

## Oregon HIV Care Coalition

### GENERAL ASSEMBLY MEETING MINUTES

**Co-Chairs:** Brad Howell and Muriel DeLa Vergne-Brown

**Date:** January 17, 2007

**Start Time:** 9:45 a.m.

**End Time:** 4:00 p.m.

**Present:** Rey Agullana, Jodi Davich, Ryan Deibert, Muriel DeLa Vergne-Brown, Linda Drach, Victor Fox, Brad Howell, Don Jarvi, Veda Latin, Susan McCreedy, Doug Moon, Loreen Nichols, Karen Pancheau, Debby Parrish, Steven Pierson, Margy Robinson, Sean Schafer, Ann Shindo, Robert Skinner, Jill Snyder, Renee Yandel

**Unable to attend:** Sherri Alston, Scott Ekblad, Becky Harmon, Suzy Holcomb, Tom McConnell, Jeff Miller, John Motter, Melissa Murphy, Sheryl Powell, Valerie Rux, Sandra Sciacotti

**Staff & Contractors:** Lisa McCauliffe, Donna Yutzy

	<b>Agenda Item</b>	<b>Discussion Notes and Conclusion</b>
1.	<b>Welcome &amp; Introductions Announcements</b>	Muriel DeLa Vergne-Brown convened the General Assembly of the Oregon HIV Care Coalition.  Attendees introduced themselves and made announcements about upcoming events.
2.	<b>PLWH Ceremony</b>	A moment of silence was observed.
3.	<b>Committee Report:</b> • <b>Quality Management Task Force</b>	<i>Co-Chairs: Becky Harmon, Margy Robinson</i> Margy Robinson reporting.  Includes members from Titles I, II, III and the AETC. The Task Force meets quarterly. <ul style="list-style-type: none"> <li>• Looking at assessment of surveillance data to find one outcome to measure for engagement in care.</li> <li>• Looking at development of protocols for how the QM Task Force might function as the quality management committee for all titles.</li> <li>• Are looking for PLWH/A members.</li> </ul> <i>Handout</i>
4.	<b>Committee Report:</b> • <b>HIV Housing Task Force</b>	<i>Co-Chairs: Renee Yandel &amp; Sherri Alston</i> Ryan Deibert reporting.  In general, in ebb stage of lifecycle. Bulk of work was putting together the original housing assessment and the initial OHOP program. Continues its work as members who are interested in

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		maintaining level of expertise on housing and provide advice to the OHOP program. Are re-organizing. Program sends out an outdate on housing. Will continue to meet perhaps annually to provide a housing symposium.
5.	<b>Committee Report:</b> <ul style="list-style-type: none"> <li><b>CAREAssist Advisory</b></li> </ul>	<p><i>Co-Chairs: Debbie Parrish &amp; Vic Fox</i>                      Debbie Parrish presenting.</p> <p>Decided to go ahead and set up a regular meeting schedule. Meeting at least twice a year. Next meeting is May 7<sup>th</sup> and then next will be in December. Reviewed program data and utilization information. Is available on the program website. Have served 1758 unduplicated clients Jan-Sept. 2006. Reviewed Medicare D plans for 2007. Kate Langley Powell at HHSC has been an invaluable resource and has been invited to attend the Advisory Committee meetings. Update on the Quality Collaborative. New Benefits Specialist available to clients. Ad hoc group will be meeting to review vision and mission statement.</p> <p><i>Handout</i></p>
6.	<b>Committee Report:</b> <ul style="list-style-type: none"> <li><b>Case Management Task Force</b></li> </ul>	<p><i>Co-Chairs: Susan McCreedy &amp; Sheryl Powell</i>                      Susan McCreedy presented.</p> <p>Getting case managers together was good. A very lively discussion. Lots of details on what assess and how assess. Reviewing forms and standards. Philosophical discussions about who should be doing case management. Nurse vs. psychosocial case managers roles &amp; responsibilities.</p> <p>Discussing the delivery model in Oregon. Is it something that needs to be looked at? Need to meet annually. Looked at acuity. Spent a lot of time looking at acuity. Discussed HIV Alliance’s new Dental Program grant.</p>
7.	<b>Program Report:</b> <b>CAREAssist</b>	<p><u>CARE Assist: Presented by Vic Fox</u></p> <ul style="list-style-type: none"> <li>• Chart showing number of clients in each of the three groups over the past three years. Described three groups. 90% of clients in Group 1.</li> <li>• Chart of demographics of clients served in CY 2006. 88% male.</li> <li>• Race/ethnicity of clients served in CY 2006. 73% white. Increase in African American from 3% to 7% because of closure of OHP. Represent 5.5% in epidemic, so are serving higher percentage in CAREAssist. Concern about how to reach African Americans.</li> <li>• Clients by FPL over three years. Fairly steady over past three years. 52% have incomes less than \$816/mo income. Overwhelming majority under 200%.</li> </ul>

