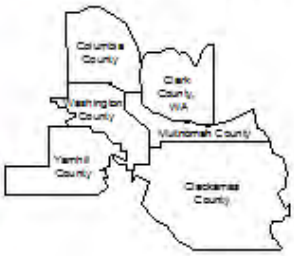
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: March 5, 2019

Approved by Planning Council: March 7, 2019

Grantee: Multnomah County Health Department

Multnomah County

MEETING MINUTES
Planning Council

Portland Area HIV Services Planning Council

March 5, 2019
4:00 pm – 7:30 pm
McCoy Building
426 SW Stark St
Conference Room 10A

Members Present:	Sara Adkins, Emily Borke, Erin Butler, Tom Cherry, Carlos Dory, Greg Fowler, Alison Frye (Council Co-Chair), Mary Rita Hurley, Shaun Irelan, Jeremiah Megowan, Julia Lager-Mesulam, Jonathan Livingston, Scott Moore, Laura Paz-Whitmore, Nathan Roberts, Michael Stewart, Michael Thurman-Noche, Robert Thurman-Noche, Rosemary Toedtemeier
Leave of Absence:	NA
Members Absent (Excused):	Myranda Harris, Lorne James (Council Co-Chair), Toni Kempner, Heather Leffler, Toni Masters, Jace Richard, Abrianna Williams
Members Absent (Unexcused):	Dennis Grace-Montero
Staff Present:	Jenny Hampton, Jesse Herbach, Amanda Hurley, Marisa McLaughlin
Others Present:	Ashley Allison (Oregon AETC), Diane Quiring (Medicaid), Valerie Warden (Multnomah County Addictions Benefits Coordination team), Dennis Torres (Gilead Sciences), Owen O'Neill (Peer, CAP), Hanna Gustafson (Manager, CAP), Erin Waid (Russell St. Dental Clinic), Jessica Jacobsen (Multnomah County Mental Health and Addiction Services Division), Jenya Gluzberg (Quest), Danielle Deer (Quest), Marc Jolin (Joint Office of Homeless Services)
Recorder:	Jenny Hampton

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

Item:	**Candle Lighting Ceremony**
Presenter(s):	Mary Rita Hurley
Summary:	Mary Rita Hurley led the lighting of the ceremonial candle in honor of three men who have been very important to her: Rob, Kenny and David.
Item:	**Welcome & Introductions**
Presenter(s):	Tom Cherry
Summary:	Tom Cherry welcomed everyone to the meeting and introductions were made with Council members declaring any conflicts of interest.
Item:	**Announcements**
Presenter(s):	All
Summary:	Announcements: • Co-Chair Lorne James is at an out-of-town training today, and Alison is having difficulty with her voice due to illness, so Tom Cherry (co-chair emeritus) has agreed to step in to assist in leading today's Planning Council meeting • Quest is celebrating their 30th anniversary this year – please save the date of 10/17/2019, 6:00-9:00 PM, for a Celebration of Wellness Event at The Evergreen (618 SE Alder St., Portland, 97214) • In the coming month, Quest will be opening LGBTQ housing for people experiencing addiction • Our House of Portland will be providing transportation for families of people living with HIV (PLWH) to go to Esther's Pantry and Todd's Corner • Grantee Announcements: o Received Notice of Award very early, before it actually started

	▪ About $18K more in total ▪ About $16K more for services ▪ Used contingency plan previously agreed to get contracts out the door o Updates re government shutdown ▪ HRSA was not impacted ▪ Impacted: food benefits, subsidized housing o Staffing update ▪ Jill Weber is no longer with HIV Care Services, but has moved on to new position with TriYoung (CAREWare consulting group) ▪ Her position description is in review with HR, will be posting very soon o New HIV Strategy ▪ Came out day after the President's State of the Union, which mentioned HIV ▪ See handout ▪ Targeting 48 specific counties and 7 states o Our next Planning Council meeting will be in new building (619 NW 6th Ave.)

Item:	**Agenda Review and Minutes Approval**
Presenter(s):	Tom Cherry
Summary:	• **The agenda was accepted by unanimous consent** • **The meeting minutes from the January 8th meeting were approved by unanimous consent**

Item:	**Public Testimony**
Presenter(s):	Tom Cherry
Summary:	No public testimony.

Item:	**Housing Panel Part 2 – A Home for Everyone presentation**
Presenter(s):	Marc Jolin
Summary:	Marc Jolin, Director, Joint Office of Homeless Services City of Portland and Multnomah County Presentation • Previous 10-year plan o 2004-2014 city and county had 10-year plan to end homelessness ▪ Federal government directed all communities to have one, in order to get access to (insufficient) funds o Shifted emphasis away from how many were being sheltered to how many are we ending their homelessness o Emphasis on housing retention, including ongoing support o Commitment to permanent supportive housing o Focus of first 10-year plan was on chronic homelessness ▪ Reasoning: 20% of people experiencing homelessness consuming 80% of resources - why not get them into housing, free up resources ▪ The intervention was the right one – supportive housing ▪ We significantly expanded supported housing and housed many people ▪ We didn't actually free up resources as hoped o We did some things well in that first 10-year plan

        - Understanding that we need to measure outcomes based on ending homelessness, not just people served
        - Understanding we needed to invest in transition and retention services
        - Understanding we needed to invest in supportive housing
    - Some things we didn't do very well
        - We created a plan, but didn't create a governance structure
            - We didn't create a mechanism to ensure implementation, updates, accountability
- New plan: established "A Home for Everyone" Joint Office of Homeless Services
    - Important change - put a governance structure in place that could create that ongoing accountability
    - Coordinating Board
        - 35 people
        - Appointed representatives of different constituencies, stakeholder groups
        - Under board are multiple working groups
        - Housing strategies – how to improve retention
        - Talked about need for local long-term voucher
            - Healthcare work group – recent conversation to come back around to supportive housing, set goal of 2000 supportive housing units, came out of this group
            - Workforce work group – how to align various rent assistance programs with mainstream work systems investments and job training programs to provide not just survival job but living wage
            - Shelter work group "Safety Off the Streets"
                - One of the limitations of first plan was we didn't talk about a shelter
                - Had previously only talked about shelters
                - For some people shelter is enough, but for others it is not
                - Point of this 10 year plan was to understand for whom is it not working to only provide shelter
                - Who shelter is serving and who is it not serving?
                - What is its role in the continuum of interventions?
                - What are the outcome measures for shelter that we should have?
                - Workgroup has been very intentional about considering what types of shelter we need – who do we need to serve?
                - In the past all shelters were high-barrier (requires program participation, sobriety, other things)
                - All new shelters (650 beds in last 3 years) are low barrier – come as you are, bring your belongings, bring your pet, bring your partner. We will not require engagement in services, but will use assertive engagement model, we'll offer services and let you guide the process of what those services look like and what order you get them. We're going to make sure this shelter doesn't become a long-term stay for you. One way or another, we're working to transition you out of this shelter back into permanent housing, to something better.
                - Geographically dispersed shelters
                    - Previously was all downtown
                    - New shelters in NE, SE, outer East, women's shelter in Gresham
                - Still in process – still needs we aren't meeting
                    - Trans-specific shelter

- Mental health shelter
- We are investing in more shelter sites and operations
- We are continuing to look for quality sites for shelters

- Equity Committee
  - Driving conversations about content of work and reforms to governance structure
  - We've done a lot within the Home for Everyone framework around racial equity
  - Not present at all in first 10-year plan – we weren't identifying rates of racial disparity, we weren't thinking about what it meant to provide culturally responsive and culturally specific services
  - There a guiding value in A Home for Everyone to address racial equity and racial justice
  - Results – we have much better data regarding who is experiencing homelessness right now, making targeted culturally-specific investments
- Executive Committee
  - Members: Mayor, County Chair, 2nd city council member, 2nd county commissioner, housing authority head, leading from Meyer Memorial Trust, leader from Portland Business Alliance, two co-chairs of coordinating committee, faith leader
  - 4.5 years into this initiative
  - Has been meeting every 2 months to create accountability of each other
  - Hear from Coordinating Board and staff: needs, suggested budget priorities, suggested policy initiatives
  - Directive from Executive Committee this year: Over next 10 years we will add at least 2,000 units of supportive housing (deeply affordable with support services)
  - High-level commitment from this group is used to have hard conversations to find $600 million
- Changes & impact
  - We've gone from moving 3,000 people per year out of homelessness, to last year almost 6,000 people
  - From 5,000 people per year getting prevention assistance to 8,000 last year
  - We've more than doubled number of unique individuals accessing emergency shelter each year (now more than 8,500)
  - Things within our control: ability locally to expand our interventions, to serve more people
  - Bigger budget ($70 million)
  - Joint Office invests city's and county's general fund into full spectrum of homeless services interventions
  - Through 40+ nonprofits, those funds touched 35,000 people last year (a little less than $3,000 per person served)
- We have more money, and are making more progress, but we don't have enough resources
  - We have 1,700 chronically homeless people on our coordinated access list for supportive housing
  - 1,300 families in the queue waiting for any kind of rapid re-housing or supportive housing assistance
  - The amount of need is not diminished
    - Housing market continues pushing people to the edge
    - Inadequate health care
    - Insufficient support for people emerging from the justice system

Questions

- Q: On the Executive Committee, there is also a faith leader?
    - A: Yes, Ben Sand from the Portland Leadership Foundation, who has been very instrumental in bringing forward church partners into this work
- Q: For housing plans you have, are you looking at building new facilities or renovating existing facilities?
    - A: Both. We know supply is an issue. If we can stabilize naturally occurring affordable housing (acquire building), then you can keep rents affordable and be more intentional about who moves in. Also significant emphasis on building high-quality, accessible, affordable housing. Benefits – can go into high-amenity areas, can purpose-build. Partnering with Portland Housing Bureau (entity responsible for development of housing) to bring modern version of SRO (single residence occupancy) back. Going to try to preserve the Joyce through a massive renovation. Just acquired Westwind downtown, will eventually take that down and build bigger better building.
- Q: So focusing on SRO, not larger units or shelters?
    - A: We're doing it all. We're building and acquiring a full range of household types, with specific targets for each type. We have transitioned our family shelter strategy to private rooms. Doing capital investments in both shelter and housing development.
    - SRO = single room/resident occupancy (shared kitchen, shared bathroom, or both)
- Q: With people you put in housing, is there any link to health care?
    - A: Yes, both in housing and in shelters. Focus is not just on providing housing, but if person needs ongoing health care, connecting to that.
- Q: Can you describe an intervention to a homeless person on the street?
    - A: Stories are unique. Assertive Engagement service delivery model: commitment to not presuming we know what the needs of any individual are, or what the best arrangement of services for them will be. Focus on relationships and walking with people through their process as they define it. Outreach workers are equipped to work with people individually, based on their skill sets / capacities, needs, and availability of resources. Ultimately, we can't help people get into housing unless housing is available.
- Q: Has there been partnership with the Catholic diocese?
    - A: Archdiocese has been awarded some level of resource, chosen as a community to expand supportive housing. We're still waiting to see how much resource that represents and how we can connect it in to some of the resources we have (such as the Portland Housing Bond and the Metro Bond). Are they going to be able to come in on the capital side or the operating support services side?
- Q: Can you talk about funding sources, and what monies are going to which specific program types?
    - A: Budget details and considerations
        - $70 million budget
            - 4% stays in Joint Office to fund operations
            - $22 million (30%) goes to fund shelter operations across the spectrum (just operations: staffing and supplies)
            - $42 million (47% of total budget) supportive services – rapid rehousing and supportive housing allocation
        - Three ways to stop homelessness:
            - Prevent them from becoming homeless – often the most cost-effective
            - Help move back into permanent housing

	• Shelter - least desirable option, we'll do it but it's not the solution ▪ As we look at our budgeting, we want to make sure that as we expand investments in shelter we are more significantly expanding our investments in what it takes to get people out of shelter and back into permanent housing • Joint Office has a 2 to 1 ratio of housing dollars to shelter dollars • Most of the rest of the funding coming from the community is going into housing • $25 million coming from Federal government to continuum of care for homeless programs – by and large going into housing • Our investment into shelter is probably 15% of total amount of money going into the range of interventions • Comment: Have noticed more information from the media on cold nights, sharing 211, offering transportation, stating that no one will be turned away. Maybe not solving homeless problem, but hopefully solving the people freezing on the street problem. • Q: When will the point in time count be available? o A: Late spring • Q: Do you know when Village of Hope (new shelter by the train station) is going to open up? o A: Foundation has been poured, I think they are on track to be open in June or July. Nonprofit group Harbor of Hope, arranged to lease a piece of land for five years. Building construction has been more expensive than anticipated, and they don't have enough money to fund operations. Joint Office has worked out an arrangement with Transition Project for Joint Office to fund operations. Will be a fairly intensively supported shelter, should serve 100 people. • If you want to know more: ahomeforeveryone.net o Budget o Spend analysis o Outcomes

Item:	**Combined presentation: Quality Management – Statewide Quality Measures Update, Update on ORPHEUS data / VSSP**
Presenter(s):	Marisa McLaughlin
Summary:	See slideshow. The group participated in a crosswalking activity which highlighted how the goals / objectives / performance measures of End HIV, the Integrated HIV Prevention & Care Plan, and Statewide Quality Management Committee intersect and overlap. Questions: • Q: Why were these very small groups chosen as focus, instead of larger populations (women of color vs. women, etc)? o A: 5 priority populations were selected based on local care continuum data, and 3 priority populations were selected based on the local epidemic and what are national priority populations. • Q: How do we apply this information to Planning Council decision making about large buckets of money?

Item:	**Subcommittee on Education & Training**
Presenter(s):	Alison Frye
Summary:	Subcommittee on Education and Training • Background o Ryan White Conference presentation from Planning CHATT o Funded by HRSA to provide TA to planning councils o Modules for PC member training o We don't do a very good job of member training o Wanted to bring back to Council • Seeking an ad-hoc group to: o Review modules o See what we need, might want to implement / adapt o Make a plan to implement • We're looking for people to participate o Consider stepping back if you've been on multiple committees in the past o Consider stepping forward if you have not joined committees in the recent past • Volunteers o Erin Butler o Scott Moore o Laura Paz-Whitmore o Robbie Thurman-Noche o Michael Thurman-Noche • **Action item: send an email to individuals who have members less than a year, to see if they would like to participate** (many of them aren't here tonight)

Item:	**Contract Updates & Preliminary Expenditures Report**
Presenter(s):	Jesse Herbach & Amanda Hurley
Summary:	Preliminary expenditures report • Have finished FY, but are still expecting invoices • Most programs on track, with 80-90% spent out by Dec/Jan • A few exceptions • We were able to do reallocations for any funds programs were unable to spend o This included last-minute email adjustments o We know that is not the most effective way, we appreciate your flexibility and attention • Exceptions o SUD Residential Treatment ▪ Only able to spend out 8% of allocation ▪ Will be giving 50K back ▪ Reasons • Internal hiring delays • Organizational / structural barriers around contracting process • Recently money was budgeted for LGBTQ competency training, but at last minute was unable to provide due to jury duty • Identified need has changed o Successes: building relationships, getting people into treatment with high priority o However, these people ended up having insurance or access to indigent funding (with advocacy from Addiction Benefit Coordinator), so Ryan White funding not needed

	o Psychosocial ▪ $10K unspent due to hiring gaps ▪ Now hired to capacity Contract Updates • We're postponing new contract for one of our MAI initiative vendors to re-evaluate effective programming o You may see an RFP coming out if we do decide to change vendors o Staffing issues o Inability to complete deliverables o $60K would need to be reallocated • We are expecting that our Part C clinic may experience cuts which would impact medical care and medical case management services • Major program change (not RW funded) o Legacy (part of Partnership Project collaborative) making changes to medical case management o Laying off current medical case manager o They are committed to providing the service, but may look different o Those FTE will be trained by Partnership and CAREAssist staff o Big question right now is transition plan o We will send updates as we receive them o Impacting 300 clients, of which 92 receive RW services

Item:	**Substance Abuse Disorder Treatment Programs panel**
Presenter(s):	Alison Frye
Summary:	Moderator: Alison Frye Panelists: • Laura Paz-Whitmore, Addictions Benefit Coordinator, Multnomah County Mental Health and Addiction Services Division (MHASD) • Danielle Deer, Director of Behavioral Health, Quest • Jenya Gluzberg, HIV Services Program Coordinator, Quest • Owen O'Neill, Peer Coordinator, Cascade AIDS Project (CAP) • Hanna Gustafson, Manager of Supportive Programming, CAP **Tell us about your program and services.** MHASD • Addictions Benefit Coordination (ABC) program o We serve people struggling with Substance Use Disorder (SUD) o I (Laura) work with people in the TGA experiencing SUD that are HIV+ o Laura (0.8 FTE) and coworker Valerie (0.2 FTE) • We connect clients with treatment resources • Referral from an agency • We do an intake – phone or in person • Options counseling – do they want services, and if so, what do they want? Quest • Finding and Sustaining Recovery (FSR) outpatient addictions program o Education / appointments up to partial hospitalization (5 days per week) o We do a lot of integrative services: acupuncture, other Chinese medicine, movement (yoga, Qigong), mental health o Coordinate care with HIV Services department o A lot of our population is LGBTQ+ and HIV+ • HIV Services program

- 4 RW contracts
- Work with primarily HIV+ individuals who qualify for Ryan White
- MH and Substance Use peer support programs
- HIV-knowledgeable mental health treatment to individuals
- Women of Wisdom (WOW) weekly psychosocial program for HIV+ women
- Recently had first meeting of Clark County WOW program

- Peer Support – both mental health and SUD
  - All peer staff either have experience with or are living with HIV, and have extensive experience with mental health and/or substance use recovery
  - We work to help individuals find out what they are looking for, meet them where they are in their stages of change, then connect them to resources (such as FSR program)

CAP

- Same contract – Ryan White mental health and SUD
- Also have peer support in two of our housing programs to help get connected to mental health or SUD treatment programs
- Peer recovery group
  - Peer led
  - Open to any CAP client
  - Monthly group is low-barrier, as you are, ask that everyone be respectful of each person's place on road to recovery
- Peers help: getting them food, clothing, make sure they are taking their meds, getting to doctor appointments

How does your program assist people with transitioning in and out of treatment and into permanent housing? Are people disqualified from housing if they accept residential treatment?

CAP

- We have a time limit of 60 days, any longer than that they lose their subsidy (there are exceptions)
- Peers help connect with and sustain housing
- One of the challenges is getting people into inpatient treatment if they have to choose between treatment and keeping their housing – almost every time they will take the housing

Quest

- In FSR program we have peers in program, not just in HIV services department
- When client comes into treatment, primary focus is to find them housing before anything else, because they will not be able to fully engage in treatment without that piece
- Our recovery housing will be opening in the next few weeks
  - Looking at hiring house manager – partnering with Bridges of Change
  - If a client needs to go to residential treatment while they are in the house, we will hold their spot in that house for 30-60 days, or we will staff it and identify from there depending on what residential program they are attending, because there are many different programs with different lengths

MHASD (ABC)

- Laura does help people transition into housing (not directly part of her job description, but part of larger role of assisting people in engaging in recovery)
- In my experience it is 90 days that people can keep their subsidy
- We have been able to do reasonable accommodation to extend to 4 months
- People want people to stay housed and stay clean, they are often open to having conversations

- When people get housing vouchers while in treatment, it is very hard to turn that down, can result in people not completing treatment
- If an individual has completed enough of the treatment program, can sometimes graduate them early
- We scheduled a meeting with CAP to talk about this problem
    - Working closely with CAP to make sure that when someone is assigned to our program, and they are going into a bed, that we are talking to a case manager to make sure that hopefully things line up
    - CAP now has a designated housing case manager that works with everyone to help with their transition

What are the gaps for SUD services, specifically related to insurance?
MHASD (ABC)

- People can only go to residential treatment in Oregon (paid by Medicaid and Medicare indigent funds)
    - Same 5 treatment agencies have been providing for 30 years
    - Some LGBTQ+ people have been in treatment in the past, have been traumatized by agencies' lack of cultural awareness
- Waits are fairly long
- Limitations of the treatment centers
    - People who have a sex offense - limits on what they can do for treatment, may need to get care at out-of-state facility
    - Abstinence-based

Quest

- Integrative model: these models are based on the ability to bill insurance, which is often not possible for co-occurring disorder treatment. An individual can be in SUD treatment, but cannot participate in mental health classes/groups without being a mental health client and having assessment (we still have them participate, but eat the cost)

What barriers exist for people accessing treatment?
Quest

- So many things are diagnosis driven when talking about money and insurance companies
    - Trying to piece services together for Medicare client so that client doesn't even realize their treatment is any different than anyone else's, while honoring where that person is in their treatment
    - We receive funds from county MHASD that pays for part of that, but not all
- Need for rapid response
    - Clients meet face-to-face with peers within 48 hours and talk about program
    - If individual is interested in program, assessment takes place in next 24-48 hours
- Meeting people where they are, especially with peer program - barrier of meeting basic needs (what we identify as need may not be what they identify)
- Program constraints - FSR is an abstinence-based program, not everyone is ready for that commitment to be abstinent from everything

CAP

- Wait time
    - Large homeless population, many don't have phones
    - Things need to happen on a fairly short turnaround time, and we have no way to contact them
- Building trust - sometimes the constraints of the program don't allow time for that

How does your program support people who are actively using?

