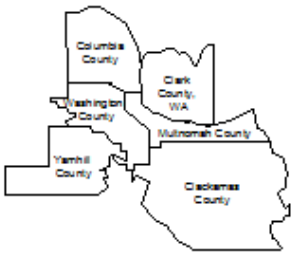
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: March 6, 2018

Approved by Planning Council: May 1, 2018

Grantee: Multnomah County Health Department

Multnomah County

MEETING MINUTES
Planning Council

Portland Area HIV Services Planning Council

March 6, 2018
4:00 pm – 7:30 pm
McCoy Building
426 SW Stark St
Conference Room 10A

Members Present:	Emily Borke, Erin Butler, Katy Byrtus, Tom Cherry (Council Co-Chair/Operations), Carlos Dory (Evaluation Chair/Operations), Maurice Evans, Greg Fowler (Operations), 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, Laura Paz-Whitmore, Jace Richard (Membership Co-Chair/ Operations), Nathan Roberts, Michael Stewart, Michael Thurman (Membership Co-Chair/ Operations), Rosemary Toedtemeier
Leave of Absence:	NA
Members Absent (Excused):	Sara Adkins, Monica Dunn, Heather Leffler
Members Absent (Unexcused):	Joseph Pyle
Staff Present:	Jenny Hampton, Amanda Hurley, Marisa McLaughlin, Margy Robinson
Others Present:	Christina Anderson, Maricela Berumen, Beverlee Katz Cutler, Domenica Gonzales, Hanna Gustafson, Charlie Hamset, Rob Inguerson, Owen O'Neill, Beau Rappaport, Lindsay Stover, Michael Taylor, Randi Triplett, Yehoshua Ventura
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):	Tom Cherry
Summary:	Tom led the lighting of the ceremonial candle in remembrance of those lost to HIV/AIDS.
Item:	**Welcome & Introductions**
Presenter(s):	Tom Cherry
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:	Announcing opening of Quest Clackamas County
	• Substance abuse disorder program, Finding and Sustaining Recovery (FSR)
	• Non-opioid pain management program Wellness Integrity and Sustainable Health (WISH)
	• Grand opening ceremony Monday, March 19
	  o Ribbon cutting at 10 AM
	  o Tours of the facility & light refreshments until noon
	• Address: 112 Beavercreek Rd., Oregon City, 97045
	
	Meaningful Care Conference coming up on 3/29/18
	
	Dining Out for Life coming up on 4/26/18

Item:	**Agenda Review and Minutes Approval**

Presenter(s):	Tom Cherry
Summary:	• **The agenda was accepted by unanimous consent** • **The meeting minutes from the January 9th meeting were approved by unanimous consent**

Item:	**Substance Abuse Services key informant panel**
Presenter(s):	**Alison Frye**

Summary:	**Panel**
	Panelists: Laura Paz, Charlie Hanset, Hanna Gustafson, Owen O'Neill, Yehoshua Ventura, Beau Rappaport, Christina Anderson, Michael Taylor
	Moderator: Alison Frye
	
	Q: Describe the services you provide, including how clients are referred to your services.
	
	Services by provider
	Addictions Benefit Coordinator (ABC)
	• Connect people to treatment & detox
	  o Connect with clients – options counseling, stages of change
	  o Connect with providers re. requirements for accepting clients
	  o Work with others on panel
	• Liaison between VOA Home-Based Recovery program bed and treatment providers
	Peer Support Specialists (PSS)
	• Meet people where they are and build support / connections
	• Anything they need: medical help, housing, phones, electricity, Medicare
	• Many conversations before they are ready for treatment, then connect with Laura Paz to find treatment
	• Relapsing - remind people that they don't lose the gains they made when sober
	• A lot of ground work, a lot of work outside the office
	  o As Peer Support Specialists, we can go out in community in ways others can't
	• One foot in community, one foot in provider world
	• One-on-one and group support
	• Giving clients hope
	Home-Based Recovery (HBR)
	• 10 bed house
	• Intensive outpatient
	• Live in supported housing while attending an outpatient treatment program
	• We're not set up to do a lot of mental health, but it is a mental health and substance abuse therapeutic environment
	  o Sessions with mental health or addictions therapist
	• Build a support group within recovery community
	  o Individuals working toward similar goals helping each other
	  o Outside groups (such as Alcoholics Anonymous)
	• Build a foundation to change their lives
	  o Job placements or school
	  o Give them every avenue for success we possibly can
	• Hope is those who complete program are self sufficient
	• Pretty successful
	• Also have Latino HBR house
	• All houses are staffed 24 hrs/day by certified recovery specialists & peer support specialists

