Palm Beach County HIV CARE Council Meeting

Minutes

Monday, February 22nd, 2021 @ 2:06 P.M.

Members Present	**Members absent**	**Guests**
Kim Enright – Chair	Ashnika Ali	Brad Mester - AHF
Kristen Harrington	Karen Gipson	Karla Drummond - AHF
Tyrina Pinkney	Kristina Rowe	Ashaki Sypher – Families First
Kenny Talbot - Treasurer	Felisha Douglas- Vice Chair	
Eileen Perry		
Cecil Smith	Mary Jane Reynolds	Ella Star cuff - Gilead
Hector Bernardino		Miguel Vasquez – PBCH
Lysette Perez		Christopher Barnhill Monarch
Thomas McKissack		Denise Brown - DOH
Lilia Perez		Skyler King – PBCBHC
Christopher Bish		Sandra Anderson - FDOH
Damion Baker		Rob Scott – FDOH
Dale Smith		Mary Sears -
'Richardo Jackson		
Chris Dowden		Mary Kennel
		Brittney McClure- FDOH
		Benjamin Barron -11th grader

CARE Council Staff Present	**CARE Council Staff Absent**
Neeta Mahani	
James Green (introduced as Neeta's new supervisor)	

Grantee Staff Present	**Grantee Staff Absent**
Juliane Tran	Anna Balla
Dr. Daisy Wiebe	
Sean Conklin	
Shoshana Ringer	
Dr. Casey Messer	
Rosa Fortuna	
Helene Hzvid	
Maria Corona	
Thomas Eaton	
Tyshon Grimsley	

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I. The Palm Beach County HIV CARE Council Community Awareness Committee meeting was called to order at 2:06 P.M**.** Roll Call was taken. Guests were introduced. There was **NO quorum.**

Neeta Mahani introduced James Green, the Director of Community Services, as her new supervisor**. Mr. Green announced that county administrators will be petitioning the governor regarding the in-person quorum requirements.** One option: granting waivers so that some of the boards can proceed with the work at hand.

A discussion ensued regarding the use of the Consensus Option given COVID's impact on in person attendance and the frequent inability to make quorum. **Mr. Green asked if it is possible for the committee to vote on a matter and put the vote on record**—without it counting—**so that if** the governor acts on the quorum requirement and **it can be applied retroactively, we'd have a record of those votes.**

This was advised against (per Helene Hzvid) as the Sunshine Law has strict requirements about actions taken during public meetings, i.e., votes must take place at the public meeting when the item is under discussion. Ms. Hzvid pointed out, however, that the CARE Council Board has given the Recipient staff authority to make crucial decisions regarding priorities and allocation in lieu of a vote of the Care Council (CC). Items such as the Approval of the Agenda can move forward via consensus. Approval of Minutes cannot. Other crucial matters like Priorities and Allocations (P&A) can be handled by staff in the interim.

The CC has given some delegated authority to the Recipients' Office to make some shifts in resource sweeps and reallocations that was approved to be effective through the end of this grant period, which ends at the end of his month. After that the CC could determine if we'd like to continue that delegation of authority.

Helene Hzvid added that it may be better not to have a larger board, because as the rule stands you need 51% to get a quorum. A larger number means more members would be required to attend in person to achieve quorum. She also stated that perhaps the board could take the same route with membership as it did with P&A—that is, asking for approval of a change, whether temporary or more permanent to the Bylaws, that allows a member to move forward on approval of, for example, the membership committee. So, there can be an adjustment of Bylaws and policies that govern to CC as a temporary fix.

Dr. Messer added that his concern is that we can increase the number of people with HIV on the board.

Chris Dowden said amending the Bylaws in an excellent idea, but he believes those changes would need to be approved by the CC and would require ratification by quorum.

II. **A Moment of Reflection: Lysette Perez shared** that her 60-year-old uncle died from COVID. If anyone still believes that vaccinations and masks are unnecessary, she'd like to remind us to keep following safety protocols.

Kenny Talbot shared that he believes our current Recipient staff is the best we've ever had.

A Moment of Silence

A moment of silence is observed in respect to the memory of those individuals Who have succumbed to AIDS and those who are living with HIV; