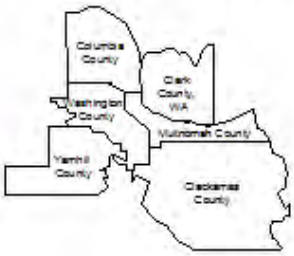
**Portland Area HIV Services Planning Council**

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

***Ryan White Program, Part A***




# Meeting Minutes

## Meeting Date: May 7, 2019

## Approved by Planning Council: June 4, 2019

## Grantee: Multnomah County Health Department

Multnomah County

# *MEETING MINUTES*
## *Planning Council*

Portland Area HIV Services Planning Council

**May 7, 2019**
**4:00 pm – 7:30 pm**
**Multnomah Building**
**501 SE Hawthorne Blvd.**
**Room 315**

| | |
|---|---|
| **Members Present:** | Erin Butler, Tom Cherry, Carlos Dory, Greg Fowler, Alison Frye (Council Co-Chair), Dennis Grace-Montero, Myranda Harris, Mary Rita Hurley, Shaun Irelan, Lorne James (Council Co-Chair), Toni Kempner, Julia Lager-Mesulam, Heather Leffler, Jeremiah Megowan, Scott Moore, Laura Paz-Whitmore, Jace Richard, Michael Stewart, Michael Thurman-Noche, Robert Thurman-Noche, Rosemary Toedtemeier |
| **Leave of Absence:** | NA |
| **Members Absent (Excused):** | Emily Borke, Jonathan Livingston, Abrianna Williams |
| **Members Absent (Unexcused):** | Toni Masters, Nathan Roberts |
| **Staff Present:** | Jenny Hampton, Jesse Herbach, Amanda Hurley, Kim Toevs |
| **Others Present:** | Ashley Allison (Oregon AETC), Linda Drach (OHA), Taylor Gleffe (EMO), Isaac Holterman (CAP), Beverlee Katz Cutler (Russell St. Dental) |
| **Recorder:** | Jenny Hampton |

**Lorne James, Planning Council Co-Chair, called the meeting to order at 4:00 p.m.**

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|---|---|
| **Item**: | **Candle Lighting Ceremony** |
| **Presenter(s):** | Toni Kempner |
| **Summary:** | Toni Kempner led the lighting of the ceremonial candle in honor of the wisdom of the people in this room and the collective wisdom of all of the people who have contributed to the Planning Council. She reminded the group that we are still losing people to HIV. |
| **Item**: | **Welcome & Introductions** |
| **Presenter(s):** | Lorne James |
| **Summary:** | Lorne James welcomed everyone to the meeting and introductions were made, with Council members declaring any conflicts of interest. |
| **Item**: | **Announcements** |
| **Presenter(s):** | All |
| **Summary:** | Announcements:<br>• Quest opened LGBTQ+ housing for people experiencing addiction last week<br>  o There will be formal grand opening later this summer<br>  o Currently have 5 clients<br>• Disability Services Advisory Council (DSAC) currently recruiting for members –<br>  o Provides input to Multnomah County Aging, Disability, & Veterans Services Division (ADVSD) on how best to serve people with disabilities in a respectful and conscientious manner.<br>  o Generally oversees Medicaid services<br>  o If interested, contact Michael Thurman-Noche or apply directly on the website<br>• From the Grantee: Thanks for your flexibility with changing meeting spaces.<br>• Please complete evaluations after each section<br>• A "Notes for Decision Making" section has been added to the agenda for your use<br>• Co-Chair and Operations Committee elections will be held in June |

| | |
|---|---|
| | ○ Michael Stewart, Jace Richard, and Julia Lager-Mesulam's terms will be completed in August (they can run again, if they choose)<br>○ 3 Operations Committee positions open for a 2 year term<br>○ Please send nominations to Jenny Hampton or Amanda Hurley |

| **Item**: | **Agenda Review and Minutes Approval** |
|---|---|
| **Presenter(s):** | Lorne James |
| **Summary:** | • **The agenda was accepted by unanimous consent**<br>• **The meeting minutes from the January 8th meeting were approved by unanimous consent, with following edits: On page 2, where it states the meeting was called to order, change Tom Cherry to "Co-Chair Emeritus"** |

| **Item**: | **Public Testimony** |
|---|---|
| **Presenter(s):** | Lorne James |
| **Summary:** | No public testimony. |

| **Item:** | **AIDS Watch Update** |
|---|---|
| **Presenter(s):** | Myranda Harris |
| **Summary:** | Myranda Harris shared her experience of attending AIDSWatch. See handout.<br><br>AIDSWatch<br>• Nation's largest advocacy event<br>• April 1-2, 2019<br>• 500 people from around the country<br>• 4 people from Oregon: Peter Parisot, Brandi Velasquez, Myranda Harris and one other attendee<br>○ Opportunity to meet with Oregon Congressional Representatives Wyden, Merkel, Blumenauer, and Bonamici (or their staff)<br>○ Each person had two minutes to discuss lived experience and ask a question<br>• Myranda shared her lived experience, and her concern about funding cuts in the future, asked them to protect Ryan White funding from any fiscal deductions from this point forward – got a very positive response<br>• We have a good team of representatives in Oregon<br>• Very empowering experience |

| **Item:** | **Medical Monitoring Project data** |
|---|---|
| **Presenter(s):** | Linda Drach (OHA) |
| **Summary:** | See slideshow.<br><br>Questions & Comments:<br>• Local questions – examples?<br>○ Housing (types of moves, impact on medication & medical care), opioid use, social support, civic engagement. Most standard questions are risk-based, so we wanted some local questions to be strength-based.<br>• Do you address Property management of tenants?<br>○ That's a good issue. We don't address it in this study, but we could in the future.<br>• Do you have a breakdown of reasons for ER visits? |

- No, only a question about ER visits for a personal health issue.
- Does non-injection drug use include marijuana?
  - No, it includes everything except marijuana.
- How do these numbers compare to general population? (depression/anxiety etc)
  - I don't have this information at this moment.
- What does "alcohol use" mean?
  - "Used alcohol" = had any alcohol in the past 12 months, "binge drinking" = 4+ drinks for women or 5+ drinks for men in a sitting
- How might these stigma statistics relate to loneliness?
- Unmet need – vision?
  - Not measured, but could be added to local section, if there is interest
- Interesting to hear people's views of met and unmet need in relation to numbers of sexual and physical violence
- What issues are people needing legal help for?
  - We don't know that.
- History of sexual/physical intimate partner violence - is 44% comparable to general population?
  - This is very high compared to general population, particularly considering most of the sample is men, and women are more likely to report.
- Health literacy – regarding self-confidence rating, only 19% had confidence?
  - No, this is an error on the slide, 19% did NOT have confidence
- For people with 3+ Social Determinants of Health (SDOH), 44% were virally suppressed (vs 62% in overall sample)
- Why is only 62% of overall sample virally suppressed, when our rate is around 87%?
  - We use a more conservative definition of virally suppressed – 2 or more VL tests in past year, with none over 200, instead of 1 or more
- What was the "n"?
  - Linda will send that information out
- STI screening – low percentage, is this because patients don't know what tests are being ran?
  - No, this data is from medical records
- Slide says screening is going down – is incidence also going down?
  - No, incidence is going up while screening is going down, so this is concerning
- Regarding facilities/providers interviewed about syphilis screening, are these medical facilities or testing facilities?
  - Medical facilities only
- Are we (Oregon) still in the top 10 for syphilis?
  - It was really the Portland area (not all of Oregon) who was in the top 10, and we're not still in the top 10, but still quite high
- What do you do with this data?
  - Work with people / organizations (such as AETC and medical facilities) to change policies, bring data to groups like this, grant writing, ask further questions.
- Comment: With all of this data, I don't know what MMP is comparing against, so I don't know if I should be alarmed.
- We're trying to make the data more accessible – hope to have all of this in Tableau by end of year
- How can I access your white paper on long term survivors?
  - Not online yet, but individuals can contact Doris or Linda (contact info on slides). Linda will also send to Amanda when it's ready.
- Could we interact when you're ready to do your next survey?
  - We have an advisory board, if you're interested please call Doris.

| | |
|---|---|
| | • Announcement: currently recruiting for an interviewer for MMP through Multnomah County Health Department. Very interested in people with lived experience, no specific education requirements, training provided. One full-time permanent position, plus will be hiring on-call part-time positions.<br>• CareAssist program is doing focus groups about pharmacy services, looking to recruit CareAssist clients 18 years or older who have used a preferred or non-preferred pharmacy in the past year and did not exclusively use a Kaiser Pharmacy or the Westside Pharmacy (see handout).<br>• Did you also ask how many are newly diagnosed, or were you able to tell?<br>o Yes, we did. There is a whole module for newly-diagnosed people. |

| **Item:** | **MCHD – HIV/STD Budget Update** |
|---|---|
| **Presenter(s):** | Kim Toevs |
| **Summary:** | Multnomah County Health Department Budget Update<br>• Introduction: Kim Toevs, Director of HIV/STD, Youth Sexual Health, Harm Reduction, and soon to be Communicable Disease program<br>• We will be integrating STD/HIV program with the Communicable Disease program<br>o Infectious Disease all together in one house<br>o One clinic<br>o One set of investigative staff<br>• We have had a hard budget year this year in Multnomah County<br>o We have a budget gap related to limits on how high property taxes can increase<br>o County's cost of doing business is high, due in part to public employee retirement<br>o Health Department medical costs go up – lab, pharmacy<br>o Gap between how much revenue we expect and our costs<br>o Population is increasing while revenue is not<br>o Public Health has taken a significant cut<br>• Considerations / priorities<br>o If there are clinical services that clinics provide, then we need to have the whole health care system take those on, we shouldn't do so much safety net clinical services<br>o If there's population-level work we do, work around built environment that helps people be healthy and active living (nutrition, clean air and water), those are core public health aspects of work that are really in our wing<br>o Focusing on racial health equity, still a top priority<br>o Intersecting with other demographics that tend to have higher burdens of disease as well - LGBTQ, low income, immigrant/refugee status<br>o Housing situation<br>o Addiction epidemic (opiates, meth)<br>o Federal policy changes that make people feel marginalized or unsafe<br>• We have a lot to do with more limited resources<br>o Some of our services we are combining with CD clinic<br>o TB and STD will be pooling our staff resources<br>o Cutting one of our harm reduction sites, which is closest to Gresham<br>o May need to reduce some of our supplies<br>• Good news: we have a new grant from OHA Public Health Division that comes out of Ryan White generated income, which is being used to shore up counties' ability to work with people who need linkage to testing and services for HIV care, as well as doing a better job for individuals diagnosed with syphilis and other STIs to make sure they got an HIV test as part of their care |

