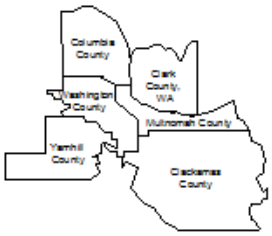
**Portland Area HIV Services Planning Council**

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

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




# Meeting Minutes

## Meeting Date: November 5, 2019

Approved by Planning Council: TBD

Grantee: Multnomah County Health Department

Multnomah County

**Portland Area HIV Services Planning Council**
**MEETING MINUTES**

Tuesday, November 5, 2019, 4:00 – 7:30 pm
Gladys McCoy Building, 619 NW 6th Ave., Portland, OR 97209
Room 850

## AGENDA

| Item** | Discussion, Motions, and Actions |
|---|---|
| Call to Order | Lorne James called the meeting to order at 4:00 PM. |
| Candle Lighting Ceremony | Michael Stewart led the lighting of the ceremonial candle in remembrance of Larry Reilly, a mentor and friend who died in 2003. |
| Welcome & Introductions | Lorne James welcomed everyone to the meeting and introductions were made, with Council members declaring any conflicts of interest. |
| Announcements | Announcements:<br>• November is Indigenous People's Month, many events going on, including a presentation on Two Spirit Health Care (LORNE)<br>• Spirit of Giving Conference, next Wed – Fri, hosted by NARA, all about recovery from an indigenous lens.<br>• Assn of AIDS Nurses having their conference here in Portland, Thurs-Sat, including showing of movie "5B" (Toni)<br>• HRSA site visit scheduled for June 10-12, 2020 – more details to come<br>• Ryan White Conference will be August 11-13, 2020 – more details to come |
| Review and Approval of Agenda | The agenda was accepted by unanimous consent. |
| Review and Approval of Minutes from Prior Meeting | The meeting minutes from the September 2019 meeting were approved, with amendment below, by unanimous consent.<br><br>Page 4, New Contract / Program Updates, 5th bullet: change to "Continuing to do Rapid Start appointments at the clinic" |
| Welcome Chair Kafoury | Emily introduced a special guest from the Multnomah County Board of Commissioners: Chair Deborah Kafoury. Chair Kafoury sits on the Board of Health, which governs the Local Public Health Administrator and the County's public health activities. She also acts as our CEO (Chief Elected Official) who officially receives and oversees the Part A funds for our TGA as well as appoints members to the Planning Council. Chair Kafoury has supported our work for years.<br><br>Chair Kafoury briefly thanked the group for their important work, and answered questions on a variety of topics. |
| Public Testimony | Robert Kenneth read his written public testimony statement: |

| Item** | Discussion, Motions, and Actions |
| --- | --- |
| | My name is Robert Kenneth, and I am an HIV-positive man who was incarcerated between 2011 and February of this year. I offer today my perspective on HIV care in Oregon state prisons.<br><br>First of all, primary care of all HIV-positive inmates throughout Oregon was the responsibility of one specialist, based in Salem. For inmates like me who were incarcerated far from Salem, this meant little one-on-one time with the HIV provider and frequent delays in routine labs, med changes, and treatment of HIV-related conditions.<br><br>Second, med refills were processed in locations far away from the prisons where I was held. It wasn't standard practice at these prisons to keep a supply of HIV meds on hand, so refill delays were common. For example, when I was moved from the Pendleton prison to Madras, my mental health and HIV meds were held up for a week.<br><br>Third, blood draws for labs were often badly mismanaged. Due to poor training of prison health services staff, blood draws often had to be repeated, and I personally had blood samples that were drawn and processed incorrectly, and even lost entirely.<br><br>Fourth, I and other HIV-positive inmates were subject to violations of state and federal medical privacy protections each time we were asked to verbally disclose our HIV status in front of guards and other inmates. This occurred regularly during blood draws, flu shots, and tuberculosis testing.<br><br>Fifth, out of ignorance, fear, or bigotry, prison guards and health services staff routinely disclosed my and others' HIV status to other guards and inmates. Due to these illegal disclosures, many of us were subject to extortion, abuse, assault, housing discrimination, and isolation.<br><br>Sixth, lack of oversight and the threat of retribution rendered DOC's internal grievance process moot or even dangerous. Several staff ridiculed inmates with special medical needs as entitled nuisances, and inmates who wrote to the Inspector General's office to complain of poor healthcare were often simply moved to other prisons.<br><br>Because of this climate of indifference and abuse within DOC -- as well as minimal public concern -- effective education, |

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| | prevention, and compassionate HIV treatment in Oregon's prisons are essentially non-existent.<br><br>In a word, this is one of DOC's best-kept secrets, despite the much-touted Oregon Accountability Model.<br><br>Finally, I want to address the lack of programming available for the virtually invisible HIV-positive persons just getting out of prison. Perennial budget cuts and organizational "re-focusing" have left many HIV-positive former inmates disempowered and struggling alone against isolation, mental illness, institutionalized thinking, and relapse into harmful sex practices and addiction.<br><br>While I don't speak for other current or former inmates, I do believe my experiences reflect a pattern of indifference and abuse that warrants scrutiny and correction.<br><br>Thank you for your time.<br><br>The Co-Chairs thanked Mr. Kenneth for his testimony. |
| New HIV Cases & Community Response | *Panel: Kim Toevs (Multnomah County), Jaxon Mitchell (Multnomah County), Chris Hamel (Multnomah County), Chris Keating (Washington County, & Jonathan Livingston (Oregon Health Authority)*<br>*Purpose of Presentation:*<br>*Summary of Discussion:*<br><br>Overview of services<br>Multnomah County<br>• Significant concern about new HIV cases among people who inject drugs<br>  ○ This has happened in other urban and rural areas nationally, so not unique, but of great concern<br>• Being unhoused and struggling with addictions can make it hard to stay in care, harder to be virally suppressed<br>• Sharing needles is the most effective way to spread HIV, more dangerous than sexual activity<br>• Q: what are the things that have changed recently that have caused this to happen?<br>  ○ A: Coming at a time when we are looking at a set of diseases with overlapping risk factors, including Syphilis, Hepatitis C, Hepatitis A, Shigella<br>  ○ A: Housing status has been a significant driver<br>  ○ A: Increase in use of meth by people who had previously used heroin<br>  ○ Increase in injection by people who had previously smoked or snorted<br>  ○ A: Still figuring out all the different dynamics |

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| | • Syndemic announced via Clinician alert that went out on June 20th<br>• Kickstarted various activities<br>• Basic call: increase testing<br>  ○ Make sure people who report using meth, injecting drugs, or both have access to HIV testing, Hepatitis A vaccination, Syphilis testing, and that Shigella also on their mind<br>  ○ Worked with community partners – specific outreach to over 40 partners, from Corrections Health, Parole and Probation, Addictions Health, Housing, and other organizations that may not be as familiar engaging their clients surrounding HIV work and testing<br>  ○ One-on-one coaching<br>  ▪ Direct engagement with executive directors of all agencies<br>  ▪ Distributed almost 5000 coupons for free testing<br>  ▪ Distributed brochures and posters<br>  ○ Increased our own testing at our needle exchange harm reduction services<br>  ▪ Every Tuesday offering HIV, syph, HepC testing (also offering Hepatitis A vaccination)<br>  ▪ Very soon will be offering Insti rapid tests and Dried Blood Spot technology, to help with people get past barriers with phlebotomy<br>• Disease Intervention Specialist program follows up with someone newly diagnosed to make sure they are linked to care, also support partner testing<br>  ○ Finding that many of these individuals are unhoused (though not all)<br>  ○ Have ramped up field-based testing services and camp outreach<br>  ○ Working with Chris to apply new technologies in the field<br>  ○ As PH, we do know when someone is diagnosed with HIV, and if we can ascertain enough information, we can do more targeted testing in that social network<br>  ○ Going out weekly in vans to particular camps where we are looking for partner contacts, as well as offering screening<br>  ○ DIS role also involves a lot of data collection<br>  ○ We've been working with OHA, epi team, harm reduction partners, community based partners, to develop Enhanced Interview Questionnaire tool<br>  ▪ Much more thorough interview<br>  ▪ Providing incentives (gift cards) in return for spending 30-40 minutes answering technical questions re sex, drug use, travel<br>  ○ Requested & received help from federal DIS through CDC<br>  ▪ Deployment of 2 federal DIS<br>  ▪ Supporting our case investigations<br>  ▪ Helping train staff on different interviewing techniques<br>  ▪ Supporting outreach for re-interviewing<br>  ○ Engagement with Ryan White partners |