Quest

- We do have a harm reduction track (LINK group)
  - Meets once a week
  - Basis: eventually you might want to quit or cut down
  - Having a place that is safe to have open discussion
  - We will meet with these clients individually to determine their goals
- HIV Services peer side
  - Clients complete goal plans
- Ryan White requirement of getting people engaged within 45 days - attending a meeting counts (even considering treatment is an accomplishment)

CAP

- We will meet anyone, no matter what degree of recovery they are in
- Monthly recovery group – we have people who have been sober for years, and people who are coming in high
  - Hearing stories from others in recovery demystifies road to recovery

MHASD (ABC)

- Assertive engagement approach
- People knowing they can call me
- Often when a referral happens, they aren't ready
- Having good relationships with case managers
- Success happens not on the first or second try, but on the third or fourth

Are there any new treatment interventions?

MHASD (ABC)

- HealthShare is creating an Assertive Community Treatment (ACT) team for people experiencing SUD
  - Multidisciplinary team
  - Often people are not stable for treatment, cannot get stable because they are using
  - Group of people to make sure they are successful once they reach the intervention
  - Needs to be a team approach

Quest

- Support for short term stabilization for MAT (medication assisted treatment)
  - There is a lot of support for long term, but short term is not always supported by prescribers
- Support for cross-agency collaboration
  - Frequently not supported by the payers
  - Reimbursement is so low that providers want to keep it in-house

CAP

- LGBTQ treatment center
  - Established in response to barrier of dealing with a population that is very hostile to them when they find out they are gay, much less HIV+

Q&A

- Q: Barrier: you cannot talk about sex within treatment. No place for conversation about exchanging sex for drugs, etc. Gender statements create implicit statements that being gay is wrong.
  - What can we do? Build really good relationships.
  - Working as partners, we are a community.
  - Instead of mindset of providing services, mindset of being of service
- Q: Services for monolingual Spanish speakers?

	- There's a treatment center in Madras, but Laura doesn't refer there anymore due to LGBTQ+ statements: "Can you tell this person to not say that they are gay?" - VOA home-based recovery Latino house – Laura refer many people there - Bridges also can accommodate a little, they have some staff that speak Spanish, but not fully - Quest doesn't offer full Spanish-speaking programing at this time. - Q: Program like Coast, which gets mental health, addictions, policy, providers all together in one room for clients who are cycling through all options. Is that something that might work? - At Quest, we do bi-monthly meetings with all care providers. Monthly behavioral health meeting, monthly all-clinical meetings to discuss clients. We try to maintain an integrative model - Q: Where are these out of state treatment programs? - A: One in Georgia, one is in Washington. - Q: What types of programs are these? - ABC: Some are 12-step, some are other modalities. Many clients are more knowledgeable than I am, they have been in treatment. - Quest is not 12-step based. Clients must attend 3 outside support meetings per week. Many clients choose Buddhist-based Refuge recovery. Church, cooking class could be an outside support meeting. We want them to develop a community that is a reflection of who they are and supports their recovery. - Q: What do you do if people choose housing, and are using, then lose their housing due to use? - ABC: Get them into treatment because they have been kicked out of housing. - CAP: That happens a lot, we try to work with people to prevent eviction. - Q: What about people who want treatment who still want to smoke pot? - A: This is not always a barrier, depending on the program

Item:	**FY19-20 Re-Allocations**
Presenter(s):	Jesse Herbach
Summary:	See handout Recommendations for reallocation of $107K from residential treatment • $20K in medical care due to significant cuts • $60K into MCM/MAI to increase funding for priority populations • $7,977 into psychosocial for increased programming planned for FY19-20 • $20K into Non-MCM for LGBTQ+ trainings provided for residential treatment centers; adequate staff support Questions: • Q: How does this fit into the decisions we made previously? o A: This amount fits into the "increase of less than 5%" contingency • Q: For which fiscal year is this for? o A: Upcoming year FY19-20 • Q: Do we need to decide this now? o We can bring this back, along with contingency plan, at May meeting o This year is a bit different, because we have received our Notice of Award early, and we have some programs that will not be able to spend their funds and/or we are not renewing contract

	After a brief discussion, this topic has been tabled until the May 2019 Planning Council meeting.

The meeting was adjourned at 7:30 p.m.

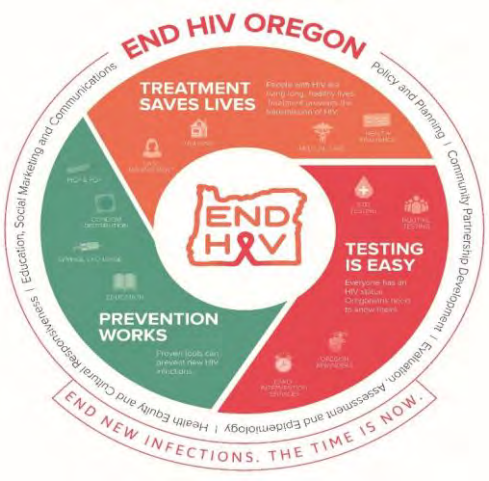
Statewide Quality Management Committee (QMC)Performance Measures
AND
Viral Suppression Support Project (VSSP)

