Meeting Minutes

Needs Assessment Committee

Jennifer Irwin, Co-Chair

Tuesday, January 15, 2008

10:00 am – 12:00 pm

GMHC, 119 West 24th Street, Room 405

Members Present: Angela Aidala, JoAnn Hilger, Jennifer Irwin, Rebecca Kim, Lenore Hildebrand, Jennifer Irwin, Rosemary Lopez, Frank Machlica, Jan Carl Park, Glen Philip, Aracelis Quinones, Dena Quinones, Troiyle Sanon, Roberta Scheinmann (for Mary Ann Chiasson), Howard Schwartz, Sayida Self, Juana Leandry-Torres, Ricardo Vanegas-Plata, DDS

Members Absent: Rosa Bramble Weed, Alison Chi, Soraya Elcock, Julie Lehane, Fabienne Laraque, MD, Luis Freddy Molano, MD, Luis Scaccabarrozzi

DOHMH Staff Present: Amber Featherstone, MD, Mary Irvine, Andrea King, David Klotz, Rafael Molina, Nina Rothschild, Clarissa Silva, Daniel Weglein, MD, Darryl Wong

Others Present: Brent Backofen, James Livigni

Materials Distributed: Agenda; minutes from the meeting of the Needs Assessment Committee on November 20, 2007; flow chart showing proposed Planning Council process for requesting CHAIN studies and funding research projects.

I. Welcome/Introductions: The meeting opened with a round of introductions.

II. Review of Minutes from Previous Meeting: The minutes from the Committee's previous meeting on November 20th were reviewed and were accepted with minor changes.

III. Review of the Meeting Packet: Ms. Irwin reviewed the contents of the meeting packet.

IV. Overview of the Care, Treatment and Housing/Public Health Practice Unit Initiatives: Dr. Weglein presented an organizational chart for the Care, Treatment, and Housing wing within the Bureau of HIV/AIDS Prevention and Control in the New York City Department of Health and Mental Hygiene. Dr. Weglein directs the Public Health

Practice Unit (PHPU) within Care, Treatment, and Housing and outlined PHPU's structure and function. When he became Governmental Co-Chair of the Needs Assessment (NA) Committee, Dr. Weglein thought that the Committee could bring data to bear in response to questions originating in the Priority Setting and Resource Allocation Committee or in the Planning Council. However, he has come to believe that the planning cycle is too compressed for the NA Committee to respond to immediate data needs and instead argues that the NA Committee needs to anticipate the data needs of the planning cycle and be proactive rather than reactive. He also called upon members of the NA Committee to consider other means of communication such as conference calls, in addition to bimonthly Committee meetings.

Dr. Weglein outlined the history of his unit within the Bureau. When he came on board, he supervised staff who were part of the Program Evaluation and Training Unit, or PETU, who focused primarily on technical assistance and capacity building for CBOs funded under the Bureau's Prevention grant from CDC. Under his leadership, PETU evolved into the Office of Outcomes Evaluation (OOE), which in turn became the Research and Evaluation Unit (REU), which in turn became the Public Health Practice Unit (PHPU).

Currently, Dr. Weglein is focusing on recruiting and hiring; reviewing Part A funded case management programs in New York City; reviewing case management activities in other EMAs funded by HRSA (looking at questions such as whether case management is more centralized in other jurisdictions and whether case management includes a larger or smaller number of contracts in other jurisdictions); monitoring and evaluating funded treatment adherence programs; and doing service mapping for New York City in order to show what health care resources are available.

Dr. Weglein provided some background on case management. In New York City, a significant number of PLWHAs – roughly 34% -- are not in care: out of the 33,992 PLWH in the City, 12,138 (35.7%) are not in care; and out of the 55,112 PLWA in New York City, 18,488 (33.5%) are not in care. Not in care is defined as having no lab reports of CD4 counts or viral load.

James Livigni pointed out disparities between races and asked for an explanation. A Committee member responded that some communities may have more access to primary care than others, and the difference in access may be related to socioeconomic status.

The core objective behind Dr. Weglein's review of case management strategies in other EMAs is to understand policies that promote effective care coordination. HRSA guidelines require medical case management for PLWHAs in the EMA, and a recommendation has been made to create a centralized intake system in New York City. Dr. Amber Featherstone is conducting interviews to learn how other EMAs have been incorporating HRSA guidelines into case management. She has focused on issues such as how other jurisdictions coordinate services and whether they have a single intake form used by all agencies. She has seen some differences in the structure of case management in other EMAs: for example, Baltimore has an additional level of hierarchy, and some

jurisdictions have a more centralized intake strategy. Dr. Featherstone has also conducted two pilot interviews (one with JoAnn Hilger of New York City and one with Tom Petro of Westchester, Rockland, and Putnam).

Health Department staff members are also conducting a review of case management programs in New York City with the core objective of describing models of service delivery. The research method is a self-administered qualitative questionnaire with targeted follow-up. To date, staff members have learned that there are only limited formal protocols for case management in HATMA Part A funded programs.

