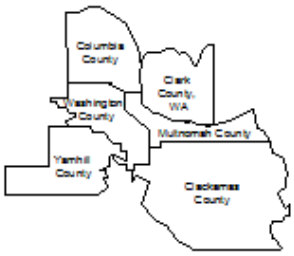
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: January 9, 2018

Approved by Planning Council: March 6, 2018

Grantee: Multnomah County Health Department

Multnomah County

MEETING MINUTES
Planning Council

Portland Area HIV Services Planning Council

January 9, 2018
4:00 pm – 7:30 pm
McCoy Building
426 SW Stark St
Conference Room 10A

Members Present:	Sara Adkins, Emily Borke, Erin Butler, Katy Byrtus, Carlos Dory (Evaluation Chair/Operations), Monica Dunn, Maurice Evans, Alison Frye (Council Co-Chair/Operations), Shaun Irelan, Lorne James, Toni Kempner, Toni Masters, Julia Lager-Mesulam (Operations), Jonathan Livingston (Operations), Jeremiah Megowan, Scott Moore, Robert Noche, Jace Richard (Membership Co-Chair/ Operations), Michael Stewart, Michael Thurman (Membership Co-Chair/ Operations), Rosemary Toedtemeier
Leave of Absence:	NA
Members Absent:	Tom Cherry (Council Co-Chair/Operations), John Conway, Greg Fowler (Operations), Heather Leffler, Laura Paz-Whitmore, Joseph Pyle, Nathan Roberts
Staff Present:	Jenny Hampton, Amanda Hurley, Jenna Kivanç, Margy Robinson
Others Present:	Jim Clay, Linda Drach, Lauren Nathe
Recorder:	Jenny Hampton

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

Item:	**Candle Lighting Ceremony**
Presenter(s):	Michael Stewart
Summary:	Michael led the lighting of the ceremonial candle in remembrance of those lost to HIV/AIDS.
Item:	**Welcome & Introductions**
Presenter(s):	Alison Frye
Summary:	Alison welcomed everyone to the meeting and introductions were made with Council members declaring any conflicts of interest.
Item:	**Announcements**
Presenter(s):	All
Summary:	Central Drug has been bought by CVS • Happening this week (last day 1/11/18) • Will re-open Monday as a CVS (and CAREAssist network) pharmacy • All staff were offered positions to stay • Clients can stay or change - prescriptions will be accessible, no action required • They have reassured that many of the practices (pre-auth, bubble-packing, client-centered) will continue National Black HIV Awareness Day • 3-on-3 basketball tournament • Boys and Girls Club • February 11, 2018 • Teams needed! Gender inclusive, high school age and above Quest Clackamas County opened this week on a limited basis • Non-opioid pain management • Substance abuse recovery • Grand opening March 19

Item:	**Agenda Review and Minutes Approval**
Presenter(s):	Alison Frye
Summary:	• **The agenda was accepted by unanimous consent** • **The meeting minutes from the December 5th meeting were approved by unanimous consent**

Item:	**End HIV Oregon report**
Presenter(s):	**Linda Drach**
Summary:	End HIV Oregon 1 year progress report (see slideshow) • Linda was here almost exactly one year ago at launch, now giving progress report • Bonus slide - HIV Medical Monitoring Project: What do you want to know? o Q: How has the data changed now that we are including data on people who are out of care? A: Not much - very few people; most people in care in Oregon

Item:	**Trauma Informed Care**
Presenter(s):	Amanda Hurley

Summary:	**Presentation – see slideshow**
	
	Panel
	Panelists: Emily Borke (HHSC), Lauren Nathe (Partnership Project), Jace Richards (CAP; filling in for Laura Camerato)
	Moderator: Amanda Hurley
	
	Q: Tell us about your organization's TIC (Trauma Informed Care) implementation planning process and committee work.
	CAP
	• Formed an internal work group - cross-staff, cross-dept group looking at policies and procedures
	• First step - housing and support services policy manual, looking page-by-page with TI lens
	• In addition, selected for national TI learning Collaborative through National Health Care for the Homeless Council
	Partnership Project:
	• Hired consultant to do 2-3 trainings with entire staff
	• Formed a group that meets every month, represents every program (small agency, this is large part of our staff)
	HHSC
	• Have been doing bits and pieces since 2010, ramping up every year more and more
	• About 2 years ago started TIC committee called TIC Talk
	  o 12-15 people, every role group, all medical teams
	  o Talks about clinic policies and practices
	  o Focus on client experience as well as staff experience
	  o Clinic clients have participated in committee
	  o Meets monthly for the last two years
	  o Has gained really good momentum
	  o Vets new policies, makes decisions, makes recommendations to management team that have been implemented
	
	Q: What are some challenges you've experienced when trying to shift the culture to be more trauma informed within your organization?

