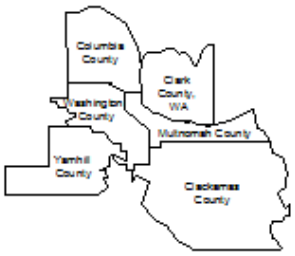
Portland Area HIV Services Planning Council

Advocacy and planning for people affected by HIV in the Portland metro area

Ryan White Program, Part A



Meeting Minutes

Meeting Date: January 10, 2017

Approved by Planning Council: March 7, 2017

Grantee: Multnomah County Health Department

Multnomah County

MEETING MINUTES
Planning Council

Portland Area HIV Services Planning Council

January 10, 2017
4:00 pm – 7:30 pm
McCoy Building
426 SW Stark St
Conference Room 10A

Members Present:	Jay Anderson, Emily Borke (Operations), Erin Butler, Katy Byrtus, Tom Cherry (Council Co-Chair/Operations), John Conway, Carlos Dory (Evaluation Chair/Operations), David Duncan, Monica Dunn, Maurice Evans, Greg Fowler (Operations), Alison Frye (Council Co-Chair/Operations), Shaun Irelan, Lorne James, Heather Leffler, Jonathan Livingston (Operations), David Macko, Toni Masters, Jeremiah Megowan, Scott Moore, Robert Noche, Jace Richard (Membership Co-Chair/Operations), Michael Stewart, Michael Thurman (Membership Co-Chair/Operations), Joseph Pyle
Members Absent:	Andrew Gadbois, Toni Kempner, Janis Koch (Operations), Julia Lager Mesulam (Operations), Chaela Manning-Ferguson, Sara McCrimmon
Staff Present:	Margy Robinson (Council Administrator), Amanda Hurley, Terry Bonnett
Others Present:	Linda Drach, Bridget Carnahan, Nicole Judd-Bekken, Renata Ackerman, Devarshi Bajpai
Recorder:	Terry Bonnett
Final Co-Chair Approval	

Tom Cherry, Planning Council Co-Chair, called the meeting to order at 4:05 p.m.

Item:	**Candle Lighting Ceremony**
Presenter(s):	Robert Noche
Summary:	Robert led the lighting of the ceremonial candle in honor of long-term survivors and in memory of George Michael.
Item:	**Welcome/Introductions**
Presenter(s):	Tom Cherry
Summary:	Tom welcomed everyone to the meeting and introductions were made with Council members declaring any conflict of interest. Margy welcomed David Macko, our newest Council member who represents Clark County and this is his first Council meeting.

Item:	**Integrated Care & Prevention Plan**
Presenter(s):	Linda Drach, Oregon Public Health Division
Summary:	Linda was at a Council meeting last Spring to talk about the Statewide Integrated Care & Prevention Plan and is here now to give a brief comprehensive review of where we are now and what the next steps are. Both Part A & Part B were required to submit an integrated HIV prevention plan. This was unique because we hadn't had an integrated prevention plan nor had we had a Part A & Part B integrated plan before. The plan has been encapsulated into the End HIV Oregon Strategy. The End HIV Oregon Strategy comprises 3 key components – Testing is Easy; Prevention Works; and Treatment Saves Lives. Oregonians need to know their HIV status—currently only 35% of adult Oregonians have ever been tested for HIV. It is estimated that about 1,100 Oregonians are infected with HIV and don't know it. If most/all of these people were tested & started HIV meds, we could prevent 150 new infections over just 3 years. To increase testing in Oregon we can implement Early Intervention Services (EIS) statewide; increase HIV testing in health care settings; and implement innovation grants to encourage new strategies to promote culturally-competent testing in communities facing HIV related disparities. Looking at prevention we know that foundational prevention programs like syringe exchange, education, and condom distribution have helped Oregon maintain low levels of new

