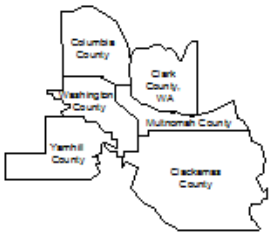
Portland Area HIV Services Planning Council

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

Ryan White Program, Part A



Meeting Minutes

Meeting Date: April 4, 2023

Approved by Planning Council: TBD

Grantee: Multnomah County Health Department

Multnomah County

Portland Area HIV Services Planning Council
MEETING MINUTES

Tuesday, April 4, 2023, 4:00 pm – 6:00 pm
Virtual Zoom Meeting

AGENDA

Item**	Discussion, Motions, and Actions
Call to Order	Bri Williams called the meeting to order at 4:00 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" or type questions in the chat box • We will mute and unmute folks as needed during the meeting • If you're calling in (not viewing slides), please mute yourself to minimize background noise, unless you have a question / comment • Meetings are recorded for accurate meeting minutes. Attendees introduced themselves via chat. The group reviewed the Council Participation Guidelines (see slide).
Candle Lighting Ceremony	Greg Fowler led the candle lighting ceremony in honor/memory of Bruce Bills, and all the people who didn't make it. Found out I was HIV positive on 30th birthday, now turning 65
Announcements	Announcements: See slides. Announcements • Welcome new members Jeffrey Gander and Steven Davies! • Introducing Grace Walker-Stevenson, new Research & Evaluation Analyst Senior with HGAP • National Youth HIV & AIDS Awareness Day • National Transgender HIV Testing Day – April 18 • "Gay Skate Night" event on Monday April 17 at Oaks Park Skating Rink. Email Justine at Quest if you're interested in getting your name on the list for free tickets. Free skating, snacks, HIV/STI/HepC testing. Oaks Park is charging for parking; we will cover parking for the first 100 spots.
Agenda Review and Minutes Approval	The agenda was reviewed by the Council, and no changes were made. The meeting minutes from the March 7 meeting were approved by unanimous consent.
Public Testimony	None.

Item**	Discussion, Motions, and Actions

Election Overview	*Presenter: Julia Lager-Mesulam*
	Summary of Discussion:
	See slides.
	
	Positions / elections in June
	• Information sharing only today – no decisions
	• Co-Chair position open (filling Tom's position)
	• 3 openings on Operations
	  o Currently have 2 nominations
	
	Co-Chair
	• 2 year term
	• Who can be nominated?
	  o Member who has completed at least one full term (2 years) as a Council member in good standing
	  o Proven ability to preside at meetings, oversee complex work plans and timelines, and supervise and direct the work of Council or committee members
	  o Agree to adhere to principles of employee supervision consistent with MCHD personnel policies
	• Key responsibilities (starred items can be delegated):
	  o Official public rep and spokesperson of the Planning Council, in consultation with Council Staff*
	  o Preside at meetings of the full Council and Operations Committee (Ops)*
	  o Appoints Committee Co-Chairs (i.e., Evaluation & Membership Committee), and other Committee members as needed*
	  o Work with Council Staff and Grantee to:
	  o Ensure compliance with Ryan White Program requirements and other federal guidance
	  o Establish priorities for Council, committee and staff work
	
	Operations Committee
	• Must be willing to serve on a committee if appointed by Co-Chairs
	• 5 At-large member positions (1 or 2 year terms)
	• 2 Membership Co-Chairs & Eval Chair, to be appointed
	• Responsibilities of Operations Members:
	  o Meet regularly to plan the meetings of full Planning Council
	  o Determine committee membership
	  o Review and update Council's Bylaws, Policies and Procedures
	  o Co-develop work plans to move Council work forward
	  o Identify Council knowledge gaps that are essential to perform high quality planning and decision-making
	
	Key Membership Committee Responsibilities:
	• Review applications & conduct interviews for Council Membership
	• Work with Council staff to:
	  o Meet orientation and training needs of new Council members
	  o Coordinate ongoing training and member development

Item**	Discussion, Motions, and Actions

	• Support Council's retention plan so as to improve member attendance, participation, and retention
	• Review the membership roster of the Council regularly to prevent and address member attrition
	• Lead the annual Council Co-Chair election process
	
	Process
	• Today's Meeting
	  o Inform Council of open positions
	  o Ask for nominations & brief nominee statement (i.e., why you are running) for all positions by Tues, May 9
	  ▪ Please nominate others only with their permission
	• Depending on whether there are multiple nominations for Co-chair, we will either:
	  o Send a proxy vote for both ahead of June meeting
	  o And/or hold elections at June meeting
	• Vote on Co-Chair position first
	  o Voting occurs, count votes
	  o Results announced
	• Ops Positions
	  o Voting occurs, count votes
	  ▪ If there is a tie, a runoff will be conducted
	  o Top 5 are elected
	  o Results are shared
	