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	<p><b>Case Management and Support Services</b></p>	<ul style="list-style-type: none"><li>• We are a safety net program for poor clients.</li><li>• Clients served by county.</li><li>• Number of clients enrolled in OMIP has steadily increased over the past three years. OMIP is the most important partner for CAREAssist.</li><li>• Approximately 600 clients are Medicare clients.</li><li>• Changes in Medicare Part D changed slightly:</li><li>• Subsidy went down</li><li>• Doughnut hole increased</li><li>• Total out-of-pocket expense increased</li><li>• Challenges in 2007<ul style="list-style-type: none"><li>- Minimum drug formulary to be required</li><li>- ADAP's must report on client level on medical outcomes</li><li>- Do CD4 &amp; VL labs work as a surrogate for medical visits? Issue with Kaiser and OHSU putting lab results on-line is when a client checks their lab results and then doesn't bother to go to follow-up appointment if everything looks OK. Docs are reporting increased appointment cancellations with new on-line reporting.</li><li>- Oregon is part of the ten state HRSA ADAP Advisory Panel which will assist HRSA to develop the required reporting elements that will become mandatory.</li><li>- Increased enrollment results in greater work load</li><li>- Considering EDMS handling of all incoming correspondence</li><li>- Looking to develop a dual system for receiving 340B discounts</li><li>- Looking at gaps in CAREAssist client service continuum, to come up to the public health service standards for lab testing and medical visits.</li></ul></li></ul> <p><i>Handout</i></p> <p><u>Case management - Annick Benson-Scott</u> Donna Yutzy reporting.</p> <ul style="list-style-type: none"><li>• HIV Case Management Task Force met November 30<sup>th</sup> to review the HIV Case Management Standards and forms. A summary of the changes requested included re-ordering information on the Assessment forms and streamlining the Re-assessment process. PDES will be validating the Acuity scale and additional improvements may be made based on their findings. Changes to the HIV Case Management Standards of Service and forms will be effective July 1, 2007.</li></ul>
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	<p><b>OHOP</b></p>	<ul style="list-style-type: none"> <li>• The program completed the 2006 site visits in December – visited Clatsop, Hood River, EOCIL, Polk and Jackson. The 2007 site visits schedule includes visits to Tillamook, Lincoln, Jefferson, Deschutes and HIV Alliance.</li> <li>• All Ryan White Title II agencies have been converted to the new system for at least a year (some for 15 months) and are using the centralized CW database “live.” Have encountered minimal concerns regarding connectivity. Most performance issues are related to local network configuration, speed or traffic and have been addressed by improving the performance of the local network. DHS has been able to respond to nearly a dozen data requests by administration, federal officials, the public and the legislature. DHS has provided training to all case managers, created a DHS-specific CAREWare manual, and continues providing ongoing technical assistance. The next CAREWare training is January 29<sup>th</sup>.</li> <li>• CAREWare priorities for next year include: (1) completion of a server transition to a multi-level fail-over configuration; (2) implementation of a data quality management plan; and (3) provision of addition training for custom reporting and creation of an on-line module for new case managers.</li> <li>• The end of the year CARE Act Data Report is due in March. The program has developed a report within CAREWare that will identify unreported or unknown data elements and is working with service providers to assure their data is complete.</li> </ul> <p><u>OHOP – Presented by Vic Fox</u></p> <ul style="list-style-type: none"> <li>• PIP grant close-out; July 31, 2006             <ul style="list-style-type: none"> <li>- 58 PLWH/A served + 29 affected family member = 87 individuals served</li> <li>- \$92,000 in direct HOPWA rental assistance</li> <li>- &gt;\$390,000 in leveraged supportive services</li> <li>- 91% of clients in stable housing at end of year</li> </ul> </li> <li>• NEW HOPWA SPNS GRANT             <ul style="list-style-type: none"> <li>- Oregon Statewide Supportive Community Reentry (OSSCR) Program</li> <li>- 3 year- \$1.37 million HOPWA special project of national significance</li> <li>- Tenant based rental assistance to 55 client households per year</li> <li>- Eligibility: low income, living with HIV, returning to</li> </ul> </li> </ul>
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		<p>community following incarceration</p> <ul style="list-style-type: none"> <li>- Assistance to 20 clients in Portland metro (through CAP)</li> <li>- Assistance to 35 clients in Balance of State (through OHOP)</li> <li>- Collaboration across all major HIV service system in Oregon</li> <li>- Ryan White Title I &amp; II</li> <li>- HOPWA Balance of State and metro</li> <li>- Cascade AIDS Project</li> <li>- Oregon Dept. of Corrections</li> <li>- Partnership Project</li> <li>- Featured by HUD as national model for reentry programs</li> </ul> <ul style="list-style-type: none"> <li>• Continued current client enrollment of ~ 110 client households</li> <li>• Oregon HIV Case Management Conference focused on housing</li> <li>• New Region 4 (Central &amp; Eastern Oregon) housing coordinator, Victoria Saldana</li> <li>• Change in wait list policy</li> <li>• Are seeking additional funding</li> <li>• Continued development of collaborative partnerships</li> <li>• Formula grant reporting in March</li> </ul> <p><i>Handout</i></p>
<p><b>8.</b></p>	<p><b>OHOP Presentation</b></p>	<p>Presenter; Ryan Deibert          “Housing as Prevention &amp; Care”</p> <p>HIV and Housing Link:</p> <ul style="list-style-type: none"> <li>• HIV prevalence 3-9 times higher among homeless vs. housed</li> <li>• Up to 60% of PLWH/A have lifetime experience of homelessness or housing instability</li> <li>• All-cause death rate among homeless PLWH/A is 5 times higher than housed PLWH/A</li> </ul> <p>HIV &amp; Housing Response:</p> <ul style="list-style-type: none"> <li>• Homeless “Continuum of Care”</li> <li>• Targeted outreach for prevention &amp; care</li> <li>• Ryan White CARE Act</li> <li>• HUD: Housing Opportunities for PLWA (HOPWA)</li> </ul> <p>Housing as HIV Prevention (Columbia University Study)</p> <ul style="list-style-type: none"> <li>• Homeless are most likely to engage in risky behaviors than marginally housed</li> <li>• Both more likely to engage in risky behaviors than those in stable housing</li> <li>• Recent needle sharing – 4X greater if homeless</li> </ul>

