Meeting of the

Needs Assessment Committee

Amanda Lugg and Marcy Thompson, Chairs

December 10th, 2020, 10:00AM -11:45AM

Zoom Video Call: https://zoom.us/j/4708943670

Members Present: Marcy Thompson (co-chair), Amanda Lugg (co-chair), John Schoepp, David Klotz, Randall Bruce, Lisa Best, Rob Walker, Tim Frasca, Jennifer Irwin, Micah Domingo, Claire Simon, Billy Fields, Fay Barrett, Finn Schubert, Jamie Walkup, Jonathan Reveil, Karen McKinnon, Maiko Yomogido, Mytri Singh, Francine Cournos, Micheal Rifkin, Leo Ruiz, James Satriano, Norine Digiulio, Matt Leseiur, Paul Carr, Karen McKinnon

DOHMH, PHS, NYS and Other Staff: Cristina Rodriguez-Hart, Claire Simon, Graham Harriman, Kimbirly Mack Rachel Crowley, Guadalupe Dominguez Plummer, Ashley Azor, Bettina Carrol, Roland Torres

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

Ms. Lawrence opened the meeting with introductions and an icebreaker. Introductions with pronouns were conducted and a moment of silence was held. The November 12th minutes were presented and accepted with corrections toward the end of the meeting.

SMI: A Review

Ms.Lawrence presented a review of what information we have gathered since beginning to assess the issue of serious mental illness (SMI).

All of the presentations received by the committee have been added to a google slide. Key themes are:

- Awareness of POLR – Payor of Last Resort requirement for Ryan White (RW) funds
- HASA application processes are not congruent with the clients served – need to better navigate or center the client
- Many HARP qualified clients never gain access to those services
- Psychiatrists are covered by Medicaid- *Mr. Leseiur* noted that almost all psych services are currently offered over telehealth – but there may be ways to support wrap around services. Ms. Thompson noted that the community is advocating for the continuity of flexible services, ie phone calls are currently reimbursed
- *Ms. Barrett* noted that for some mental health services – it has to be a certain amount or type. Question of whether we are making services broad enough to be accessible to clients who need the services.
- *Ms. Thompson* noted that services are geared around what funders will pay – but what about low threshold services? Who is willing to find those – but these are the programs that get people into more intensive care.
- Low threshold services meet clients where they are – low bar/easy access. Clients may not be ready for prescribed clinical care.
- *Mr. Harriman* advocated for clients to be able to access same day psych or prescription writing person- this could be funded by RW
- *Mr. Schubert* supports the Collaborative Care Model, where the psychiatrist consults with the primary care provider to make recommendations for medication that the primary care provider then prescribes
- Psychiatrists are in incredibly high demand – even higher for psychs of color – only psychs can write the medication

- Possibility to do some sort of task sharing – where psychiatrists supervise the social workers who provide direct client services
- Should the forum discuss COVID-19 and it's impact?
- How do we improve access to psychiatry?
- Need for TA in RW so that providers are clear that their agencies do have an MOU with a mental health provider
- No cohesive response for agencies to implement when a client is in crisis: Establish best practices and mandate the submission of a plan
- Navigators versus health home: benefit of accompaniment – can advocate for clients who are having trouble with routine service visits
- Psychiatric nurses could help alleviate the pressure on psychiatrists
- The waiting period – moving the wait for a psychiatrists from 3 months to a week
- Health home program – one deals directly with SMI – leverages already existing services in the community – need to hear more about health homes manage SMI
- Inclusion of mDOT in behavioral health services to provide medication support
- Would make sense to enhance the behavioral health care model with HIV care and prevention capacity
- *Mr. Harriman* noted that we can allocate 5% of the grant to training for providers
- Integration is super important. We have found that providers say this reduces stigma for PWH and it resonates with the CC's recommendations from their QI Project a few years ago that said mental health needs to be addressed at all visits.

Thinking about Behavioral Health Integration

Mr. Harriman discussed the need to bring together the services in the portfolio that support behavioral health and ensure that services are culturally humble. Must ensure all clients can be served – dearth of Spanish speaking services. Need to better integrate across systems – need to seamlessly provide services to a client. Fast tracking of referrals and access to services. Are clients constantly repeating extensive intakes – one provider created a seamless intake for all the funders. The RW intake should have the capacity to integrate into other systems.

PWH with SMI Provider Panel

The SMI subcommittee brought together providers from across the behavioral health service categories. Key themes:

- AOT incredibly difficult to access
- Additional navigation services
- Small providers should have free access to RHIOs and other data points that inform agencies when to ramp up services
- Low threshold services are incredibly important
- Not clear when clients are suspended from a Medicaid funded program – due to not showing up, etc – so doesn't necessarily trigger additional support from RW side to re-engage client
- Mandate to address stigma
- Integration of HIV with primary care is a powerful stigma reducer – less likely to be inadvertently outed, normalizes HIV
- Creating guidelines or standards for integration is useful – one clinic had all the providers rotate around the client – instead of the client going to different providers. This also improved communication between providers
- Need to talk to clients about their experience
- No show rates inhibit willingness to experiment
- Significance of SMI patients presenting in primary care settings
- Patients sometimes have ACT teams that are not coordinated with patients primary or behavioral health care.
- Need for funding support for case conferencing with psychiatry

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Public Comment

None