	Questions / Comments:
	• Any nominee for membership co-chair position with you needs to be consumer/PLWH? Yes
	• Operations Committee at large members – why do some have 1 year terms, and others 2 year terms? We want to stagger terms. Right now we have a number of positions that are open. Usually a term would be 2 years.
	• I'm currently SW Washington representative, but I have moved. If I'm serving in a different capacity, can I nominate myself to remain on Operations in a different role? Yes
	• Historically we have required members to serve 1 year on the Council before becoming an Operations Committee member, but given our unique situation, we are waiving that requirement.

Voices of the Broader TGA	*Panelists: Dr. Chris Evans, Julia Lager-Mesulam, Tessa Robinson, Jeffrey Gander, Edgar Mendez* *Summary of Discussion:* See slides. Amanda Hurley shared Portland TGA Epidemiological data – see slides. Panelists: • Dr. Chris Evans, Associate Professor, HIV Clinic Team Lead, Oregon Health & Sciences University (OHSU) • Julia Lager-Mesulam, Director, Partnership Project, OHSU

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	• Tessa Robinson, Public Health Nursing Supervisor, Washington County Department of Health and Human Services • Jeffrey Gander, Communicable Disease Registered Nurse, Clackamas County Public Health • Edgar Mendez, Manager of Clinical Health Services, Cascade AIDS Project Note: Julia will speak about Columbia and Yamhill counties. The Operations Committee tried to get someone from those counties to come and speak, but there are not many people living with HIV in those communities, and therefore not many people to speak about them. Questions for Panel: • Please describe your role and an overview of HIV testing, support for newly diagnosed PLWH, and linkage to care from your County Health Dept or with folks from more rural areas (e.g., Yamhill, Columbia counties). • What are the biggest challenges you have in engaging/ connecting these folks to care (including service gaps, changes in population you serve) • What unique opportunities, solutions, or partnerships have been identified? • What other resources or support do you need to do this work? Julia Lager-Mesulam • When anybody comes into our system of care, we do an intake. We are always doing insurance screening and getting them insured the same day, if possible. We assess their linkage to care • Linking to care based on insurance and preference about where they want to go • There are no HIV providers in Columbia and Yamhill counties, so they have to travel to Washington, Clackamas or Multnomah counties. • We provide cabs, gas cards, bus tickets. This can be very expensive for clients in Columbia and Yamhill counties, but these are the people who need it. • There is a clinic in Scappoose where clients can get labs, but they must make an appointment • Many barriers to care o We are constantly trying to find ways to help and support clients to get into care, and using transportation dollars is a lot of what we do o Language barriers o Providers with closed panels o Providers changing systems o Transportation o Gaps of services in mental health and substance use o Stigma • Unique opportunities o All of our CBOs in continuum of care with whom we partner and work very closely o DIS is a very important partner – we refer to each other ▪ Wonderful relationships with Disease Intervention Specialists (DIS) in Multnomah, Clackamas, Washington counties ▪ In Yamhill & Columbia counties, DIS are very good, but this is a small part of what they do, so we are educating them about our work

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	o Some HIV providers exist within HIV clinics, while others exist within Internal Medicine clinics o Internal Medicine clinics are not wrapped around the HIV population, doesn't understand nuances of insurance and needs of HIV clients, so we must educate clinic staff on how what we do is different o In Washington County, they do an amazing job connecting us with resources – very collaborative • Needs o More time o Structural system change in mental health, substance use and housing o More staff – we are exploding, caseloads are 180-200, clients presenting with complex needs we don't have time to address appropriately Chris Evans • Infectious Disease physician at OHSU • Also see clients in Corrections • Barriers – people transitioning out of corrections have multiple barriers to care o limited amounts (30 days) of medications – antiretroviral and opioid use disorder medications o insurance interruptions o hard to find providers in community who can see them immediately and will prescribe their medications o Many small county prisons are having difficult time providing medications and care o Need to ensure warm handoff to providers in community • Telehealth has expanded, allowed us to think creatively how we can provide care for people further outside the metro area. • Ability of people to step away from their job during their lunchtime and talking to a provider about their care has opened access • People we never saw in our outreach before – cisgender women from African counties like Tanzania • What is the best way to have outreach with cultural appropriateness? How do we best serve that community while respecting people's privacy? • Q: Is your work in jails, or prisons, or both? Some have EPIC, which provides some continuity of care. A: Prisons. We still use paper charts! We also struggle finding providers in the area in which they are paroled. Tessa Robinson • Washington County • We offer HIV testing at STI clinic on Thursdays in Washington county – full panel STI screenings • Two years ago began providing rapid HIV testing at syringe exchange services twice per week • Follow up with newly diagnosed cases – two parts • Public health follow up – surveillance questions, partner services (identify any partners and refer to their provider or provide testing / PrEP) • Conversation re case management and other services – work closely with Partnership Project