How clients are referred
Clients are referred in a variety of ways

- Directly from providers (particularly for peer support specialists embedded in clinics)
- To/from other members of this panel
    - Peer Support Specialist referring to Addictions Benefit Coordinator
    - Addictions Benefit Coordinator referring to Home Based Recovery

Q: How many people have you served thus far (since October)?

- Addictions Benefit Coordinator: about 42 clients (10/1/17-2/28/18)
- Quest (Peer Support Specialists): 13 engaged, 9 pending referrals
- CAP (Peer Support Specialists): 20, including 6 engaged in program plus more in recovery group
- Home-Based Recovery: 7 referrals, served 3 engaged in program

Q: Describe how you coordinate your services with other services.

- It was helpful to have all of these programs start at the same time, as it gave opportunity to get together and start collaborative.
    - Talk about what works and what's not working.
    - Working together to maximize services.
- Challenge – one client may have multiple people working with them for different things
    - ABC role to work with treatment providers
    - Peer support specialists role to work with clients through stages of change
- Group emails very helpful
- All community partners have been extremely supportive
- Service coordination is very important
    - Getting services can be difficult and traumatizing
    - Peer Support Specialist role is coordination – ability to walk beside individuals through these broader health care systems
- Individuals going into treatment still call their Peer Support Specialists to check in.

Q: How has service been received? Are you already busy? Is it taking a while for others to know about services?

- Addictions Benefit Coordination
    - "I was busy the day it started."
    - Busy within the tri-county area (Multnomah, Washington and Clackamas), not as much in other counties.
        - That is a goal, to reach out to those outside this area.
- Peer Support Specialists
    - Yes, we are busy, and there is a need.
    - All Peer Support Specialists must be in recovery themselves
    - CAP just started art recovery group
    - Recovery awareness campaign - inform the public of process of recovery.
- Home-Based Recovery
    - Steady stream of referrals
    - Individuals seem to feel comfortable and safe, which is very important for recovery

Q: Other things to highlight? Greatest positive impact? Barriers?

- Reduction in wait time for treatment
    - Previously 3 months, with need to check in every day
    - Now 3 weeks, with peer checking in every day.

- Important to hear clients' stories (re HIV and LGBTQ+), as well as provide assistance with filing grievances when necessary
- PSSs have unique ability to use lived experience to build connections and hear untold story.
- Systems are big and overwhelming. PSSs bridging gap between medical model and culture / community model.
- Stigma is a barrier
    - Stigma around use of medical marijuana (prevalent with PLWH)
    - Stigma around medication assisted treatment
    - Stigma goes beyond institutions to street culture – homeless clients trying to hide diagnoses (not taking meds) or hiding identity as LGBTQ+
- Lack of providers that are LGBTQ+ friendly
    - Partnered with SMYRC and Bridge 13 to provide training to help bridge gap
- Meth epidemic in Portland – we have to get creative with housing after treatment, to limit exposure to meth and help prevent relapse
- No treatment providers that accept sex offenders in Oregon
    - Referring to other states (where individual is not listed as a sex offender)
    - "Frankenstein program" of outpatient treatment plus sex offender housing
- HBR expanding to meet needs of LGBTQ+ and medication assisted treatment
- Issues with time limits for response to treatment availability
    - Some clients have no phone
    - Client priorities of food and where am I sleeping tonight
- Getting someone in program can take months and months of conversation and building trust.
- 40% of ABC time spent on clients who are severely and persistently mentally ill
    - Substance abuse treatment providers won't take them unless they are stable
    - Must be placed in facility linked to hospital or mental health facility
- Greater ease in finding treatment placements
    - Before the grant, had to find places we trust by word of mouth within our agency
    - Working with ABC has been a huge asset in the team effort to support recovery
- We're so happy to have this funding, but we need so much more. We're frontline, but we're triage frontline. There are lines behind us, and we need more.