Staff members in Dr. Weglein's unit are also monitoring and evaluating treatment adherence programs. The core objective is to identify successful strategies to maximize the effective treatment of HIV. Programs funded to provide treatment adherence have to report data on a regular basis, and validated models may be expanded. Preliminary findings from this work have revealed a need for greater oversight by NYC DOHMH. At Lincoln Hospital, a pilot project has been underway since October 2007; to date, data collection has been reliable, and DOHMH is projecting to add additional sites. Dr. Weglein has approached some treatment adherence programs funded under Ryan White to ask whether they want to switch to a newer model, and some providers have expressed interest. Between 5 and 10% of the population infected with HIV/AIDS in New York City may need directly observed therapy (DOT). Some of the programs with which DOHMH has been speaking on this topic provide low level monitoring, while some provide DOT.

Another initiative in Dr. Weglein's unit is service mapping. Andrea King has been examining the overall distribution of programs in New York City funded by a variety of sources, including Ryan White Parts A, B, C, and D and SAMHSA (Substance Abuse and Mental Health Services Association) in order to identify gaps. (Queries to Medicaid are pending.) Andrea's goal is to show the geographic distribution of all HIV counseling and testing-related programs throughout New York City and to determine the award allocations for all programs funded with non-Ryan White Part A dollars. The methodology for the mapping project includes reviewing earlier funded initiatives (such as the MHRA mapping collaborative and the New York Academy of Medicine payer of last resort analysis) and also to examine the geospatial analysis of the Medical Monitoring Project sampling data.

JoAnn Hilger asked how Dr. Weglein ensures that there is no overlap between agency initiatives and how he differentiates between a population focus and a service focus. A Needs Assessment Committee member pointed out an apparent disparity revealed by the mapping project, namely, Manhattan receives much more money than Queens and Brooklyn. Jan Park commented that other funders have different cycles for their grants, and a document such as this can really only show the funding picture at a given moment in time. The data are incomplete. Ms. Hilger also noted that NYC DOHMH has always been careful about not equating dollars with need because some services may be more expensive than others, a point with which Dr. Weglein disagreed. Lee Hildebrand asked whether there has been any geocoding of case management clients, to which Dr. Weglein

replied that follow-up data in the HIV/AIDS registry such as CD4 count and viral load do not usually have address information and cannot be mapped. Dr. Weglein suggested using the locality of the place of care instead of the patient address in geomapping, although this strategy is problematic because patients may live in one borough and seek care in a different borough. The epi team of the Medical Monitoring Project reached out to hundreds of providers to obtain their estimated patient load. The goal is to learn where to optimally situate case management so that case managers intersect with patients' primary care providers. Howard Schwartz pointed out that confusion sometimes exists between the role of the case manager and the role of the social worker.

Other key activities in which Dr. Weglein's staff is engaged include going to the literature to see overall reviews of case management and descriptions of major models and reviewing the literature on navigator models (a strategy from cancer care). Dr. Mary Irvine on Dr. Weglein's staff will distribute a list of particularly useful articles.

Clarissa Silva presented information on the referral verification process for case management clients. Her goal is to see how the agencies funded to do case management capture data. For example, do they use a paper referral, an escort, or an electronic referral, or a combination of these three strategies? The agencies have protocols to standardize service delivery and ensure quality and cost-effectiveness of patient care throughout the health care continuum. Many programs, in fact, use a combination of models and theories, including the AIDS Institute guidance and COBRA case management. Ultimately, Ms. Silva aims to see how the different approaches interact to form a unified service delivery package. Some agencies without protocols have expressed interest in the idea of a protocol to inform agency practices and standardize service delivery. As it turns out, 43% of case management programs funded by Ryan White have material outlining how service delivery is captured for the agency. The goal is to deliver high quality patient care in an environment of limited financial and human resources.

To conduct her research, Ms. Silva is reviewing existing case management general practice standards, disease-specific case management practice standards for illnesses such as TB and cancer, and Ryan White Part A case management practice guidelines, standards, and procedures. Most of the protocols reviewed by Ms. Silva are for public health practice and were not developed by private insurance companies.

Howard Schwartz asked about an announcement by the New York State AIDS Institute that Medicaid will more stringently enforce a two- or three-year case management program and may dis-enroll individuals who exceed that time limit. This strategy, in which case management is a temporary intervention, is currently taking place in COBRA case management. It may, however, be a shell game; the client who exceeds his or her time limit for case management may simply go around the corner and receive case management services funded by another source. We need to have an internal conversation about the limits of case management and how to determine who needs lifetime case management.

Needs Assessment Committee members reviewed a chart outlining the proposed Planning Council process for requesting CHAIN studies and funding research projects. Lee Hildebrand asked about the history of such requests. Jan Park responded that Needs Assessment makes inquiries for information to facilitate the planning process. In addition to its use for planning purposes, CHAIN data is very helpful in our grant application to HRSA. Ms. Irwin requested a list of current CHAIN reports so that the NA Committee can learn about what has been done and what is happening. She encouraged NA members to develop ideas about what they'd like to see CHAIN investigate for the next meeting.

The group discussed a follow-up meeting date. Ms. Hildebrand underscored the importance of anticipating the needs of the Planning Council and commented that meeting more frequently is important in order not to lose momentum. The next meeting will take place on February 26th from 9:00-11:00. NA Committee members may discuss work plans developed by other Planning Council committees at the NA meeting and use these plans as a basis for developing a similar document. The presentations from today's meeting will be distributed by e-mail, along with an updated contact list and updated minutes from the November meeting reflecting changes agreed to by Committee members.

Follow-Up:

- Distribute updated contact list of NA Committee members
- Distribute list of current CHAIN projects
- Distribute presentations made by staff of Public Health Practice Unit at the January meeting of the NA Committee