Greater Hartford Ryan White Part A Planning Council
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September 2, 2015

MINUTES

Members Present		
Nitza Agosto	Moneca Liz	Vanessa Taylor
Kate Bassett	Andre McGuire	Dorine Testori
Janier Caban Hernandez	Myrna Millet-Saez	Danielle Warren Dias
Cassie Cain	Denise Morin	
Alice Ferguson	Yolanda Potter	
Loyd Johnson	Janette Rodriguez	
Leander Kelly Jr	Jose Rodriguez	
Members Absent		
Mary Prince	Monica Martinez	Sylvia Miller
Staff		
Angelique Croasdale	LaShaunda Drake	Peta-Gaye Nembhard
Renata Dixon		
Guests		
Vivian Riera-Llantin	Melanie Alvarez	Shawn Lang
Nicole Adelkopf	Keysha Starks	Yanira Garcia
Jennie Wakefield		

Action Items Completed:

- Approved Minutes from June and July Planning Council Meetings
- Approved 2016 Directives to the Grantee
- Raffle winners

1. Welcome & Announcements

Co-chair Loyd Johnson called the meeting to order at 11:00 a.m. Loyd reminded everyone that Planning Council meetings are open to the public, but some of the information discussed in these meetings, including people's HIV status, is of a confidential nature, and everyone is expected to honor and respect that confidentiality. Loyd then asked staff to re-introduce meeting procedures. Renata Dixon, staff, reported that the Steering Committee decided to reinstitute the public comments portion of the agenda. During this time, members of the public are invited to address the Planning Council for no more than two minutes. A timer and an applause button will be used to indicate to the speaker that their 2 minutes has expired. Also, members were provided with name tents and a chime would be used to call the meeting to order or regain member attention.

2. Moment of Silence/Introductions

Co-Chair Loyd Johnson asked the group to observe a moment of silence to remember persons we have known and loved who have been lost to the AIDS epidemic and to remember all individuals living with and affected by HIV/AIDS.

To comply with the Planning Council Conflict of Interest policy, Loyd asked those in attendance to introduce themselves, state what organization they work for, and what funded Ryan White Part A services their organization provides, if any.

3. Council Meeting Minutes:

Minutes for June 3, June 24, June 26 and July 8 were reviewed and approved.

4. 2015 Resource Allocation

Next, Co-chair Loyd Johnson introduced Renata Dixon to review the 2015 Resource Allocation. Renata distributed a schedule reflecting the allocations that were voted on via electronic mail. The resource allocations were passed

5. 2016 Allocation Resolution

Renata Dixon distributed the resolution, Roberts Rules of Order and the Bylaws pertaining to voting. The Steering Committee passed a resolution for the 2016 allocations that were discussed in the July 8th meeting. Committee members requested clarification on the resolution. The Steering Committee relied on the following sections of the By Laws and Roberts Rules of Order to allow the abstaining Co-Chair the opportunity to vote. His vote was in the affirmative and the allocation was passed. Subsequently, via electronic mail, the membership was informed.

Per By Laws:

Section VI – Voting

Each member of the Planning Council shall be entitled to one vote upon any matter before the Council. Voting upon any issue shall be by voice vote, or by show of hands, of the members. A majority is 51% of those voting. An abstention is considered a vote.

Per Roberts Rules of Order – Article VIII.Vote:

On a tie vote the motion is lost, and the chair, if a member of the assembly, may vote to make it a tie unless the vote is by ballot. The chair cannot, however, vote twice, first to make a tie and then give the casting vote. In case of an appeal [21], though the question is, "Shall the decision of the chair stand as the judgment of the assembly? In a tie vote, even though his vote made it a tie, sustains the chair, upon the principle that the decision of the chair can be reversed only by a majority, Including the chair If a member of the assembly.

6. 2016 Directives to the Grantee

Renata Dixon provided the draft 2016 Directives to the Grantee. The members provided revised wording and additions that had been included in this draft. See attached revised approved 2016 Directives to the Grantee.

Those revisions are:

Housing – members wanted to ensure that the directives match information in the provider agreements.

- Change #4 from step-down housing [preference given to clients with a history of substance abuse and their families] with a case management component to step-down housing [preference given to clients with a history of reunification with their families] with a case management component.
- Delete #6 make homeless shelter(s) available to PLWHA during daytime hours,

Medical Case Management –

- Replace #3 Provide centralized training, supervision, and education to all case managers (medical site and community based) with Provide centralized and/or decentralized training, supervision, and education to all onsite case managers within the facilities (medical site and community based).

Medical Transportation Services –

- Add Special consideration should be given for non-traditional hours

Pyschosocial Support Services – to provide much clearer direction as it relates to the Planning Group's intentions. This information was pulled directly from job descriptions developed by the Boston Group which HRSA established to develop peer employment programs. The intent is to seamlessly integrate the PLWHA Peer into the Care Team.