- Those funds are helping backfill losses in County, supporting both subcontracts and direct service
- Where we are in budget process: Chair has released her budget, now commissioners get to have input (consider additions / changes), plus public testimony
- Public hearings
  - First meeting was on April 22
  - Three more meetings scheduled, one each week for next three weeks in various locations throughout the county
  - Meeting information on County website

Questions & Comments:

- Clarification: HIV Health Services Clinic (HHSC) is part of Integrated Clinical Care, not Public Health, and is NOT combining with STD and CDS clinics.
- Are you in the new building?
  - Yes, STD Clinic is on the 2nd floor (HHSC is on 3rd)
- With the influx of new people, what is your capacity?
  - Trump Administration has changed immigration requirements, resulting in fewer immigrants entering the country. People coming into the country tend to have more TB infection, so this change is resulting in less work for TB staff, resulting in possibly more capacity for sexual health work.
  - We have also recently begun to get support from other counties for care provided to their residents.
- Is the county putting out information on the budget cuts on their website?
  - The county provides so much information about the budget on their website that it can be difficult to sort through it. Maybe we can look to see if there are any documents about the budget that are more digestible, and share with this group?

HIV Care Services (Grantee) announcements

- Update on Jill's position (CAREWare administrator)
  - Position will be posted this week, external and internal recruitment
- Update on Council staffing
  - As Kim's position is changing, Jenny's job is also changing to provide more support to her
  - Looking at hiring a Community Engagement Coordinator – half-time position, hybrid of Jenny's work and Amanda's
  - Excited to have a person devoted to staff the Planning Council
  - Hoping to have someone in place before the next retreat
  - Not sure if it will be a transfer, or if it will be posted
- New Building
  - As we've moved into the new building, there has been some confusion about "HIV Support Services", patients coming up to the 2nd floor instead of HHSC on 3rd floor
  - Working on name change from HIV Care Services to "Ryan White Planning & Grant Administration"
- Quality Management training
  - Submitted application to National Quality Center
  - Our application was accepted, will be sending 3 consumers and 1 staff person to Cincinnati at end of month to participate in Quality Management training
  - From that training, we will be able to do some trainings here, work with client advisory boards, enhance our Quality Management efforts

| Item: | **FY18-19 Expenditures Report** |
|---|---|
| **Presenter(s):** | Jesse Herbach |
| **Summary:** | See "FY18-19 Expenditures" handout.<br><br>Review of draft expenditures report<br>• End of year changes<br>  o Funding was moved out of SUD Residential Treatment<br>  ▪ Moved into Medical and MCM categories, who could spent out those funds<br>• Underspent<br>  o Mental Health – largely due to staffing gap, also some new staff learning about budget monitoring<br>  o Psychosocial – significant staffing transitions<br>• Total carryover request of $53,915<br>• We spent out 98.7% this year |

| Item: | **FY19-20 Reallocations** |
|---|---|
| **Presenter(s):** | Jesse Herbach |
| **Summary:** | See "FY19-20 Reallocations" handout.<br><br>Reallocation Discussion<br>• At the last meeting, we had a discussion about reallocating SUD Residential funds<br>  o Need has changed<br>  o There is a continued need to support people in treatment<br>  o At that meeting there was concern about not enough time and not in line with contingency plans<br>  o Based on your concerns and previously identified priorities, we have created a 2nd proposal<br>• Handout shows Proposals 1 and 2 (you don't have to choose only these two options)<br>  o Proposal 1 takes into consideration new and changing needs since contingency plan was made<br>  o Proposal 2 strongly based on previous contingency plan, including increased COLA<br>• Note: No programs applied for Assertive Community Treatment (ACT) services<br>• Comment: Proposal 2 has significant administrative burden for both grantee and providers (contract amendments) for in some cases not very much money<br>• Third proposal: Adapt Proposal #1 by reducing MCM to $50K and adding $10K to Psychosocial<br>• **Decision: Adaptation of Proposal #1**<br>  o **Reduce SUD Residential allocation by $107,977**<br>  o **Increase allocations to Medical Care ($20,000), Medical Case Management ($50,000), Psychosocial ($17,977), and Non-Medical Case Management ($20,000)** |

| Item: | **Review & Activity: PSRA Process, Service Categories & Guidance** |
|---|---|
| **Presenter(s):** | Alison Frye |
| **Summary:** | PSRA Process review – see PSRA Planning Cycle handout.<br><br>Planning Council trivia game – see slideshow & answer key<br>• Winner: Cashmere team – Laura Paz-Whitmore, Jeremiah, Toni K, Scott M, Mary Rita, guest |

| | |
|---|---|
| | • Prize: Choosing the dessert for the July retreat!<br>• Selected dessert: cream pies, such as Boston cream and banana<br><br>Service Categories & Guidance review – see handout<br>• Please review this guidance and consider any changes/additions to bring to next month's meeting<br>• Comment: Consider that very specific guidance is difficult to enforce and maintain |

| **Item:** | **Develop Preliminary Priorities, Guidance & Service Categories for FY20-21** |
|---|---|
| **Presenter(s):** | Alison Frye |
| **Summary:** | Unmet needs brainstorming:<br>• Getting IDs<br>• Eye exams<br>• Eyeglasses<br>• Hearing aids<br>• Helping homeless stay in care – both storage (lockers?) and connection (peer services?)<br>• Support for transgender people<br>• Phones<br>• Transport<br>• Legal services (wills)<br>• Long Term Survivors assistance to break isolation<br>• Sexual wellness<br>• LGBTQ+ seniors<br>• Emergency resources (cash, rent, utilities)<br>• SUD services for people still using marijuana<br>• Long term care<br>• Team of people to help stabilize clients – intervention for high needs behavioral health<br>• Alternative medicine – acupuncture & chiropractic<br>• Clinic-based substance abuse counselors (CATC)<br>• More patient navigators<br>• Caregiver respite<br>• Caregivers<br>• Safe injection spaces |

| **Item:** | **Feedback on Space – Multnomah Building, Room 315** |
|---|---|
| **Presenter(s):** | Alison Frye |
| **Summary:** | Feedback:<br>• Like something different<br>• Room is very nice, though HVAC turns off at 6<br>• Parking is easy<br>• Can hear without mikes |

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

MEDICALMONITORINGPROJECT

# Part A HIV Planning Council Meeting

## May 7, 2019

# Presentation Goals

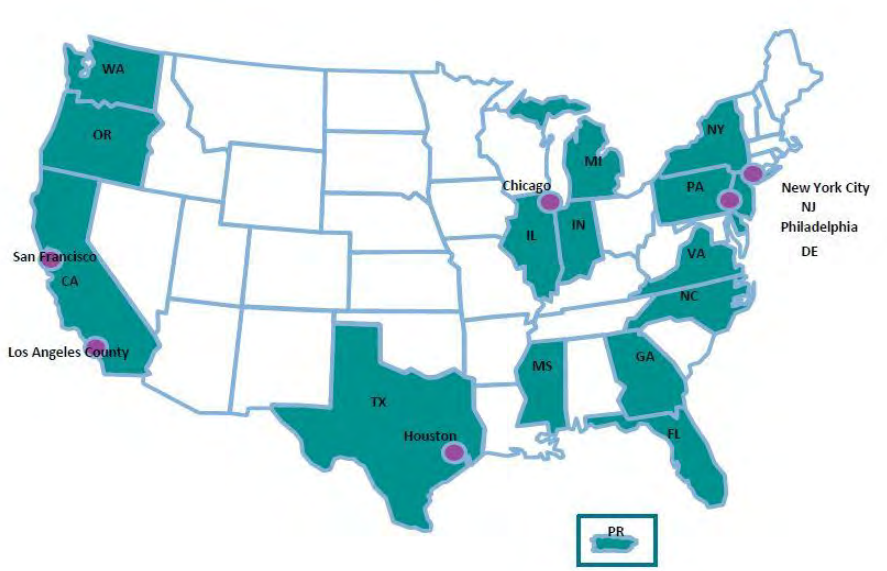
- MMP overview
  - What is it?
  - How does it work?
- Share & discuss data
  - What have we found?
  - What does it mean to you?
- Data dissemination
  - How we share results. Other thoughts?