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	<ul style="list-style-type: none"><li>• People in unstable housing situations are not inherently riskier people</li><li>• They are people in riskier situations – paradigm shift from “riskier person model” to “riskier situation model”</li><li>• Housing is an independent, structural factor affecting HIV transmission risk</li></ul> <p>Housing as HIV Care</p> <ul style="list-style-type: none"><li>• Improved housing situation linked to increase in outpatient health care links</li><li>• Improved housing situation linked to increased use of ARV medicines</li><li>• Results – Outpatient HC visit in last 6 months improved by 5X and ARV medication use improved by 6 times.</li><li>• CDC study to be published this year: homeless people are less likely to report good health status, undetectable viral load, are taking HIV meds and are adherent in past 48 hours.</li></ul> <p>Cost Effectiveness of HIV/AIDS Housing</p> <ul style="list-style-type: none"><li>• Preliminary research discussed – if preliminary results hold true, housing as HIV prevention strategy likely to be more cost-effective than PSA screening, breast mammography and medical therapy for congestive heart failure.</li><li>• NYC “Housing First” – costs less to provide housing first then provide shelter (\$22K vx. \$28K) and had better outcomes.</li><li>• NYC supportive housing programs for Severely Mentally Ill: recoup 95% of per capita cost through savings to shelters, jails and hospitals</li><li>• Denver “Housing First” – saved \$4,754 per person over 2 years – if applied to all chronically homeless - \$2,424,131 savings.</li></ul> <p>Challenges/Barriers</p> <ul style="list-style-type: none"><li>• Require clean time before entering program</li><li>• Methadone users excluded</li><li>• Criminals excluded</li><li>• Ryan White Modernization Act – not a core service</li><li>• HUD’s budget has decreased as percentage of overall budget</li><li>• Housing is not being funded well by feds</li><li>• Analysis is difficult and costly</li><li>• Costs and savings across multiple systems</li></ul> <p>Implications for Policy</p> <ul style="list-style-type: none"><li>• Increase coordinated investment in supportive housing for PLWH/A</li><li>• Decrease barriers to entry to housing programs</li><li>• Support Housing First model with harm reduction</li></ul>
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		<p>Implications for Program</p> <ul style="list-style-type: none"> <li>• Coordinate supportive housing services with prevention activities</li> <li>• Demonstrate prevention-related outcomes</li> <li>• Adopt Housing First model with strong supportive services</li> <li>• Continue coordination with HIV care system</li> <li>• Demonstrate HIV-related health outcomes</li> <li>• Demonstrate cost-savings</li> <li>• Review shared data</li> </ul> <p><i>Handout</i></p>
<p><b>9.</b></p>	<p><b>Lunch Presentation</b></p>	<p>Presenter: Sean Schaffer “HIV EPI Profile”</p> <p>Summary</p> <ul style="list-style-type: none"> <li>• Named reporting in Oregon</li> <li>• In Oregon             <ul style="list-style-type: none"> <li>- &gt;5,000 Living with HIV</li> <li>- Cases disproportionately in Portland area</li> <li>- Incidence and prevalence low vs. US</li> <li>- MSM is predominant transmission mode</li> <li>- Rates higher in Blacks, Hispanics but few overall cases</li> <li>- Foreign born cases increasing, Africa, Latin America</li> </ul> </li> <li>• Survival increasing</li> <li>• Late diagnosis too common             <ul style="list-style-type: none"> <li>- Young/Old, Hispanics, Men, IDU</li> </ul> </li> <li>• Increasing relevance co-morbid chronic disease</li> <li>• Testing appropriately concentrated in high incidence/prevalence areas</li> <li>• Some testing locations have no positive tests last 5 years</li> </ul> <p>Future Goals to Consider</p> <ul style="list-style-type: none"> <li>• Better understanding of location of transmission, risks among foreign-born</li> <li>• Expand/target testing             <ul style="list-style-type: none"> <li>- Routine “opt-out” testing in medical settings?</li> <li>- Examine priorities where few positive tests</li> <li>- Earlier testing for men, IDU, Hispanics</li> </ul> </li> <li>• Introduce testing for acute HIV in high risk settings</li> <li>• Increase number of new patients that get partner counseling and referral.</li> </ul> <p>Partner Counseling for HIV in Oregon, 1997-2005</p> <ul style="list-style-type: none"> <li>• New HIV/AIDS Diagnosis = 2490</li> <li>• 624 were interviewed (doctors contacted to verify report and are asked if their client would like to be contacted for partner</li> </ul>

