INTEGRATION OF CARE COMMITTEE

God's Love We Deliver
166 Avenue of the Americas, Boardroom
NY. NY 10013New York, NY
April 24th, 2019 10:00am-12:30pm

MINUTES

Members Present: Danielle Beiling (Co-chair), Randall Bruce, Paul Carr, Rose Chestnut (phone), Michael Ealy, Dorothy Farley, Billy Fields, Ronnie Fortunato, Deborah Greene, Bill Gross, Graham Harriman, Christopher Joseph, Peter Laqueur (phone), Jan Carl Park, Saul Reyes (consumer-at-large), Annette Roque, John Schoepp, Claire Simon, Brenda Starks-Ross
Members Absent: Dorella Walters (Co-chair), Katrina Balovlenkov, Lauren Benyola, Bettina Carroll (non-voting), Mary Correa, Janet Goldberg, Donald Powell, Joel Zive
Other DOHMH Attendees: Jose Colon-Berdecia, X. Pamela Farquhar, Scarlett Macias, Kimbirly Mack, Tye Seabrook, Scott Spiegler

Agenda Item #1: Welcome/Introductions/Moment of Silence/Minutes

Ms. Beiling opened the meeting, welcoming everyone and leading a round of introductions. *Mr. Park* led the committee in a moment of silence, acknowledging the loss of Humberto Cruz and Janet Goldberg's husband, Andy. *Ms. Simon* and *Mr. Carr* reflected on the contributions of Umberto Cruz to ending the AIDS epidemic.

Agenda Item #2: Review of Meeting Minutes, Schedule & Packet

Ms. Lawrence introduced the meeting packet and asked if there were any changes to the minutes. The March minutes were accepted.

Agenda Item #3: Side by Side Comparison of Short Term Housing Providers & Transitional Care Coordination

Ms. Beiling introduced the purpose of the meeting, explaining that the committee has come to understand that significant duplication exists between Transitional Care Coordination (TCC) and Short Term Housing (STH).

Mr. Speigler explained the side by side document created to illustrate where the same services are provided. Targeted case finding is a payment point in TCC, and while included in STH, it is not a discrete payment point. The descriptions of intake and assessment look different on the side by side but are actually the same, because some items were not broken out in the same fashion. TCC does not provide short term housing or housing placement – clients are linked to a housing specialist for those services. Service Plan development actually happen at the same frequency in both programs.

STH is described as having more hand holding throughout the programs processes. STH has home visits, supportive counseling and life skills training but TCC does not.

Ms. Lawrence reminded the committee that at the last meeting, it was decided that TCC should be dissolved. The goal of this meeting is to query STH providers to deepen our understanding of the category and decide if a new service directive should be written.

Contractually, service plans must be updated every 6 months, but programs can do it more frequently.

Mr. Powell: Can we put more emphasis on getting people ready to live on their own? Life skills training approximates that, but is not as intense as programs have been in the past where people learned to cook and budget.

Ms. Farquhar: Providers currently provide this service in STH, including nutritional counseling, interpersonal skills, lease negotiation. The purpose of the program is to get individuals ready, i.e. substance use counseling, mental health (MH) counseling, and whatever additional support – which in some cases is supportive housing.

Mr. Reyes: We would like the specifics of the program. In thinking about developing an appropriate directive, we want to understand the reality. As an HIV+ individual who had to seek help to get into housing… when we think about 'keeping house' those things go sideways, whether because of drug use, MH, etc. It's a process of re-education. Need specifics, because lives like mine who need that help.

Mr. Carr: Under STH, isn't congregate housing described as long term? Some are considered permanent housing. How does TCC work with clients that are re-integrating, especially around addiction and homelessness? Congregate is a communal setting – how are these issues handled?

Ms. Beiling: What are the strengths and weaknesses of STH?

After Hours Project Provider: Strengths speak for themselves. Transition clients from precarious or dangerous living situation to affording them a scaffolding of tools to get back into a functional lifestyle. Structure and mores of living in a communal society. Some are coming from long term living in SROs – become institutionalized. Gives them a vigor to live in a real home. It's difficult to share space – a lot of growth occurs. Many clients have significant MH conditions – diagnosed and undiagnosed substance use; others do not know how to play with others. Sometimes for the benefit of the many, we must make difficult choices. Cannot put other people in danger. Breaks your heart to discharge them. Many clients come with a need for a higher level of care and they are just getting passed from program to program to program. And they're tired of that. Still are clients falling through the cracks- that is who we need to focus on.

Mr. Joseph: Does STH have clinicians?

