# INTEGRATION OF CARE COMMITTEE

March 18, 2008
3:00-5:00 pm
GMHC, 119 West 24th Street, Room 720

## DRAFT MINUTES

**Members Present:** Ivy Gamble-Cobb (Chair), Caridad Aguirre-Pellicer, Brent Backofen, Elaine Greeley, Roberta Greengold, Deborah Greene, Peter Laqueur, Fabienne Laraque, MD, MPH, Jun Matsuyoshi, Carline Numa, Jan Carl Park, Ed Viera, Jr., Jan Zimmerman

**Others Present:** Victor Benadava, Drew De Los Reyes, Billy Fields, Tom Petro, Sarah Spool

**Staff Present:** Todd Noletto, John Rojas, Nina Rothschild, Anthony Santella

**Welcome/Introductions:** Ivy Gamble-Cobb welcomed the participants. Members introduced themselves.

**Review of Minutes:** Jan Carl Park reviewed the minutes from the previous meeting on February 26, 2008. The minutes were accepted with no revisions.

**Medical Case Management (MCM): Tri-County RFP:** Tom Petro presented on the recent RFP for medical case management services (including treatment adherence) in Tri-County (Westchester, Rockland, and Putnam). Tri-County had been funding outpatient medical care (medical case management at medical facilities), treatment adherence (at medical facilities) and case management (mostly at community based organizations). Tri-County examined the services provided and documented in order to see whether the three categories (outpatient medical care, treatment adherence, and case management) could be combined into one category with the goal of improving client health outcomes and reducing the administrative burden of reporting for providers.

When Tri-County re-bid MCM services, it received 13 proposals. All proposals were funded with an average grant of $161,000. The most difficult activity for the applicants to describe in their proposals was the protocol to increase the communication between medical and social service providers, i.e., who would contact whom under what circumstances and how often The goal was to enhance the exchange of information so that case managers could inform medical providers about important information, such as patients missing doses of medications. In its RFP, Tri-County emphasized that the goal is not the duplication of effort, but, rather, a wraparound continuum of care. Meetings of

the thirteen funded programs in Tri-County will take place to promote such communications, and NYSDOH/AI will facilitate a new quality management learning network in Tri-County to broaden understanding of what the expectations are.

Ed Viera, Jr. asked about the depth of the screening for domestic violence and for drug use during intake and assessment. Mr. Petro acknowledged that he does not know how comprehensive the current screenings are, but that a new minimal intake/assessment tool being developed for the region would certainly address both these issues. Mr. Laqueur asked about Tri-County's use of linkage agreements between medical facilities and CBOs. Mr. Petro responded the content of the agreement is not specified, and the linkage agreement functions as the collaboration agreement. Mr. Park asked how Tri-County ensures enhanced communication between social service and medical providers. Mr. Petro noted that the assessment of enhanced communication is currently based on self-report by clients, but that a protocol greatly enhancing such communications will be developed by the providers in the MCM learning network. Mr. Noletto asked whether the medical case managers and the social service case managers have different credentials, to which Mr. Petro responded that the RFP doesn't specify the credentials.

Ms. Greeley asked how teams of providers are managed when each grant only totals an average of $161,000. Mr. Petro responded that the philosophy is that the participants work collaboratively with an MCM grant made to every medical facility in the region and all but one CBO providing case management. Providers cannot segment patients off and say, for example, that they have seen and referred Patient X, who is no longer his or her patient; they must follow-up with patient and provider contacts. Ms. Greeley also asked whether this model will address the needs of the newly diagnosed versus the chronic care patients, to which Mr. Petro responded both groups will be addressed. Since the provider pool is small in Tri-County, everyone knows everyone, and participants in the wraparound continuum function like a family. Mr. Petro also noted that the structure provides for flexibility based on client needs and that some clients who achieve stability may not wish to interact to a great extent with CBO providers.