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		<p>notification counseling, majority say “no”)</p> <ul style="list-style-type: none"> <li>• 515 partners elicited</li> <li>• 414 partners contacted</li> <li>• 45 new positives were identified</li> </ul> <p><i>Handout (copy of presentation will be emailed to all attendees)</i></p>
<p><b>10.</b></p>	<p><b>Joint Session (OHCC &amp; SPG)</b></p>	<p>Prevention/SPG Overview: Doug Moon</p> <ul style="list-style-type: none"> <li>• Description of community planning</li> <li>• Tasks of SPG</li> <li>• Description of Comprehensive Plan             <ul style="list-style-type: none"> <li>- Ensure the greatest reduction of HIV transmission in Oregon</li> <li>- Identify &amp; prioritize target populations that need HIV prevention services</li> <li>- Identify a set of evidence-based interventions for each priority population</li> </ul> </li> <li>• Community Planning Process</li> <li>• Products of SPG             <ul style="list-style-type: none"> <li>- Epi Profile</li> <li>- Community Services Assessment</li> <li>- Prioritized Populations</li> <li>- Set of Interventions for Each Population</li> </ul> </li> <li>• Description of HIV Prevention System</li> <li>• Clarifying roles &amp; SPG organizational chart</li> <li>• Prevention efforts with PLWH/A:             <ul style="list-style-type: none"> <li>- Counseling &amp; testing</li> <li>- HIV-specialized disease intervention specialist</li> <li>- Integration into case management and medical services</li> <li>- Comprehensive Risk Counseling Services (CRCS) – used to be called “Prevention Case Management”</li> </ul> </li> <li>• Prevention in Oregon             <ul style="list-style-type: none"> <li>- Statewide CRCS</li> <li>- HIV-specialized PCRS (HIV-DIS)</li> <li>- Integrated prevention in MCHD HIV clinical settings</li> <li>- Prevention interventions for PLWH and their partners through county health departments &amp; CBO</li> <li>- “HIV Stops With Me” social marketing campaign</li> </ul> </li> </ul> <p><i>Handout</i></p> <p>Care/Treatment/OHCC Overview: Donna Yutzy</p> <ul style="list-style-type: none"> <li>• National HIV Service System             <ul style="list-style-type: none"> <li>- HRSA/HAB</li> </ul> </li> </ul>