After Hours: We have clinicians in house who handle MH and substance use.

When client is not comfortable seeing someone in house, we make external referrals.

Ms. Greene: Do you have someone who can assess clients for MH and substance use.

AH: Yes, this happens in house. For clients in denial, work with them until they are ready. One of our biggest programs is harm reduction – we are experienced working with clients with these issues.

Harlem United: For scattered site it's a little different. Single adults. Many of our staff are LSW's and CASACs and they do weekly and biweekly home vists, doing MH assessments, providing crisis interventions, short term MH counseling and the referrals for long term and substance use treatment. Coordinate regularly with case managers. Have a behavioral health program at Harlem United. In STH the major strength is that clients are housed. Life skills training happens in their homes. Is the fridge stocked? What training does the client need? If we see trends, we focus a health education workshop on this, whether budgeting, cleaning, maintenance, etc. Only drawback is that the housing is not permanent – hard to push clients out of the comfort of their home.

Mr. Park Weekly home visits seem very intensive interaction with staff. As time goes and the client gets their life together, does the intensity of home visits lessen?

HU: Minimum intervention is a monthly home visit – do more if more is needed. STH case loads are smaller, so staff can provide intensive care as needed. If it is not necessary, only see them once a month. It's not linear – people relapse, it can go back and forth in terms of intensity.

Provider: We assess who will do better in congregate versus scatter site. Our congregate site is very small – eight people in a large house. When clients cannot do well on their own in a shared unit, can bring them back to the congregate. The one on one work with clients is a big strength.

Alliance: Echo my colleagues. Being in a congregate, having staff on site allows us to really be available and see what's happening with clients.

Ms. Roque: There are different STH models – why aren't they all the same model – seems like each agency chooses what to integrate. Who would want to leave their own apartment. STH is two years – that's enough time to get to know a person. If you move me, I might relapse. I was a housing director for the state. We were able to transfer the lease when we saw the client was capable and able to stay abstinent.

Ms. Farquhar: Per the RFP, we wanted to provide providers with flexibility, so some agencies can have a congregate setting – we want to allow them to use that. Agencies can lease units in the community, from a studio to a 2-3 bedroom. Don't want to handcuff an organization from using what is available in the community. Some agencies even use congregate to scatter site as a graduation.

Provider: The intake process is thorough but brief – having that 2 year window is really critical to creating a plan for the client that is responsive to their needs. Also, people thrive in different situations. We have elderly clients who benefit from the socialization of a congregate model.

Mr. Reyes: Mixed models and flexibility are great, but from the point of view of a client, if the limit is 2 years, is that strict or flexible? Good for organizations to have different service models and housing types. By high level care, explain what you mean – care that clients cannot give themselves? Linkage to mental health – seems intrinsic to independent living. Is this a part of the directive. With regard to the limit of two years – how do you address that with the client, besides mentioning it during intake?

Provider: The two year limit is a standard but things don't work like that. There are a lot of people who don't get there in two years. Clients today have a higher need of care, whether its MH or substance use or that they have never lived independently. Perhaps because they are too sick to go anywhere else?

Ms. Roque: We want to hear the challenges. How the landscape has changed. Do they need to be in the program for longer than 2 years?

Mr. Reyes: Need to hear your programmatic recommendations. What are your experiences? Perhaps we can add another year?

Project Hospitality: STH program transitioned from congregate to scatter site – 3 buildings with 2-4 bedrooms. Strengths are stabilization, first stop off the street whether SRO or the street. Weaknesses – limited case management staff – could use a part or full time worker. Have undocumented residents – incorporating a food line. Even with a pantry, its limited. We need clothing – we can buy scrubs – who wears scrubs every day? Some clients exceed 2 years – entitlements, status, Our program does not work with TCC. AOD (Alcohol and Other Drugs) counseling would benefit our clients, substance use counseling. A lot of clients are actively using. Having a CASAC on board would be helpful.

Alliance: A barrier is the time limit, lots of resistance when moving someone from short term to permanent because it appears they are already housed, so not prioritized.

CAMBA: NYNY3 housing is where a lot of the vacancies are – have to be aligned with HASA, and have MH and substance use. HASA will only take clients from HASA. Have 2 buildings, one is HASA one is RW (Ryan White) and there's no difference, but clients have different access. Finding a lot more housing with independent landlords. HASA will not pay for a lot of housing because it does not meet their requirements. We have a mixed model, congregate and scatter site with roommates. That helps with socialization – and also the roommates will reach out to us to check on their roommate. In congregate housing, can monitor clients and ensure that no medical issues are arising. Work with TCC – get lots of referrals and will case conference – but try to limit it so there isn't duplication. In a world without limits we would have onsite clinicians. That's a barrier for TCC as well. Getting our clients connected to NYNY3. But because clients are not being classified appropriately, they will not get access to supportive housing, which is what many of our clients really need. Putting some clients in permanent housing is a disservice.

Alliance: In a perfect world, with more resources, I would add more clinical and personnel services. Always fires to put out and that's a priority. More hands on deck to help with the basics – how to clean, how to budget, etc.

Ms. Starks Ross: We have had people call 311 because the toilet is backed up. Sometimes people are not ready to be housed, even if they present well in an interview. Its not fair to our other clients. We don't want to set them up for failure. Clients can act out because of extensive rejection. One client brought her boyfriend in a big suitcase. These are some of the behaviors that say a client is not ready.

Provider: Challenges to scatter site in general. 80% its ideal, 20% it just won't work – need a higher level of care, whether medical or a short term rehab. They might need a 90 day treatment program or a 6 month treatment program but then they will lose their housing with us – and that's a deterrent to them getting the help they need. Could be MH, but clients aren't in a place to accept MH treatment. Our staff

are experts at meeting clients where they are. We have the lease and are paying the rent – so landlords are not prioritizing us – gentrification makes pushing out our clients desirable. Not a fan of e-share, big fan of ecompas.

Acacia: Put extra providers in house to bring clients into MH immediately. Once they agree, onsite treatment begins immediately which helps with the engagement. Huge limit of housing placement, with rents higher than the fair market rent (FMR). Discouraging for clients, who are searching on their own. Need for more congregate and supportive housing. Lots are unstable, small percentage that are resistant. In TCC biggest challenge is the housing availability. Could use more housing opportunities.

CAMBA: Credit scores is a big issue. Every broker asks for credit scores. We get landlords that are willing to accept the vouchers but our clients have low on no credit scores. The vouchers are only FMR – and if someone is willing to pay more – they are going to get the apartment. Moving clients into independent living is really difficult when the voucher is FMR. Brokers are very focused on credit scores.

After Hours: No weaknesses but a lot of challenges. Very successful at engaging undocumented persons and getting them legal status and housing. Do more work than what is documented on paper? The way the system collects data is a weakness – home visits don't go in each share – it's not calculated anywhere – the time and effort that staff put in. Go in homes and inspecting apartment to address things that are broken or unhygienic. Set up a cleaning rotation to facilitate equal shares of work. Learning to do small tasks, as well as budgeting. Some clients have to pay toward the rent, help them learn to do that. Some clients refuse to pay their portion of the rent, and end up back in an SRO or on the street. Some clients are living in nicer apartments than I do, thanks to 80-20s.

Mr. Park: In delivering STH services, there are pieces of the work you are not getting paid for. What happens when you bring that up to the health department? This is a cost based contract, and the forumals comes from PHS that they use to calculate time and effort.

Provider: Because it is cost based, the minimum is 5 hours, so its as a package.

After Hours: We have very strong relationships with community partners – this is a critical part of the program. DOHMH has put together a housing advisory board which gives us an opportunity to interact with permanent housing providers. Networking the programs is very valuable and provides good outcomes.

Mr. Bruce: Have not heard you talk about the clients – how are clients doing in terms of medical issues, adherence, etc? What are the difficult clients like?

After Hours: We offer a lot of intensive case management. We provides accompaniment to doctor and appointments – we monitor labs, and we do intensive engagement, including behavioral health, emphasize U=U. Let clients know they are not alone. Conduct case conferences with their doctors.

Mr. Bruce: TCC does a more comprehensive work up with the client. Would TCC's client monitoring help in STH?

Provider: Even if we don't have a payment point specific to adherence, we still need to do it.

Provider: We track the labs and ensure that clients are not having issues with adherence. Do a lot of case conferencing if there are issues.

Bailey House: Very new – so not very familiar with STH. Currently oversee TCC. Credit scores are a huge challenge, even getting them, before dealing with what they look like. Once clients are done with TCC we move them into health homes for follow up and maintenance. To improve credit scores we connect them to agencies that help build credit like open bank accounts, apply for credit cards with small limits.

Ms. Lawrence: Landlords are not supposed to use credit scores to determine housing eligibility, but it does not stop them. What are providers doing about this population?

Mr. Reyes: What percentage would you define as "difficult"?