HHSC

- No money new staff to do any of this
- Clinic leadership is very supportive
- Larger organization not as focused on TIC, can create barriers

Partnership

- Big job - time is an issue
- Different sites, different cultural perspectives - making sure people are being heard
- Trans program is a TIC program from its birth – programs in very different places
- Defining as a team what it means to make these changes
- Do what you can do (A to M instead of A to Z)
- It's messy, and we're feeling our way along

CAP

- Hard to find funding and time
- Honoring the trauma of others and self
- Acknowledging that something may not be able to be resolved right then and there

Q: What are some examples of types of trauma you are witnessing with clients, and what recommendations are you making?

HHSC

- Sexual abuse, physical abuse, domestic violence
- Institutionalized racism
- Becoming HIV positive
- Experiencing homelessness
- Experiencing crisis in a way that alters our understanding or belief in the world and safety
- Service provider carrying client trauma with them - vicarious trauma

Partnership

- Client always late, then can't see them, forms a cycle. Is there a way that we can better meet them?

Q: How do you pass a client through your organization and share trauma information between staff?

- Universal precaution: Everyone has experienced some kind of trauma, so everyone needs the same kind of accommodation. Severity does not affect ideology of how we interact with clients.
- Creating a system instead of client-specific.
    - Interdisciplinary staff huddle
    - Creating a culture vs. individuals – when I walk into this facility, how do I feel and how am I treated?
- Quest – different trainings for different staff
- Have discussed yearly county training for new staff
- Good point about coordination of care - trying to improve within organization and across TGA

Q: Have you seen any improvements that have benefited clients/patients?

CAP

- No, we're still in the very early stages, haven't moved to implementation yet
- Staff are trauma informed warriors!

Partnership

- Yes, maybe
- Have been working on low-hanging fruit - front waiting room: signage, materials, physical space issues

	• Will be looking at intake - how does it feel, is it TI, are we asking questions in a way that supports what we're trying to do HHSC • Absolutely (have been doing it longer) • Clients have had a different experience - feel welcome, feel treated with respect, if they have a problem there are staff members who will listen and try to respond • Staff: not a new term to them, everyone could tell you what it is, staff buys into it **Q: Are there any specific needs that staff have around trauma that you are trying to address?** HHSC • Staff wellness room! Converted exam room - nice lighting, yoga mats, sound machine (all items donated by staff). Staff responding positively. Partnership • Working on lunchroom (too tight on space for a separate wellness room) • Supporting folks to do self-care and trauma work • Got the lights fixed in the parking lot - feels safer CAP • Everyone wants a wellness room like at HHSC • Staff have been asking for additional training - trying to get everyone on the same page is difficult **Q: Has there been any dialogue on including intentional peer support as part of TIC?** • Comes up often, but has not necessarily been addressed in learning collaborative • Quest has stepped up in providing additional support and training for peers – we can learn from their experience • Work in HHSC has been done outside of funding, all volunteers, because the need was there • CAP has a client advisory board, they are aware of it **Q: How do you make people realize that they need to take ownership of trauma and get past it?** • "Get over trauma" is a bit of a simplification, and implies that there is no current trauma. Do they have the capacity / resources to do that work? Some can't, for very good reasons, and it's our job to support them regardless. • What can we do about the causes of trauma? • Part of TIC is asking not "what's wrong with you?" but "what happened to you?" • Importance of daily self-awareness Additional Feedback: when visiting clinic (HHSC), have witnessed frontline staff doing a magnificent job with "difficult" clients.

Item:	**Client Satisfaction Survey report**
Presenter(s):	Jenna Kıvanç

Summary:	Client Satisfaction Survey report – see slideshow
	• What we do with this data (collected every other year)
	  ○ Agency-specific reports
	  ○ Larger TGA report
	  ○ This same presentation will be given to Provider Meeting

