Meeting of the
Needs Assessment Committee
Amanda Lugg and Marcy Thompson, Chairs
February 13th, 2020, 10:00AM -12:00PM
LGBT Center 208 West 13th St, Room 101
By Conference Call – 1-866-213-1863, Access Code 3587454#

Present:

Welcome/Introductions/Moment of Silence/Public Comment/ Review of the Meeting Packet/Review of the Minutes:

Ms. Lawrence opened the meeting with an icebreaker. Introductions with pronouns were conducted and the Mr. Bruce led the moment of silence. The committee reviewed the meeting packet. The December minutes were presented, corrected and accepted.

Public Comment/New Business

None.

Presentation: Persons with Serious Mental Illness Referred to Select Bureau of Mental Health Services and Matched to the NYC HIC Registry

Ms. Perminder Khosa from the NYC DOHMH BHIV Epidemiology Unit led us through the slides on the analysis. The following are the questions (all questions are indented) that arose on the presentation.

Is this data statistically significant?

No, It is a simple match.

Would a person with depression be retained in this cohort?

Yes – if there is a significant functional impairment. This match is based on two referral databases. They matched at the time of referral – people are not purged from the data set if they are treated. Whether they accepted treatment is unknown.

Do you have diagnoses?

Diagnoses are coming.

Did MSM report specific drug use?

Epi data is limited – so do not know what types of drugs are being used in all cases. Ms. Khosa can look into this.

Often people have multiple health disorders – how was the primary selected?

When we receive the referral – we will select a primary diagnoses, and rely on the diagnosis from the referral source.

It takes about 3 years to receive a correct diagnosis. Highest numbers around SMI look to be among 50 year olds – what is the correlation?

On slide 16 – for patients that end up in in-patient services – how does that impact the care continuum?

For providers – when you have a patient that goes in-patient, what are the challenges?

Epi would not know if people are in-patient – most of the data comes from labs

Often get alerts through MyChart – try to coordinate with the hospital, but usually they are not getting medicated - even when we send their meds.

If patients are off ART, would not re-start it – this is an issue. Won't bring an ID to run labs – have to wait, get them released – get them an appointment. If you're on ART, you should get your meds, as usually you can see through the electronic record, what they are on.

Not all providers have access, because different EMRs (electronic medical records) exist

Can you do a multivariate analysis to see what and how race and ethnicity interplay with poverty?

Interested in an analysis looking at poverty and race. Would need an appropriate justification that considers who exactly is in the match.

The results can be stratified by poverty and race – a multivariate analysis is not necessary to get to that.

Are incarcerated people included in this population?

SMI registry is based on referrals – this is not everyone with SMI. Vast majority are from lower socio-economic status.

The literature matches the findings of this analysis.

If we eliminate the deceased, gives an overly optimistic picture of viral suppression. What is the medical rationale for not starting people on ART during in-patient treatment.

People being treated on MH units are not staying as long as they used to – but when they are coming off the unit, they are still pretty ill – so follow through is a high concern.

Why are we releasing people – this is an opportunity – to develop a team approach to care.

We should include in the analysis the deceased.

A death data analysis, based on cause of death. Are you asking to look at viral load before death? We can track viral load within a certain amount of time before death.

For inpatient, meds and diagnoses, I was inpatient – its like going to an ER – they only treat the crisis.

Any discussions about HIV may come up, but they are not going to do diagnoses – most case managers do not have the ability/bandwidth to help manage this. You are incredibly isolated when inpatient.

Is immigration status included?

We do not have that info, but can do place of birth.

How are the housing programs handling the revolving door that many MH patients pose?

There are no housing program providers at this meeting.

Revisiting the Rikers questions: Are incarcerated people included in this data set?

We do get referrals from correctional agencies, including our forensic teams which are supposed to work with justice involved individuals.

Do you see clients cycling in and out of care?

It's very hard to keep clients engaged in MH care. My best service is my MH patient care navigators. They are skilled in working with people who are mentally ill – most people do not have this training – they establish trust with the patients – we have the same team and not having that turnover makes a big difference – that trust results in folks confiding to us. And they have to trust us for us to get them into appropriate care. Even when he is actively psychotic he still came in. His housing is stable, but a lot of the people who work with him have no idea how to provide care for people in psychosis. Incredibly difficult to get an ACT team – have only had one patient qualify.

It is incredibly difficult to get ACT teams. Must have multiple psychotic visits.