**Comprehensive Case Management for HIV in NYC:** Dr. Laraque gave a presentation on a proposal for a comprehensive case management model for HIV in NYC. The goal is to increase integration, efficiency, and accountability, and to reduce duplication. We recognize that some patients will need long-term assistance support, and TB is used as a model for case management. The plan is to retain patients in care, reduce their viral loads, and ensure stability and access to comprehensive services (a copy of the presentation is attched) The questions introduced by IOC members and others present in the room, along with Dr. Laraque's answers, are as follows:

- Q (Todd Noletto): Has any data been collected on rates of treatment failure and multi-drug resistance in the EMA?
  A: The HIV/AIDS Reporting System (HARS) collects data on CD4 count and viral load. A staff member will look at the data we have for program planning and needs assessment. The Research and Evaluation Unit is also hiring research scientists to analyze available surveillance and service data. The State receives

data on resistance patterns, but we have not yet had access to this data. We hope this data is forthcoming.

- Q (Nina Rothschild): How will you ensure confidentiality and privacy for patients with chronic mental illness in a system with enhanced communication between medical and social service providers?
- A: We want formal linkage agreements between case management agencies (case managers) and medical agencies in order to deal with such a situation. Once you have a formal linkage agreement, you become part of the provider team and have the right to look at the data and are part of the same system of care.

- Q (Victor Benadava): Will PLWHAs have input into the plan for reorganized case management?
- A: Yes. This is why we are having this conversation. However, an advance look at the RFP is not possible because that would give some people an unfair advantage when this service category is re-competed.

- Q (Elaine Greeley): This is a vertically integrated model with the various entities linked by contract. The case management guidelines dictate who is allowed to provide what services. Does this arrangement eliminate a lot of community based agencies that are not JCAHO-accredited? You are now talking about a model that is going to have to fit into an accredited system of care.
- A: The NYC DOHMH thought about putting all case management in hospitals but decided against this approach. We will encourage linkages and anticipate a better outcome with co-located services. No one is eliminated.

- Q (Elaine Greeley): It's easy for a hospital to contract with a case management CBO, but it's not possible to go the other way. It's also not possible for a CBO to have the Medicaid reimbursement support of the medical provider. If you're talking about a system with one point of entry, the money will be an issue. A hospital will be able to bill, but the CBO will not be able to bill for food, transportation, supportive services, and treatment adherence.
- A: We are not expecting the agencies to provide everything, but they will provide an entry. For example, if they know that someone needs food, they will refer for the food.

- Q (Elaine Greeley): The point of entry has to collect the data. There has to be a system of debit and credit. If you make a referral, you have to make sure that the referral is completed. This means that you don't have control over the referral agency, and you cannot prove that a linkage agreement is going to deliver the food. Who will be responsible for ensuring that the linkage is completed? It's easy to obtain verification for a referral to a medical provider, but it's not as easy to obtain that kind of verification of a referral for food services or mental health.
- A: Our key services will be linkage to care, maintenance in care, visits to medical providers, stable CD4 count, viral load, and treatment adherence. Providers will be responsible for ensuring that wraparound services are delivered. Ultimately, if

the patient is stable and their health care is stable, their CD4 count is increasing, and their viral load is decreasing, something is working. I don't need to ensure that they are obtaining their food because I'm pretty sure that they are obtaining their food. We are not going to dictate how much food is provided or where that food is provided. We want people to be healthy and stable.

- Q: Who would be held accountable if a patient is not healthy and stable?
- A: The team – the people who are being paid for this service.

- Q (Elaine Greeley): This is what is happening right now with managed care. We are not being paid.
- A: Managed care has slightly different goals. We are not emphasizing cost saving and cost containment.

- Q (Peter Laqueur): What is the role of HASA in this arrangement?
- A: Case management as provided by HASA is focused on receipt of entitlements, whereas DOHMH is focused on receipt of treatment and care services. In addition, the Director of Housing in the Bureau of HIV/AIDS Prevention and Control talks to the deputy commissioner of HASA regularly. The agencies are sharing data on a more uniform and sustained basis and working to solidify their relationship. In the RFP, we will specify that we need to know whether the patient is COBRA-eligible, Medicaid-eligible, HASA-eligible – and if yes, you need to contact the HASA case manager. We are addressing the issue so that there will be as little duplication as possible.

- Q (Elaine Greeley): What would be the purpose of having a client who is COBRA-eligible in this proposed arrangement?
- A: Clients will go through COBRA-funded case management first and then through Ryan White-funded case management as needed.

- Q (Elaine Greeley): How will you avoid duplication of services, given the large number of emergent needs in this population?
- A: Clients could have something akin to a Ryan White-swipe card. That card would have a record of services received so that clients cannot go to multiple sites and obtain duplicate services. This centralized system can verify eligibility and make sure that the client is not receiving the same service down the street. If the card is not possible, we will have a computer-based de-duplication system where providers would call in.