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	• We have a FQHC as well as an OHSU provider that we are able to refer to within Washington County, as well as the Multnomah County HIV clinic • Over the years our cases have become more complex – housing, mental health, substance use, corrections involvement – more time intensive and requires more coordination with community partners • Our team works closely with providers at the jail • If someone is in booking and state that they are not engaged in care and/or not on medication, this provides an opportunity to speak with them at the jail (captive audience!) • Checking in with inmates – what are the challenges, barriers; how can we help? • Nurses able to go into medical to have clients sign paperwork (referring to case management, CAREAssist) prior to release to set them up with appointments, medication • Resources / support • There is a lot of great social and support services, but they are pretty Portland-centric. Some clients don't want to go into Portland, so having services outside of the Portland metro area would be valuable. Jeffrey Gander • Communicable Disease Nurse with Clackamas County Public Health • Nurse DIS on Infectious Disease Control & Prevention Team • Case investigation for new STI diagnoses • Disease investigation: taking detailed sexual history, STI prevention education, education on particular STI contracted, treatment verification, referrals to social work and PrEP navigation, partner services • Currently we do not perform any of our own HIV testing through our own PH staff • Subcontracted to CAP and Outside In o CAP – free full panel testing at Father's Heart, Love One, Beavercreek and Sunnyside Health Centers, and other sites on our behalf o Outside In – testing at Clackamas Service Center and Needle Exchange • We do purchase HIV home test kits and give them to anyone who wants them at various events (fairs, etc) • Robust relationship with Clackamas County jails, provide home test kits to individuals leaving incarceration • Clackamas has purchased a van for HIV/STD testing – eagerly awaiting it's arrival • Case management is relatively short • Only follow newly diagnosed HIV patient until after their second viral load, see reduction in viral load and confirm they are on ART • All new HIV cases are referred to social work • Linkage to care relies heavily on partnerships: Multnomah County HIV clinic, Partnership Project, CAP, Care Link • Our health centers are completely independent from Public Health, and are not able to take newly diagnosed HIV patients • Excited to use van to expand testing to more rural areas • Linkage to care will be more difficult, with expectation of driving in to appointments largely placed on patients • Challenges o Clackamas is both rural and has urban center

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	o COVID has created some distrust in public health in general o More rural areas are more underserved in meeting medical needs of population, as well as being more distrustful of public health services o Multnomah County HIV Services Clinic (HHSC) is quite a distance for patients in rural parts of county o It can be difficult to get patients into HHSC in timely manner o In urban center, difficult to connect houseless population to care o Difficult to locate them o Primary referral and communication method is by phone o We can provide phones, but we need to find them in order to provide the phone and initiate the conversation o Transportation to appointments is also challenging for houseless patients o We provide rides (once we are in contact) • Van will increase testing, as well as general visibility in county o To prepare for van, we have hired an intern from OSU to better understand the needs of rural population of the county o Who is and who isn't accessing services, and why? • It would be great if we had more state / top level messaging about testing and PrEP that is less queer focused o Current messaging doesn't cut through to non-queer-identified individuals who have risk factors o Stigma is a huge burden in these rural areas o Need messaging that HIV is something that can affect anyone • Q: What might be the ART and PrEP client totals in Clackamas County? A: That is a very difficult number to obtain, because Oregon doesn't track PrEP usage. • Comment from Chris Evans: our HIV Clinic is housed in a general medicine clinic, which is helpful for individuals to might struggle in going to an HIV-specific clinic. We also have Harbor walk-in clinic for access to buprenorphine • Q: I'm wondering about the results that you're getting. Some people can't afford the medication, and that seems like a basic right. Dr. Evans was talking about prisoners not having access to medication and care. What kind of departments can help solve some of these problems? We need to start a dialogue about how to solve these problems. We know the problems. What can we do, between city and county and jails, about the problem in jail regarding access to care? o A: We have to look creatively about how we fund medications. This doesn't mean that jails are not going to provide care, but it might not be to the standard of care that we expect. It's a dollars and cents issue. And are you going to offer testing to prisoners if you can't afford the treatment? o Clackamas County was able to access meds through 340B pricing to help. Pilot program – Clackamas County Jail became it's own 340B, with increased oversight from OHA • Comment from Tessa Robinson: Washington County is responsible for providing the medical care for their inmates. Washington County contracts with a jail health entity. Some of the barriers are paying for the medication, justifying the cost (not knowing if someone is going to be incarcerated for three days or six months). Their pharmacy isn't even located within the state, so they have to order it and have it delivered. • This isn't a matter of denying medication or not wanting to provide it, but instead is a matter of working within the system that is set up.