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		<ul style="list-style-type: none"><li>- CMS</li><li>- CDC</li><li>- SAMHSA</li><li>- HUD</li><li>• Ryan White &amp; HOPWA funds in Oregon<ul style="list-style-type: none"><li>- Title I (Portland EMA)</li><li>- Title II</li><li>- Title III</li><li>- SPNS/Dental Grant</li><li>- AETC</li><li>- HOPWA Portland MSA</li><li>- HOPWA Balance of State formula &amp; competitive</li><li>- HOPWA SPNS</li></ul></li><li>• Oregon’s Title II organizational structure</li><li>• HIV Client Services’ Advisory Groups<ul style="list-style-type: none"><li>- OHCC</li><li>- CAREAssist Advisory Committee</li><li>- Quality Management Task Force</li><li>- HIV Housing Task Force</li><li>- HIV Case Management Task Force</li></ul></li><li>• Overview of CAREAssist</li><li>• Overview of Case Management Program</li><li>• Overview of State Managed Services</li><li>• Overview of OHOP</li></ul> <p>Discussion facilitated by Doug Moon</p> <p>Comments:</p> <ul style="list-style-type: none"><li>• It’s about time; long overdue to get together</li><li>• Need talk about STD screening – MSM getting screening every three months</li><li>• Need to talk about risk assessments and how it will work in care system</li><li>• Needs to be more training Partner Notification – DIS training</li><li>• Look at cost effectiveness – include programs based on prevalence, SPG plan, big picture look</li><li>• Can’t forget population that receive HIV care outside our “silo” – how to reach</li><li>• Network with OHP care folks – other resources</li><li>• Using existing services – using existing intake &amp; assessments – through acuity – highlight client’s prevention needs</li><li>• Housing as HIV prevention</li><li>• Need increased dialogue with prevention &amp; care to increase outreach and connection to all at risk HIV+ people</li><li>• Localized services for prevention &amp; partner notification</li></ul>
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	<ul style="list-style-type: none"><li>• Prioritize HIV+ clients who are riskiest – for HIV care – eg. Housing/stability</li><li>• Increase outreach &amp; connection to all risk groups</li><li>• Better understand PCRS w/ DIS and how clients can be better served</li><li>• Risk assessment in care especially related to internet hook-ups and STD/Hep C</li></ul> <p>Broke into 3 small groups to answer three questions:</p> <ol style="list-style-type: none"><li>1. What should HIV Prevention for PLWH/A accomplish?</li><li>2. What do case managers/clinical providers need from HIV Prevention/SPG to serve their clients better?</li><li>3. What do HIV Prevention folks (administrators, health educators, outreach workers) need from HIV Client Services/CARE Coalition?</li></ol> <p>Question 1:</p> <ul style="list-style-type: none"><li>• Introduce wrap around services, life stabilizing services</li><li>• Reduce transmission</li><li>• Adhering to medications, housing are prevention</li><li>• Identify/ diagnose HIV earlier and get into care earlier</li><li>• Increase overall health and well-being of PLWH\</li><li>• Reduce their risk behaviors that transmit to others</li><li>• Support PLWH to notify their partners of possible exposure</li><li>• Decrease STD transmission</li><li>• Comprehensive response for HIV services/HIV education</li><li>• Decrease transmission to partners – educate providers/case managers</li></ul> <p>Question 2:</p> <ul style="list-style-type: none"><li>• Training at service level/for county staff (AETC?)</li><li>• Sharing information and networking between two groups</li><li>• Basic messages &amp; talking points (prevention),</li><li>• Guidance on “core transmitters” and how to work with high risk clients</li><li>• Teach case managers how to do risk reduction counseling (dual role of case manager as risk reduction counselor isn’t always successful)</li><li>• Clear message/condensed package so consistent throughout the state</li><li>• Bus ticket to Eugene</li><li>• Case manager need to communicate with DIS</li><li>• Understand peer and community level interventions</li><li>• Holistic (Prevention in general health care)</li></ul>
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		<ul style="list-style-type: none"> <li>• Quick response with appropriate information for different risk groups</li> </ul> <p>Question 3:</p> <ul style="list-style-type: none"> <li>• More technical information to link programs,</li> <li>• Ask about service needs, ie. At a needle exchange program</li> <li>• Care providers can provide better referrals to prevention services</li> <li>• How do you refer to resources outside own county</li> <li>• Better communication between prevention and care providers</li> <li>• Know better what services are offered in each program</li> <li>• Reduce barriers &amp; wider, clear training (climb 1 mountain at a time, not tons of hills – gentle leading)</li> <li>• Information from care service providers about their clients’ risk behaviors (their demographics, other needs &amp; resources they have)</li> <li>• Case managers &amp; clinicians can use their relationships to leverage clients into prevention activities</li> <li>• Care providers could give feedback on what prevention messages are working in the community</li> <li>• Using dialogue and relationship that case managers have with clients to get them involved in prevention/intervention</li> <li>• It seem evident that prevention services are best provided in a care services setting – e.g. SHOP gets 80% of their referral within the STD clinic, how can prevention and care work together without infringing upon each other</li> </ul>
11.	<b>Partner Reports:</b>	See below
	<p><b>Partner Report:</b></p> <ul style="list-style-type: none"> <li>• <b>Title I</b></li> </ul>	<p><u>Presented by Margy Robinson</u></p> <ul style="list-style-type: none"> <li>• TOURS has been in use for the entire contract year. It is providing a level of information previously unavailable that now can be used for quality assurance and quality management.</li> <li>• Using Chronic Care Model as system model             <ul style="list-style-type: none"> <li>- new referral form for use with Prevention &amp; Care model</li> <li>- Narrative report required on documentation of a PDSA cycle now required by each agency</li> <li>- Narrative report forms also document improvements in six elements of CCM</li> <li>- Self management workshops being offered</li> </ul> </li> <li>• Quality Management Plan in final draft form.</li> <li>• Service Standards are finalized.</li> <li>• Implementation of 3% decrease funding scenario for upcoming</li> </ul>