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| | ▪ CAP – discussing ways we as public health can more quickly access services for people who are unstably housed, and that is contributing to their inability to achieve viral suppression, as an opportunity to prevent transmission through housing – helpful new and emerging partnership<br>▪ Partnering with HGAP and RW Part A to coordinate outreach to those who are not in care, based on data to care project, and address barriers to care<br>Washington County<br>• Work closely with other counties and state – regional approach<br>o Also participating in extended interviewing<br>• Though we are seeing a rise in people who use injection drugs, not on same level as Multnomah County<br>• Washington County seeing increase in young Latino men<br>o 50% of new cases were Latino men (previously 38%)<br>o Almost half were men in their 20s<br>• 65% of new cases have an STI or history of STIs (previously in high 30s)<br>• Interventions<br>o Syringe exchange started 2 weeks ago<br>▪ Currently at one site, hoping to expand to others<br>▪ Nurse is present – testing, wound care triage, Hep A vaccine<br>o Increased number of people tested 72% from last year<br>o Doing a lot of work in community around stigma and community education<br>Oregon Health Authority<br>• HIV/STI Prevention & Surveillance programs<br>• Primarily supporting efforts of counties<br>• Liaison to CDC<br>• Looking at contract requirements – removing barriers<br>• Monitoring trends and reporting back to counties, providers, community, and planning bodies<br>• Special needs funding available<br><br>Questions:<br>• Q: In Washington County, what's driving increase in young Latino men?<br>o A: Primarily MSM. 11% of new cases had reported ID use last year, this year 14%, so not large increase (though syphilis is seeing large ID use increase). Many factors: access to care, access to services, education, stigma. Recently funded Familias in Accion to do work with community-based education to do education with staff about HIV. Working on multiple fronts.<br>• Q: Is this increase in young Latino men an impact of recent public charge / immigration issues?<br>o A: Fear of immigration issues and accessing health care is part of it. Young Latino men are quickly cut off from their families, looking for support and not finding it. |

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| | • Q: Who is experiencing this increase?<br>  ○ A:<br>  ▪ Group of people we presume to be connected, including: people recently diagnosed with HIV who have been using meth (whether injecting or not) or have been injecting other drugs, their sex partners; and people who have recently been diagnosed with syphilis with same drug use history and their sex partners<br>  ▪ Most of these people, especially the females, are unhoused or unstably housed (housing is an indicator of not being virally suppressed), though a subset are housed<br>  ▪ Most are white, but not entirely<br>  ▪ Most are men who have sex with men, but there is an increase among bisexual men, heterosexual men, and females<br>  ▪ Housing instability<br>  • For those who are couch surfing, sexual connection and relationship happens as part of that<br>  • For people living in camps, when camps are swept, sexual networks get disbursed<br>  • Housing First model – housing is HIV prevention<br>• Q: Can you talk more specifically about new partnerships or operational procedures?<br>  ○ Washington Co: a lot more outreach to nontraditional partners – mental health providers, addiction coordinators, corrections counselors. We want to talk to people on the front line, teach them how to have conversations about risks and behavior<br>  ○ Multnomah Co:<br>  ▪ Trying to get some funding out into community for increasing testing and health promotion.<br>  ▪ Merger with Communicable Disease program, allowing for new opportunities<br>  ▪ Joint Office of Homeless Services hosts weekly calls about future sweeps; joining these calls have given us contacts and allowed us to request specific sweeps be postponed at need<br>  ○ OHA: More partnerships, particularly with organizations run by and for communities of color, including one in another area with Confederated Siletz Tribes<br>• Q: What is the increase of HIV cases?<br>  ○ A: Multnomah County in general is around average to date this year. However, for the cluster (group with these specific risk behaviors), previously has been less than 20 per year in this population, over the past two years has been closer to 70.<br>  ○ A: Washington County saw our first increase in 2018; average 35-38. Funding through OHA has allowed increase in staffing. A rise in positive test results may be due to testing more people.<br>• Q: What does this new testing technology look like for a person being tested? |