Replace - Services focus on peer-to-peer lead support groups - with

a. The PLWHA Peer is to provide a bridge between providers and clients that facilitates the medical and psychosocial care of clients.
b. The PLWHA Peer is to be an integral part of the treatment adherence program as he/she provides specialized services in a professional environment.
c. The PLWHA Peer works to encourage engagement into care and support adherence to treatment by providing client centered individual and group level skill building sessions to achieve client goals.

d. The PLWHA Peer works in a team setting as one component of the clients coordinated care. However, the PLWHA Peer is an advocate for the client, and maintains a relationship with the client that fosters trust and understanding distinct from the provider role.

e. The PLWHA Peer is expected to serve as a model who provides reliable information, appropriate referrals, and emotional support to clients who are infected with HIV or AIDS.

f. Peers also help clients access services (medical, emotional, economic, and legal) and sometimes accompany clients to appointments or arrange for transportation as needed.

One member's comments and concerns, that were previously submitted, were discussed in detail. Following the discussion and amendments, the directives were passed.

8. Grantee Office Report

Angelique Croasdale from the Grantee's Office provided an update on the issue raised about the sharing CareWare information with the State. The Planning Council's PEC has taken a proactive approach by joining with GLADD to engage legal representation to be able to obtain an injunction stopping the City from sharing CareWare information with anyone, including the State. Angelique explained that there were releases signed by clients to allow their information to be placed in CareWare for a specific period of time. This strictly specific release impacts client's expectation of privacy (HIPAA) as well as the one year time limit imposed. Additional releases would need to be secured from each provider using the system as well as each individual.

7. Committee Reports

The following committees met and the chairs provided an update to the Planning Council.

Membership – The committee reviewed the Planning Council reflectiveness to the community. It was noted that the membership application has been revised to include age and exposure category. A confidential form was passed out to members to complete to obtain age and exposure category information to enable the Membership

Committee to determine the demographics of recruitment. During the meeting, the Membership Committee interviewed one candidate.

Evaluation
The committee reviewed the CDC HRSA Integrated Prevention and Care Plan Guidance. The committee has recommended that the Grantee's Office begin(continue) conversation with CHPC (CT HIV Planning Consortium) and Department of Public Health to coordinate an integrated state/city prevention and care plan to CDC and HRSA.

PEC
Andre' and Janette noted that the most pressing concern of PEC at this time is the possibility of the release of confidential information in direct opposition to the intent of the releases signed. PEC is working with partner agencies and making sure that the community understands the severity and importance of this issue.

Priorities and Needs Assessment
Committee set up an Ad Hoc Committee to review the EFA and Housing Program requirements. Issues this committee will address include the requirement for utility shut off notices prior to providing RWA assistance and the documentation required for housing assistance.

8. Raffle Winners

Andre McGuire, Janette Rodriguez and Moneca Liz won the monthly raffle drawing.

Meeting adjourned at 2:30 p.m.

Ryan White Planning Council
FY2016 Directives to the Grantee for Part A & MAI Services
(Specific directions provided to the Grantee for each service category as noted below)
Approved by Planning Council September 2, 2015

Service Category	Directive
All Service Categories	1. Provide services in a culturally and linguistically competent manner 2. Address service gaps for all special populations with emphasis on, men who have sex with men and Black and Latina women, aging and transgendered 3. Whenever possible, provide services during nontraditional hours and at locations that offer ease of access 4. Give preference to providers who demonstrate successful systems of culturally and linguistically competent service provision for the special populations they are either serving or seeking to serve. Characteristics of successful systems include: PLWHA Peer to PLWHA Peer staff and are reflective of the demographics of the population served, culturally competent care, diverse staff and leadership, education and training, language access (written, oral, sign, etc.), strategic planning, use of epidemiological profiles and needs assessment data, and community and consumer involvement 5. Points on the Request for Proposal shall be added to bidders who show successful PLWHA Peer-to-PLWHA Peer staff and are reflective of the demographics of the population served. 6. In an effort to address unmet need and fill service gaps of those in care, agencies must demonstrate the ability to collaborate with both Ryan White and non-Ryan White funded providers in their proposed service plans and through the provision of current Memoranda of Understanding or Agreement 7. Select providers and provide services in such manner as to foster and sustain the TGA's HIV Wellness Centers 8. Ensure services are proportionately available to rural areas to the extent possible 9. Require service providers to conduct annual client satisfaction surveys 10. Require contracted providers to request membership on Planning Council and participate in committee meetings
Housing	• Provide, if funds are available: 1. short-term rental assistance [$150 month], 2. one-time emergency rental assistance [back rent, 1st month rent],