Planning Council, March 5th 2019

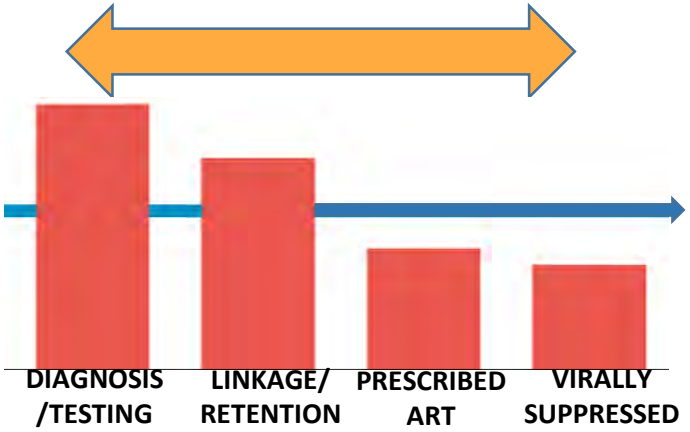
Objectives

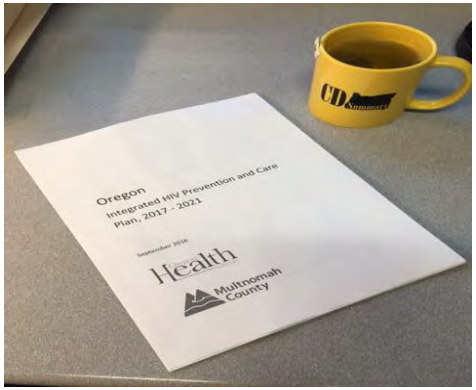
- Activity!
- Review Statewide Quality Management Committee (QMC) Performance Measure preliminary results
- Visualizing Care Continuum Disparities
- Viral Suppression Support Project Updates

