INTEGRATION OF CARE COMMITTEE
April 15, 2008
GMHC, 119 West 24th Street, Room 405/410
10AM – 12PM

DRAFT MINUTES

Members Present: Ivy Gamble-Cobb (Chair), Caridad Aguirre-Pellicer, Joan Edwards, Soraya Elcock, Elaine Greeley, Roberta Greengold, Deborah Greene, Peter Laqueur, Fabienne Laraque, MD, MPH, Theresa Mack, MD, Gonzalo Mercado, Carline Numa, Jan Carl Park, Terry Troia

Others Present: V. Benadava, T. Benston, G.Cruz, T. Petro, S. Janicki (PHS)

NYC DOHMH Staff Present: J.Hilger, R.Molina, T. Noletto, A.Santella, DrPH, D.Wong

Welcome/Introductions: Peter Laqueur led the moment of silence, Jan Park and Ivy Gamble-Cobb welcomed the participants, and members introduced themselves.

Review of Minutes: Jan Park reviewed the draft minutes from the previous meeting on March 18, 2008. The minutes were accepted with no revisions.

Review of Bylaws: Jan Park reviewed the description of the duties of the Integration of Care Committee (Article VII, Section 4, Article VI).

Review of Meeting Materials: Currently, we are in the third year of a three year re-bidding process, with the focus on case management and redefining its service components vis-a-vis the continuum of care.

For historical reference, Mr. Park presented the Program guidance for Case Management, which was approved by the Planning Council in July 2006. This guidance was developed in tandem with the objectives articulated in the 2005-2008 Comprehensive Strategic Plan in anticipation of the re-bidding to occur in that time period.

In June 2007, IOC revised its guidance for Outpatient Medical Care to emphasize an increase in availability and range of HIV medical services, which may be co-located with mental health and substance abuse services. HRSA Service Category Definitions were reviewed, with emphasis placed on the distinction between core medical case management services (Section IL) and non-medical case management services (Section IIA).

The April 2008 comparison of current case management, treatment adherence and outpatient medical care programs with DOHMH plans for improved care, through care coordination, was presented, highlighting the consolidation of outpatient medical care, medical case management and treatment adherence. The goal is to keep patients in care, reduce their viral loads and ensure stability and access to comprehensive services while increasing integration, efficiency, and accountability and reducing duplication.

Members of the IOC met earlier this month with specific questions on the proposed program model. Dr. Laraque's responses are noted below:

CASE MANAGEMENT

Q: *What is changing in Case Management, Outpatient Medical Care and Treatment Adherence?*

A: The case management plan (for care coordination) uses the same principles as the service model established by the IOC in 2006. The goal is to keep patients in care while coordinating access to other services. Plans include coordinating services so that new medical case management programs have complete responsibility for care coordination, including ensuring that clients receive HIV primary care and all other medical care required and have access to other services that are needed to help them stay in care. This would include ensuring access to transportation, entitlement support, housing, mental health and AOD services and nutrition support (food). Increase funding for medical case management and care coordination by consolidating OMC, medical case management, and treatment adherence to more effectively use limited resources. The PSRA would reassign a portion of OMC funds to medical case management using this new model of care. New programs would start in 2009 via the new RFP. Funding for OMC would be reduced to medical care for the few who are not eligible for Medicaid or ADAP+ and do not have other insurance or who are undocumented. Standards of care will be developed for these services. All funded programs will be required to adhere to these standards. These will be included with the RFP, based on published evidence and information learned from local programs. Data collection will be improved via patient management software for programmatic and outcome monitoring, and data sharing will be facilitated via formal agreement between providers. Formal linkage will be required between medical providers and case management providers that are not medical centers for better care coordination and improved sharing of patient information

Q: *What is the definition of medical case management?*

A: There is no difference from the HRSA service category definition. Case management is a function that is best delivered where the client is; the focus is on keeping patients in care. Retention in care increases adherence to medication regimens. Much of the work centers on working with clients in the community. Patients need to see the MDs in order to remain healthy. We anticipate a close linkage with medical providers as the nexus of the case management paradigm. Field-based services are proposed for those who are difficult to reach.

Q: *If the proposal is to combine the three categories and shift a portion of Outpatient Medical Care, what would happen to the other elements of Outpatient Medical Care? Will this apply to both CBOs and hospitals? Can hospitals offer off-site case management? Would primary care have to be integrated on-site?*

A: The NYC DOHMH anticipates RFPing this as a model of care. This would be beneficial to our contract agencies with respect to the billing and allocation of case mgmt services, which could be either in outpatient medical care or medical case management. Outpatient medical care would then provide only that service. However, these services would be RFPd as a group so that the same providers would have the ability to bill for Case Management, Treatment Adherence and Outpatient Medical Care. Treatment adherence, while teased apart by IOC, is at its core, part of the case management entity. The Case Managers will be doing the patient education, which is a large part of Treatment Adherence services.

