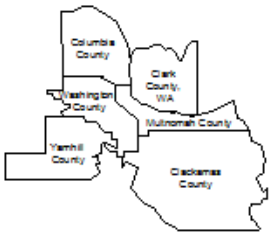
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: March 5, 2024

Approved by Planning Council: April 2, 2024

Grantee: Multnomah County Health Department

Multnomah County

Portland Area HIV Services Planning Council
MEETING MINUTES

Tuesday, March 5, 2024, 4:00 – 6:00 pm
Zoom meeting

AGENDA

Item**	Discussion, Motions, and Actions
Call to Order	Scott Moore called the meeting to order at 4:05 PM.
Welcome & Logistics	Bri Williams welcomed everyone to the meeting and reviewed meeting logistics. • Please say your name each time you speak • Please raise your hand • Meetings are recorded for accurate meeting minutes.
Candle Lighting Ceremony	Bee Velasquez lit the candle in honor / memory of Debs and Mo.
Announcements & Introductions	Announcements: See slides. Attendees introduced themselves. Announcements • Welcome Derek Smith, he/him, new HGAP Manager • Awareness Days o Women & Girls (March 10) o Native Communities (March 20) • Council Priority Setting and Resource Allocation (PSRA) Training: Tues. 3/19, 2:30-4:00 **rescheduled to April 25 and 26** • Provider perspective: EFA (Emergency Financial Aid) funds applications were waiting for release of funds on Monday morning (3/4). The group reviewed the Council Participation Guidelines (see slide).
Public Testimony	None.
Agenda Review and Minutes Approval	The agenda was reviewed by the Council, and no changes were made. The meeting minutes from the February 6 meeting were approved by unanimous consent.
Client Experience Survey Data	*Presenter: Grace Walker-Stevenson* *See presentation slides.* *Summary of Discussion:*

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	Questions / Comments: Q: What is "Ryan White community?" A: Clients accessing Ryan White services. Q: What is the shared meaning of "housing insecurity"? A: Defined by question "Is your housing likely to be unstable and/or uncertain?" Q: What is considered rural? Washington County has both rural and urban. A: Survey doesn't necessarily look at urban / rural. We would like to see more responses from counties other than Multnomah. Transportation noted. Is there a shift in need for more services in more rural areas? Q: Were the questions all necessarily asked in the same way? Or were they possibly refined / asked in a different way? A: We have tried to keep the questions the same. However, we switched to a new survey platform this year, which switched extremely satisfied and extremely dissatisfied. We did have some people who reported selecting the wrong box. Additional member questions- • Have we lost our effectiveness? • Is this due to a lack of collaboration to get the referrals they need? • Are clients not feeling hopeful? • What is the role of supervisors? • What's the reason for the decline? • Oftentimes doctors can't help the social worker because there is a divide between these services. • Need to be careful that the client doesn't feel belittled by the social worker. • We don't want to have social workers in a situation where they can't help. Q: Is there an opportunity to have conversations with people who feel their needs weren't being met, their privacy wasn't being respected, etc? Focus groups, etc? A: This survey is anonymous, but we did collect the contact info of people who said they were interested in participating in a focus group. We just completed the focus group; results coming soon. This is a symptom of high caseloads, not enough services that our community needs? Q: Re referrals, is the dissatisfaction in the referrals (or lack thereof) themselves, or lack of services to which to be referred? A: Upon review of question, definitely refers to the referrals themselves. Q: Any outliers? More information coming in annual report, as well as subsequent presentations. Will be doing a deeper dive into satisfaction by provider and by demographic groups, then meeting with each provider to discuss survey results. Qualitative analysis on survey text responses and focus group conversations. Check in with providers on Quality Management strategies / Quality Improvement projects. What comes next? What data questions do you have that would help this group in future meetings? Please email Derek Smith (derek.smith@multco.us) Additional member comments: -I have repeatedly noticed PC rarely integrates the full LGBTQIA 2-spirit – specifically 2 spirit cohort definition. I would hope this would be integrated so community members have this option available. -[Satisfaction slide] reminds me of the Medical Case Managers who presented in the panel that were saying their case loads were really high