End HIV---Integrated HIV Prevention & Care Plan---Statewide QMC Connection

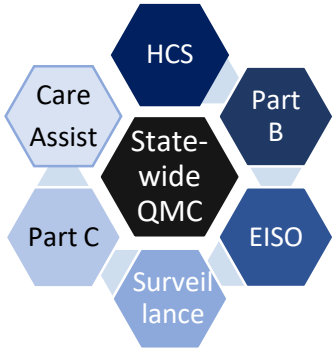


3 END HIV GOALS





8 INTEGRATED HIV PREVENTION AND CARE PLAN PRIMARY OBJECTIVES

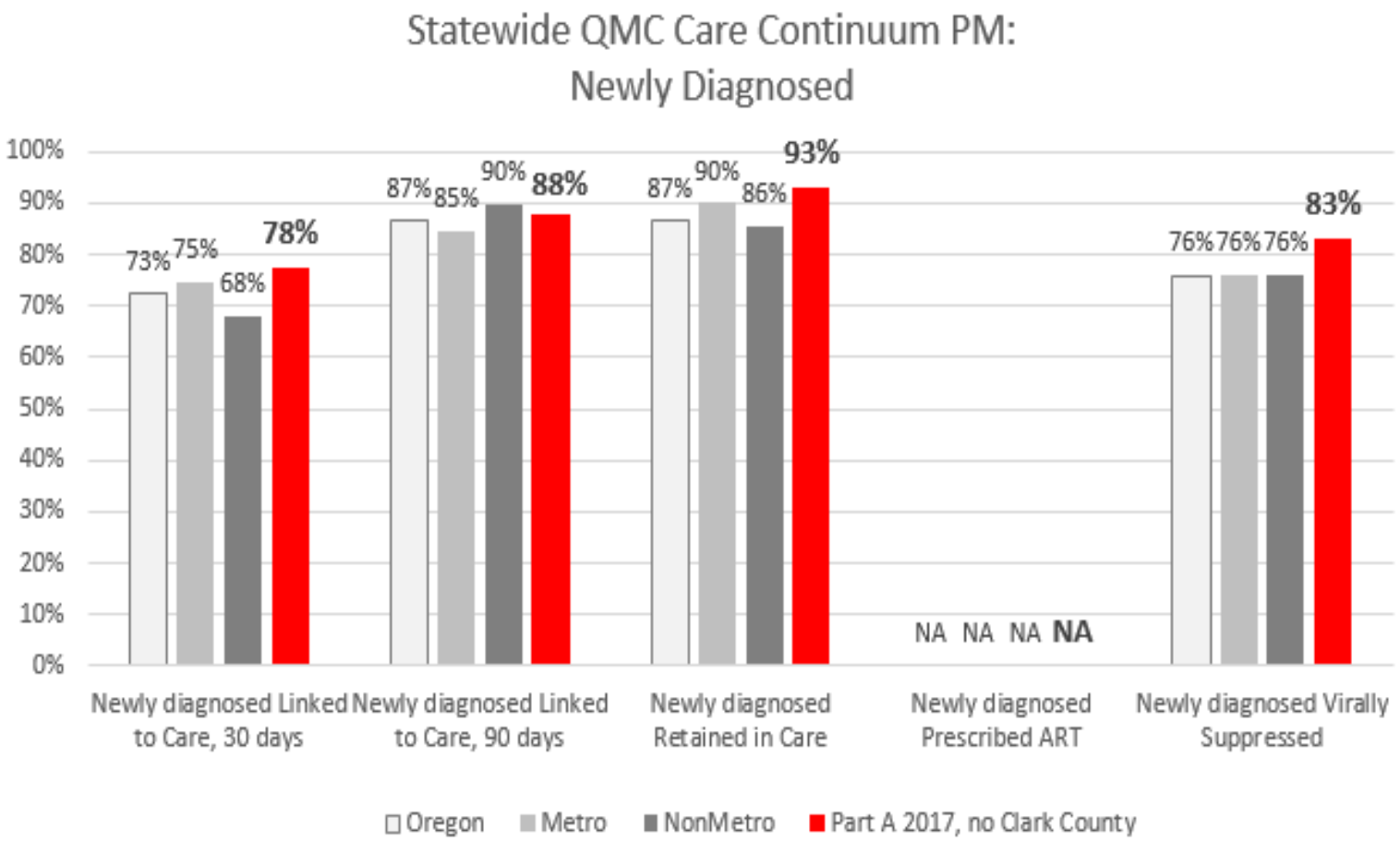


10 STATEWIDE QUALITY MANAGEMENT COMMITTEE PERFORMANCE MEASURES

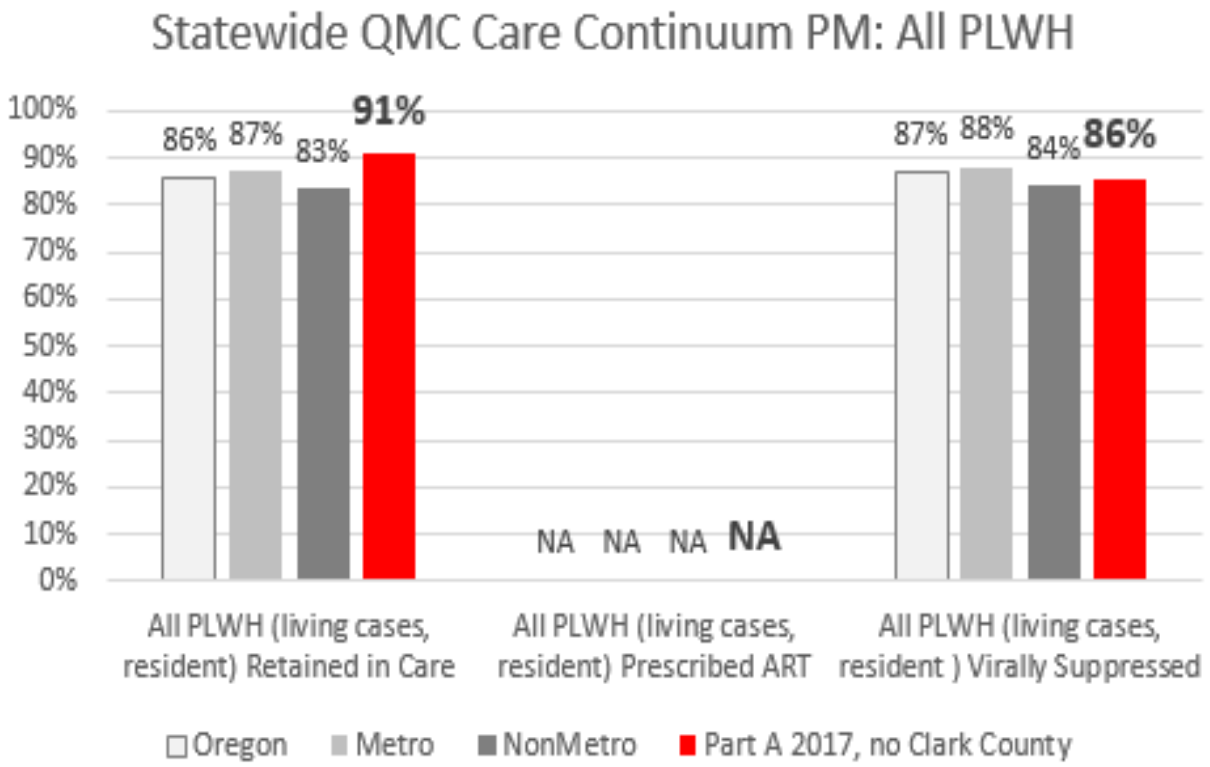
CROSSWALK ACTIVITY (10-15 minutes)

- CARE CONTINUUM OBJECTIVES are hung around room
- Will be handed a measure:
    - END HIV GOAL;
    - INTEGRATED HIV PREVENTION AND CARE PLAN OBJECTIVE;
    - STATEWIDE QMC PERFORMANCE MEASURE
- Walk to the CARE CONTINUUM OBJECTIVE that you best think the End HIV Goal, Integrated Plan Objective or Statewide QMC Performance Measure best fits.
- Discuss with your group why you feel this best fits here.

Preliminary Statewide QMC Performance Measure Data: Newly Diagnosed PLWH

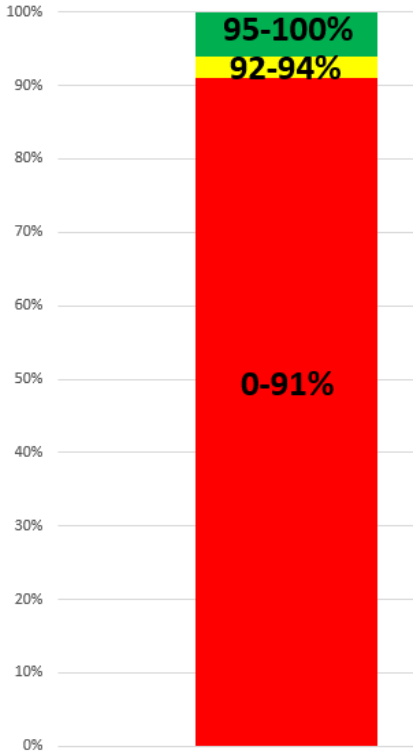


Preliminary Statewide QMC Performance Measure Data: ALL PLWH



Introduce: Care Continuum Stoplight System

Retention in Care (Annual Lab)

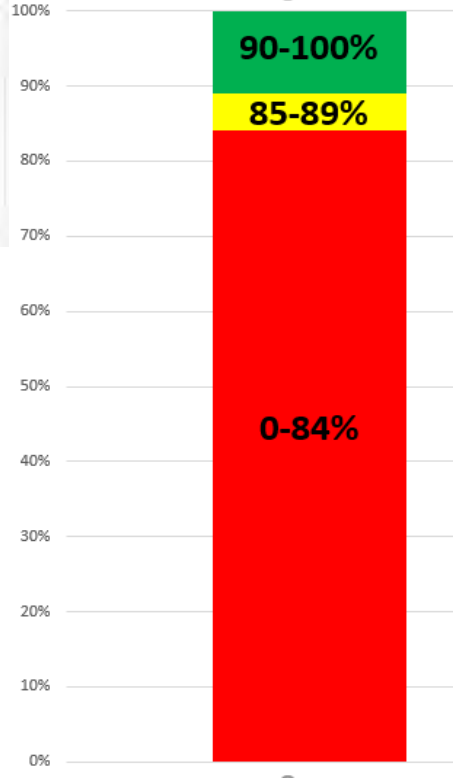


Maintain Current Activities, Look for Promising Practices

May need to examine further, May not be a priority

Stop and examine further, May be a priority

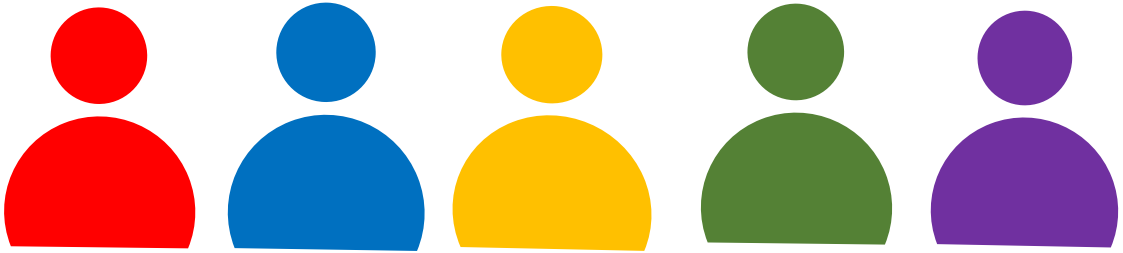
Viral Suppression (Out of Retained)