Item:	**Bylaws Revision**
Presenter(s):	Michael Thurman

Summary:	Bylaws Revision review & approval
	• Bylaws were sent out by email - we are presuming that everyone has read them
	• Process
	  o 7 people (Council members & staff) reviewed them, a lot of time spent revising
	  o Then reviewed by Operations Committee, who changed a few things
	• Significant changes to point out:
	  o Elections of committee chairs - total of 6 members elected to Ops, then committee chairs appointed from Ops
	  o Terms of Council co-chairs
	  o Bylaws amendments distributed 10 days in advance (instead of 30 days)
	  o Green highlighted phrase: small error found in previous version, the words "appointing committee chairs and" to be removed from final version
	• Bylaws very hard to change, so committee tried to keep bylaws to critical rules and topics
	• We will do policies and procedures next, where we will spell out things more in depth
	• Q: Removal of co-chairs - what does this mean? What is the difference between consensus and simple majority? A: Consensus is typically enacted by calling for "ays" and "nays," while simple majority is enacted by conducting a vote, with the "winner" receiving 50% plus one vote.
	• **Revised bylaws are approved by unanimous consent**

Item:	**Comparison of ADAP Washington and Oregon**
Presenter(s):	Amanda Hurley

Summary:	This year we had question: should we continue to provide prescription assistance for Clark County residents?
	• WA has made major changes to their ADAP program
	• Didn't have much data
	• Evaluation process
	  o Hired outside consultant to complete evaluation (10 hours of work)
	  o Talked to ADAP of each state, provided write-up
	  o Got more detailed accounting of what people are getting health insurance for
	  o Had conversations with both ADAPs
	• In Oregon ADAP is CAREAssist
	• In Washington ADAP is EIP
	• First category - eligibility
	  o OR = 500%
	  o WA = 400%
	  o We only provide up to 250%, so no difference
	• Second - pharmacies
	  o Pharmacies must apply to be vendor in Washington State (not required in OR)
	  o Example: Kaiser not a vendor in WA
	  o Oregon doesn't have vendor application, but must use in-network pharmacies
	  o Washington's pharmacy vendor list is actually more extensive, don't offer out-of-network option
	  o WA clients may need financial assistance
	• Third – bridge programs for immediate medication need
	  o OR has bridge program

	○ WA does not ○ Could be a small window of time when WA client could not get assistance (next day available, but not same day) • Fourth - Formularies ○ OR and WA pretty much aligned, except in situation of uninsured ○ In WA, uninsured have more restrictive formulary, therefore may need financial assistance • Worked with providers to track what exactly they were paying for ○ 145 payments ○ 71 not contracted from EIP (WA), Kaiser Permanente was 28 of them (clinics in Vancouver; this is different from Kaiser Washington) ○ 10 were co-pays from before WA moved to open formulary in July ○ Need more info about why WA denying claims • Next steps ○ At this point, not recommending we dismantle our funding for Clark County residents ○ Still need this service ○ Do not recommend increasing, possibly small decrease ○ Suggest guidance to provider regarding what is appropriate to pay for (no problems) ○ Make sure all clients are applying for EIP when they are eligible ○ Work with EIP regarding why claims are being denied ○ If we're able to advocate for providers not currently on list of vendors, would like to advocate so we're not paying so much

Item:	**Health Insurance Open Enrollment Updates**
Presenter(s):	Jonathan Livingston & Sara Adkins
Summary:	Oregon (Jonathan Livingston) • Not a lot of changes from last month's update • At end of open enrollment period, enrolled 800 PLWH • Very impressed with our community's response • 99% insurance rate for CAREAssist clients • Trend - Increased premiums • Regence Blue Cross Blue Shield was requiring new clients to provide proof of Ryan White (for clients enrolling outside of the Marketplace) ○ English-language letters sent to Spanish-speaking clients ○ This group of clients does not necessarily connect "Ryan White" with HIV care. ○ Jonathan is following up with regulating agencies Washington (Sara Adkins) • Similar experience with Regence ○ Initially denying insurance for those premiums paid by a third party (such as Evergreen) ○ CAP working on this issue - some clients had to reapply • 241 clients at CAP Clark County, no clients unenrolled in insurance right now (a few are pending) • CAP enrolled or renewed 26 clients in a QHP through the ACA (EIP pays these premiums) • CAP enrolled 10 clients in an Individual Plan through Regence, outside the exchange (EIP pays these premiums) • WSHIP (Washington State Health Insurance Pool) ○ 10 Clark County residents were enrolled in WSHIP in 2017.

	○ All 10 residents have returned their Eligibility Verification forms and will remain insured by WSHIP for 2018 • Medicare clients who did not want to change their plans did not need to complete a renewal. Clients who are enrolled in EHIP did have to complete a New Payable form for EHIP to continue to pay their premium. • Majority of clients on Medicare or Medicaid

The meeting was adjourned at 7:15 p.m.