqueur, Julie Lehane, PhD, Kelsey Louie, Gonzalo Mercado

NYC DOHMH Staff Present: Graham Harriman, JoAnn Hilger, Rafael Molina, Nina Rothschild, DrPH

Public Health Solutions Staff Present: Bettina Carroll

Others Present: Victor Benadava, Juan David Gastolomendo, Ricki Mann

Material Distributed:

- Agenda
- Minutes from the January 14, 2011 IOC Meeting
- IOC Committee Membership Contact Information
- Planning Council Bylaws Section on Duties and Composition of IOC Committee
- Presentation by Fabienne Laraque, MD, MPH on Outpatient Substance Use and Harm Reduction Model Community Forum
- Planning Council Scorecards Data on Mental Health Service Category
- February 2011 Planning Council Month at a Glance
- February Planning Council Calendar

Welcome/Introductions/Moment of Silence: Committee Co-Chair Charles Shorter welcomed meeting participants. Members introduced themselves. Victor Benadava led the moment of silence.

Review of the Meeting Packet/Review of the Minutes: Nina Rothschild reviewed the contents of the meeting packet. The minutes from the January IOC meeting were approved.

Overview of the Work of the IOC Committee: Jan Carl Park discussed the work of the IOC Committee and reviewed the material in the packet from the Planning Council Bylaws on the duties and composition of IOC.

Overview of Harm Reduction Interventions: Dr. Fabienne Laraque stated that the IOC Committee developed and approved the guidance for HRR (Harm Reduction, Recovery Readiness, and Relapse Prevention) – i.e., substance abuse services -- last year. Currently, some of our Ryan White (RW) funding pays for services for HIV-negative individuals, and we need to follow HRSA guidelines and provide HRR services only to HIV-infected individuals.

The goals of substance use and harm reduction services include:

- providing easily accessible help to clients
- increasing treatment adherence
- enhancing viral load suppression
- using targeted case finding
- decreasing risky sexual behavior
- using a harm reduction approach for all AOD substances, including increasing syringe access
- providing buprenorphine, methadone, and naltrexone, along with other drugs, as needed
- providing counseling and behavioral interventions
- offering acupuncture
- increasing linkage to primary care, including a reassessment within 30 days of program entry
- encouraging clients to progress to graduation
- allowing programs to apply for HIV testing dollars
- offering training in evidence-based counseling services
- offering technical assistance to providers

Staff from NYC DOHMH talked to two dozen providers, convened an advisory group of providers and researchers, and decided on a model known as the Community Reinforcement Approach (CRA). CRA employs environmental contingencies (i.e., a reward system) to support individuals in recovery, encouraging clients to voice their issues, identify triggers, and reward good behavior. All participants are encouraged to try abstinence, although not all

clients will be able to achieve long-term complete abstinence. Providers are encouraged to negotiate a time – one day or 90 days or whatever number of days of abstinence seems reasonable and achievable. CRA offers a treatment model to help the client find rewards other than drugs and alcohol, given that drugs and alcohol provide only short-term rewards.

Committee member Carline Numa noted that CRA seems to be using motivational interviewing and asked how a provider using CRA would approach a client who is in pre-contemplation. Dr. Laraque responded that the client would staged regarding his/her readiness for CRA. Counseling is the mainstay of the approach.

Dr. Laraque also described an add-on component of the CRA Program known as the Therapeutic Education System (TES). TES is based on CRA and is offered as an adjunct to the main, counselor-driven intervention. TES is offered on a computer and will work for low literacy clients because it comes with an audio component. Some of the benefits of a technology-delivered intervention include:

- low cost
- available in a wide array of settings
- easily exportable
- replicable
- can be readily modified
- can employ contingency management

TES has been evaluated with a diverse array of substance users and is as good as a science-based intervention delivered by a highly trained clinician. It is an interactive video-based computer assisted simulation. It has 65 modules; some but not all are specifically focused on HIV. The provider can track the client's earning of incentives.

Dr. Laraque also described an optional intervention known as Seeking Safety which provides a behavioral intervention for people with alcohol and other drug problems and a history of trauma. Seeking Safety was developed as a group treatment, educates the patient about PTSD and substance use, enhances coping skills, and employs cognitive and behavioral approaches and case management. Although Seeking Safety has 25 treatment topics, DOHMH through the organizations with which it contracts will offer only 12 modules. SS can be used with clients suffering from recent PTSD and also with more chronic and complex PTSD and was developed and tested on clients with multiple traumas. It focuses on the present but does not exclude the past and can be conducted by a wide range of mental health providers.

Victor Benadava expressed doubt about whether the treatment would work, but Dr. Laraque noted its inherent flexibility because it allows some clients to choose harm reduction and some to choose abstinence. The guidance will include specific language about milestones and graduation, but abstinence should not be the only criterion for graduation. A client is ready for graduation when he/she is functional, stable, and taking medications.

Nancy Cataldi noted that addiction is, by nature, an isolating disease and asked whether using computers would reinforce clients' self-isolating behavior. DOHMH staff responded that the computer is not a stand-alone treatment approach and that the entire model allows for connection to the community. Clients who graduate, moreover, can come back if they feel the need to reconnect with treatment providers.

Reviewing Mental Health Services: IOC Committee members and DOHMH staff discussed the next service category to be re-bid – mental health services. We have been funding them as a core service. They are underutilized because many clients already receive MH services paid for by Medicaid or ADAP+, and Ryan White can only cover the cost when there is no other payer. This Committee, at its next meeting, will begin to look at what we fund, the characteristics of the clients served, and the goals of the treatment services.

Adjournment: The meeting was adjourned.