Care Continuum Stoplight System: Priority Populations

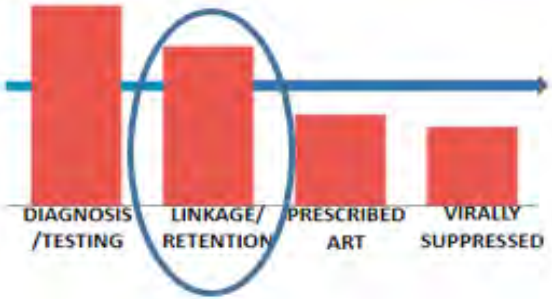
	2016							2017
	PLWH		d in Care (Ann		ession (out in Care (A		iral Suppressio	
	#	%	%	#	%	%	%	# Go
All PLWH	2698	100%	94%		89%	94%	89%	
<25+	80	3%	92%		77%	90%	76%	
25 - 44	1127	42%	93%		85%	93%	85%	
45+	1491	55%	94%		92%	95%	92%	
Women	336	12%	96%		87%	95%	85%	
Men	2325	86%	93%		89%	94%	89%	
Transgender	37	1%	100%		86%	100%	82%	
MSM	1658	61%	94%		90%	95%	90%	
MSM-IDU	283	10%	93%		83%	94%	81%	
IDU	203	8%	89%		79%	92%	79%	
Hetero	410	15%	96%		91%	94%	90%	
Black	259	10%	92%		83%	92%	81%	
White	1663	62%	94%		89%	95%	89%	
Latinx	445	16%	95%		90%	95%	91%	
Other	324	12%	93%		87%	92%	87%	
Black Men	185	7%	90%		81%	90%	78%	
AI/AN	173	6%	93%		87%	92%	85%	
NH/PI	53	2%	98%		82%	98%	84%	
NA/AN Men	136	5%	92%		88%	92%	86%	
NH/PI Men	44	2%	98%		80%	97%	79%	

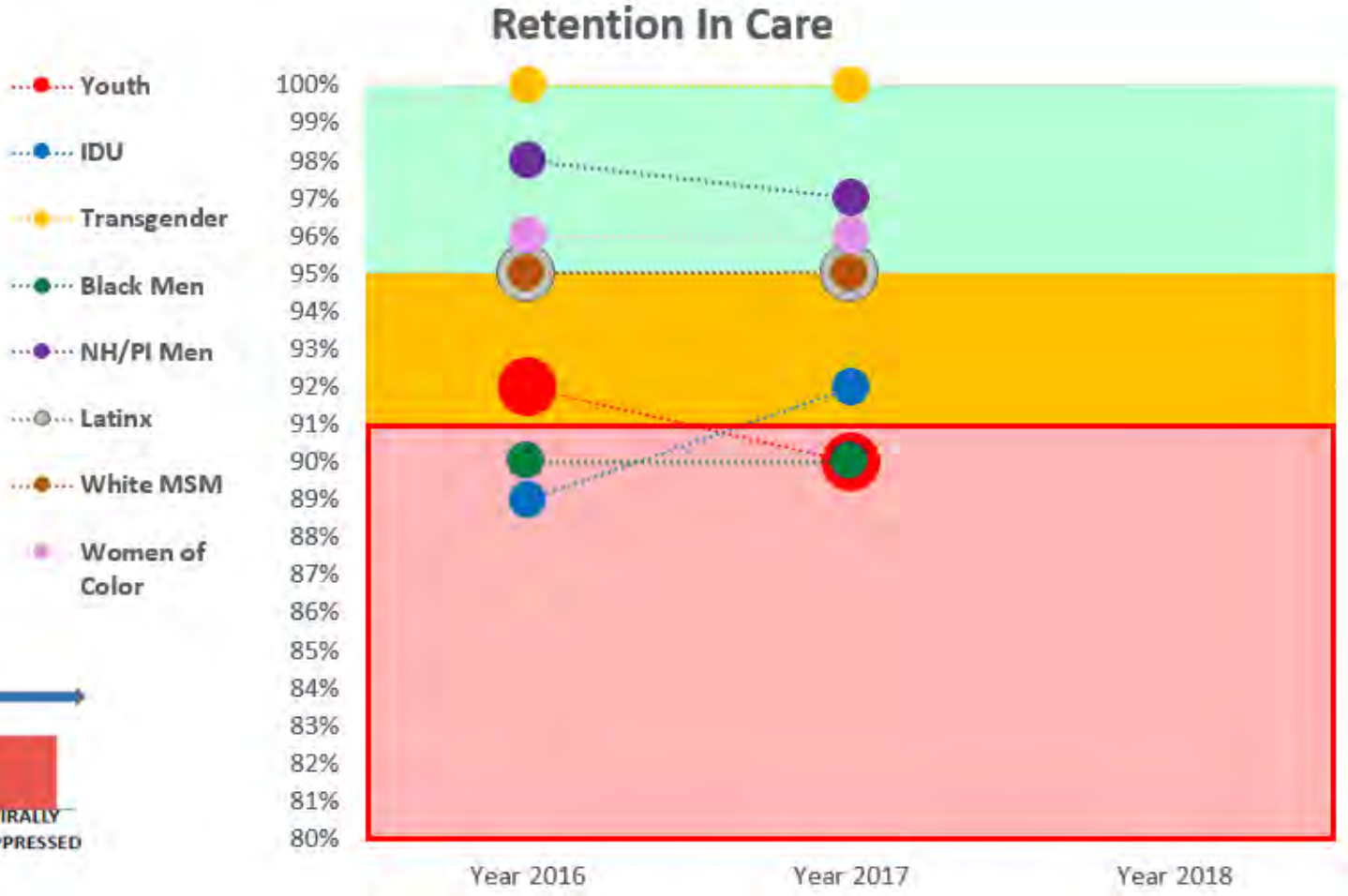
Based on local care continuum data



Based on local epidemic & national priority populations

Care Continuum Stoplight System: Retention in Care





Retention in Care: How many 2017 clients to reach 95% Goal?