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	• Planning for discharge
	  o If someone has a provider, either jail provider or community provider having a script in place
	  o OHP is temporarily turned off while in jail
	  o After discharge, there can be a gap before insurance is turned back on
	• Timing issue with labs – some take time to come back, and patient may already be gone
	
	Edgar Mendez
	• CAP's director of prevention
	• Primarily an HIV/STI testing service
	• Also offer PrEP and insurance navigation
	• Primarily work in Multnomah, Clackamas, and Washington counties
	• Services completely free at point of access – no cost to client
	• We offer our services in Spanish as well
	• Landing page for testing: https://www.capnw.org/get-tested
	• We offer rapid HIV testing, blood draws for syphilis testing, and swabs for chlamydia and gonorrhea testing, and HCV rapid test
	• Various different clinic sites and days/times
	• We don't offer direct services in Yamhill and Columbia county
	• No one is disqualified from benefitting from CAP services, regardless of risk factors, demographics, or county of residence
	• We also partner with many organizations
	• We're interested in partnering with you
	• Challenges / resources
	  o Persistent unmet need for HIV/STI testing and services among people who are houseless, people who inject, people on the sex work continuum
	  o Serving these clients requires cultural competency, trust building
	  o Cost of labs is barrier
	  o Oregon is #14 in entire country for congenital syphilis
	• CAP provides testing and warm handoff to medical providers

Preliminary FY22-23 Expenditures	*Presenter: Jonathan Basilio*
	Summary of Discussion:
	See slides.
	
	Status:
	• Part A
	  o Goal is 95% spent
	  o Currently at 94% spent
	  o Contract ends on 2/28, but subrecipients have 10 more days to submit invoices
	  o If we don't meet 95% goal, we submit waiver to HRSA, which we have already submitted
	• Part B
	  o Currently at 97% spent
	
	Question:

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	• Q: In Part A, why is medical care at 86%? Usually we're considering adding funds to them? o A: They're under new leadership, hiring challenges. We're also waiting for some additional personnel costs and other expenses to come in. o A: Across medical providers, we're experiencing fallout of COVID, people avoiding "higher risk" environments.
Client Experience Survey – Qualitative Data	*Presenters: Marisa McLaughlin, Carlos Dory* See slides/video recording. Second half of recorded presentation was screened for the Council. If you have any questions, please send them to Aubrey, and we will get back to you and a response for those questions.
Awareness Day Observation	*Presenters: Tom Cherry, Bri Williams* National Youth HIV & AIDS Awareness Day – April 10 TABLED due to lack of time. Video and slides emailed to Council members.
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.
Adjourned	6:05 PM

ATTENDANCE

Members	Present	Absent*	Members	Present	Absent*
Emily Borke, she/her	X		Heather Leffler, she/her	X	
Tom Cherry, he/him	X		Marisa McDowell, she/her	X	
Claire Contreras, she/ella	X		Scott Moore, he/him	X	
Steven Davies	X		Jamal Muhammad, he/him	X	
Carlos Dory, him/his	X		Diane Quiring, she/her	X	
Michelle Foley, they/them	X		Tessa Robinson, she/her	X	
Greg Fowler, he/him	X		Taylor (Gleffe) Silvey, she/her	X	
Jeffrey Gander, he/him	X		Nick Tipton, he/him	X	
Kris Harvey, he/him	X		Shane Wilson, he/him	X	
Shaun Irelan, he/him	X		Joanna Whitmore, she/her	X	
Julia Lager-Mesulam, she/her	X		Abrianna Williams, she/her (Co-Chair)	X	
Robb Lawrence, he/him		A			
PC Support Staff			**Guests**		
Lisa Alfano			Rayna Appenzeller, she/her (ORAETC)		
Jonathan Basilio	X		ASL Interpreter: Katie	X	
Laura Bradley			ASL Interpreter: Christine	X	
Aubrey Daquiz, she/her	X		Chris Evans, OHSU	X	
Jenny Hampton, she/her (Recorder)	X		Edgar Mendez, he/him, CAP	X	
Amanda Hurley, she/her	X		Meka Hill	X	
Marisa McLaughlin, she/her			Brighid W, ORAETC	X	
Kim Toevs, she/her or they/them					
Grace Walker-Stevenson, they/them	X				

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