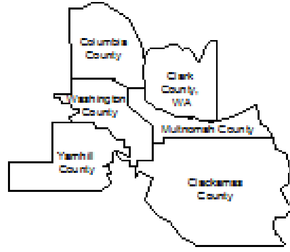
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: June 6, 2017

Approved by Planning Council: July 14, 2017

Grantee: Multnomah County Health Department

MEETING MINUTES
Planning Council

Portland Area HIV Services Planning Council

June 6, 2017
4:00 pm – 7:30 pm
McCoy Building
426 SW Stark St
Conference Room 10A

Members Present:	Emily Borke, Erin Butler, Tom Cherry (Council Co-Chair/Operations), Carlos Dory (Evaluation Chair/Operations), Monica Dunn, Maurice Evans, Greg Fowler (Operations), Alison Frye (Council Co-Chair/Operations), Shaun Irelan, Julia Lager-Mesulam (Operations), Heather Leffler, Jonathan Livingston (Operations), David Macko, Toni Masters, Scott Moore, Robert Noche, Jace Richard (Membership Co-Chair/ Operations), Michael Stewart, Michael Thurman (Membership Co-Chair/ Operations)
Members Absent:	Katy Byrtus, John Conway, Lorne James, Toni Kempner, Sara McCrimmon, Jeremiah Megowan, Joseph Pyle, Nathan Roberts
Staff Present:	Jenny Hampton, Amanda Hurley, Jenna Kıvanç, Margy Robinson, Jill Weber
Others Present:	Stephen Arnold, Kristen Cedar, Julie Collins, Laura Paz-Whitmore, Rosemary Toedtemeier
Recorder:	Jenny Hampton

Tom Cherry, Planning Council Co-Chair, called the meeting to order at 4:00 p.m.

Item:	**Candle Lighting Ceremony**
Presenter(s):	Michael Thurman
Summary:	Michael led the lighting of the ceremonial candle in remembrance of Jacob Shroyer, a long-time volunteer in the HIV community.
Item:	**Welcome & Introductions**
Presenter(s):	Tom Cherry
Summary:	Tom welcomed everyone to the meeting and introductions were made with Council members declaring any conflicts of interest.
Item:	**Announcements**
Summary:	• Quest is opening a new recovery facility at NE 28th & Flanders o Will help improve capacity o Acupuncture and mental health services

Item:	**Agenda Review and Minutes Approval**
Presenter(s):	Tom Cherry
Summary:	• **The agenda was accepted by unanimous consent** • **The meeting minutes from the May 2nd meeting were approved by unanimous consent**

Item:	**Public Testimony**
Presenter(s):	Kristin Cedar
Summary:	• Cascade Aids Project (CAP) housing manager embedded in Multnomah County HIV Clinic • Clients with multiple housing barriers, evictions, not virally suppressed • Position created a year ago to work with patients being assisted by navigators • Problems had been coming up when these clients were assigned to housing case managers for general population • This position works with clients long-term, after client has moved into permanent housing, to help maintain housing • Kristin shared a client success story

Presenter(s):	Stephen Arnold, MSW, LCSW

Summary:	• Janus Youth Programs
	• New program called Rivera House
	  o Transition for gay/bi/trans youth leaving incarceration
	  o 9-bed in Portland
	• Case study
	  o While incarcerated, this population at much higher risk of sexual assault
	  o Once placed in community program, run at 3X rate of cis-gender hetero peers
	• Two people were working with these youth, saw these problems firsthand
	• Oregon Youth Authority agreed to fund this kind of program
	• Rivera House built on Janus' success with youth leaving incarceration
	• This program will be highly informed on LGBT issues
	• Youth have not had the opportunity to learn adult life skills
	• Program is at its very beginning - Janus has building, and is renovating
	• Expects to have clients in program by end of summer or early fall
	• This population is at much higher risk of becoming HIV positive, or being HIV positive and not connecting to resources in community

Item:	**TGA Disparities Report**
Presenter(s):	Jenna Kıvanç

Summary:	• Presenter Jenna Kıvanç
	  o Analyst working for HIV Care Services
	• What is a disparity? Differences based on demographic factor, usually measured against the group "best off"
	• Reference group for this report is white men 45 and older (other groups did better, but sample too small) - this group getting annual labs and are virally suppressed at highest rate
	  o Annual viral load lab - tells us if they're going to the doctor
	  o Specific to Part A clients (for whom we have data)
	  o 94% of all clients - very high percentage
	  o Of those who had a lab, 89% were virally suppressed (VL value of less than 200 on last lab)
	• Comparisons
	  o Annual Viral Load (VL) lab by race/ethnicity - not a lot of variation, all above 90% target
	  o VL Suppression by race/ethnicity - statistically significant variation between reference group and:
	    ▪ Native Hawaiian/Pacific Islander
	    ▪ Black/African American
	    ▪ American Indian/Alaska Native
	  o VL Suppression by Gender - statistically significant variation between reference group and:
	    ▪ Transgender
	    ▪ Female
	  o VL Suppression by Age - statistically significant variation between reference group and:
	    ▪ Age 13-24
	    ▪ Age 25-44
	  o VL Suppression by Risk Factor - statistically significant variation between reference group and:
	    ▪ IDU (Intravenous Drug Users)
	    ▪ MSM-IDU (Men who have Sex with Men who are also Intravenous Drug Users)
	  o Annual VL Lab and VL Suppression by Housing Status - statistically significant