Council questions:

- Q: What about women?
    - A: Right now don't have funding for safer house for women. Women are easier to place - more programs for women, including culturally specific programs.
- Q: How much time and what type of training is required to become a PSS?
    - A: 2 weeks of Oregon Mental Health Association training (80 hrs), plus multiple follow up trainings and required continuing education hours. PSS means we have lived experience. Quest is unique in PSS trained in Intentional Peer Support. Lived experience: "turning my sickness into medicine"
- Q: How does keeping people on HIV meds fit into treatment / program?
    - A (PSS): Work with participants to make sure they make their medical appointments. First question at every client visit is, "Are you taking your meds?" Giving clients meds in blister packs to make dosage clear. Struggle with homeless - sometimes providers won't prescribe meds due to fear of becoming resistant.

	- A (HBR): Individual service plans, getting med providers & getting on medications. - A (CAP): Helping clients navigate change of Central Drug to CVS; working with immigrants / undocumented. - A (Quest): med adherence is vital, but we need more than just meds. Med adherence written into goal plan, along with substance use reduction, diet - Q: Can Council impact length of program (30 days vs 6 months) via funding or instructions to HCS? - Mostly talking about services funded by other types of insurance, so cannot impact that - Peer support can help by recreate the system/services - We're paying for these programs using 4 categories - residential substance abuse treatment, outpatient substance abuse treatment, non-medical case management, and housing - There are some programs that provide longer term 27 day programs not working, but 6 month program working - Multnomah County Addiction Services is trying to encourage HBR - cheaper than longer inpatient stays - Suggestion - have OHSU Meth Research group present to Council

Item:	**Quality Management Update from the Grantee**
Presenter(s):	Marisa McLaughlin
Summary:	See PowerPoint Question to Council: How does PC believe they should be providing feedback and input into these types of QM activities? - Q: Membership - is it just staff, or should PC members be on this committee? A: Right now, only reps on committee are members on Part A, Part B and some surveillance staff. Once we get through determining what data we have, group would welcome other members to join. - Suggestion: Also include Part C & D, also consumers - Q: How did emailing the survey go? A: See Jenna's analysis (emailed to Council today) - Q: Are you also looking to see how other agencies are aligned? A: To extent able, always love to align.

Item:	**Grantee Financial Report**
Presenter(s):	Amanda Hurley
Summary:	Grantee Financial Report - As of right now, unspent may end up less than the $75K previously projected - Looks like we will be able to spend about 98% of grant - Haven't received February invoices, also some January invoices - At May meeting, should have final numbers to present - Three service categories with more than 10K unspent: substance abuse treatment, oral health & psychosocial

Item:	**Finalize Council calendar for remainder of the year**
Presenter(s):	Alison Frye
Summary:	Council calendar (see annual work plan handout)

	• For Council members to review • Comments and questions welcome both in the meeting and later - just let us know • Note we will be meeting May, June & July

Item:	**Services outside the central core**
Presenter(s):	Alison Frye
Summary:	**Panel** Panelists: Julia Lager-Mesulam, Domenica Gonzales, Bevan Hurd, Randi Triplett Moderator: Alison Frye **Q: How are clients referred to your program?** • CAP housing: weird, roundabout ways • Quest pain management program: self-referral or through primary care physician • Quest substance abuse recovery: parole/probation • CAP MAI: some directly from providers; program is well known in the area • Partnership: various ways of referral, including social workers at hospital discharge **Q: Are you able to meet with clients face to face? Where? If not, what other methods do you use to connect with clients?** • CAP: most of the time intakes come directly to CAP. o Recently hired Equity Outreach Coordinator to go out into community. o Once in program, meetings face to face in office or at home. • Quest: clients from Sandy, Estacada, Molalla o Ride to Care (CareOregon) o Have peer specialist at Quest Clackamas location • CAP (MAI): try to make as available as possible, after hours, wherever they want. o Reach out through Facebook o Fear is a factor ▪ Fear of running into someone they know ▪ Fear of deportations • Partnership o Domenica: meet everyone face to face. ▪ medical appointments ▪ travel to their homes ▪ normally clients in rural areas are very sick, so meet in hospital. o Julia ▪ 90% of time, clients are walking in to office in SE Portland regardless of where they live ▪ Can do intake over the phone ▪ For those farther out, travel time is considerable – meet people halfway **Q: What other services are you able to coordinate?** • Almost no other services o Make most referrals to services in Multnomah County o Nothing in Gaston o 1 provider in McMinnville, but clients prefer to come into town due to confidentiality concerns o In-home counseling • Within Providence system, there are clinics in outer areas, including HIV specialist at Mt. Hood Medical Center.