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| | ○ A: "New to us" technology. Previous outreach testing has been limited to phlebotomy (blood draws), which is very challenging in the field and with this population due to dehydration, damaged veins. New technology:<br>○ Insti – finger stick rapid tests that take 1 minute to develop<br>○ Dried Blood Spot testing – similar to heel stick testing on an infant, when you apply blood to a card, and allows for syphilis and Hepatitis C<br>○ Anticipating greater access using both of these<br>○ Previously used other rapid tests, but 15-20 minutes to develop meant results could not be given at that time<br>• Q: What are you prepared to do when result is positive?<br>○ Washington Co: generally will draw blood for confirmatory test, which provides a buffer. Individual is usually pretty upset. Important to be able to respond in the moment to the client, knowing what support is out there.<br>○ Multnomah Co: we have access to HIV Clinic, so if we get a positive result in clinic, we can do a warm handoff to get someone into care immediately. More challenging in the field. We frontload conversations to get information about how to find/reach them, and make plans with them.<br>• Q: Do you have conversations around PrEP and PEP?<br>○ Multnomah Co: anyone we test, we will discuss PrEP<br>○ Washington Co: We rely on CAP to do a lot of that navigation for clients. On-site navigators are ideal, to move directly from testing to on-site PrEP navigation<br>○ OHA: CAP locally, HIV Alliance in rest of state |
| Quality Management – New Quality Improvement Projects & Care Continuum | *Presenter: Marisa McLaughlin & Carlos Dory*<br>*Purpose of Presentation:*<br>*Summary of Discussion:*<br>See slideshow with audio content annotations.<br><br>Questions:<br>• Q: Re. Care continuum slide, why are there two virally suppressed numbers?<br>○ A: Note asterisk next to the numbers, with an explanation at the bottom of the slide. The smaller number is the percentage who are virally suppressed out of all PLWH who have been diagnosed (including those who have not been tested). The larger number is the percentage who are virally suppressed out of PLWH who have had a viral load test.<br>• Q: Why are the Retained in Care percentages so low?<br>○ A: This is due to use of very specific definitions of "retained in care" with required numbers of medical visits and/or viral load or CD4 tests that do not necessarily match current standards of care<br>• Q: Has HGAP considered discussing changing how we calculate retention in care? |

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| | ○ A: We have already changed this going forward, but these are the data we have for 2018 |
| Finalize Contingency Planning for FY19-20 | *Presenter: Emily Borke*<br>*Purpose of Presentation: Finalize contingency planning based on September 2019 meeting discussion*<br>*Summary of Discussion:*<br>See handout<br><br>Decision needed: 3% decrease funding scenario<br>• Scenario #1: Proportional decrease across all service categories<br>• Scenario #2: Hold harmless service categories not receiving Part B (including housing for Clark County only), proportional decrease across all other categories<br><br>**Decision: Scenario #2 is approved by unanimous consent** |
| Program Updates / Mid-year Scorecards | *Presenter: Amanda Hurley & Jesse Herbach*<br>*Purpose of Presentation:*<br>*Summary of Discussion:*<br><br>We did get our carryover request<br>Per PC guidance, $19,659 was put into Medical<br>See FY19-20 Mid-Year Scorecards<br><br>Program updates:<br>• Overall- narratives really pointed toward strong collaborative work happening<br>• MHASD<br>○ HBR Updates:<br>▪ Referrals mostly coming from HIV clinic and CAP (often shared clients), OHSU clinic PP Medical Navigator have started referring recently<br>▪ Current strong coordination with CAP: As soon as client is assigned to a bed, client assigned to CAP HCM, so when they exit they are placed in sober housing. 3 people have gone through this fully, 6 months clean and housed!<br>▪ No waitlist currently<br>▪ Previous issues finding placement for folks with sex offenses on their records. Lifeline, Quest House and Bridges will all accept those with sex offenses on their records. 2 new referrals for folks this background.<br>○ Quest House<br>▪ 3 spots at quest house, 6 clients placed at quest house, 3 still in the house, 2 have graduated<br>▪ Bridges to Change<br>▪ 1 spot, filled currently<br>▪ Strong relationship with this program<br>○ VOA |