	infection for a decade. There are also new tools, like PrEP, that need to be used. When taken consistently, PrEP can reduce risk of HIV infection in people at high risk by up to 92%. Syphilis &/or gonorrhea infection may indicate that someone is at high risk for HIV infection also. It is estimated that if 1,000 Oregonians at highest risk for HIV infection start PrEP, we could prevent about 8 new HIV infections per year. We want to develop new capacity to deliver PrEP to those who need it, including MSM and partners of PLWH; address gaps in the health care system to deliver PrEP to those who need it; and partner with CBOs to conduct consumer education & service navigation with individuals who could benefit most from PrEP. The third component is treatment. With early testing and treatment, people who are HIV infected are leading long, healthy lives. Effective HIV treatment can reduce transmission by up to 96%. Oregon's care system does a good job, with 85% of people linked to care within 90 days of diagnosis, but we are aiming for better. It is estimated that if all Oregonians who know they are HIV infected were virally suppressed, we could prevent over 2/3 of new HIV infections. To increase viral suppression, we can develop enhanced case management and patient navigation services statewide for people who experience significant barriers to adherence and are not virally suppressed: increase housing subsidies and support for PLWH who are homeless; develop peer support programs to support long-term medication adherence and to address treatment fatigue; and ensure all prevention & care services are trauma-informed through capacity building and training. There is a website, www.EndHIVOregon.org, focusing on disparities, health equity and stigma; clear messaging around the connection between treatment and prevention; expansion of supportive systems like EIS, patient navigation, and case management, as well as use of new tools like PrEP. Linda reviewed the End HIV Oregon baseline report card. The next Integrated Planning Group meeting is scheduled for March 1st and will be in Portland. To get involved, contact to End HIV Oregon website – Josh Ferrer; through IPG, and other ad hoc committees.

Item:	**Mental Health & Substance Abuse Systems**
Presenter(s):	Nicole Judd-Bekken, Renata Ackerman, Devarshi Bajpai
Summary:	Nicole is with the Quest Center for Integrative Health where she is the Director of HIV Services. She manages 3 Ryan White contracts; 2 of which are under mental health. One is for mental health treatment for which there is one mental health provider and the other is for peer mental health services. Renata works in the HIV Clinic as a psychologist/behavioral health provider. Prior to that she was at the Quest Center, providing mental health services in the community. Devarshi is with Multnomah County Mental Health & Addiction Services where he manages the behavioral health plan for people on Health Share. Devarshi explained that there is a continuum of care from visits with a peer all the way up to inpatient care. Services a person gets is determined by the severity of symptoms at the time they present for care. With Health Share there are 4 levels of care, A-B-C-D; with A being the lowest level of care and D being the highest. Renata receives referrals from physicians or social workers, with the behavioral health model of the County, she sees anyone who is having difficulties. Devarshi added that Multnomah Mental Health went from managing about 60,000 people to 135,000 but the number of social workers did not increase, so capacity issues exist. At Quest, there are certain priority populations with HIV+ individuals having priority. If an individual has Medicare or Medicaid they are also seen as a priority. Privately insured individuals may have a longer wait than those with public insurance. Current wait time at Quest is about 3 weeks. With Health Share, more providers are being added and there is the possibility of being seen within the same week. The biggest capacity issues exist in East County – wait times may be 4-5 weeks. Medicare is another complication. It only pays for Licensed Clinical Social Workers. The number of providers who can work with Medicare and bill for that is fairly small and that makes getting care more difficult. Renata can see clients within 2 weeks but if it is a crisis, they may be seen the same day. Those who have the longest wait times are those who can't speak up for themselves until they end up in crisis mode. People who need access to services can call the Multco Mental Health Intake at 503-988-4888 which is open to any Multnomah County resident. They usually have a sense of who has openings and can get one in sooner.

	Over the last decade, Renata has seen a more diverse population at the Health Department and addiction issues are a big concern because there aren't enough places to send people. There is less availability. Nicole added that clients present with more co-morbidities. With so many issues being presented, the Council can support the mental health services through the peer program. Housing is a trend being addressed now that wasn't such an issue 10 years ago. If people can get housing and start taking medication then other issues can be addressed. Devarshi added that they can't bill Medicaid until there is a mental health diagnosis. Medication is another issue being seen now that wasn't an issue 10 years ago. Ten years ago methamphetamine was an issue but now we are seeing more opiates as a problem. At Quest, peer support specialists have been a great help. They have had up to 3 peer support specialists but currently only one because it is a high stress position and burnout is an issue. The peer role is the glue that brings people together. They support the client while they are getting ready for treatment and offer support while the client is in treatment. Devarshi stated that they recently received a grant from the State to create a peer facilitation center so peers can support each other, as well as receive clinical supervision. Devarshi would like to see in the addiction field the offering medications as treatment. If a person has housing, they can receive medication and be sent home. It is better to have someone medicated than just left on their own. Also, recognizing that addiction is a chronic relapsing disease, having recovery services available to avoid relapse. Nicole spends time cobbling services together to provide as much as what a person should have; filling gaps with different levels of care. There are other ways to promote mental health and wellness than just mental health services. The integrated care model works so well. Renata added that mental health is serious with lives on the line. Sometimes a specialist is necessary and should be available to everyone. Amanda gave a quick update on a facility, Unity Center for Behavioral Health, which is scheduled to open on January 19th. It is a partnership between Legacy, Kaiser, Adventist Health and OHSU. It will include 80 adult beds and 22 adolescent beds. They are encouraging walk-in or self check-in.