- No mental health providers
- Very concerned about deportation
- Clients reluctant to use church-based services - concerned about stigma, choose not to go
- Quest Clackamas is still developing, finding, and walking with clients to find resources

Q: Challenges?

- Housing needs: emergency rent assistance, at risk of losing housing, seeking stable apartment.
    - Not many housing resources in Clackamas County
    - if person is not on the lease, can't help with rent
- Gaps in case management
- Income
- Finding support they need that works around working schedule
- Need for anonymity
- Transportation
    - Oregon does not provide drivers licenses for undocumented immigrants, so clients are concerned about driving
    - Funding does not cover transportation
    - Clackamas County – long bus ride
    - Partnership: provide gas cards, but doesn't help with driving
    - Bus passes not helpful outside Portland
    - Do provide cabs, but can be very expensive from McMinnville into Portland and back
- People are scared to access anything in their own communities, even if it does exist
- Lack of culturally competent providers

Q: What else would you like the Council to know?

- More peer services can always be utilized, particularly in Clackamas County (next for Quest Clackamas is peer)
- Need for cell phones - undocumented clients cannot access government phones
- Need funds for transportation
- Take time to educate providers & clinics serving rural clients on working with HIV clients

Council questions / comments:

- Comment: changes coming to Ride to Care
- Q: Have any of you had experiences with your clients who have faced deportation?
    - A: Yes. Client taken to Tacoma and held. Getting his medications very difficult. Making sure medical documentation gets to destination provider prior to his arrival.
    - A: Yes. Concerns that client will not be able to get current medication regimen if deported, which will likely be fatal (currently has an undetectable viral load). There is one medication regimen available at his proposed deportation destination.
    - A: Sometimes judges will assist, but often is not the case.
- Clark County update (provided by Margy Robinson – Sara Adkins out sick)
    - CAP Clark County has been able to serve anyone who comes into their office in Clark County
    - Collaboration with Lifeline AIDS and others working in rural areas of Clark County

Item:	**Operations Committee transition**
Presenter(s):	Michael Thurman
Summary:	Current status • At the January meeting, we adopted new bylaws • We are currently out of compliance with these bylaws – three Operations Committee members were appointed (not elected) Transition Plan • Today we ask the Council to elect the three members of the current Operations Committee that have not been elected: Jace Richard and Michael Thurman (Membership Committee Co-Chairs) and Carlos Dory (Evaluation Chair). These three will be elected for a short term, i.e. through the July retreat. • New elections for Operations Committee members will be held in July, at the retreat. • This year those who are willing to run for election to Operations Committee will have a choice of running for a one-year term or running for a two-year term. Three people will run for one-year term and three will run for a two-year term. (This will result in only half of the committee transitioning off at a time.) **The motion to elect Jace Richard, Michael Thurman and Carlos Dory to the Operations Committee through the July retreat approved by unanimous consent.**