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| | ▪ 7 placements, not as long engagement as the Quest House<br>▪ Anecdotal reflection: good fit for those with military or jail system background, as it is more structured. One person transferred from a VOA house to the Quest house and was very successful at Quest house in a way that he wasn't able to be at VOA.<br>▪ All house spots are filled<br>▪ 9 intakes through VOA that didn't engage<br>▪ Entry is a week to two weeks after screening intake<br>• EMO<br>○ Two MSW interns for the upcoming year – one with a background in military service; one with a background in case management working with folks experiencing mental health issues and has worked at Quest previously. Both also providing support to DBX program in the area of food delivery and home visits. DBX program also taking steps to implement better tailoring of meals to specific health needs.<br>○ 1st Long Term Survivor workshop happened in Sept "The Power of Volunteers;" 2nd happening November 10th "Community Leadership"<br>• CAP<br>○ CAP and Urban League collaboration underway- New Black/AA MAI Navigator hired and right now connecting with past participants, getting referrals primarily from CAP, UL, and EMO. Real Talk will be happening again but hasn't started back up yet. Splitting time between CAP and UL offices.<br>○ Congratulations to CAP SW Washington on their move! 100 E. 33rd St., Suite 201A, Vancouver, WA 98663. (working on expanded services, including peer and employment – not RW funded); WoW partnership continuing with meetings happening monthly.<br>• Russell Street<br>○ No word yet about Dental Navigator position from HRSA, but steps have begun around reengaging clients back into dental care in the meantime. Rosemary staying on one day a week to begin developing the position and client re-engagement.<br>• Quest<br>○ Watch the video that was sent out to the PC - peer participant at Resilient Voices event<br>○ Emergency Finance Assistance (EFA) contract awarded. Program continuing to take referrals through the contracting process that is underway.<br>• HHSC<br>○ Integrated Clinical Services at the County was awarded funding for a Behavioral Health Specialist to provide addictions support to people interested in accessing Medically Assisted Treatment. Not exclusively working with PLWH but will be embedded at HIV clinic.<br>• PP |

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| | ○ Spanish speaking MCM to started at Neighborhood Health Center in Wash Co on Mondays starting in October.<br>○ Continuing to navigate the system changes with the Legacy and Providence's changes to their HIV case management.<br>• HGAP<br>○ Client Satisfaction Survey underway<br>▪ Almost 300 responses (800 response goal)<br>○ Team Frequency consumer pilot is complete (3 workshop series for HIV clinic Client Advisory Council)<br>○ CareWare 6 migration on target to occur before the Ryan White Services Report is due in February.<br>○ Carryover funding approved as requested to HRSA; $19,659 to Medical per PC decisions.<br><br>Comments/questions:<br>• Q: What is the timeframe for participants in substance abuse treatment?<br>○ A: 4 months is minimum to graduate, 6 months is ideal, can go longer if needed.<br>• Re Quest house, there are many more people (70-80%) who are HIV positive than are paid by Ryan White funds<br>• Q: Will PC get a chance to talk to the person doing MAI for Urban League?<br>○ A: Working on scheduling (Jan 2020?)<br>• Q: What is cultural humility?<br>○ A: This concept is related to cultural competency. Cultural competency makes it sound like a person can learn enough to become competent, like completing a task. Cultural humility is a lot more flexible and responsive. This is a way of recognizing that an individual doesn't know everything, but is willing to work on it.<br>• Multiple questions about how dental needs are being met, increase in other resources for dental – topic to be added to list as potential future presentation<br>• Q: Re Food, is the provider going to run out of money?<br>○ A: Funds are tight in this area, so it is likely that HGAP will make recommendations in January to reallocate funds into this category.<br>• Comment: scorecards are very helpful; wish it were more simplified, so it could be handed out to clients and other staff without requiring explanation |
| Discuss U=U Endorsement | *Presenter: Amanda Hurley, Emily Borke & Lorne James*<br>*Purpose of Presentation:*<br>*Summary of Discussion:*<br><br>See handout<br><br>**Decision: By unanimous consent, the Planning Council officially endorses U=U, and authorizes the co-chairs to sign an endorsement letter** |

