Oregon HIV Housing Task Force

Meeting Minutes: January 25, 2006

Participants:

Name	Agency
Jerae Bjelland, Co-Chair	*Marion County Health Dept.*
Renee Yandel, Co-Chair	*HIV Alliance, Lane County*
Annick Benson-Scott	*DHS, HIV Client Services*
Ryan Deibert	*DHS, HIV Client Services*
Vic Fox	*DHS, HIV Client Services*
Donna Yutzy	*DHS, HIV Client Services*
Karen Smith	*DHS, HIV Client Services*
Elizabeth Anguiano	*DHS, OMHAS*
Kathy Pickle	*Program Design & Evaluation Services*
Ryan Deibert	*OHOP (DHS)*
Cheryl Owen	*Lincoln County Heath Dept.*
Patty Thomas	*Jefferson County Health Dept.*
Judith Rizzio	*Our House & HAAP at OSP*
Denise Fry	*DHS, OHOP*
Jack Duncan	*Oregon Housing & Community Services*
Lynn Adams	*Oregon Housing & Community Services*
Mike Moore	*DHS, OMHAS*
CJ Reid	*DHS, OMHAS*

Welcome and Introductions

Welcome & Introductions facilitated by Donna Yutzy. The next meeting will be the final one in this strategic planning process, where we will develop objectives for the goals derived from previous meetings. The complete plan will be reviewed on January 26 by the Oregon HIV Care Coalition, in which the HIV Housing Task Force is one of six groups.

Program Updates

HIV Client Services – ***Annick Benson-Scott***: CAREWare development and customization is in process for a housing database for OHOP. Benefits are that the same record will be used for one client from both the case management program and the OHOP program, and this will give more information for queries and coordination of programs. The customization is currently a bit behind, but Case Managers will be fully implemented by the end of February. The process is expected to complete by the end of June.

Case Manager Manual revisions will include a section on OHOP to facilitate the exchange of information and understanding. We're looking to complete revisions at the end of June for a July 1 start.

One of our funding streams ends in July; we are looking at grants for continuance of the PIP program.

Assessment and Evaluations – *Kathy Pickle*

Four aspects considered:
1. Consulting on development of select database – how information is gathered.
2. Post-intake surveys of all clients in OHOP are starting in a couple of weeks (client satisfaction survey). Surveys will be collected between February and May - reporting will be in August.
3. Key Informants interviews – This is a follow-up from 2004, getting more information from clients regarding support services.
4. Analysis of information from needs assessment; safety, quality of housing, services.

OHOP - ***Ryan Deibert***

Ryan started with the program in July 2005, and feels the program has made significant strides in the past six months. There are 120 active clients, compared to the October report, and around 40 new intakes. A good dent was made in the waiting list, bringing it down from 50 to 35. The sick and homeless are served first.

Three of the four OHOP Housing Coordinators will attend the New HIV Case Manager training on February 1 & 2, and the Case Manager Meeting, to be held later this year, will focus on OHOP and housing services.

The first HUD site visit was recently completed, and was mostly positive. Almost all previously noted deficiencies were improved. The HUD officer was impressed with the general model of leveraging support services. Ryan expects the HUD report in the next 35-40 days.

NOFA in March or April: OHOP will partner with OHCS on applications and expand on services.

The four housing coordinators are working hard; Ryan is very impressed with what they've been able to do.

LIEAP (Low Income Energy Assistance Program) funds are now available – $50K for OHOP clients. It's already been successful for two weeks; OHOP can use up to $650 per client.

Announcements

Judith Rizzio will be leaving "Our House" after 16 years of service as Community Relations Manager – her last day is March 31, 2006. She is currently looking at what she wants to do next.

Jack Duncan – funding cycle due end of Spring; application process open until 2/24; Group homes for chronically mentally ill, disabled vets

Presentations

Mental Health – Mike Moore and CJ Reid, Oregon Mental Health and Addiction Services (OMHAS)

Mike Moore works to build a foundation of case management & mental health. He coordinates about 36 community mental health programs. Mental health clients are diagnosed with severe, serious or chronic mental illness: schizophrenia, bi-polar disease, etc. Statewide, there are 14,000 to 15,000 seriously mental ill clients in service.

OMHAS is trying to change from therapy to a case management model – Mike asked for thoughts at the table on what are current questions/problems.

- Looking for unique housing needs, if there are any. What about security?
- It's difficult for Case Managers to get clients into mental health programs.
- Lane County has changing criteria.
- There is an ethical dilemma with how to get seriously ill people to track & be accountable to the community, rules/structure or else be removed from the facility.

Mike talked about motivational interviewing; central planning.

- Examples in the system of Mike's knowledge where case managers are working together to decide who will be primary manager after primary diagnosis = shared management.

Mike: State talks to locals and asks who has ownership.

- Our focus is on HIV, but Case Managers focus a lot on other issues; there is a need for a lead case manager.

Mike: The case management model is the same as the medical model, with all different doctors coordinating. He has been studying Community Mental Health for nearly a decade in Oregon – not an easy situation.

- Case where mental health workers wouldn't touch client because they said case was an HIV issue.
- Expanding program funding and service for a specialized population; the two exiting systems are broken/difficult – is the community system something we can count on?

Mike: Respects the idea of "broken," but it's what we have; it's easier to point fingers than to help build it. "Building it is what I'm about, and I see some eager people. Bumps against directors are rare – we can make a difference." It's wise to get to know the systems on both sides.

- Referring to the Governor's Mental Health Task Force document: systems are under-funded & poorly managed. How well are mental health and substance abuse coordinated?

Mike Moore: segue into presentation

1. Discussion of graphs
2. Medical complications: chances of having HIV or Hepatitis B & C are up.
3. Article from Journal of Psychiatric Research Center
4. Depression and dementia as side effects of HIV.