	variation between reference group and: ▪ Temporary housing ▪ Unstable housing o VL Suppression by FPL (Federal Poverty Level) - statistically significant variation between reference group and: ▪ Income <100% of FPL (a lot of overlap with temporarily or unstably housed) o Intersectionality ▪ Reviewed Race/Ethnicity by Gender, Race/Ethnicity by Age, Race/Ethnicity by Risk Factor, Race/Ethnicity by Housing Status, Race/Ethnicity by FPL ▪ Be aware of very low "n" numbers, can make numbers unstable, less generalizable • Summary - see presentation summary slide o Disparity Ratio: the higher the number from 1, the more disparate the result • Questions / Comments: o Request: send electronic copy to group o Q: What is behind these disparities? Does culture play a role? A: Very difficult to say causes. o Q: Do we have any data on education? A: No, we do not collect that in CAREWare (CW). o Q: What is the trigger that gets youth in testing the first time? And how to we make sure we don't miss others? A: Presenter does not have answer at hand at this moment, would need to consult with others before responding. It was thought that youth might be not virally suppressed due to being newly diagnosed, but that's not what we're seeing - both newly diagnosed and those longer in care show lower viral suppression o Q: Is this data presented to our providers? A: We do something different with providers. We don't look at disparities, but we look at their clients specifically to discuss outcomes (disparity analysis requires a large "n") o Q: Have you looked at insurance and history of insurance in relation to viral load? A: No, but we should.

Item:	**Decisions about additional Services for this current year**
Presenter(s):	Amanda Hurley
Summary:	• Background o State has given our Part A service area some money we are going to have for 5 years for housing, which will give us some funds for other things o Fully funded original requests in grant o Increased our FPL percentage to 250 percent o See handout "Allocations as of 3/1/17" o We have approx $392K (don't have notice of award yet) to allocate for this fiscal year o We are already a few months into this fiscal year, so it is important that we determine spending soon • Last meeting, we brainstormed ideas, voted, asked Care Services to put dollar amounts on these, figure out service categories • Proposal - see handout "HIV Care Services Allocation Proposal" o Everything highlighted in yellow is new funding o Substance Abuse Treatment (outpatient treatment): $200K for substance abuse peer mentor program, as well as outpatient treatment o Non-Medical Case Management - $130K for Addictions Benefit Coordinator to assist clients in getting into treatment o Residential Substance Abuse Treatment: $62.5K for Medicare or uninsured, as there are no Medicare residential treatment beds in this area o Requesting guidance on determining funds for outpatient vs. residential treatment

	• Questions/Comments: o Q: how much does inpatient treatment cost? A: 10K-25K per person o Q: Do we not have a substance abuse provider? Did we ever find another substance abuse provider after the contractor ended their Ryan White contract last year? A: Last year we eliminated substance abuse as a category, as it was a small amount of money tied to a particular program. This looks much different. Would be put out for bid as a contracted service. o Q: What is the cost for outpatient treatment? We tried to get info, but people did not get back to us on this. Program we are looking at, home-based recovery, is comprehensive (not split into housing and treatment). Per Laura Paz, estimate of $80/day for the treatment part of the cost (vs $350+ per day for inpatient) o Out of what categories will these be paid? If home-based recovery, funding would have to go through outpatient substance abuse treatment o How many people would this serve? Hard to say. Peer mentors could have caseload of 12 every 2-3 months. ABC (Addiction Benefits Coordinator) caseload of 20 per 3-4 month period. o Logic: group had asked for medical case management. We have heard that medical case managers are taking significant time (weeks and weeks) to get clients into treatment. Addiction Benefits Counselor can get clients into treatment much faster, and decrease workload of medical case managers. o Laura Paz, incoming new member, shared her experience as Addiction Benefits Coordinator in Multnomah County Mental Health and Addiction Services. o This would be set up to say there are no other viable options - funds of last resort to get people into service o Looking at proposal, what is thought process behind putting amounts where they are? ▪ Based on conversations with this group, providers, survey. Open to discussion o Other priorities previously discussed - storage facility for homeless clients ▪ HIV Care Services did some research, we couldn't find a place where we could fund it in our service categories ▪ However, we have been in communication with a provider who provides storage, will be sharing information with other providers ▪ It would be very difficult to monitor how storage units impact health outcomes • What we need to do now: decide if we accept these general categories o We need to come up with some way to prioritize spending (we don't know exactly how much money we will get) o Suggestion: separation between mentor program and outpatient substance abuse in proposal o Prefer to fund Home Based Recovery (HBR - 6 months of outpatient while living in house with others who are clean) rather than shorter inpatient ▪ Level 1 - intensive outpatient ▪ Level 2 - finding a job ▪ Level 3 - preparing to move out o NPR did a documentary on home based recovery o We're already in the funding year for these - we can try several of these and see what works best for our clients o We are already in conversation with Home Based Recovery, may be some details that need to be worked out o Q: are we funding beds in inpatient that are not gay-friendly, and maybe setting people up for failure? ▪ Excellent question, may not be very friendly, we would need to require trainings and monitor. ▪ Also trainings on HIV and stigma. ▪ Trainings not just for staff, but also residents. o This proposal tries multiple different things