MEDICAL MONITORING PROJECT

# Oregon
# HIV Medical Monitoring Project
# Overview

# Medical Monitoring Project Overview

- National population-based sample of adults receiving medical care for HIV/AIDS




- Representative statewide data for participating project areas

CDC Centers for Disease Control and Prevention

- Linked interview and medical record data

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# Sampling Design

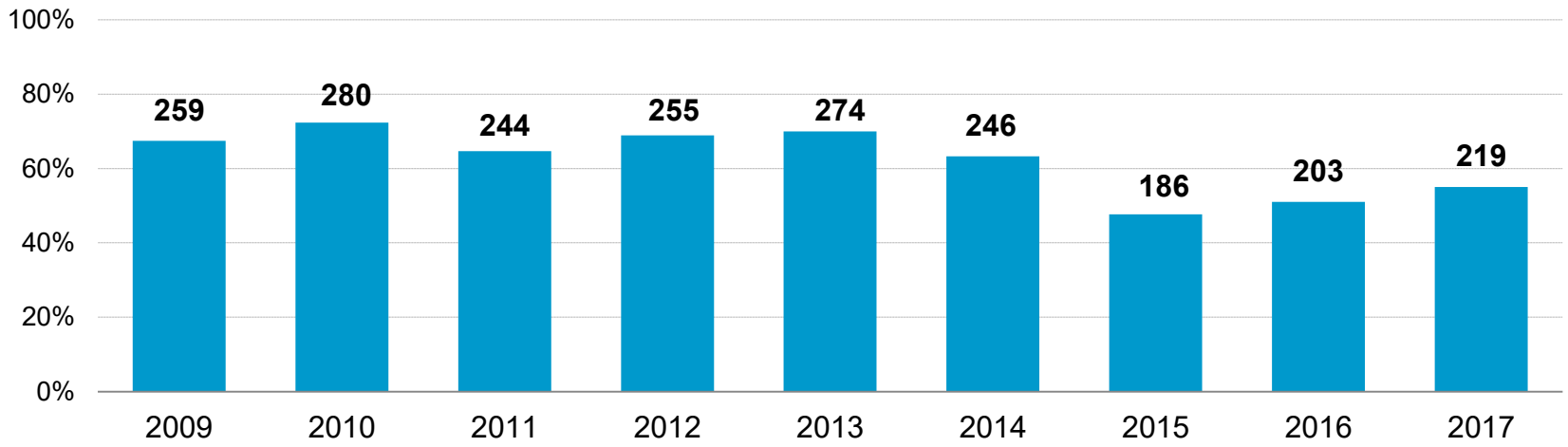
- Early years:  2007 - 2014 cycles
  - Three-stage sampling design:  states, facilities, patients
  - Patients randomly selected from patient lists provided by selected facilities

- 2015 and beyond
  - Case-based sampling -- patients randomly sampled using surveillance data
  - Includes participants both in & out of care
  - Opportunity to link patients to care
  - Less burden on facilities

MEDICAL MONITORING PROJECT

# Annual Data Collection

- 400 people in Oregon sampled each year
- Participation includes ~1-hour interview & medical record review
- MMP interviews use both Core & Local questionnaires




MEDICAL MONITORING PROJECT

# Statewide Demographics

- MMP data are weighted to represent the Oregon population of PLWH:
  - Majority of participants identify as male (87%), gay or bisexual (69%), and white, non-Latinx (70%)
  - Mean age 49 years (range 22 – 86)
- With 3+ years data, we now are reaching sample sizes that allow some subgroup analysis:
  - 96 Latinx participants, 37 Black/African American
  - But only 7 transgender individuals

MEDICAL MONITORING PROJECT

# What Kind of Information Does MMP Collect?

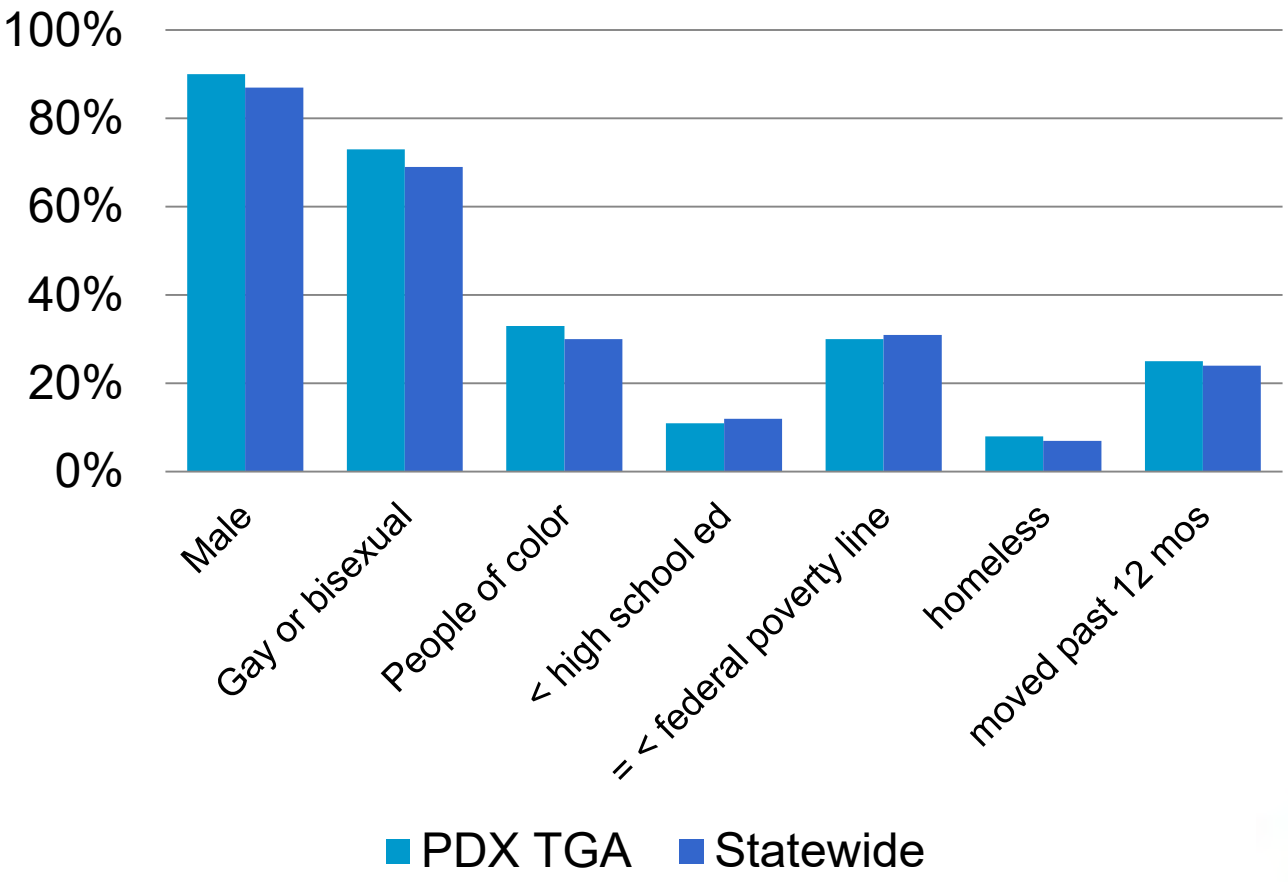
- Demographics & finances
- General medical care, health insurance, health literacy
- HIV care — testing, linkage, treatment & adherence
- Depression & anxiety
- Sexual behavior
- Substance use
- Intimate partner violence
- Met & unmet service needs
- Stigma & discrimination
- Local questions

MEDICAL MONITORING PROJECT

# Results: What Have We Found?

2015 - 2017

# Demographics of Portland TGA Participants (n= 414, 70% of Oregon MMP)

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# Medical Care Coverage & Access

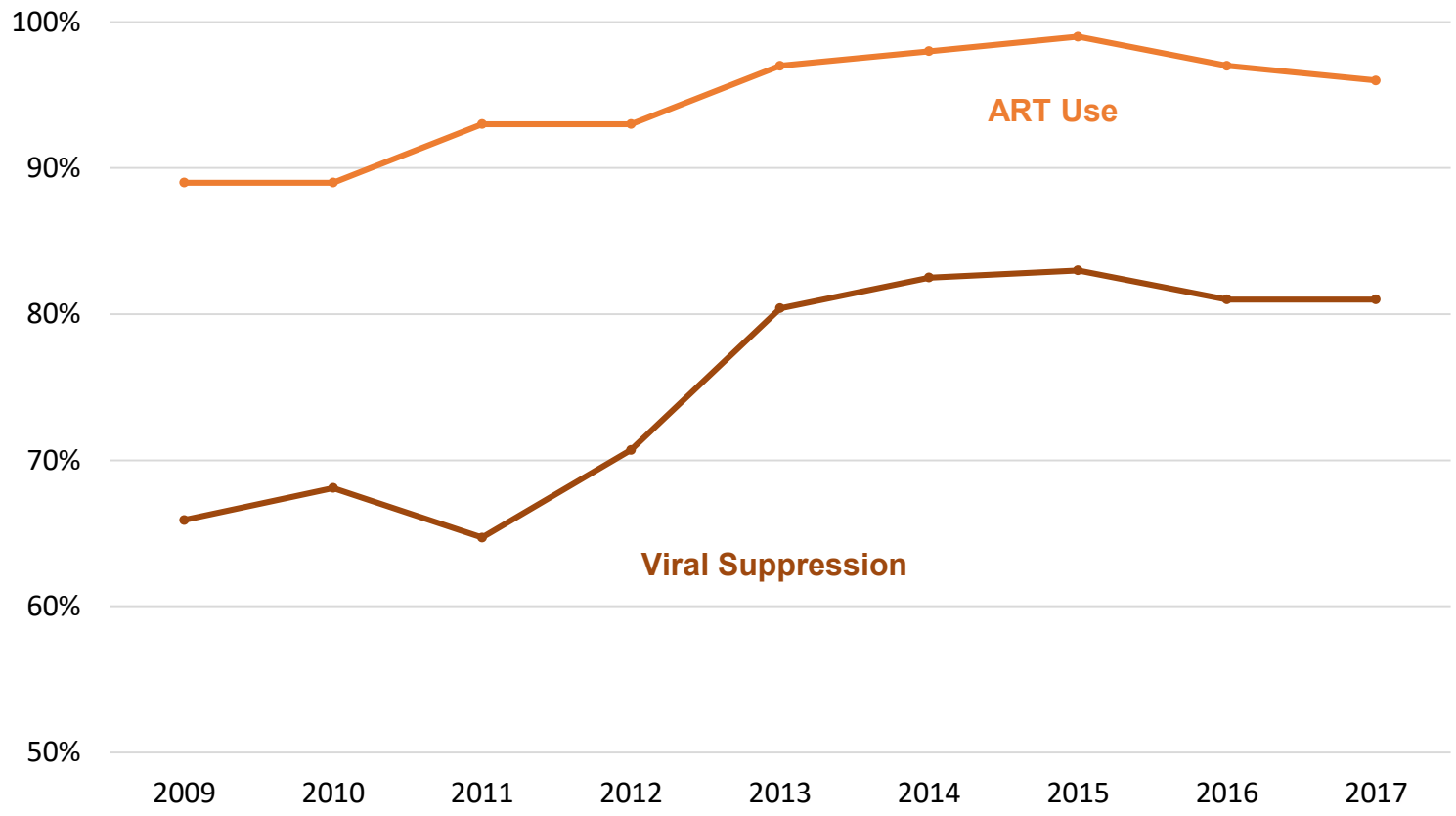
- Most MMP participants are insured, but 8% report a past-year insurance gap.
- 33% had an ER visit in past year
- 19% reporting difficulty completing medical forms

MEDICAL MONITORING PROJECT

# Sustained Viral Suppression, Current ART Use

## All VL readings within 12 months preceding participation undetectable or <200 copies/ml

## Portland TGA Participants

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# Depression, anxiety & substance use

- About 1 in 5 reported having mild to severe anxiety (21%) or depression (19%) in past 2 weeks.
- 37% received mental health services past 12 months; 10% needed, but did not receive the services.