Our suggestion is to remove the case management/care coordination component. This model would apply to both CBOs and hospitals. However, a hospital would need to adhere to the

guidelines that NYC DOHMH develops in order to qualify for the funding. While having primary care integrated on site would be optimal, we can envision a Case Management agency that would be co-located, i.e., maintain a space or cubicle with that agency's staff person, on-site at a medical provider. The agency staff person would then become an integral part of the primary care team.

TREATMENT ADHERENCE

Q: *How does treatment adherence fit into the model? Who does treatment adherence in this new model – the nurse, community workers, or case managers? How are the different tiers of treatment adherence reflected in the model? Will the current model that is being developed indicate the credentialing of these case managers? If so, how will that limit the ability of grass roots organization to compete in the RFP, as few peer case managers may have advanced (college or graduate level) education? Will the protocol in development specify that several levels of case management are necessary?*

A: Treatment Adherence is an integrated part of the navigation model used to get patients the services that they need and want. We envision the role of the RN as a primary one with respect to patient education – in the assessment of treatment adherence readiness, explaining treatment regimens or explaining possible side effects. The person who talks with the patient on a day-to-day basis will be a non-nurse case manager/peer. However, this will not be dictated to providers. NYC DOHMH does not believe that RNs need to be involved in every level of care coordination, e.g., tracking appointments, and so there will a certain level of latitude afforded to contractors in designing their programs as we are suggesting a wide range of staffing configurations.

Q: *We are discussing both the clinical aspects (as delivered by a physician or nurse) and the critical aspects (as delivered by support staff) of treatment adherence services. In my view, the best case management is delivered by a clinical person who has a medical understanding of the patient's situation. Because multiple levels of case management staffing can be problematic, the RN should provide the management of and direction to the subordinate staff. We understand from this model that all case management programs for PLWHAs will need an RN or clinical medical person as the team leader who in turn works with case managers who coordinate the individual components of entitlements. However, depending on the community or population served, different staffing levels may be required to achieve the outcome of retaining patients in care. Also, as experienced providers, we have witnessed much progress in treatment advances. We are now dealing with issues of chronicity versus acuity which dictate that different program approaches/staffing configurations should be used.*

A: The medical provider will be experienced, credentialed, and will formulate the plan, order specialty consults and assess client entitlements and function as the medical team leader. The Case Managers will execute and implement the plan.

Q: *Because some CBOs offer longstanding primary medical care on site, will the IOC vote on a template that will enumerate service elements and guide respondents to the RFP? Will the outpatient medical care guidance remain the same, except for separation of Medical Case Management? How will the ratio of services be affected?*

A: We are asking the committee to re-affirm the guidance. All case management services are designed to promote access to and utilization of primary medical care services. We should be thinking in terms of shifting the funds where the services are being enhanced, approx. 75% to case management and the remaining 25% to outpatient medical care. The model will contain different levels (weekly, monthly, DOT) of treatment adherence. Because HIV is now a chronic disease, the overarching goal is for clients to become self-sufficient; clients should be educated and given

the training and supports necessary for them to receive the services they need so that they are not necessarily receiving life-long case management services.

COORDINATION BETWEEN PROVIDERS

Q: *What is the motivation for primary care providers to confer with case management providers? Does the model mandate that primary care providers and case managers case conference? How is case conferencing defined? What is being built into the model to facilitate coordination between providers? Will there be guidelines as to frequency of case conferencing, participation, etc.? What will motivate the primary care providers to attend case conferences, given the demands on their time?*

A: Our model asks for formal linkages between case management and medical providers. This will be positioned so that case management is a service to the medical provider and will represent cost-savings for the medical provider entity through reduction of missed appointments, etc. An initial, as well as ongoing meeting/case conferences are a part of the model and there will be guidance, but we want to preserve some flexibility for agencies. There will be contractual agreements/formal linkages, in lieu of more loosely fashioned MOUs. There will be checklists of referrals, but much of the accountability will fall upon the case management team.

Q: *From an accountability perspective, the model does not demonstrate a mechanism for ensuring that the primary care provider will follow through and attend case conferences.*

A: There will have to be some flexibility, but there will be ongoing conversations with providers to assure accountability. The model will fit into existing services.

Q: *With respect to co-location, will primary care providers need to provide space for every CBO with which the provider works? In the case of CBOs providing primary care, how would this work? Because of space constraints at primary care facilities, this model could be logistically problematic.*

A: NYC DOHMH does not propose that providers should be linking with every CBO, but rather link with a case management provider that works closely with the primary care site. Widely dispersed case coordination is not effective and accounts for the large # of patients out of care. The hospital would offer the services of a case management provider to the client, which the client can accept or refuse. Even though care coordination can include agreements with, for example, twenty agencies, the actual care coordination piece must be located at the primary care provider. The provider who performs the medical assessment of the client will refer the client to a pre-identified case management provider.

Q: *Is this model designed for the approximately 30,000 PLWHAs diagnosed but not in care, or for those already in care who need occasional assistance in accessing needed services?*

A: It actually benefits both populations, keeping in mind that it is not feasible to case manage the entire universe of NYC residents living with HIV/AIDS. We are targeting those not in care and those who are newly-diagnosed.