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

Grantee Quality Management Activities Updates

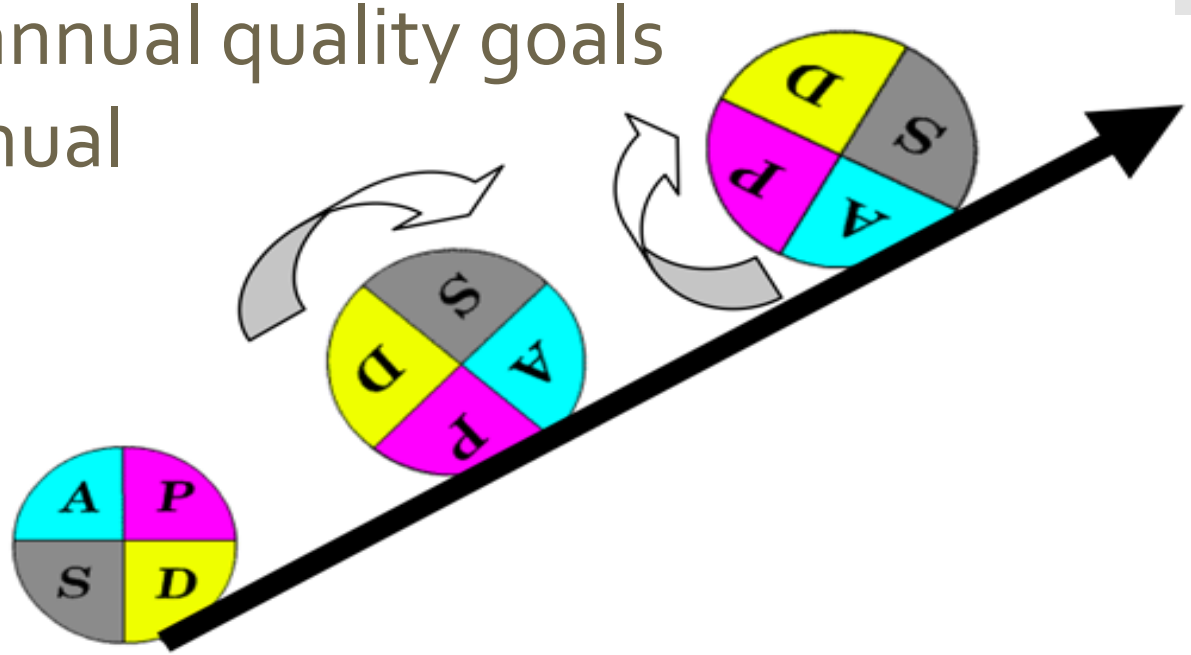
HIV Planning Council, March 6th

Overview

- Grantee/Contractor Data Review and QM Planning Sessions
- Grantee/TGA Annual Quality Goals
- Oregon HIV Quality Management Committee

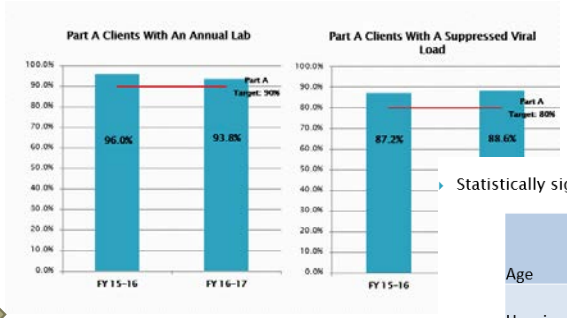
Grantee/ Contractor Data Review and QM Planning Sessions

- Meet with each Ryan White funded agency to:
  - Review and have purposeful discussion around data
  - Prioritize quality goals/PDSAs
- Agency level annual quality goals inform TGA annual quality goals



Grantee/ Contractor Data Review and QM Planning Sessions: Data Review and Discussion

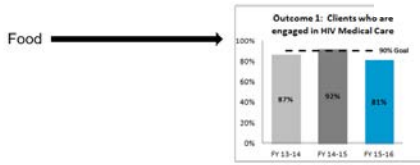
- RW TGA and agency level viral load data trends

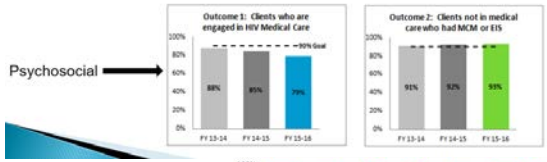


- Statistically significant demographic and service differences I

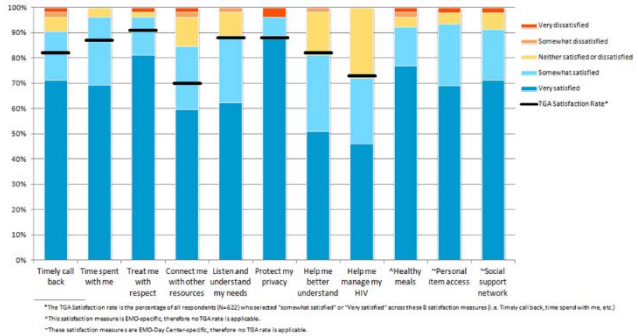
Age	25-44 yrs: 73% 45+ yrs: 88%
Housing Status	Stable: 83% Unstable: 68%
Poverty level	<100% FPL: 80% 100%+ FPL: 91%
Service Category	Medical: 76% Housing: 76%