- 7% (n= 30) used injection drugs past 12 months.
- 40% (n= 163) used non-injection drugs past 12 months.
- 73% (n= 300) used alcohol past 12 months; of those, about 1 in 5 reported binge drinking past 30 days (16%, n= 67)

MEDICAL MONITORING PROJECT

# Intimate partner violence

| Physical violence | n (%) |
|---|---|
| Physical violence, ever | 143 (35%) |
| Physical violence, past year | 10 (2%) |

| Sexual violence | n (%) |
|---|---|
| Sexual violence, ever | 95 (23%) |
| Sexual violence, past year | 5 (1%) |

MEDICAL MONITORING PROJECT

# Stigma

- CDC used 10 questions to measure 4 dimensions of HIV stigma:
  - personalized stigma
  - disclosure concerns
  - negative self-image
  - perceived public attitudes about people with HIV
- A stigma score is created based on the 10-item scale, ranging from 0 (no stigma) to 100 (high stigma).

MEDICAL MONITORING PROJECT

# Personalized Stigma & Disclosure

| Statement | Agree (%) |
|---|---|
| I have been hurt by how people reacted to my HIV status | 196 (48%) |
| I have stopped socializing with some people because of their reactions to my HIV status | 150 (37%) |
| I have lost friends by telling them I have HIV | 122 (30%) |

| Statement | Agree (%) |
|---|---|
| I am very careful who I tell I have HIV | 306 (75%) |
| I worry that people will tell others I have HIV | 193 (47%) |

MEDICAL MONITORING PROJECT

# Negative Self-Image & Public Attitudes

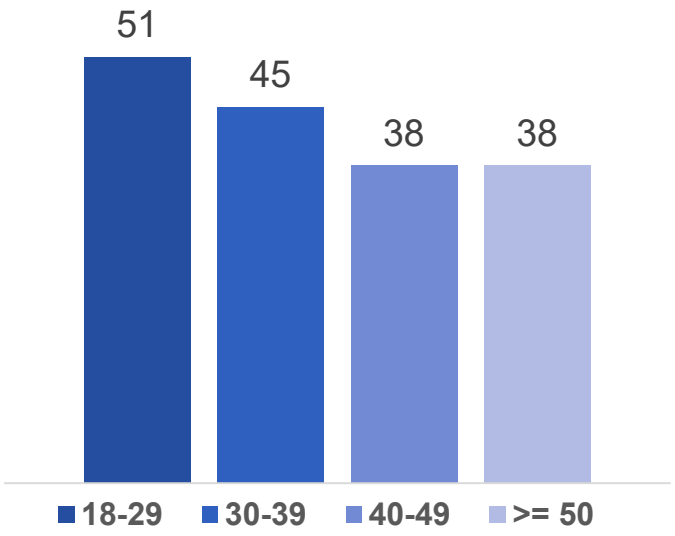
| Statement | Agree (%) |
|---|---|
| Having HIV makes me feel unclean | 85 (21%) |
| Having HIV makes me feel I am not as a good a person as others | 82 (20%) |
| Having HIV makes me feel that I am a bad person | 33 (8%) |

| Statement | Agree (%) |
|---|---|
| Most people think that a person with HIV is disgusting | 144 (35%) |
| Most people with HIV are rejected when others find out | 192 (47%) |