Q: *Some CBOs have particular cultural and/or linguistic capacities which enable them to work effectively with certain populations. With this model, those CBOs would be stretched to limits in order to serve clients who access primary care at facilities throughout the city. With respect to COBRA case management, will there be continued and improved access to Medicaid-reimbursable intensive case management services by accessing treatment adherence funding for these services?*

A: We anticipate this to be the case as we would like to provide services that are not already covered by other funding streams.

Q: *How do we ensure that through their case managers, those not in treatment follow through with their appointments? Many patients are referred and given appointments but do not keep their appointments.*

A: This has been discussed – whether the ER can maintain a list of appointments, or if the case manager can get appointment info for the client. We are considering the feasibility of a variety of different mechanisms.

COMMUNITY/CONSUMER OUTREACH

Q: *Where does the community factor link into this model? Where does education of consumers, especially of the newly diagnosed, occur? What incentives are there for disconnected consumers to engage in services? Does the proposed model allow for the integration of peers to partner with case managers doing outreach and home visits? How does this model address the issue of distrust of systems by consumers? What is the relationship between he COBRA-funded programs and the proposed model? Are home visits a component of this model?*

A: Education/health promotion is an integral part of the model. Apart from the medical benefits derived from ongoing medical care for HIV/AIDS, there are the tangible benefits of housing assistance, food and other life-sustaining needs being met. Peers will be integrated into this model. The model will encourage the staffing of programs by committed and competent professionals who will build trust with their clients. Home/field visits will be encouraged to get the client into care.

MENTAL HEALTH SERVICES

Q: *How are mental health services incorporated into the model?*

A: They are one component of the services which will be facilitated if the client's assessment demonstrates this need.

DATA

Q: *What do we know about the 30,000 HIV+ persons unconnected to care? What are the characteristics of this group?*

A: NYC DOHMH can utilize information from the NYS AIDS Registry: the AIDS Registry contains the names of PLWHAs, and we can tell who is not receiving care because we are missing CD4 and viral load data (within the previous (9) months). NYC DOHMH will not mandate any specific data management software for the purposes of data collection and information coordination.

OTHER ISSUES

Q: *Is this an SNP model for case management services? When the client enters this model, is it a closed system – is the client limited to a finite list of providers based on where he or she receives medical care? Does the medical community have the capacity to serve the 30,000 persons unconnected to care once they are identified and linked to care? How does this affect those who are currently in care and have established relationships with case management providers? How will this transition be managed, from the perspectives of agencies funded to do case management and from the perspective of the clients served? There would be serious contraction in the number of case management providers, especially in terms of a chronic model of HIV disease management. How are quality management issues being addressed?*

A: This is not a SNP, per se, but clients will be limited to the case management providers with whom the primary care provider has linkages. Currently, 24 case management providers are funded, and the number of medical providers is large in NYC.

Q: *How does the relationship between the patient, case manager and provider change? The case manager may be more familiar on a longer term and more individual basis with the client. He/she needs to be able to exercise independent judgment in making appropriate referrals for the client, without regard to the impact on the primary care facility where they are housed.*

A: While we recognize that many clients enjoy long-term relationships with their case managers, the focus of this initiative is on those who are not in care and consequently do not have such relationships. In addition, the magnitude of the number not in care indicates that something is not working. Our goal is to provide care coordination for those who need it, not for those who already access services. There will be various levels of care coordination offered, with treatment adherence an integral part of medical case management.

PUBLIC COMMENT:

Q: *How would this model affect special populations with respect to culturally and linguistically appropriate services? There would be an overburden on specific agencies who may be the sole provider of services to that particular population. How will capacity be ramped up so that peer case managers or mentors have the appropriate level of training?*

A: Well-trained, diverse staff are key to successful programs.

Given the quorum, a motion was requested that the **proposed Integrated Model of Care, as presented in the 4/2/08 document, in which Treatment Adherence, Outpatient Medical Care (75%) and Case Management are collapsed into the Integrated Medical Case Management Model and the remaining 25% of Outpatient Medical Care will focus on provision of primary care and medical services, be recommended for consideration by the PSRA and Executive Committees and the full Planning Council.**

Jan Park made the motion, the motion was seconded, and the vote was taken:

10 (ten) in favor, 1 (one) opposed and 3 (three) abstentions. The motion carried.

Dr. Laraque verbalized the request for a separate motion to be made regarding Transportation services:

Depending on needs or level of functioning, clients would be able to access a wide range of transportation services, including Access A Ride, taxi service, Metrocards and van service, as opposed to the services of one sole provider.

Ivy Gamble-Cobb asked for more data to be presented on utilization, cost comparison, and the nature of services used in order for a decision to be reached. There was additional clarification that the Transportation category needed re-definition.

The next meeting was scheduled for May 21, 2008 from 3-5PM.