INTEGRATION OF CARE COMMITTEE

February 23, 2010
NYSDOH, 90 Church Street
3:15-4:30pm

M I N U T E S

Members Present: Damian Bird (Co-chair), Nancy Cataldi, Steve Gordon, Glenda Hasty (for Elaine Greeley), JoAnn Hilger, Geraldine Joseph, C. Numa, Miriam Piñón,

Members Absent: B. Backofen, A. Cohall, M.D., J. Edwards, Deborah Greene, T. Hamilton, Maria Irizarry, P. Laqueur, K. Louie, Leslie Mack, J. Matsuyoshi, Jan Carl Park, MA, MPA, Ed Viera, Jr., Lisa Zullig, MS, RD

Staff Present: *NYC DOHMH:* David Klotz, Marybec Griffin-Tomas, Yoran Grant, Sekai Chideya, Terri Wilder; *Public Health Solutions:* Bettina Carroll

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I. Welcome/Introductions/Minutes

Mr. Bird welcomed members, followed by a moment of silence and introductions.

II. Overview of Ryan White Part A Harm Reduction Programs

Ms. Griffin-Tomas, Project Officer for Harm Reduction Programs, gave an overview of the NY EMA's Part A-funded (core) Harm Reduction programs (HRR), which have been in the portfolio since 1994 (under the current service model since 2007), is the 4th highest ranked service category, and receives $11.2M (13%) of the Part A award. Highlights of the presentation included:

- Only 20% of HRR clients are documented HIV-positive or AIDS;
- 43% of HRR clients are female, 56% male, 1% transgender;
- 53% of HRR clients are Black, 34% Hispanic, 10% white, 1% A/PI; 3% unknown;
- 20% of HRR clients are 20-29 years old, 20% are 30-39, 32% are 40-49, 25% are 50+;
- Service sites are located throughout the City;
- The goals/objectives of the program include: reduce HIV risk and substance use behaviors among active and recovering users, connect them to HIV primary care, screen for substance use and linkage to services, increase access to Narcan (overdose prevention drug);
- The HRR service model includes the following "families" of service types: rapid testing, medical services (outreach in SROs, provision of Buprenorphine), AOD (alcohol and other drug) services (includes counseling), and Low threshold AOD services (LT);

- LT services can be provided to people of unknown HIV status for 90 days;
- 16 of 25 HRR programs provide rapid testing. Most HRR agencies provide AOD and LT individual and group services as well as assessment, and only a few provide family or medical services;
- Service targets have generally been lowered from original projections, but programs have generally met those revised targets;
- Strengths of the HRR model include: counseling in a variety of settings, flexibility of the "sobriety requirement", services for client with unknown HIV status, usually payer of last resort;
- Limitations of the HRR model include: underutilization of counseling services, difficulty in retaining clients, narrow focus on opiate users (no similar interventions for users of other hard drugs, such as crystal meth);
- Possible next steps include: linking HRR agencies with other programs to increase the number of HIV+ clients, expanding to non-opiate users (most clients are poly-drug users), more harm reduction services and referrals, funding inpatient treatment.

III. Testing and Care Among Clients of RW Part A-funded Harm Reduction Programs

Ms. Grant, Senior Analyst in the Research and Evaluation Unit of the HIV Care, Treatment and Housing Program, presented on testing and care among HRR clients. Highlights of the presentation included:

- Of clients who accessed testing at HRR programs, an average of 2.17% tested positive;
- Rates for confirmatory tests varied widely across programs (from 0% to 100%);
- An overage of 77% of those confirmed positive received their results;
- Only 29% of confirmed positives were successfully linked to care;
- It is not clear why some programs are more successful with retention (e.g., the adoption of social networking strategies, use of mobile units).

Highlights of the ensuing discussion included:

- Many HRR programs are co-located with medical facilities, and most others are located within CBOs that have case management services;
- Especially for transient populations (esp. youth), retention will only work if confirmatory testing is offered right away after rapid testing;

The next step is to present information on best practices and successful service models from around the country, in order to advance the Committee's discussion of how to revise local service models.

There being no further business, the meeting was adjourned.