- Other agency level outcomes data trends





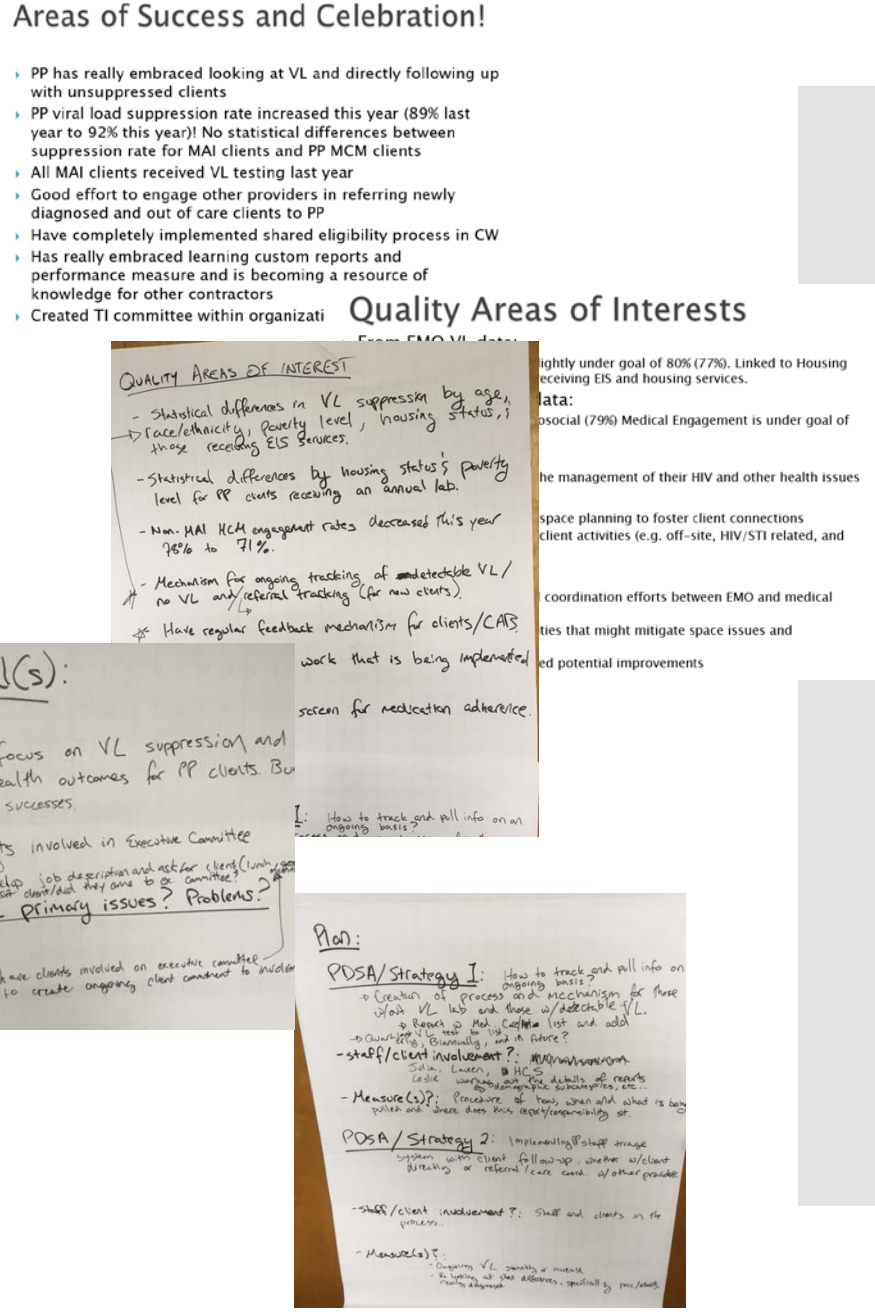
- Agency-level client satisfaction data



- Trauma Informed Care data

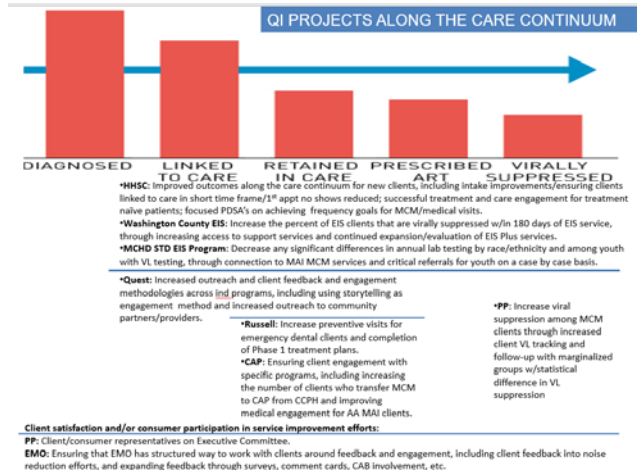
Grantee/ Contractor Data Review and QM Planning Sessions: Prioritize Annual Quality Goals