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	-One perceived point of satisfaction regarding referral services might be the actual client/new resource initiated by either client or case manager. Could clients be introduced to a new resource via conference call, along with the exchange of direct lines? Might already be a standard practice.
Panel on PLWH who are or have recently been incarcerated	*Facilitators: Scott Moore, Bri Williams* *Panelists: Sarah Tapp, Manager of CareLink Services CAP NW; Leona Kanczula, Institutional Registered Nurse, Department of Corrections; Megan Auclair, 1115 Waiver Implementation Director, Oregon Health Authority; Dr. Angel Platas, Physician, HSC; Dr. Chris Evans, OHSU* *Summary of Discussion:* Aubrey Daquiz provided some general context on HIV in correctional facilities – see slides. Panel Questions: • Please describe your role in offering or linking to care PLWH who are or have been incarcerated, and provide an overview of services. • What are some successes, such as coordination of care among care team / services and especially client outcomes? • What are key care challenges and gaps you or your clients experience (e.g, HIPAA concerns, medication access/coverage)? And how do you use data to learn about and/or address these? • What resources or support would you need from the Ryan White program or other sources to more effectively serve clients? **Leona Kanczula**, Institutional Nurse, Department of Corrections Medical Transition Nurse Consultant (aka case management) • Assisting with releasing adults in custody when they have medical issues • Works with aging and people with disabilities • Ensure release with proper medical equipment • Assists with follow up appointments, getting injectable medications in community • 58 incarcerated PLWH in Oregon • Work with PLWH, role in that is very small; • If they are releasing within 4-5 months, I meet with them, have them fill out ROI paperwork, then connect them with external providers • Used to have a program, but don't now, trying to restart, will take some time • Problem is connecting outside with inside • Adults in custody can be transferred between facilities without me knowing, so connection is lost • Once released from custody, don't have a way to know if what we did worked Other challenges • Getting access to care without having OHP • DoC is applying almost all people being released to OHP • Application is held until released • If we want to do follow up appointments, provider wants Medicaid number that isn't available until they are released, but then I no longer have access to them

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	• This may change soon, which would be great Resources • Anything that would help AIC reach resources before they are released or immediately after they are released **Megan Auclair**, 1115 Waiver Project Implementation Director, OHA Aubrey will send out Megan's slides after meeting • I'm not in direct service • 1115 Waiver • Working on waiver with federal government that would allow full enrollment with limited benefit package 90 days prior to release (IS THAT RIGHT?) • Medicaid would cover services while is custody • Would also allow coverage of medical related social needs to allow for smoother transition • Still negotiating • Goal to ensure continuity of coverage as people move between settings • Also reduce risks of relapse, medical destabilization Challenges • Internal support – application assisters etc. • Coordination challenges between institutions, external providers • Confidentiality protections • Submitting claims for reimbursement • Lack of continuity in covered medications • What are the operational challenges? • Where do you need us to step in? • Where do you need us to step back? Resources / support- I would love to learn from you about gaps / needs **Dr. Angelina Platas**, General internist & geriatrician, HSC • Worked at MCDC for 8 years • Currently work for HSC on call • At MCDC was primary general medicine • Responsible for people with HIV and many other medical conditions • We are responsible for every piece of their health care • AETC provides training for clinicians • Sent notes back and forth from MCDC to HSC providers • Training and relationship establishment made a big difference • Were able to modify protocols to decrease length of time needed to reestablish ART medications • HSC provider came to visit clients in MCDC, warm handoff Challenges • Short and unpredictable length of stay – many are there for short length of time, very difficult to coordinate care, get insurance coverage • People may not feel comfortable revealing they have HIV, may not be in a mental / emotional state to take medications appropriately • Advantage – many people are in and out of custody repeatedly • I was a primary care provider for adults in custody

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	• It is crucial to try to establish treatment, have a discharge plan • Having an AIC on medications increased possibility that medications would be continued if transferred to different facility • Building trust / rapport with patients can be quite sensitive • Jail / prison is dangerous, and discussing medical needs can be difficult • Maintaining confidentiality is crucial • Medication would be given regardless of costs • Giving combination medications separately is just as effective and more cost efficient than giving in one pill. Needs note that one cannot be given without the other. Cost remains an issue as new medications come out and people on these medications come into custody. Example – receiving injectable HIV medications. • We need to be establishing relationships with people in all levels of administration in correctional facilities • Clinicians need education and relationships established to provide optimal care • When something seems more rare / difficult to care for, it's easy to push it aside. **Sarah Tapp**, Manager of CareLink Services, CAP PDX • Primary goal is connecting PLWH to HIV medical care • Can assist with scheduling appointments, attending appointments with them • Connect people with ongoing case management • Transportation assistance • Connecting people with CAP's other services and other social supports • Receive referrals from DoC • Make contact while they are incarcerated, start making plans, so when they are released they have someone they can connect with who they know to help • Have been collaborating with Dr. Chris Evans (ORG?), he is referring to us • Have been able to get release counties changed to Mult Co to allow access to CAP's housing program Challenge – needs address to get released early, but need to be released to get address • Clients often released with only 30 days of medication, which is a very short time for someone to get into an appointment to get more meds. Often need primary appointment first, then referral (which can be weeks out), client runs out of meds. • If we did not connect to client who was incarcerated, they did not connect to our services at all. Resources / support • Prioritizing people who are/ have been incarcerated for sooner appointments • Often we don't know far enough ahead that someone is being released, not enough time to connect before they are released • Community is lacking resources in general, any supporting resources are welcome **Dr. Chris Evans**, OHSU • ID provider with OHSU • See patients at Columbia River and OSP • In prison you know when someone is getting out • Person on meds can fly underneath the radar because they look stable • Consider injectables while in custody, then go on oral as prep for transition