Provider: People are at various levels of readiness – when we say ready we mean independent living with no subsidy, The purpose of STH is to get them ready. I would say the number varies, but about 20% of clients are really struggling.

This is usually due to relapse of MH. Some clients are selling their meds – there is a huge market for this, even for sending the meds out of the country to family that needs it.

For all of our clients our goal is viral suppression. Whether they are TCC or STH. Try to limit duplication between these programs. TCC is from 9 months to a year – would remove this time frame. We know TCC and STH are in competition so we limit interaction.

Mr. Park: We want to strengthen STH be incorporating what works in TCC.

Ms. Beiling: How can we strengthen outreach in STH?

Provider: By doing what TCC is doing, going into homeless shelter and finding the clients. My issue with TCC is critical time intervention (CTI) because our clients do not work in stages. It's not realistic.

Clients have to pay fees for brokers – even when they don't get the apartment – the clients have to pay for the credit scores.

Ms. Chestnut: Getting the credit scores lowers clients credit scores

Ms. Roque: My clients could be in the program for 5 years.

Mr. Fields: How long does it take STH clients to be ready to go into housing?

Providers: It really varies, depending on the clients. Some clients know what they want and go and get it, but on average it's about a year.

Ten years ago we didn't have an 80% suppression rate. Its two factors: tenant readiness, and housing availability. You can be ready but not able to graduate.

Mr. Reyes: What's the difference between older and younger clients.

Providers: Younger wants to transition to permanent housing right away, even if they are not ready – don't have savings, etc. Older folks are more patient, and are willing to wait because they have been in a precarious living situation for longer.

Mr. Fields: How do you deal with terrible landlords?

Providers: Landlords are clients almost as much as our clients. We deal with them. We can't touch electrical or plumbing. Have a small maintenance unit to address these issues. Will teach them to change lightbulbs, will change locks if clients lose their keys. Work with the landlord – it's not easy. Try to hold landlords accountable to the laws.

And clients have to respect the space -

Mr. Powell: How many of you do mental health first aid for your clients. What are the 5 top issues that you're seeing among your clientele? Its very difficult to have conversations with young folks, how are you handling that.

Provider: We have 24 on call cell phone lines, we step up emergency protocol, so that if someone has a breakdown or an event, we follow protocol.

Great idea to take our qualitative data to look at what trends we are seeing. And come up with a tool to demonstrate milestones. Everything we are saying is really social work – clients go forward, they step back.

Mr. Powell: identifying trends would help identify the best interventions, i.e. if they are selling meds – finding peer work to generate income.

Providers: This is what we do – we find ways to get money in their pocket so they can adhere to the meds.

Link clients to job fairs, educational opportunities – difficult to quantify because we are doing it on a day to day basis.

Ms. Greene: Does everyone deal with undocumented persons? What do you do at 2 years?

Providers: Yes it is difficult to house them. It's likely they will remain undocumented – we look for a rental assistance program that provides housing. As soon as client comes in, we are trying to figure out next step. If the client is with a rental assistance program – it's the agency that is the tenant of the apartment, so the lack of documentation is not the issue. The landlord isn't the problem, but the bandwidth of the agency is.

Do a lot of wheeling and dealing to get clients housed, especially when they have a history of incarceration, or have legal issues.

Ms. Farley: How many clients have health home case managers as well – and who does what?

Harlem United: We have health homes also – don't know the percentage that overlap. Some aren't interested, some get closed out because they won't engage – its primarily about the medical. For the

20% who need a lot of attention, we will coordinate with health home – so clients are getting additional intervention. Health home gets a hospital alert first – and will share it with us, which is very beneficial. Takes ongoing conversations and clear delineation of who does what.

One of the benefits we have – 60% of our clients have health home and that person lives in the building, which really facilitates coordination. The risk is duplication so must be clearly delineated.

TCC cannot work with health home – clients cannot be in both programs – so TCC ends up doing the health home work of case management.

Bailey House also has a health home program. TCC will refer to health home when clients leave TCC. All of our staff get Mental Health First Aid training. We are well located for walk ins, and partner with Housing Works.

Agenda Item #4: Committee Business

Are we writing a new service directive – what about the new ETE plan? Will it make our work null and void. The plan is still being rolled out and will affect 4 of the 5 boroughs and does not deal with housing. We should come together and look at what it means to write a new service directive.
The committee has already committed to removing the TCC service category.

Allocations are not the decision of this committee. At the last meeting we voted to merge TCC and STH. Amd of that's what we are doing, we need to develop a new service model.

Agenda Item #4: Public Comment & New Business

None.