Item:	**FY 17-18 Grant Proposal Key Points**
Presenter(s):	Alison Frye
Summary:	Margy thought it would be helpful for the Council to hear about what goes into the grant application. The application is broken up into sections and each section is scored. The biggest section is the Need section where we talk about what the TGA looks like as far as who is living with HIV; what our Ryan White population looks like as far as whom we serve; some of the social determinants of health like housing and Federal Poverty Level (FPL). The section that is worth the most points in the Need section is the Early Identification of Individuals with HIV/AIDS (EIIHA) that is all about how we find new people and get them into care. The Response section includes information about the Planning Council and our planning and allocation process, our services system. The Evaluative Measures section is about the quality management program that we are starting to do more with involving the Planning Council. Then we describe how the Grant Administration works; the administration of Care Services and the programmatic and fiscal oversight that is provided; and the Support Needed is our budget. For our population, there are over 5500 PLWH in the Portland TGA which represents a 26% increase over the last 5 years; a signal that our population is growing. Over time the population of non-Hispanic Whites among PLWH has decreased while Blacks/African-Americans have comprised a proportion of PLWH 3 times that of their representation of the general population. While Latinos are not overrepresented among PLWH, they have been slightly overrepresented in HIV incidence. Everything in the application is structured around to the care continuum – getting PLWH linked to care, retained in care, on ART, and virally suppressed. As in other areas, we have some disparities based on race/ethnicity – more Whites were linked to care than Blacks/African Americans and a greater proportion of U.S.-born PLWH were linked to care than foreign-born PLWH. The EIIHA plan is to reduce the number of people who are infected by referring patients at targeted test sites who test negative, but are high risk, to prevention services; reduce the portion of individuals living with HIV who are diagnosed by increasing

	access to routine, targeted and partner testing and increasing willingness to test by providing testing in culturally specific and competent contexts; increase the portion of diagnosed individuals who engage in care through a strong integrated set of linkage activities; and medication adherence to support ultimate viral suppression with provision of all Part A- funded services. All of these efforts align with what Linda was talking about in the Integrated Plan and EndHIVOregon strategy. We also have to describe what the gaps are in our service area and what Part A is doing about it. We discuss insurance enrollment, the economic challenges, long term survivors and gaps in access to mental health. We are given 60 days to write the grant application but it takes a concerted effort by many individuals.

Item:	**By-Laws Change re Membership**
Presenter(s):	Tom Cherry
Summary:	As discussed by the Operations Committee and presented at the last Council meeting, the by-laws change allows greater flexibility in the limitations of the number of people on the Council. The by-laws change was reviewed and accepted by unanimous consent.

Item:	**Review Reallocation Decisions**
Presenter(s):	Amanda Hurley
Summary:	Amanda gave an overview of this year's (FY 16-17) allocations for the year ending February 28, 2017. There was approximately $61,000 in carryover that was allocated to Dental ($51.000) and Housing ($10,000). Approximately $11,000 was moved from Mental Health due to under spending in that category which was moved to Medical Case Management ($7.000) and Housing ($4,000). That left a 73% / 27% split between Core and Support Services but since we have a waiver, we are not out of compliance. Without the waiver, we would have to maintain at 75/25 split. Beginning March 1st (FY 17-18), there have been some changes with Clark County services. Washington State Part B Program will cover all Medical Case Management Services which means we don't have to pay for MCM with Part A funds. The services are not going away. It just means they will be covered by a different funding source. This past year there was approximately $130,000 that was geared to Medical Case Management for Clark County residents. The funds will remain in Medical Case Management to cover more Part A services, increase operation hours, possibly decrease case loads, and cover insurance enrollment and Ryan White certifications.

Item:	**Evaluation of Administrative Mechanism Report Out**
Presenter(s):	Carlos Dory
Summary:	The Evaluation team included Carlos, Toni Kempner and Michael Thurman. The evaluation was staffed by Amanda Hurley. The HIV Care Services. Grantee of Multnomah County, has exceeded expectations for upholding the duties of distribution of funds accordingly to the priorities established by the Planning Council, using fair and equitable procurement process, while ensuring that the Planning Council truly represents our HIV/AIDS community, who are informed and knowledgeable of the most up to date data and background information to make informed decisions around HIV care and support services. The recommendations for 2016 based on the evaluation include: inform Planning Council of contractors' website; compare all day planning meeting evaluations from past several years; ensure speakers at Planning Council meetings are aware of the audience's understanding of the data; and reallocate unspent funds in a timely manner to spend down funds before end of the year by contractors.

The meeting was adjourned at 6:35 p.m.