- Q (Elaine Greeley): Within the current payment structure, a provider cannot be reimbursed for more than one visit per day. A person cannot, for example, come in for mental health and substance abuse services on the same day.
- A: We are examining this situation.

- Q (Carline Numa): Have you thought about the composition of the teams? How much choice will clients have under the proposed system when they select their primary care providers?
- A: We will not dictate the choice of primary care provider. The focus of the new system will be on the primary care provider, but we will not limit client choice. Clients can receive medical and case management services in one borough and food services in another borough, if they wish. The medical team/case management team will be located in one place.

- Q (Peter Laqueur): Will most funding go to hospitals, not to CBOs, under this reorganized system?
- A: We are not dictating which organizations will obtain the contracts. The selection of organizations will be based upon the quality of the grant applications they submit, with some attention to geographical distribution.

- Q (Elaine Greeley): Will the system fall into line as quickly as this particular model will require?
- A: We hope to sell the plan to medical providers and help them to understand that this is not one more burden but, rather, a way of providing assistance to their patients to stay in care. We will also provide technical assistance.

- Q: Will treatment adherence no longer exist as a stand-alone category? And will it be staffed in a medical facility?
- A: Treatment adherence will be consolidated. It will not be a stand-alone service category.

- Q: Would the assessment of readiness for treatment adherence be done by the medical provider, rather than by the treatment adherence counselor?
- A: Yes.

- Q (Drew De Los Reyes): A medical facility may have a relationship with CBOs A and B, but a client who is connected to CBO C may come in to the medical facility. How would this situation be handled? Can the medical facility establish a contract with CBO C?
- A: Some issues may have to be handled on a case by case basis. The important point is where the patient is receiving medical care.

- Q (Sarah Spool): Nutrition programs and treatment adherence programs work collaboratively. Will non-treatment-adherence services face cuts in the reorganized system of care? Already the nutrition program at GMHC is receiving an influx of clients from other programs that are not funded.
- A: We are not de-funding food and nutrition, but programs will need to have linkages.

- Q (Ed Viera, Jr.): I am a PLWHA who has been living with the virus for 25 years. When are you going to start educating me about the services you provide and let

- A: The illness is caused by a virus that is treatable, and the starting point for care should be the medical providers. The patient isn't going to get better without seeing a medical provider. You aren't going to receive treatment from your church. Granted, you cannot get treatment in isolation – you need a roof over your head – but the roof cannot come in isolation from the treatment. We need to provide the best care and wraparound services that we can and to provide the choices.

- Q (Sarah Spool): Will other services (non-treatment adherence) be cut? Many agencies aren't able to maintain their food programs because of cuts, and we're receiving a lot of people to feed. Will we have the funding to continue to provide services that we absolutely need?
- A: We want to make sure that services are accessible and that case management teams are providing access to housing, food and nutrition services. This can be done via a formal linkage. This case management program does not aim at cutting other services but, rather, coordinates care, support services, and access to entitlements.

- Q: Has this model been tried elsewhere?
- A: Many components of the model come from published studies. We are also talking to other Ryan White programs and making visits. We plan to visit Chicago and see how their system works. We want to visit Philadelphia, which has a single point of entry, although the medical center is not the point of entry into the system.

Integration of Care Committee members discussed next steps. Does this proposal move to the Priority Setting and Resource Allocation Committee for a vote? Dr. Laraque stated that she wants to move money from outpatient medical care to case management for this proposed reconfiguration. Mr. Park stated that IOC can send a recommendation to PSRA, and PSRA can decide to move money from outpatient medical care to case management. He also noted that we are backing into the Planning Council's 2009 spending plan. Peter Laqueur asked about a timeline, to which Dr. Laraque responded that she hopes to accomplish this transfer within a couple of months.

Ms. Gamble-Cobb stated that she is missing some specifics and that Committee members need to be fully informed so that they can explain why they have signed on to the model. Mr. Laqueur commented that the proposal is a monumental movement and has implications for how we change the whole care system. He noted, however, that there are major long-term consequences and stated that he needs to mull over the proposal. In particular, he would like more information on the structure and the foundation. The proposal is like a Ryan White-SNP model.

The Committee will meet again on April 15th from 10:00-12:00.