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	Questions / Comments:
	• Q: Can't believe they still use paper charts and there are no electronic records system to coordinate care.
	  o A: I have heard EMR system has been upgraded, but it's a hybrid system.
	  o Tessa Robinson: Have heard Coffee Creek is transitioning to HER.
	  o Dr: Platas: It is literally getting reams of paper and reviewing often when people are transitioning between facilities.
	  o Steven Davies: Avatar Medical software!
	  o Evangeline Nichols, RN, HSC: From my knowledge, King co, Tillamook co, and Multnomah Co are the only facilities in the region with EMRs. (Tillamook county is only electronic because the county lost their contract and Adventist took over)
	• Don't hear much about foster care or relapse in facilities
	• Outreach to transition programs at jails/prisons to make sure that they are aware of resources for people and the best way to access them would be very helpful.
	  o For example for jail transition programs: tell them to refer as soon as people arrive regardless of having a release date. Resources for transition programs is limited as well, of course!
	• CareLink can start working with clients 180 days (6 months) before release!
	• I worked w/ Leona a lot in transitioning inmates into Oregon Housing Opportunities in Partnership (OHOP) housing in Part B over the years. Coordination / continuity of care is always challenging. Exciting to consider how the 1115 waiver will help things, which Megan spoke of.

Awareness Days	*Presenters: Scott Moore, Bri Williams* *Summary of Discussion:* See slides. National Women & Girls HIV Awareness Day (March 10) VIDEO LINK Native Communities (March 20) VIDEO LINK
Evaluation and Closing	*Presenter: Bri Williams* Thank you for participating in this meeting. If you have feedback / comments / ideas, please include them in your evaluation. Next meeting: April 2, 2024, 4:00-6:00 PM, via Zoom
Adjourned	6:00 PM

ATTENDANCE

Members	Present	Absent*	Members	Present	Absent*
Tom Cherry, he/him	**X**		Robert Middleton, all pronouns	**X**	
Jamie Christianson, she/her	**X**		Scott Moore, he/him	**X**	
Claire Contreras, she/ella		**L**	Jamal Muhammad, he/him	**X**	
Steven Davies	**X**		Fabian Primera		**A**
Carlos Dory, him/his	**X**		Diane Quiring, she/her	**X**	
Michelle Foley, they/them		**E**	Tessa Robinson, she/her	**X**	
Greg Fowler, he/him	**X**		Jake Schmieder, he/him	**X**	
Jeffrey Gander, he/him	**X**		Taylor Silvey, she/her	**X**	
Kris Harvey, he/him	**X**		Nick Tipton, he/him	**X**	
Shaun Irelan, he/him	**X**		Bee Velazquez	**X**	
Zachary Jones		**A**	Meghan Von Tersch	**X**	
Julia Lager-Mesulam, she/her	**X**		Shane Wilson, he/him	**X**	
Robb Lawrence, he/him	**X**		Joanna Whitmore, she/her	**X**	
Heather Leffler, she/her		**E**	Abrianna Williams, she/her (Co-Chair)	**X**	
Sean Mahoney, he/him		**E**			
PC Support Staff			**Guests**		
Sandra Acosta Casillas			Leona Kanczula	**X**	
Jonathan Basilio	**X**		Dr. Angel Platas	**X**	
Aubrey Daquiz, she/her	**X**		Megan Auclair	**X**	
Jenny Hampton, she/her (Recorder)	**X**		Sarah Tapp	**X**	
Sara McCall, she/her			Dr. Chris Evans	**X**	
Eric Richardson, he/him	**X**		ASL Interpreter: Katie	**X**	
Derek Smith, he/him	**X**		ASL Interpreter: Gina	**X**	
Kim Toevs, she/they			Rachel Greim, she/her, ORAETC	**X**	
Grace Walker-Stevenson, they/them	**X**				

* R = Attended Remotely (for an in person meeting); A = Unexcused Absence; E = Excused Absence; L = On Leave