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		<p>contract years.</p> <ul style="list-style-type: none"> <li>• Reauthorization – contains significant changes for Portland EMA. Planning Council expenses now included in administrative cost cap of 10%. PC moving to reduce expenses.</li> <li>• Seattle EMA visit – colleagues from Seattle EMA will be visiting to discuss TOURS and quality management. They are hoping to use TOURS for their own use.</li> <li>• County budget – are in middle of county budget process - are writing “program offers”.</li> </ul> <p><i>Handout</i></p>
	<p><b>Partner Report:</b></p> <ul style="list-style-type: none"> <li>• <b>Title III</b></li> </ul>	<p><u>Title III, Multnomah County – Jodi Davich</u> Presented by Margy Robinson.</p> <ul style="list-style-type: none"> <li>• Jodi Davich was the former grant writer for Title I and Title III – is very familiar with both programs. Is the new clinic manager.</li> <li>• Received flat funding again for clinic.</li> <li>• Client increase at clinic in 11% in FY 05-06 and 10% in FY 06-07.</li> <li>• Are seeing more clients who are on OMIP who have a pre-existing condition clause so have unreimbursed HIV-related medical care (including labs).</li> <li>• Uninsured visits remain constant at about 15%.</li> </ul> <p><i>Handout</i></p>
	<p><b>Partner Report:</b></p> <ul style="list-style-type: none"> <li>• <b>AETC</b></li> </ul>	<p><u>Presented by Steven Pierson</u></p> <ul style="list-style-type: none"> <li>• There is a wide library of education/training support materials available throughout the country – example from Mountain Plains,</li> <li>• Discussed upcoming workshops/conferences</li> </ul> <p><i>Handout</i></p>
12.	<ul style="list-style-type: none"> <li>• <b>Dental SPNS Grant – Southern Oregon</b></li> </ul>	<p><u>Presented by Renee Yandell</u></p> <ul style="list-style-type: none"> <li>• New HIV Alliance Oral Health Care Initiative – Oregon Rural Alliance of Dental Leadership (ORAL)</li> <li>• HIV Alliance was awarded a \$2 million grant (\$400,000 per year for five years) to create a model dental clinic for people living with HIV/AIDS in Southern Oregon.</li> <li>• The project is a partnership between HIV Alliance, Lane Community College (LCC) Dental School, and Community Health Centers of Lane County (CHC).</li> <li>• Over the next three years will expand services to clients from 15</li> </ul>

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		Southern Oregon Counties (Lane, Benton, Coos, Deschutes, Douglas, Linn, Crook, Curry, Harney, Jackson, Jefferson, Josephine, Klamath and Malheur.  <i>Handout</i>
<b>13.</b>	<b>Adjourn</b>	Adjourned at 4:00 pm