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| Open Enrollment period information | *Presenter: Jonathan Livingston, Emily Borke, Julia Lager-Mesulam & Matthew Moore*<br>*Purpose of Presentation:*<br>*Summary of Discussion:*<br><br>OHA:<br>• We have 45 days to enroll statewide over 800 people in new insurance<br>• Many are renewing benefits, but a lot have to go through a complete application process<br>• 5 agencies doing enrollment work: Partnership Project, Multnomah County Part C, CAP, HIV Alliance, Eastern Oregon Center for Independent Living<br>• Most done through Healthcare.gov, also using certified insurance agents for those who don't qualify for insurance through the marketplace<br>• So far, no significant changes this year from last year<br>• Have maintained at least two insurance carrier options in every county<br>• No significant premium changes or benefits changes<br>• PacificSource continues to provide out of network benefits, but no one else is offering them<br>• Starting Oct 15, all OHP members received a letter stating that they have the option to change CCOs<br>  ○ People should be able to keep the options they have right now, and should not be auto-enrolled in a different CCO<br>  ○ If it happens (assignment to a CCO that does not work with their provider), there is an official process to get that changed<br>• Still wrapping up formulary review for this year<br>• Q: Has there been a change regarding whether or not individuals have a choice of mail order pharmacies?<br>  ○ A: Jonathan will look into that<br><br>CAP SW Washington:<br>• No longer has health insurance navigator, so working with EIP and their Evergreen Health Insurance program<br>• Waiting to hear EIP's recommendations for insurance outside of the exchange<br>• There are five QHCs now available, including PacificSource and Columbia Clark County.<br>• Q: What happened to insurance navigator? Are they going to be replaced?<br>  ○ A: They went on to bigger and better things. This position will not be replaced as official title / certification, but other navigators do this work.<br><br>Partnership Project<br>• All assisters (including new Legacy Case Managers) are fully trained and ready! |

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| | • 253 clients with enrollments (on exchange and off exchange)<br>• Done tune up calls and many people scheduled already (~10 completed so far)<br>• Completed 11 Medicare enrollments as this is also Medicare open Enrollment time<br>• Clients who have employer coverage: confirming whether this has changed<br>• 5 clients currently on UPP: will be scheduled and enrolled in appropriate coverage.<br>• Zero clients are uninsured.<br>• We are confident that we will get all our clients enrolled in appropriate coverage!<br><br>HIV Clinic:<br>• Will probably assist 315 clients for on and off exchange applications<br>• Have made first round of calls to all 315 clients<br>• Will do second round in mid-November, will catch most people<br>• Will do intensive outreach to remainder<br>• We have 42 clients on original Medicare and prescription plan, and it may make sense for them to be on a Medicare advantage plan - focusing on individuals who have a choice to get on a better plan<br>• Clinic has 42 clients on UP program, we are prioritizing them<br>• We have done 9 Medicare enrollments in the last two weeks of October<br>• Doing this among big staff changes - Patti retired the day before open enrollment started |
| Time of Adjournment | 7:25 PM |

## ATTENDANCE

| Members | Present | Absent* | Members | Present | Absent* |
|---|---|---|---|---|---|
| Emily Borke (Council Co-Chair) | **X** | | Julia Lager-Mesulam | | **E** |
| Erin Butler | **X** | | Heather Leffler | | **E** |
| Tom Cherry | **X** | | Jonathan Livingston | **X** | |
| Jamie Christianson | **X** | | Toni Masters | | **L** |
| Carlos Dory | **X** | | Jeremiah Megowan | **X** | |
| Michelle Foley | **X** | | Matthew Moore | **X** | |
| Greg Fowler | **X** | | Scott Moore | **X** | |
| Alison Frye | | E | Laura Paz-Whitmore | **X** | |
| Dennis Grace-Montero | **X** | | Diane Quiring | **X** | |
| Myranda Harris | **X** | | Jace Richard | **X** | |
| Mary Rita Hurley | | E | Michael Stewart | **X** | |
| Shaun Irelan | **X** | | Michael Thurman-Noche | **X** | |
| Lorne James (Council Co-Chair) | **X** | | Robert Thurman-Noche | **X** | |
| Chris Keating | **X** | | Erin Waid | **X** | |
| Toni Kempner | **X** | | Abrianna Williams | **X** | |
| | | | | | |
| **PC Support Staff** | | | **Guests** | | |
| Lisa Alfano | | | Michelle Sobers (Janssen) | **X** | |
| Aubrey Daquiz | **X** | | Robert Kenneth | **X** | |
| Jenny Hampton (Recorder) | **X** | | Chris Hamel | **X** | |
| Jesse Herbach | **X** | | | | |
| Amanda Hurley | **X** | | | | |
| Jenna Kıvanç | | | | | |
| Marisa McLaughlin | **X** | | | | |
| Kim Toevs | **X** | | | | |

* A = Unexcused Absence; E = Excused Absence; L = On Leave