INTEGRATION OF CARE COMMITTEE

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

MINUTES

Members Attending: J. Grimaldi, MD (Co-chair), T. Troia (Co-chair), E. Greeley, K. Huang-Cruz, P. Laqueur, E. Levine, D. Ng, W. Okoroanyanwu, MD, R. Quattrochi, A. Richardson, J. Shields

Staff Present: DOHMH: D. Klotz, J. C. Park, S. Bailous, D. Wong

Guests Present: F. Laufer (AIDS Institute), M. Weinberg (HHC), K. London (Health Bridge)

I. Meeting Opening/Minutes

After introductions, the minutes of the April 19, 2006 meeting were approved with one change from Mr. Laqueur noting that the Health Sub-committee agreed that it is important to keep psychiatric home visits as part of the home care model.

Mr. Klotz reminded the Committee members that they are encouraged to attend Data Day on May 19th, which will focus on service gaps of four special populations (youth, women of child bearing age, incarcerated/paroled, and immigrants).

As a process note, the program guidance recommendations of the IOC sub-committees will be finalized by the full IOC in June, and then sent to the Executive Committee and full Council. It will be sent to the Priority Setting & Resource Allocation Committee, as the program guidance may affect their rankings, but PS&RA will not have authority to change the IOC's program guidance.

II. Presentation: HIV Quality Management Program

Dr. Laufer presented on the Title I Quality Management program. The program's principal goal is to allow providers of HIV-related services in the EMA to evaluate and improve the quality of services they offer. This is accomplished through developing performance standards and

measures; data collection, analysis, and presentation; and providing technical assistance. There is a focus on client retention (reducing the risk that a client falls out of care) resulting in improved clinical outcomes. Literature was reviewed on why people drop out of care and the negative effect on clinical outcomes and public health. Strategies for improving client retention were explored, such as reminder calls, pairing patients with "retention care coordinators", and improving access to support services (mental health, case management, substance use treatment, HIV drug assistance, food and nutrition, and housing).

The program also features "Quality Learning Networks" divided by service category, which seek to improve the quality of HIV care and services, strengthen the quality infrastructure of HIV providers, increase competency in performance measurement and quality improvement strategies at the provider level, and provide an opportunity for ongoing networking and peer learning. Details of two programs were featured.

The program works on developing primary care indicators to assess primary care visits, ARV adherence and viral load and CD4 testing. The indicators measure the attainment of the EMA's primary care goals: increase the number of patients who are linked to a primary care provider (PCP), improve ARV therapy assessment rates, improve rates of VL and CD4 testing, improve documentation of referral to PCP and follow-up that appointment was kept for those clients who have not had a PCP visit, been assessed for therapy, or been tested.

The final component of the program is the Outcomes Evaluation Project, whose goals are: evaluate the continuum of care offered to people living with HIV/AIDS (PLWHA) in New York City; use the results to improve the quality of non-clinical support services; and examine the effect on clinical outcomes. A pilot study is currently underway using a variety of Title I and non-Title I data sources. The study can link clinical and support service databases to provide a more comprehensive picture of service delivery, use matched results to evaluate and support policy-related issues, and examine the impact of support services on clinical outcomes.

Comments from IOC members included:

- Socio-economic data is needed to better understand clinical outcomes among patients who missed appointments
- Additional data should be cited that support services improve retention in care
- Housing is a key underpinning of maintenance in care and not just a support service
- Clinical guidelines for viral load and CD4 testing (3 months) should coincide with the outcome project's (6 months)
- Challenges include integrating data systems across various funding streams (URS, SAMHSA, OASAS, etc.), and better integrating the data into the Title I planning process
- The Needs Assessment Committee should examine the data integration issues.

III. 2006 Planning: Program Guidance

The IOC broke up into two sub-committees to continue consideration of the program guidance for the categories still to be re-bid. The following is a summary of the discussion.

A. Social Services Sub-committee

The sub-committee revisited the program guidance for the 24-hour Drop-in Center for Prison Releasees. The sub-committee decided that more information was needed on the services provided at Riker's Island in preparation for discharge. It was agreed that a representative from DOHMH will be invited to attend the next Sub-committee meeting to provide that information.

The sub-committee reviewed the goals and program guidance for Food & Nutrition Services. The sub-committee discussed the issue of nutritional assessment and whether they should be mandatory, for which programs and how often. It was agreed that the program should be reframed as a medically necessary program and not just distribution of food. It was also agreed that the Sub-committee will get information from the AIDS Institute on their food & nutrition program guidelines.

B. Health Sub-committee

The sub-committee reviewed the goals and program guidance for Home Care. They discussed two different clinical situations involving home care:

1. The more conventional situation involves provision of skilled nursing services in a client's home. In this model, services such as home health aides and home visits by an RN are generally reimbursable through other payers such as Medicaid. Therefore it is the other, ancillary services such as mental health and substance use that rely on Title I dollars for funding. Some members of the subgroup proposed that these ancillary services (mental health, substance use and others) be folded into other service categories, namely mental health, AOD, maintenance in care, etc. The downside risk to this proposal is that these services would be given low priority within these other service categories and would thereby risk loss of their funding. There was a consensus that these services are essential and should be preserved if possible, even though we are talking about a relatively very small amount of money and small number of clients here.
2. The other situation involves provision of outreach medical services in very challenging situations such as SROs where there are very poor living conditions and active drug use. Clients in these situations are among the most difficult to reach. These clients have multiple unmet needs and require a well coordinated approach involving many different ancillary services including housing, mental health, substance use as well as skilled nursing. Some members of the subgroup noted that this situation could be improved through better coordination of efforts between the outreach medical providers and other already existing resources and programs, such as housing placement programs and homecare programs.

At last month's IOC meeting, the idea of broadening the home care service category to include and pay for medical services provided to clients in their homes was discussed. Some members of the subgroup raised several reasons why this idea was impractical; we are talking about a relatively very small number of programs and limited funding; the already existing funding is in jeopardy of being eliminated; and outreach medical services (MD, PA, NP) that are provided to

clients in locations where they reside are already being funded through ambulatory care/outpatient service categories.

The following preliminary "Goal" and "Program Guidance and Service Model" descriptions were proposed by the subgroup. These were intended to replace the existing goals and program guidance:

Goal: Improve the health outcomes of at risk populations by promoting access, maintenance and adherence to treatment through provision of a range of home care services.

Program Guidance and Service Model: Outreach and assessment to determine and facilitate appropriate skilled nursing, medical, mental health, substance use, and food and nutrition services that are non-Medicaid reimbursable (such as ADAP and ADAP+) for at risk populations.

The two sub-committees will meet on Wed., May 24th to complete their work in advance of the next full IOC meeting. The full IOC will review and finalize all program guidance at the next meeting, which will take place on Fri., June 9, 10am-12pm at GMHC, room 450.

There being no further business, the meeting was adjourned.