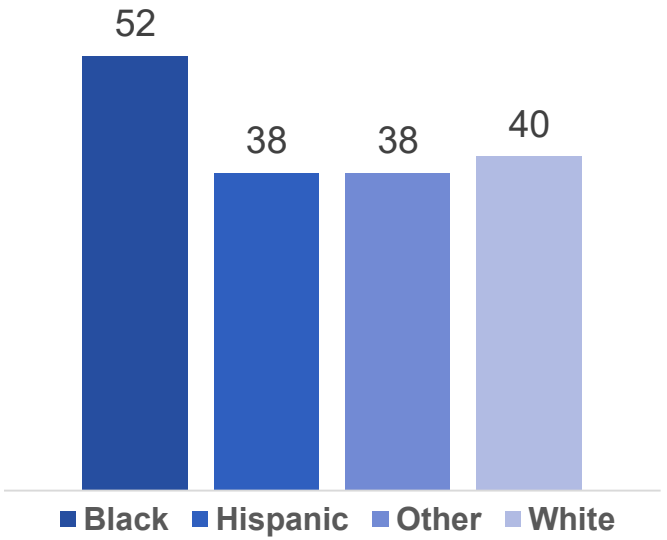
MEDICAL MONITORING PROJECT

# Which groups have higher stigma scores?

By Age



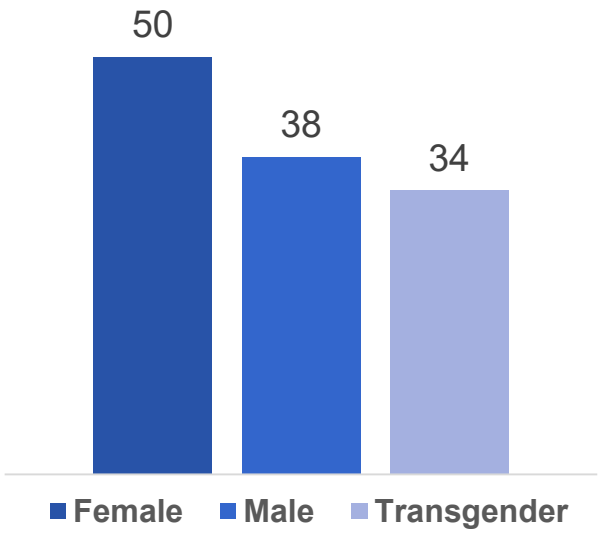

By Race/Ethnicity



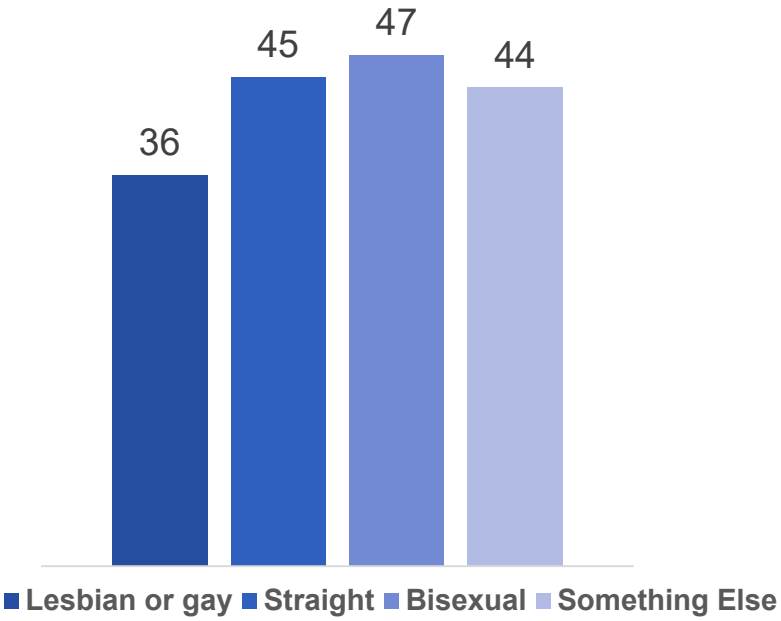

MEDICAL MONITORING PROJECT

# Which groups have higher stigma scores?

By Gender

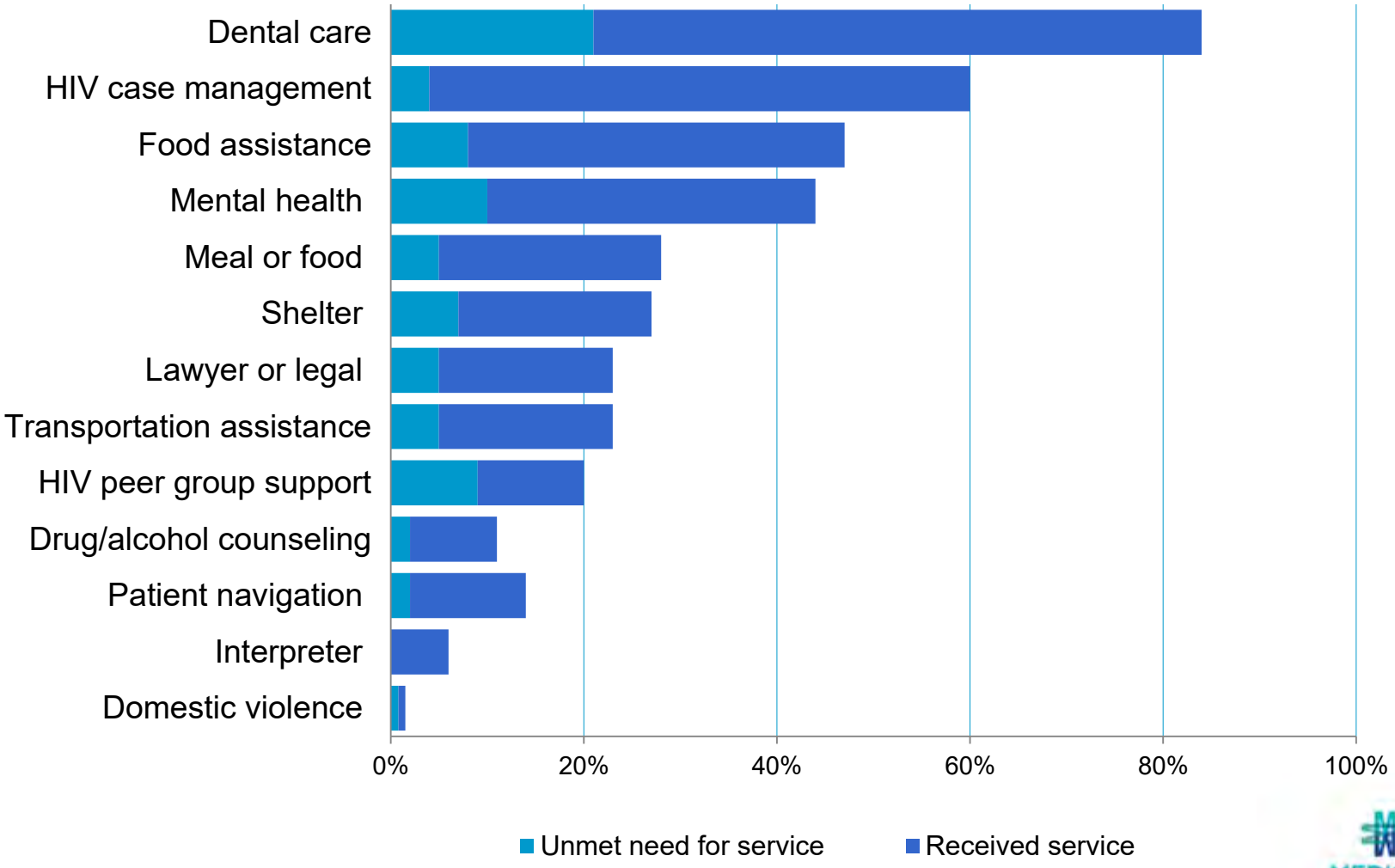



By Sexual Orientation




MEDICAL MONITORING PROJECT

# Met and Unmet Needs for Services




MEDICAL MONITORING PROJECT

# Barriers to receiving HIV care services

| Unmet Need | Lack of Money/ Insurance | Lack of info needed to receive service | Service not meet needs/not eligible for it | Personal reasons |
|---|---|---|---|---|
| Dental Care (n=88) | 19 (22%) | 13 (15%) | 6 (7%) | 57 (65%) |
| Mental Health Counseling (n=40) | 4 (10%) | 14 (35%) | 9 (23%) | 23 (58%) |
| Food Assistance (n=35) | - | 7 (20%) | 23 (68%) | 7 (20%) |
| Peer Group Support (n=29) | - | 9 (31%) | 5 (17%) | 16 (55%) |
| Shelter/Housing (n=27) | - | 6 (22%) | 18 (67%) | 5 (19%) |
| Transportation (n=23) | - | 13 (57%) | 6 (27%) | 4 (17%) |

MEDICAL MONITORING PROJECT

# Social determinants of health

The conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes (CDC)


Five Key Areas of SDOH (HP 2020)

MEDICAL MONITORING PROJECT

# Creating a Social Determinants of Health Index

- Education:
  - Education level – less than high school **(11%)**
  - Health literacy – self-ranking confidence in filling out medical forms **(19%)**
- Economic Stability:
  - Poverty – at or below the federal poverty level **(30%)**
  - Food security – past-year experience of being hungry, but didn't eat because there wasn't enough money for food **(17%)**
- Health & Health Care:
  - Gap in insurance – past-year gap in health insurance or coverage **(8%)**
  - ER visits – past-year visit to ER for own health reason **(33%)**

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# Creating a Social Determinants of Health index (cont'd)

- Neighborhood & Built Environment:
  - Unstable housing – past-year experience of homelessness &/or 2+ past-year moves **(12%)**
  - Transportation help – needed transportation services **(20%)**
- Social & Community Context:
  - Criminal justice involvement – ever experiencing jail, detention, or prison for longer than 24 hours **(28%)**
  - History of sexual/physical intimate partner violence – ever experiencing physical or sexual violence **(44%)**

MEDICAL MONITORING PROJECT

# How does SDOH predict viral suppression?

| | % durably virally suppressed | Adjusted PR | P-value |
|---|---|---|---|
| SDOH (3+ items vs. <3 items) | 44% | 0.70 | .003 |
| Gender (male vs. all other) | 64% | 1.06 | .629 |
| Sexual orientation (gay vs. all other) | 66% | 1.08 | .321 |
| Portland metro resident (vs. outside of metro) | 65% | 1.19 | .042 |

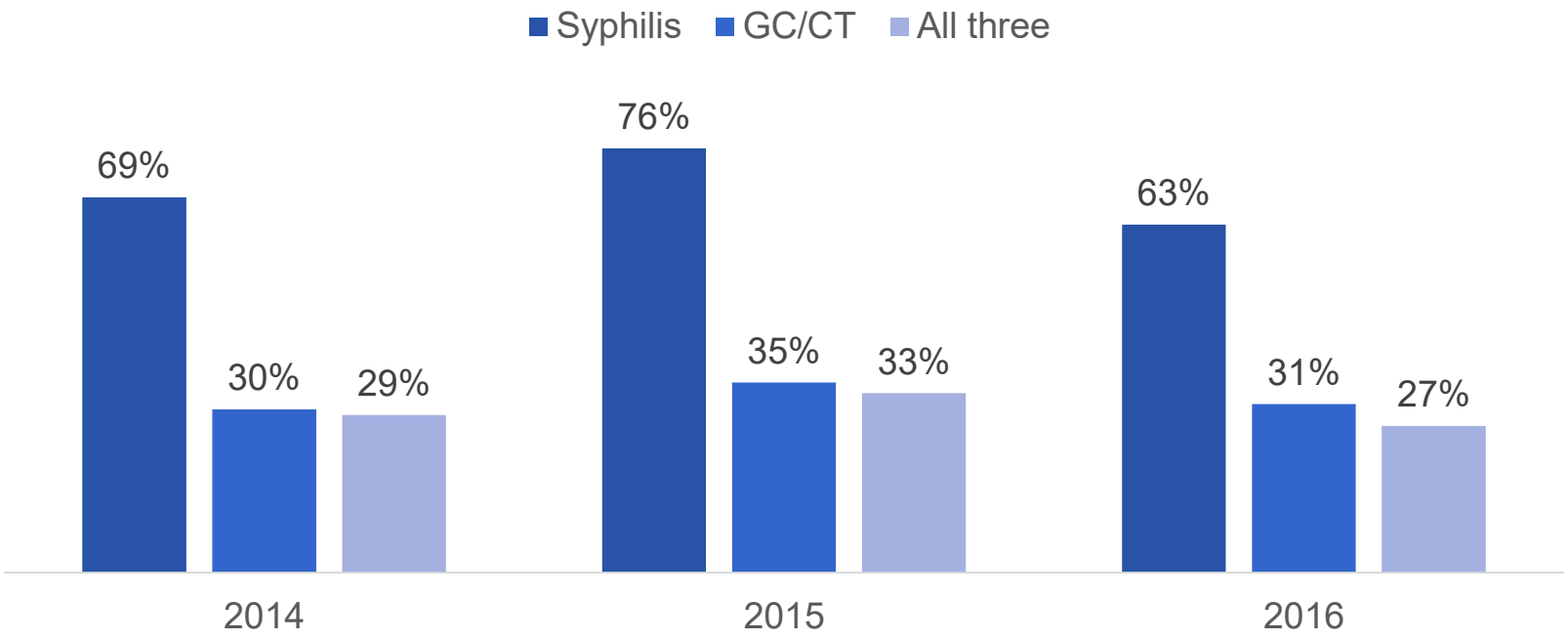
PR, prevalence ratio; CI, confidence interval