	3. supportive housing [scatter site with case management], 4. step-down housing [preference given to clients with a history of verification with their families] with a case management component, 5. transitional housing programs [emergency – hotels], 6. housing related referral services, with an emphasis on persons with HIV who are homeless. • Give preference to providers able to provide a multiplicity of housing services in the most cost effective manner.
Medical Case Management (incl Treatment Adherence)	1. Provide centralized and/or decentralized medical case management services that increase the number of case managers in medical settings and, where appropriate, the number of case managers employed directly by medical sites, while recognizing the continued need under appropriate circumstances for community-based case management services. In either model (centralized or decentralized) whether medical setting or community sited, there needs to be proof (such as the availability of office space for confidential meetings, inclusion of the medical case manager in client case conferences, or other methods to ensure that the medical case managers can work to help keep clients in care) of the incorporation of the medical case manager into the clinical care team. 2. Give preference to providers, when available, who offer a co-location model of core clinical services such as mental health, substance abuse treatment and medical case management and support services designed to contribute to increased health outcomes for those in care. 3. Provide centralized and/or decentralized training, supervision, and education to all on site case managers (medical site and community based). 4. Provide treatment adherence support. 5. Ensure services are proportionately available to rural areas to the extent possible. 6. Ensure services are available to Black women and Black men who have sex with men.
Outpatient/ Ambulatory Medical Care	1. Ensure medical care is available to disproportionately infected minority populations including adolescent/ youth 2. Provide women's and men's health services that is specific to the population seeking health services, to the extent possible 3. Provide mid-level providers (APRN, NP, PA, with HIV specialty) to make available more HIV care and to free up

	Infectious Disease physicians' time to work on more complex cases, and provide RN/LPN support as needed 4. Ensure services are proportionately available to rural areas to the extent possible 5. Ensure that a referral process is in place to link individuals in homeless shelter to clinic and support services 6. Give preference to providers, when available, who offer a co-location of core clinical services such as mental health, substance abuse treatment and medical case management and support services designed to contribute to increased health outcomes for those in care
Mental Health	1. Provide co-location of mental health services in clinic and community settings. 2. Provide mental health services at homeless shelters.
Early Intervention Services (EIS)	1. Provide services that act as a bridge between testing and care by steering individuals from testing and linking them to primary medical care and medical case management, mental health and substance abuse treatment and support services. EIS services should be designed to work closely with key points of entry thus facilitating easy access to the HIV care system once an individual learns of their status. Key points of entry are places where HIV testing occurs. For the Hartford TGA these include but are not limited to public health departments, private providers, HIV counseling and testing sites, emergency rooms, substance abuse and mental health treatment programs, detoxifications centers, detention facilities, STD clinics, and homeless shelters. EIS providers must have referral/linkage agreements with key points of entry that should be monitored by the grantee to ensure effective linkage mechanisms are in place and active 2. Provide intensive support over a course of several months (3-6months) to build trust, orient clients to the system of HIV care, increase their knowledge about living with HIV, educate them regarding the importance of routine medical care, increase their health literacy and begin the process of developing the foundation for disease self-management 3. Provide co-location of services, where possible at Outpatient Ambulatory sites that reengage individuals with HIV who have fallen out of care, are erratically engaged in care, or are at risk of falling out of the HIV care system 4. EIS services should serve to identify persons with HIV who are unaware of their status; make them aware of their HIV infection; educate them about HIV, the importance of care and the Ryan

	White system; and link them to primary medical care and case management 5. EIS services to target those neighborhoods disproportionately affected with HIV/AIDS and STD based on epidemiological data 6. Whenever possible, provide services during nontraditional hours and at locations that offer ease of access. These hours should include weekends and nights 7. Ensure EIS services are linked to partner notification and the TGA's Early Identification of Individuals with HIV/AIDS (EIIHA) model 8. Where there is co-location of EIS with other HIV testing services, EIS should become a referral based linkage program without creating a barrier to services 9. Where possible use PLWHA Peer-to-PLWHA Peer model to deliver services
Substance Abuse-Outpatient	1. Provide substance abuse services at homeless shelters and where possible in conjunction with housing providers who provide links and referrals to outpatient ambulatory medical care. 2. Provide co-location of substance abuse services in clinic and community settings. 3. Provide acupuncture to reduce drug cravings.
Medical Transportation Services	1. Special consideration should be given to individuals in the rural area based on cost. 2. Special consideration should be given to nontraditional hours to offer ease of access to care during these hours.
Case Management (non-Medical)	1. Provide HIV positive persons with assistance in obtaining medical, social, community, legal, financial and other needed services. 2. Provide services through the TGA's HIV wellness centers.
Pyschosocial Support Services	• The PLWHA Peer is to provide a bridge between providers and clients that facilitates the medical and psychosocial care of clients. • The PLWHA Peer is to be an integral part of the treatment adherence program as he/she provides specialized services in a professional environment according to the agency. • The PLWHA Peer works to encourage engagement into care and support adherence to treatment by providing client centered individual and group level skill building sessions to achieve client goals.

	• The PLWHA Peer works in a team setting as one component of the clients coordinated care. However, the PLWHA Peer is an advocate for the client, and maintains a relationship with the client that fosters trust and understanding distinct from the provider role. • The PLWHA Peer is expected to serve as a model who provides reliable information, assist in the coordination of appropriate referrals with the client care team, and emotional support to clients who are infected with HIV or AIDS. • Peers also help clients access services (medical, emotional, economic, and legal) and sometimes accompany clients to appointments or arrange for transportation as needed.
Food Bank/Home Delivered Meals	1. Involves the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such hygiene items and household cleaning supplies should also be incl in this item. The provision of food or nutritional supplements by someone other than a registered dietician should be included in th item as well. 2. Food vouchers provided as an ongoing service to a client should be reported in this service category. Food vouchers provided on a one-time or intermittent basis should be reported in the Emergency financial assistance category.