I'm a patient navigator – you have to stay with them, even when they go in and out. Many times, they just don't understand. I do accompaniment. I work to get them into housing. You have to stick with them.

Slide 8 – Diagnosis facility – really big difference in where people are being diagnosed – are people living with HIV longer? Do we have data on concurrent AIDS diagnoses.

Yes – we can get this data (epi). Want to be careful when looking at diagnoses facilities – don't have clear diagnoses facility for all the patients as it was only standardized after 2014.

I'm a care coordinator, work with people who are IDU. Incredibly difficult to do coordination with inpatient facilities – my patient who was suicidal was denied entry – on the way home he jumped out of the car. How can we work better with these providers and not feel like a burden to them.

To the grantee: are there meetings that bring behavioral health providers together?

Have a regular annual meetings. In process of hiring a social worker to overview this portion of the portfolio – may be a good idea to start a learning collaborative.

Quality Management does operate teams for some categories –

Happens on a service category by service category basis – which is why we are hiring a behavioral specialist.

Question about diagnoses facilities – what exactly are these – how are people being connected to care. Can provide a list of how these facilities are defined.

Can we striate with which of these are primary vs behavioral health?

Whenever someone is in a H+H ER they are offered an HIV test.

Suspect we don't have specifics on all of these facilities, but can provide lists to be categorized.

How do we understand that 60% of people with SMI are Black?

These are the referrals that come through our door – but this data is not representative of all people with SMI.

What are the primary barriers to clients getting the care they need? What tools could you use to better support this population?

Better communication between providers – better responsiveness. Need more training in working with each other – everyone is so busy but who is going to help the client?

Get services to stabilize people when they have decompensated. Work very hard to bring people back in and get them psych care.

Coordinating as a team is very helpful – even pairing up navigators can help broaden perspective.

Worthwhile to bring Article 28 and Article 31 providers to understand the landscape.

My program is SCI – almost all clients come in needing MH services – would be great to have such services in house.

As an article 28 and 31 provider – technology is a big barrier – we can make referrals, but we are not as well connected as we should be. The EMR needs to be better integrated – because we are not part of a larger system, we cannot put data into the system.

Which providers are using PYSCHES? A larger data system that collects claims to services – can get alerts on your clients.

Trainings about crystal meth and MSM and MSM drug use – and brochures to distribute to clients.

Need a repository of information specific to the population I work with – ie crystal meth – challenging to counsel them when we don't have adequate training.

A lot of crystal meth is being seen. More evidence based trainings would be helpful – that hone in on PLWH and MH. Very helpful to be able to provide home visits.

Look at the harm reduction coalition – have awesome trainings.

Clients have so so many needs- that's what makes it difficult. Have a waiting list, but can't refer people out because other agencies have waiting list. Need more staff and have to deal with too much paperwork. Have to put separate notes – all these grant requirements. This MHV assessment is not useful. Finding statistics on MH and HIV – they are collected, but not released. When we track SMI, by looking at benefits – the numbers double. Therapy note must be separate from treatment adherence. Takes a really long time.

Have a very long waitlist. We do not get Part A funding for MH but theres a long waitlist for services, and even for referrals to hospitals there is a waitlist. Finding space to conduct these services – and to pay social workers what they are worth – not fair to ask people to work for low wages. A psychiatrist is very expensive and they are not available.

Need more funding to deal with stigma and to have a psychiatrist in a CBO that they trust.

Need funding for hand holding. I've run focus groups and consumer advisory groups – and when you're looking at the recidivism, you see a need for more patient navigators and peer support.

We do a lot of treatment readiness. But when they are ready, it's a 6 month wait to get them into a program.

Client navigation and loss to follow up – need more staff, have a high turnover of staff, and so we don't have adequate capacity. Lose many people in article 31 to follow up- do better with Ryan White.

From the grantee: Planning a provider forum on crystal meth use on May 8th – will outline training opportunities; working on getting an alert system up and running, working on a new e-share – will take years; working on incorporating opportunities for data to care; for documentation - will support the BH specialist to manage this issue. Required every RW program to be located in an Article 31 or 28- how do you make this seamless – its difficult to share staff and information. Have a hurdle with helping programs effectively create a structure that helps manage these two programs.

Maybe need to look at peer certification for behavioral health.

Those are different requirements from the AIDS Institute.

Have contracted with CUCS to develop trainings around subjects like motivational interviewing, trauma informed care, etc.

How are youth of this population impacted?