MEDICAL MONITORING PROJECT

# Sexual Behavior & Syphilis Screening

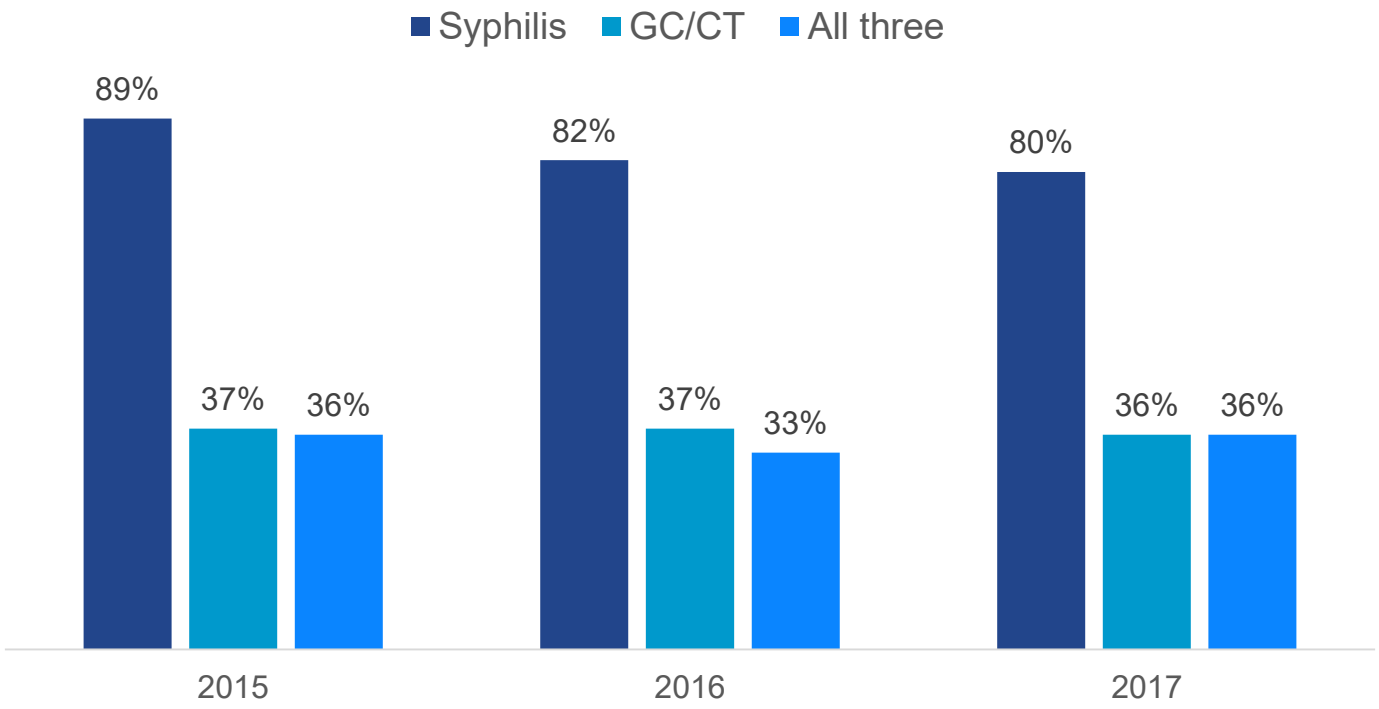
2015 - 2016

# Screening for STI among is low (and declining)




MEDICAL MONITORING PROJECT

# Screening for STI among Part A is low (and declining)




MEDICAL MONITORING PROJECT

# Syphilis Screening
## (2015-2016 weighted data, statewide)

- 59% of participants reported past-year sexual activity:
  - about half (48%) of sexually active patients reported only one past-year partner
- Among participants with >1 past-year partner:
  - the median number of partners was four (IQR: 2.5-12 partners)
  - 78% reported a new partner
  - 57% reported condomless serodiscordant sex
  - 100% met past-year partners online or at public sex venues

MEDICAL MONITORING PROJECT

# Syphilis Screening

- 69% received past-year syphilis testing (95% CI: 64, 74)
- About 1 in 6 tests were positive for syphilis (15%)
- Syphilis testing rates significantly declined over the two-year period (from 76% in 2015 to 63% in 2016, p<.01)

MEDICAL MONITORING PROJECT

# Facility & Provider Information

- Supplemental interviews with providers from 25 of the 28 identified facilities (99% of 2015-2016 MMP participants):
  - 72% reported systematically screening for syphilis
  - 88% self-reported taking sexual histories with all their patients
  - But only 12% reported working in a facility with a written policy for systematic STI screening
  - 32% reported written policies for when and how to take a sexual history

MEDICAL MONITORING PROJECT

# Written screening policies increase syphilis screening

| Facility-level characteristic | % screened for syphilis | Adjusted PR | 95%CI |
|---|---|---|---|
| Written STI screening policy | | | |
| Yes | 94% | 2.04 | 1.57, 2.66 |
| No | 43% | REF | |
| Written sexual history policy | | | |
| Yes | 86% | 1.50 | 0.97, 2.33 |
| No | 53% | REF | |
| Barriers to screening | | | |
| None | 87% | 1.75 | 1.19, 2.57 |
| One or more | 49% | REF | |
| Location | | | |
| Tri-county area | 80% | 1.81 | 1.09, 3.01 |
| Outside tri-county area | 38% | REF | |

MEDICAL MONITORING PROJECT

# What influences screening the most?

- Patients receiving care from facilities with written STI screening policies were far more likely to be screened for syphilis in the past year than those who received care from facilities without written policies (94% vs. 43%, $p<.001$).

MEDICAL MONITORING PROJECT

# Final note:  It's not all about risk

- MMP Core questionnaire lacks strength-based items.
- Oregon added items to local Q in 2018 & 2019:

- Social support
- Resilience
- Loneliness/social connectivity
- Civic engagement

Stay tuned!

MEDICAL MONITORING PROJECT

# Questions?

**For more information…**

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FY18-19 Expenditures

Ryan White Council-May 14, 2019 Meeting

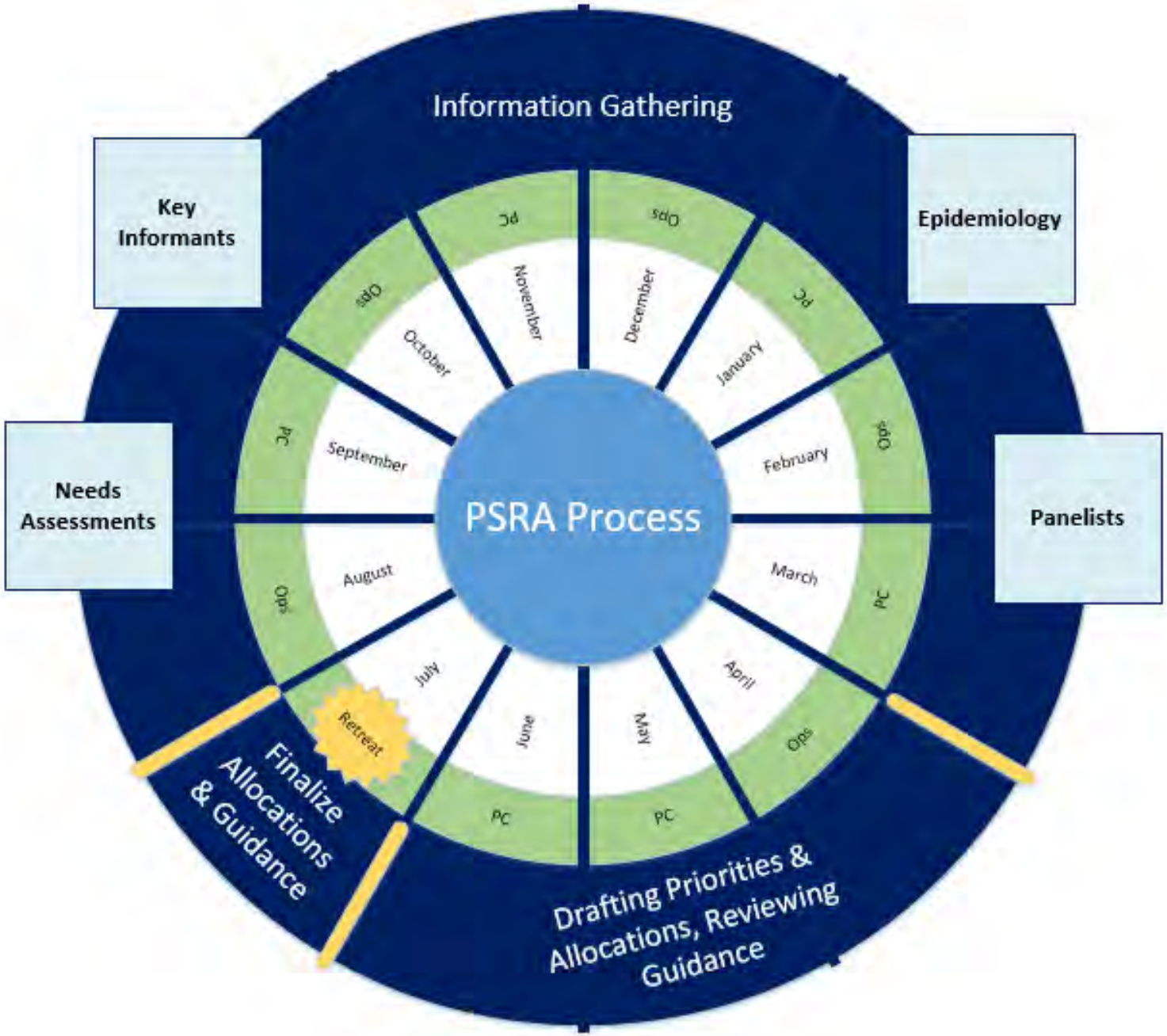
DRAFT Expenditures

| Priority | Service Category | FY18-19 Final Allocation (includes Carryover) | FY18-19 Expenditure | Unspent Funds | % Expended of Award |
|---|---|---|---|---|---|
| 1 | Medical/Ambulatory Care | $ 911,247 | $ 911,247 | $ - | 100.0% |
| 2 | Health Insurance | $ 35,216 | $ 31,319 | $ 3,897 | 88.9% |
| 3 | Mental Health | $ 276,449 | $ 269,124 | $ 7,325 | 97.4% |
| 4 | Dental Care | $ 18,227 | $ 17,440 | $ 787 | 95.7% |
| 5 | Medical Case Management | $ 1,322,224 | $ 1,313,637 | $ 8,587 | 99.4% |
| 6 | Early Intervention Services | $ 158,584 | $ 157,889 | $ 695 | 99.6% |
| 7 | Substance Abuse Treatment | $ 156,900 | $ 156,431 | $ 469 | 99.7% |
| 8 | Housing | $ 86,345 | $ 82,647 | $ 3,698 | 95.7% |
| 9 | Psychosocial | $ 394,558 | $ 375,187 | $ 19,371 | 95.1% |
| 10 | Food | $ 75,714 | $ 74,698 | $ 1,016 | 98.7% |
| 11 | Non-Medical Case Management | $ 144,394 | $ 144,394 | $ - | 100.0% |
| 12 | Residential Sub. Abuse Treatment | $ - | $ - | $ - | #DIV/0! |
| | **SERVICES TOTAL** | **$ 3,579,858** | **$ 3,534,013** | **$ 45,845** | 98.7% |

| | | |
|---|---|---|
| Unspent Services Funds | $ | 45,845 |
| Unspent Admin/QM Funds | $ | 8,070 |
| **TOTAL CARRYOVER REQUEST** | **$** | **53,915** |