Integrated Dual Disorder Treatment: part of evidence-based practice.
Fidelity Scales: 14 dimensions - Multidisciplinary teams, integrated substance abuse specialist on team, access for comprehensive services for clients, time-unlimited services; outreach is preferred mode, motivational interventions, counseling, groups, family counseling, alcohol and drug self-help groups.

"Interventions to promote health "
What kind of groups on diet, substance, avoiding victimization
Looking at charts
Asking clients

Worked with Washington, Jackson, Josephine, Deschutes counties

Improved: housing, % hospitalizations, prison incarcerations down

Incentive?: Dedication, strong leadership, stick it out over time.

Training?

CJ Reid, Program & Policy unit for OMHA: Working on initiative to support counties in evidenced based practices; using training dollars to contract. The second phase of the Service Improvement Project (SIP) will compare which way programs are going.
Incentive: the bottom line is, if you're not doing evidence based practices, you're out.

Web Site: Approved practices on web with info and research

Overview How Substance Abuse System Works

Focus is on recovery-based system and ongoing therapeutic relationship.

Education of funders is on addiction as destruction; ideas are being changed. The Governor's council on alcohol and abuse is coming up. Every $1 spent in treatment saves $7 in costs.

"Harm reduction" – CJ is in favor of this, and refers to an article from Canada: homeless alcoholics were costing the government huge amounts. The program gave the clients

three bottles a day, with marked improvement in reduced costs. The clients are in housing, eating better, some are holding jobs, and they're drinking less.

Mike: Angela Kimbal, Oregon Association of Community Mental Health Programs – is a good source for discussion of impact on Oregon. Other states: Massachusetts.

CJ: working on work force development; site reviews; world changes to be more in line with integrated treatment. Chart: money sources: general funding, lottery, Federal block grants. Block grant money is prioritized (good for HIV priority is IV drug users) for women, pregnant women, and WIC children. Bad news is no priority for single men, except IV drug users. Priorities are set by the Federal Government.

Resources:

- County implementation plan work happening now – how to spend funds – contact them & discuss now to affect. Contact mental health authority.

- Counties have beer & wine taxes. The Governor's Council is working on putting a tax increase into plan to equal the rest of the country. The State gives money back to the counties with directions on how to spend.

- Problem: OHP funds – legislators do not understand the difference between paying $500/day (emergency room) and $85/day (county services).

- Local Alcohol and Drug Planning Committee

- DHS web site to addiction services: look on right side for treatment directory by county (PDF), also community correction programs

- Governor's Council on Alcohol and Drug use Programs welcomes speakers

TO CONTACT CJ: c.j.reid@state.or.us

- One of the barriers to serving HIV clients is that no felony or drug-related offenses funds are received if the client commits under treatment. Is there anything to help around that?

Mike: Vickie Skryha, Manager, Housing and Homeless Services
Office of Mental Health and Addiction Services

- There needs to be a rent subsidy component in the program. OHCS has money to build, but not to run.

OCHS Programs - Elizabeth Anguiano, OMHAS

Programs – MHS (Mental Health Services) Housing Fund for New Development of Housing -- new construction, rehab. or acquisition.
Renovation funds – under $5K

Community Mental Health Housing Fund- also for new development.

Applicants are often non-profits.
Eligibility requirements: recipient will serve the mental health population; HIV included, if documented as within severe mental illness class.

One acre at former State Hosp site is reserved for MI housing = 22 sites

Alcohol Drug Free Housing Fund: OMHAS transfers $1 million over to OHCS to be distributed through OHCS Consolidated Funding Cycle.

ADF housing assistance Services to 7 counties and one tribe to provide housing coordination services and rental assistance to persons in recovery.

Oregon Recovery Homes (substance abuse) are called Oxford Houses; there are 142 in Oregon. Oxford House residents self-govern: must have a job and contribute monthly. A Revolving Loan Fund is used for establishing a new home. Note: medical marijuana excludes.

Elizabeth can send info on training to Annick to distribute.

Every other month there is a statewide mentally ill/substance abuse housing discussion from 9:00 -12:00. Participants can phone in.

Donna asked for update at every meeting.

FOCUS AREA: **MENTAL HEALTH AND SUBSTANCE ABUSE**

Goal #1: Distribute the January 2006 Adult Mental Health Recovery Case Management Services Contact List to all HIV Case Managers and Housing Coordinators.

Goal #2: Develop a strategy to talk to the local county Health Administrators and/or the Mental Health Directors about participating in the conversation to develop the local County Implementation Plans, targeting the high-incidence counties such as Lane, Marion, Deschutes and Jackson.

Goal #3: Distribute information about the Priorities required by the local SAMHSA Block Grants that fund substantial amounts of money to local communities. Priorities: IDU, Pregnant Women, Women with children, Women. These clients move to the top of the waiting list for Mental Health and Substance Abuse services.

Goal #4: Gather more information about SB1 – requiring health insurance plans to treat mental health treatment equitably with medical treatment. Call Angela Kimbal, Oregon Association of Community Health Programs.

Goal #5: Develop a strategy to send representation to Local Alcohol and Drug Planning Committees in target counties.

Goal #6: Distribute information on accessing the most current copy of "Alcohol & Other Drug Prevention & Treatment Services Directory" (which includes information on Mental Health Services and Corrections Services) to HIV Case Managers and Housing Coordinators.

Goal #7: Present information on HIV & Housing to the Governor's Council on Alcohol and Drug Abuse.

Goal #8: Send a representative to the OMHAS bi-weekly Community Briefing.

NEXT HIV HOUSING TASK FORCE MEETING:
March 22, 2006, FROM 1:00 – 4:00 P.M.
Review mission & goals, strategic planning, finish the plan