	o Opportunity to possibly build capacity and knowledge o Q: Can we put a bid out to have an LGBT facility? A: That would greatly exceed our funds. o It sounds like people are generally okay with this o If we don’t get flat funding, what do we do: either cut by percentages, or prioritize o Suggestion: prioritize ABC first ▪ Why don’t we just get 2 ABCs, then figure out the rest? ▪ You can hire 20 ABCs, but if you don’t have anywhere to place clients, there’s not much point o Thinking about the time we have available, best if we can put our money somewhere where we can put people immediately o Peers are very important, and they make a difference, but having a place for people to go when they are ready is most important o Peer program is an intensive program - we need to have longer conversation about commitment to that • **Approved by unanimous consent to prioritize funds in this order: ABC, inpatient substance abuse treatment, outpatient substance abuse treatment to support HBR slots, then substance abuse peer mentor program.**

Item:	**Decide upon allocations for Carryover Request**
Presenter(s):	Amanda Hurley
Summary:	• Every year we have a carryover request based on money not spent last FY, to spend this FY • Carryover often doesn’t come to us until very end of fiscal year (Nov) • Important to put money in areas where it can be spent very quickly (FY ends at end of Feb) • First worksheet is how funds were expended last year o Only $22K services unspent ▪ Mental Health mostly due to staffing changes ▪ Psychosocial funds were not available until last 4 months of FY o $25K unspent admin/QM funds o Total of $48K we can put into services again • Proposal: put all $48K into medical care o Medical care was listed as a priority in last month’s discussion o We know that medical expenses always exceed allocation, can be spent very quickly • **Proposal to put all $48K into medical care was accepted by unanimous consent.**

Item:	**Establish Priorities & Service Categories for FY18-19**
Presenter(s):	Amanda Hurley
Summary:	• See list of service categories on “HIV Care Services Allocation Proposal” • Establishing a service category does not obligate us to fund it • **The revised list of service categories (including those additional service categories approved for FY17-18 at this meeting) is approved by unanimous consent.** These include: o Medical Care o Health Insurance o Mental Health Services o Oral Health Care o Medical Case Management o Substance Abuse Treatment o Housing Services

	○ Psychosocial Support Services ○ Food/Home-Delivered ○ Non-Medical Case Management ○ Residential Substance Abuse Treatment • This is the basis for decision making at next month's retreat

Item:	**Finalize Decision-Making Criteria for FY18-19 allocations**
Presenter(s):	Alison Frye
Summary:	• These are the ones we read last time • Fix #6: eliminate word duplication "services shall be services shall be" • At the last meeting, there was discussion about cultural proficiency ○ Margy Robinson has added some defining language ○ This does not solve this issue ○ There are other cultures that are completely different. Can we add something to address that? ▪ Hard to identify all cultures, but cultural competency definition seems to provide space for that ○ Glad to see trauma informed included ○ Are we at some point going to run into issues with providers' religious beliefs causing them to refuse service? And do we need to include that in our cultural competency language? ▪ We put out services for contract, if people cannot provide the service, we would not contract with them ○ Do people like that Margy added this language? Yes • **Criteria for FY18-19, with minor correction to #6, approved by unanimous consent**

Item:	**Guidance Review & Amendments**
Presenter(s):	Alison Frye
Summary:	• Council reviewed this at the previous meeting, and said that any additional guidance ideas could be discussed at this meeting • Additional guidance was written on a sheet at last meeting, which was not incorporated into this document • **Guidance Review tabled until next month to allow for inclusion of additional guidance – Margy will draft language based on notes from last meeting.**

Item:	**Co-Chair Election (for term beginning 9/1/17)**
Presenter(s):	Tom Cherry
Summary:	• Alison Frye has agreed to accept a nomination for this position ○ As this would be Alison's third term, approval by a two thirds majority is required ○ **By unanimous consensus, the group decided to use number of people in attendance at tonight's meeting to determine the required two-thirds majority for a third term election** • Tom Cherry did not hear from anyone who said they wanted to be placed on the ballot • Michael Thurman nominated from the floor • **Election result: Alison Frye is re-elected as co-chair**

The meeting was adjourned at 7:00 p.m.