# FY19-20 Reallocations

| FY 19-20 | Allocation with Final NoA | Proposed Re-allocation #1 - New Priorities | | | | Proposed Re-allocation #2 - COLA & Contingency Priorities | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Service Categories** | **Allocation (Part A)** | **Allocation Reduction** | **Proposed Reallocations** | **Total Allocation** | **Justification** | **Allocation Reduction** | **Proposed Reallocations 1.82% COLA** | **Total Allocation** | **Justification** |
| Medical Care | $ 720,538 | | $ 20,000 | $ 740,538 | significant cuts to Medical Care at Part C clinic | | $ 13,113.79 | $ 733,652 | COLA |
| Health Insurance | $ 32,725 | | | $ 32,725 | #1 - Already applied the increase with original NoA. | | | $ 32,725 | #1 - Already applied the increase with original NoA. |
| Mental Health | $ 273,531 | | | $ 273,531 | #3 - No programs applied for ACT services. HCS is working with Part B to identify additional MH needs and resources. | | $ 4,978.26 | $ 278,509 | #3 - COLA - No programs applied for ACT services. HCS is working with Part B to identify additional MH needs and resources. |
| Oral Health | $ 32,416 | | | $ 32,416 | | | $ 589.97 | $ 33,006 | COLA |
| Medical Case Management/MAI | $ 1,303,658 | | $ 60,000 | $ 1,363,658 | #5 - to increase funding for priority populations | | $ 61,298.58 | $ 1,364,957 | # 5 - COLA +$37,572 |
| Early Intervention Services | $ 163,541 | | | $ 163,541 | | | $ 2,976.45 | $ 166,517 | COLA |
| Substance Use Disorder Treatment (Outpatient) | $ 155,673 | | | $ 155,673 | | | $ 2,833.25 | $ 158,506 | COLA |
| Housing | $ 80,694 | | | $ 80,694 | | | $ 1,468.63 | $ 82,163 | COLA |
| Psychosocial | $ 390,746 | | $ 7,977 | $ 398,723 | #4 - increased programming planned for FY19-20 | | $ 17,111.58 | $ 407,858 | #4 - COLA + $10,000 |
| Food | $ 67,621 | | | $ 67,621 | | | $ 1,230.70 | $ 68,852 | COLA |
| Non-Medical Case Management | $ 130,564 | | $ 20,000 | $ 150,564 | LGBTQ+ trainings provided for residential treatment centers; adequate staff support | | $ 2,376.26 | $ 132,940 | COLA |
| Substance Use Disorder Treatment (Residential) | $ 107,977 | ($107,977) | | $ - | | ($107,977) | $ - | $ - | |
| Total | $ 3,459,684 | $ (107,977) | $ 107,977 | $ 3,459,684 | | $ (107,977) | $ 107,977 | $ 3,459,684 | |
| | | | | | #2 - 0.43% COLA was already applied with original NoA | | | | #2 - 0.43% COLA was already applied with original NoA<br>Total COLA would be 2.25%. |


Information Gathering
Key Informants
Epidemiology
Needs Assessments
Panelists
PSRA Process
Finalize Allocations & Guidance
Drafting Priorities & Allocations, Reviewing Guidance
Retreat
Ops
PC
January
February
March
April
May
June
July
August
September
October
November
December

# PLANNING COUNCIL TRIVIA NIGHT

5/7/19

1. In what month do we meet to approve the final grant allocation and guidance?

2. Is **HOUSING** a *core* or *support* service?

# 3. WHICH OF THE FOLLOWING SERVICE CATEGORIES DO WE NOT FUND?

A. EARLY INTERVENTION SERVICES
B. EMERGENCY FINANCIAL ASSISTANCE
C. NON-MEDICAL CASE MANAGEMENT
D. SUBSTANCE ABUSE OUTPATIENT CARE

# 4. What percentage of planning council members must be consumers?

5. WHICH OF THE FOLLOWING ACTIVITIES IS THE PLANNING COUNCIL NOT RESPONSIBLE FOR?

A. INTEGRATED COMPREHENSIVE PLAN
B. PRIORITY SETTING
C. ASSESSMENT OF THE ADMINISTRATIVE MECHANISM
D. CONTRACT MONITORING

# 6. What is the last stage of the HIV Care Continuum?

It is also the overall health outcome RW programs strive to achieve.

7. What county within the Portland grant area does Part A pay for health insurance assistance?

8. Which service category pays for congregate meals, support groups, and workshops for long term survivors?

# 9. Core services funding must make up what percentage of the total services funded?

10. During each meeting to ensure decisions are made based on community needs, PC members disclose any personal or professional interests. This is also called what?

# 11. WHAT IS THE NAME OF THE HIV CAMPAIGN IN OREGON?

*BONUS QUESTION*

WHAT ARE THE 3 STRATEGIES?

12. What is the process we go through every year to decide which services will be funded and the amount of funding for the following grant year?

*BONUS Point* for spelling it out.

Planning Council Trivia

Questions & Answers

1. In what month do we meet to approve the final grant allocation and guidance? July
2. Is **HOUSING** a *core* or *support* service? Support
3. Which of the following service categories do we NOT fund?
    a. Early Intervention Services
    b. Emergency Financial Assistance
    c. Non-Medical Case Management
    d. Substance Abuse Outpatient Care
4. What percentage of planning council members must be consumers? 33%
5. Which of the following activities is the Planning Council NOT responsible for?
    a. Integrated Comprehensive Plan
    b. Priority Setting
    c. Assessment of the Administrative Mechanism
    d. Contract Monitoring
6. What is the last stage of the HIV Care Continuum? It is also the overall health outcome Ryan White programs strive to achieve. Viral suppression
7. What county within the Portland grant area does Part A pay for health insurance assistance? Clark Co., WA
8. Which service category pays for congregate meals, support groups, and workshops for long term survivors? Psychosocial
9. Core services funding must make up what percentage of the total services funded? 75%
10. During each meeting to ensure decisions are made based on community needs, PC members disclose any personal or professional interests. This is also called what? Conflict of Interests
11. What is the name of the HIV campaign in Oregon? End HIV Oregon
    a. Bonus: What are the 3 strategies? Testing is Easy; Prevention Works; Treatment Saves Lives
12. What is the process we go through every year to decide which services will be funded and the amount of funding for the following grant year? (Bonus for spelling it out) Priority Setting & Resource Allocation

# Portland TGA Program Guidance FY 19-20

The following document outlines the current HRSA Ryan White (RW) Part A program service definitions for all HRSA RW Part A service categories and the Portland TGA Planning Council guidance for the services funded within the Portland TGA in FY 19-20.

FY 19-20 General Planning Council guidance includes:

1. Services must be provided to historically underserved populations, including but not limited to women, children, youth and people of color, at least in proportion to their representation in the TGA's estimated HIV prevalence demographics.
2. Services must be provided to clients in all counties in proportion to their representation in the TGA's estimated prevalence demographics, except where stated in specific service category guidance.
3. Preference in service delivery will be given to providers that demonstrate the ability to leverage other sources to enhance funded services, and develop working relationships with non-Ryan White funded providers.
4. Providers will coordinate services and refer to other Ryan White service providers, whenever appropriate.
5. Providers will utilize client self-management to better support client access to necessary services and improve health outcomes, as appropriate.
6. Service delivery will use harm reduction principles, whenever possible.
7. Service providers will prioritize interventions that improve their ability to increase client retention at all stages of engagement in the HIV Cascade.
8. Ryan White services will be effective, linguistically appropriate, fully understandable by the client, trauma informed, and respectful of the client's beliefs. Providers will provide culturally proficient services to clients of all socio economic backgrounds, all races and ethnicities, all educational levels, all sexual orientations, all ages and all genders – including transgender or gender non-conforming individuals.
9. Attempt to increase availability of RW services during evenings and weekends or justify why not possible.
10. Clients will not be asked about immigration status as part of Ryan White eligibility determination.
11. Ryan White providers will seek client input when making policy decisions.

This guidance is applicable to all funded service categories, except where indicated.

# Core Services

## Outpatient/Ambulatory Medical Care

All general guidance. Medical care providers must provide coordinated care and implement and monitor strategies to support patient centered medical homes.

## Oral Health Care/Dental Care

All general guidance. Grantee will work to ensure equity of access to dental care for residents of all counties of the TGA.

## Early Intervention Services

All general guidance. Services for newly diagnosed will be tailored to address needs found in current HIV incidence data.

## Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

All general guidance, except #1 and #2. Health insurance assistance is based on local needs where other resources are not available. For example, the Portland TGA allocates funds to Clark Co., WA specifically because Oregon's ADAP program (CAREAssist) provides some services not currently provided by Washington's ADAP (Early Intervention Program EIP). Assistance is provided to any Clark Co., WA resident that needs additional health insurance payment assistance, meets eligibility, and pending funds are still available.

## Mental Health Services (includes peer programs)

All general guidance. Services must address dually diagnosed clients (mental illness and substance abuse) in their service delivery model. The grantee will work with providers to develop strategies to support people with HIV who are aging and/or are long-term survivors.

## Medical Case Management (MCM), including Treatment Adherence Services

All general guidance. Coordinate client linkage to transportation services. Service will develop and utilize client self-management models to better support client access to necessary services and improve health outcomes. Medical case management services must coordinate and engage clients in support programs, including housing, to improve health outcomes of those with multiple diagnoses. Grantee will work to provide support for integration of case management programs into medical care (support medical home model). Clients must have access to comparable case management service regardless of where they receive medical care.

