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
Maria Irizarry and Damian Bird, Co-Chairs

June 22, 2010
Cicatelli Associates, 505 Eighth Avenue, Lavender Room
3:00 pm – 5:00 pm

Members Present: Damian Bird, Steven Gordon, Elaine Greeley, Deborah Greene, Fabienne Laraque, MD, MPH, Jun Matsuyoshi, Carline Numa, Jan Carl Park, Miriam Pinon, Ed Viera, Jr., Lisa Zullig

Members Absent: Brent Backofen, Nancy Cataldi, Alwyn Cohall, MD, John Anthony Eddie, Joan Edwards, Marya Gilborn, Terry Hamilton, Glenda Hasty, Tracy Hatton, Maria Irizarry, Peter Laqueur, Julie Lehane, PhD, Kelsey Louie, Leslie Mack, Gonzalo Mercado, Jim Shields, Kimberleigh Smith

NYC DOHMH Staff Present: Marybec Griffin-Tomas, Graham Harriman, Rafael Molina, Nina Rothschild, DrPH, Terri Wilder

Public Health Solutions Staff Present: Bettina Carroll

Others Present: Manuel Ducret

Material Distributed:

- Agenda
- Minutes from the May 25, 2010 IOC Committee Meeting
- HRR Service Category Scorecard (6/15/2010)
- Needs Assessment Committee AOD Population Recommendations
- DOHMH's Proposal for Substance Abuse Services
- Food and Nutrition Service Proposed Program Guidance

Moment of Silence/Welcome/Introductions/Review of the Meeting Packet: Members observed a moment of silence. Committee Co-Chair Damian Bird welcomed meeting participants. Nina Rothschild reviewed the contents of the meeting packet.

Charge of the Committee: Redefine Substance Use Services: Jan Carl Park stated that the charge of the IOC Committee is to provide guidance on service models and populations to the grantee as the grantee prepares to re-bid the substance use service category. Mr. Park distributed the Food and Nutrition Services guidance developed by IOC during the previous community planning cycle as an example of the type of document to be crafted. He noted that the HRR (harm reduction, recovery readiness, and relapse prevention) service category scorecard included in the meeting packet provides data for three years on the dollar amount allocated for the service category, clients by special populations, gender, race and ethnicity, and age, projected and actual units of service, etc. The HRR service category is funded at slightly over $11 million. The IOC Committee is involved in a discovery process at the present time and will affirm or recommend changes to the HR/RR/RP service category and develop a directive to the grantee.

Substance Use Services Overview: Nina Rothschild gave a presentation on the DOHMH's current substance abuse services, the Needs Assessment Committee's recommendations for working with AOD populations, and the Care, Treatment, and Housing Program's recommendations for reconfiguring the HRR service category. After she finishes delivering the presentation at the next IOC meeting on June 29th, it will be posted on the Planning Council website at nyhiv.org. Several of the comments during the discussion are captured here:

- Public Health Solutions focuses on ensuring that clients receiving HRR services are in medical care.
- Drug treatment programs help the client to accept responsibility for his/her behavior.
- Setting a goal of 100% sobriety (a standard used by OASAS programs) would be a potential barrier to success in a program. We do, however, want the client to move forward. We don't want to enable him/her to remain in a state of stasis. We need to use both the carrot and the stick, emphasizing to clients that their behavior has consequences
- Right now, OASAS enforces sobriety but is moving toward a harm reduction approach.
- Committee members should agree on a definition of harm reduction and a definition of milestones in the guidance so that we can have standardization across programs.
- AIRS, which captures Ryan White program data, does not include a place for graduation from substance use programs.
- Some programs use incentives such as $10 in cash and a Metrocard to bring clients to services or to make progress with reducing drug use, but clients are nomadic and may go from program to program for the incentives.

- Follow-up after graduation from substance use treatment programs is required so that clients don't become lost to the system and relapse.
- A small population of chronic relapsers uses 80% of the resources. We should design a level of care appropriate to this population. Working with these individuals may require a higher level of staff skills.
- The Federal government uses a statistical method called GPRA (government performance results) at designated intervals (6 months, one year, etc.) to assess success of the substance abusing and mental health populations in treatment programs.
- With DOHMH's new care coordination program, we expect monitoring of viral load, CD4 count, etc. If a patient falls out of care, he or she is reenrolled in case management. Since clients are in primary care for the rest of their lives, they are never disenrolled altogether from programs.
- Motivational interviewing is potentially a very useful technique for working with substance using populations. Training opportunities in motivational interviewing are currently offered by the Harm Reduction Coalition and by NDRI and should be expanded. DOHMH offers training in care coordination and may consider arranging for MI training. Motivational interviewing takes the stages of change approach to behavioral change and gives it legs. It is very non-judgmental and helps clients to find resources for change.
- Services for substance using patients should be bundled and take place in a one-stop shopping format overseen by a medical director.
- Currently, about 75% of substance use treatment programs are not hospital-based.
- Community health centers can provide a medical home and may be one among several suitable locations for substance use treatment services. Providing services where the majority of patients receive care is important. Services must be integrated and co-located within medical homes. If various different services are all part of the same system of care, they can share information electronically and provide more coordinated patient care. The SNPs (Special Needs Programs) are an example of integrated care: clients can receive mental health, substance abuse, counseling, and housing assistance, and service delivery entities can speak to each other. We need to figure out how to integrate and to avoid duplication.
- The target population is disenfranchised and mistrustful of hospital-based outpatient clinics which they see as sterile and clinical.
- The model needs to be responsive to client needs.
- The Needs Assessment Committee's second recommendation for AOD populations states that programs should be required to have a working relationship with clients' case managers to ensure the coordination of all medical and support services needed for the treatment of addiction. As clients may have different case managers for different services, we

need to specify that the working relationship should be with the client's primary case manager.

- The Needs Assessment Committee's third recommendation states that harm reduction programs should use low threshold models such as street outreach and peer workers supervised by a trained professional staff member. The words "low threshold" should be removed.
- HRSA allows us to provide services to HIV-negative individuals via early intervention services and also when the services benefit the negative person – for example, services to the negative partner of a positive individual. The Needs Assessment Committee's recommendation that HR/RR/RP services be targeted to at-risk youth needs to be reconsidered.
- DOHMH is putting out an RFP for services to youth.

Review of the Minutes: The minutes from the May IOC meeting will be reviewed at the next IOC meeting on June 29th.

Adjournment: The meeting was adjourned.