- Areas of Success and Celebration
- Quality Areas of Interest
- Priority Identification
- Setting Annual Quality Goals



Grantee/TGA Annual Quality Goals

- Agency-level goals along Care Continuum



- TGA-wide Quality Areas of Interest and Prioritization Process

- Project plans and TGA QM Plan

Grantee/TGA Annual Quality Goals

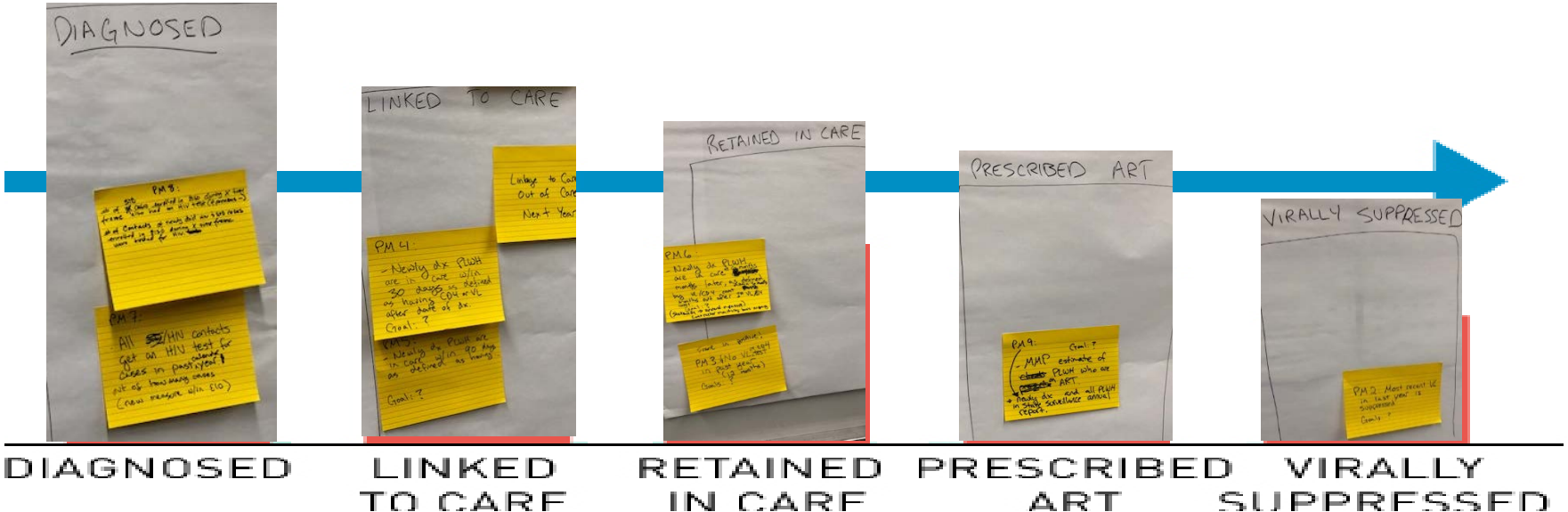
- **Annual Goal 1 – Evaluating the impact of Trauma Informed Care Efforts on Agencies and Clients**
- **Annual Goal 2 – Increase the capacity of providers to measure and respond to clients who are not virally suppressed and/or engaged in care**
- **Annual Goal 3 – Increase client/consumer feedback and participation in quality improvement efforts**

Oregon HIV Quality Management Committee

Oregon Quality Management Task Force 2008 – 2015

Oregon Quality Management Committee – 2017

- 1st meeting: Committee charter
- 2nd and 3rd meeting: Statewide performance measures



Q & A

- Any questions?
- HCS question: How does the Planning Council believe they should be providing feedback and input into these types of quality management activities?