### Substance Abuse Treatment – Outpatient (includes peer programs)

All general guidance. Services will be provided to clients who are uninsured, underinsured, or are insured but cannot access treatment within a reasonable amount of time and distance. If clients are also in alcohol and drug free housing, Substance Abuse treatment should coordinate with those services.

## Support Services

### Non-Medical Case Management

All general guidance. Services will include addictions benefits coordination services. Services must be coordinated with medical case management.

### Food Bank/Home Delivered Meals

All general guidance.

### Housing Services

All general guidance. Coordinate between HOPWA and Part A programs. Prioritize services that assist clients to access and preserve permanent housing. Services to clients living outside of Multnomah County must constitute a minimum of 20%. Service delivery model will support BOTH leveraged housing units and direct housing assistance to engage the highest possible number of clients in stable housing. Housing options must include access to alcohol and drug free housing. Housing services must be coordinated with core services (specifically early intervention services, mental health care, substance abuse treatment and medical care) whenever possible. Housing case management services may include services to develop housing readiness.

### Psychosocial Support Services

All general guidance, except #2. Efforts should be made to improve access to services for people in outlying areas. Services must be coordinated with medical case management. The grantee will work with providers to develop strategies to support people with HIV who are aging and/or are long-term survivors. As part of psychosocial support services, services must be offered to support clients who have multiple diagnoses.

### Substance Abuse Treatment – Residential

All general guidance. Services will be provided to clients who are uninsured, underinsured, or are insured but cannot access treatment within a reasonable amount of time and distance. Services must be coordinated with outpatient treatment (including peer support) and housing to support healthy transition back to the community after residential treatment. Efforts should

be made to contract or work with culturally appropriate treatment facilities, especially those who support gender inclusiveness.

# Quick Reference Handout 5.1: Quick Guide to RWHAP Part A-Fundable Service Categories

## Introduction

The chart below provides brief summary explanations of the 28 service categories that can be funded through Part A of the Ryan White HIV/AIDS Program (RWHAP). They are designed to provide an understanding of the kinds of services supported through RWHAP Part A, but are not intended to provide formal definitions.

The service categories are arranged into two groups, RWHAP Core Medical Services and RWHAP Support Services, and are listed alphabetically within those groups:

- The 13 RWHAP Core Medical Services are specified in the legislation [§2604(c)(3)(A-M)].
- The 15 Support Services were approved by the Secretary of Health and Human Services, and are defined as "needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care for persons caring for individuals with HIV/AIDS, outreach services, medical transportation, linguistic services, and referrals for health care and support services)." "Medical outcomes" are "those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS" [§2604(d)(1-2)].

The brief descriptions below are based on HRSA/HAB Policy Clarification Notice (PCN) 16-02 (Revised 10/22/18),[1] supplemented by clarifications in the related Frequently Asked Questions (FAQs) document.[2]

## RWHAP Core Medical Services (13)

| SERVICE CATEGORY | EXPLANATION |
|---|---|
| 1. **AIDS Drug Assistance Program (ADAP) Treatments** | Provides HIV-related medications to low-income clients living with HIV; can also provide access to medications by using program funds to purchase health insurance coverage and through medication cost sharing; administered by the state through RWHAP Part B, but Part A program can contribute funds |
| 2. **AIDS Pharmaceutical Assistance [Local Pharmaceutical Assistance Program] (LPAP)** | Serves as supplemental local source of medication assistance that can be used when ADAP has a restricted formulary, a waiting list, or restricted financial eligibility criteria |

| SERVICE CATEGORY | EXPLANATION |
|---|---|
| **3. Early Intervention Services** | • Includes a combination of services designed to identify individuals with HIV and help them access services<br>• Can serve newly diagnosed as well as PLWH who know their status but are not in care<br>• Is the only RWHAP service category that can pay for HIV testing |
| **4. Health Insurance Premium & Cost Sharing Assistance for Low-Income Individuals** | Provides financial assistance to enable PLWH to maintain health insurance or standalone dental insurance by paying their premiums or other cost-sharing expenses, including co-pays, deductibles, and funds to contribute to a client's Medicare Part D true out-of-pocket costs (TrOOP) |
| **5. Home & Community-Based Health Services** | Provides services in the home or in community settings based on a medical care team's written plan of care; services may include mental health, developmental, and rehabilitation services; day treatment or partial hospitalization; durable medical equipment; and/or home health aide and personal care services in the home |
| **6. Home Health Care** | Supports medical-related services provided in the home by licensed medical professionals, such as administration of prescribed treatments, preventive and specialty care, and routine diagnostic testing |
| **7. Hospice Services** | Provides end-of-life services to clients in the terminal stage of HIV-related illness, at home or in a residential facility |
| **8. Medical Case Management, including Treatment Adherence Services** | Provides client-centered activities designed to improve health outcomes, such as assessment of service needs, development and updating of an individualized care plan, coordinated access to medical care and support services, continuous client monitoring, treatment adherence counseling, and sometimes assistance in accessing public and private benefits for which the client may be eligible |
| **9. Medical Nutrition Therapy** | Provides nutritional assessment and screening, evaluation, education and/or counseling, and food and/or nutritional supplements, all based on a medical provider's referral and on a nutritional plan developed by a registered dietitian or other licensed nutrition professional |
| **10. Mental Health Services** | Provides psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling in an individual or group setting by a licensed mental health professional (usually a psychiatrist, psychologist, or licensed clinical social worker) |

| SERVICE CATEGORY | EXPLANATION |
|---|---|
| **11. Oral Health Care** | Supports outpatient diagnostic, preventive, and therapeutic oral health services by dental health care professionals based on an oral health treatment plan |
| **12. Outpatient/ Ambulatory Health Services (OAHS)** | Supports diagnostic and therapeutic services, such as primary care, diagnostic testing including laboratory testing, treatment adherence, and specialty services provided directly to a client by a licensed healthcare provider in an outpatient medical setting |
| **13. Substance Abuse Outpatient Care** | • Provides outpatient services for the treatment of drug or alcohol use disorders, including both drug-free treatment and counseling and medication-assisted therapy<br>• Includes harm reduction; can include syringe access services that meet current appropriations law and applicable HHS-, HRSA-, and HAB-specific guidance; does not include purchase of syringes |

## RWHAP Support Services (15)

| SERVICE CATEGORY | EXPLANATION |
|---|---|
| **1. Child Care Services** | • Pays for intermittent services for children living in the household of clients with HIV so they can attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions<br>• Can be provided by a licensed or registered child care provider or informal child care provided by a neighbor, family member, or other person |
| **2. Emergency Financial Assistance (EFA)** | Provides limited one-time or short-term payments to assist RWHAP clients with an urgent need for essential items or services necessary to improve health outcomes, including utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an ADAP or LPAP, or another RWHAP-allowable cost |
| **3. Food Bank/ Home-Delivered Meals** | • Provides food items, hot meals, or a voucher program to purchase food<br>• Can be used for essential non-food items limited to personal hygiene products and household cleaning supplies, plus water filtration/purification systems in communities with water safety issues |
| **4. Health Education & Risk Reduction (HERR)** | • Provides education to PLWH about HIV transmission and how to reduce risk, and information about services to improve their health status<br>• Includes treatment adherence services provided as a stand-alone activity |
| **5. Housing Services** | • Provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care<br>• May include core medical or support services<br>• Also includes housing referral services, including assessment, search, placement, and housing advocacy services, and related fees |
| **6. Linguistic Services** | Provides oral interpretation and written translation services by qualified providers when necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services |

| SERVICE CATEGORY | EXPLANATION |
|---|---|
| **7. Medical Transportation** | Provides nonemergency transportation services so clients can access or be retained in core medical and support services; can use various methods, including contracts with transportation providers, non-cash mileage reimbursement, purchase or lease of organizational vehicles for client transportation, voucher or token systems, and organization and use of volunteer drivers |
| **8. Non-Medical Case Management Services** | • Supports client-centered activities focused on improving access to and retention in needed core medical and support services<br>• Provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and other needed services, and sometimes help in accessing public and private programs for which clients may be eligible, based on activities such as an initial assessment of service needs, development and regular re-evaluation of an individualized care plan, client monitoring, and timely and coordinated access to medically appropriate levels of health and support services and continuity of care |
| **9. Other Professional Services [Includes Legal Services and Permanency Planning]** | Supports professional and consultant services, including legal services, permanency planning, and income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits |
| **10. Outreach Services** | Identifies PLWH who either do not know their HIV status or know their status but are not currently in care, and carries out activities to link or re-engage PLWH who know their status into RWHAP services, including provision of information about health care coverage options |
| **11. Psychosocial Support Services** | • Provides group or individual support and counseling services to assist clients to address behavioral and physical health concerns, including support groups, nutrition counseling provided by a non-registered dietitian, and other types of counseling<br>• Does not require that services be provided by a licensed mental health professional |

| SERVICE CATEGORY | EXPLANATION |
|---|---|
| **12. Referral for Healthcare and Supportive Services** | Supports referral of clients to needed core medical or support services in person or through telephone, written, or other types of communication; may also include referrals to assist clients in obtaining access to public or private benefit programs for which they may be eligible |
| **13. Rehabilitation Services** | Provides HIV-related therapies, including physical, occupational, speech, and vocational therapy, intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis |
| **14. Respite Care** | Provides periodic non-medical care for clients in community or home-based settings, designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV |
| **15. Substance Abuse Services (Residential)** | • Provides services for the treatment of drug or alcohol use disorders in a residential setting, including screening, assessment, diagnosis, and treatment, based on a written referral from the clinical provider as part of a RWHAP-funded substance abuse disorder treatment program<br>• Includes detoxification if offered in a separate licensed residential setting |

*Note: Direct cash payments to clients or primary caregivers are not permitted under any RWHAP Part A service category.*

## References

1 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf.

2 Frequently Asked Questions for Policy Clarification Notice 16-02. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/faq_service_definitions_pcn_final.pdf