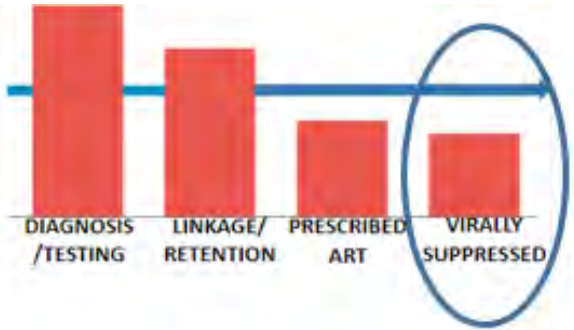
18 TOTAL CLIENTS

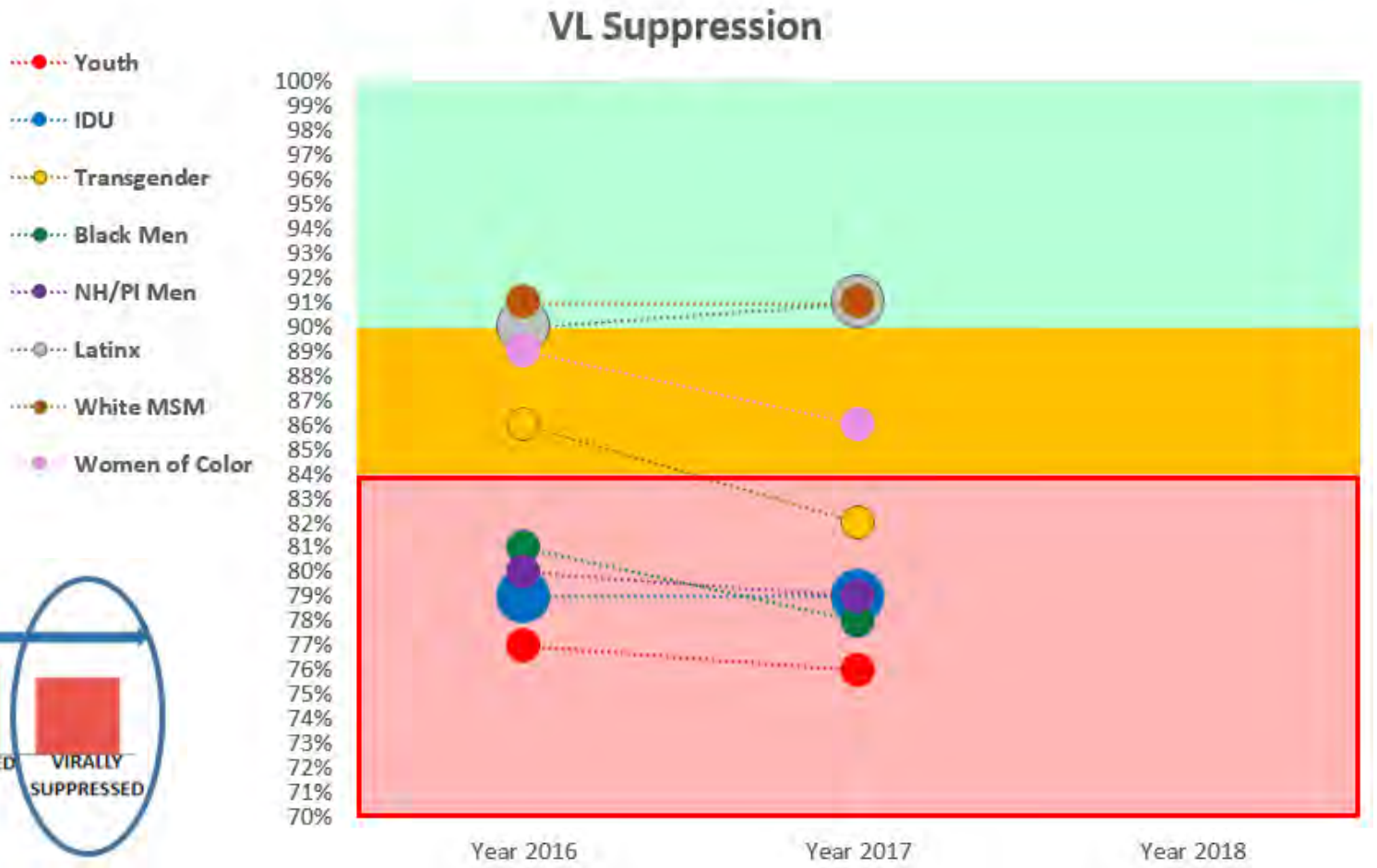
How many 2017 clients in each priority population would it have taken to reach goal?

Youth: 👤👤👤

Black/AA Men: 👤👤👤👤👤👤👤👤

Care Continuum Stoplight System: Viral Suppression

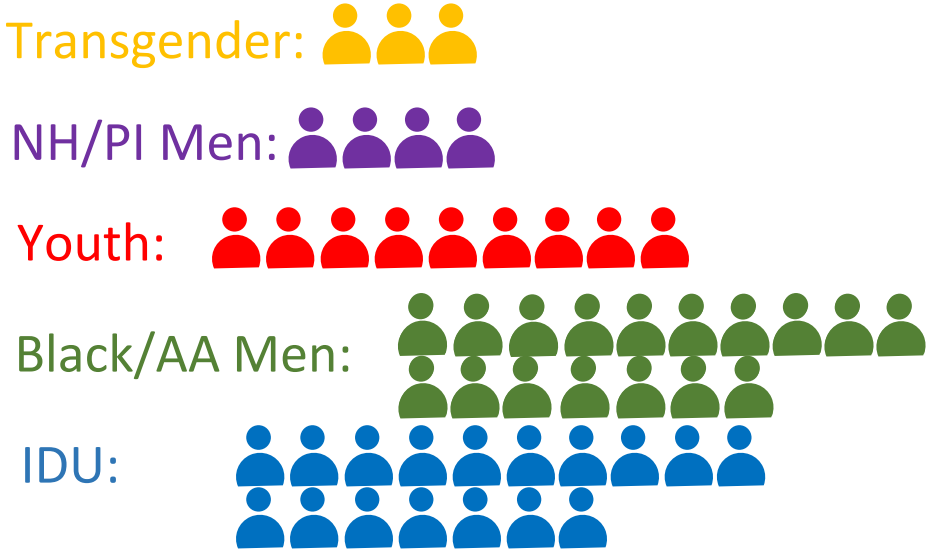




Viral Suppression: How many 2017 clients to reach 90% Goal?

35 TOTAL CLIENTS

How many 2017 clients in each priority population would it have taken to reach goal?



Viral Suppression Support Project (VSSP) Updates

- VSSP purpose:
  1) *Orpheus (State Monitoring Data System) lab data imported into CAREWare (RW Part A data system) to use for...*
  2) *Ensuring strategies implemented for care coordination and client outreach/follow-up around viral suppression and/or engagement in care*
- Orpheus data in CAREWare: Began 10/15/2018
  - 1778 client records matched to Orpheus record
  - Close to 11,000 Orpheus CD4 and VL test results in CW
  - Custom reports and care continuum performance measures designed for HCS and contractors

Viral Suppression Support Project (VSSP) Updates

- Initial strategy meetings in late 2017/early 2018.
- Planning Meetings for Coordination between EISO providers and RW Providers to support VSSP.
  - Newly Diagnosed PLWH
  - Client Viral Suppression Support
  - Out-of-Care Client Support and Outreach
- Building into current care systems
- Will evaluate and assess whether additional funding and support necessary to truly implement

FY 19-20

Service Categories	Allocation (Part A)	Allocation Reduction	Suggested Reallocations	Total Allocation	Justification	Core vs Support
Medical Care	$ 720,538		$ 20,000	$ 740,538	significant cuts to Medical Care at Part C clinic	
Health Insurance	$ 32,725			$ 32,725		
Mental Health	$ 273,531			$ 273,531		
Oral Health	$ 32,416			$ 32,416		
Medical Case Management/MAI	$ 1,303,658		$ 60,000	$ 1,363,658	to increase funding for priority populations	79.8%
Early Intervention Services	$ 163,541			$ 163,541		
Substance Use Disorder Treatment (Outpatient)	$ 155,673			$ 155,673		
Housing	$ 80,694			$ 80,694		
Psychosocial	$ 390,746		$ 7,977	$ 398,723	increased programming planned for FY19-20	
Food	$ 67,621			$ 67,621		
Non-Medical Case Management	$ 130,564		$ 20,000	$ 150,564	LGBTQ+ trainings provided for residential treatment centers; adequate staff support	20.2%
Substance Use Disorder Treatment (Residential)	$ 107,977	($107,977)		$ -		
Total	$ 3,459,684	$ (107,977)	$ 107,977	$ 3,459,684		100%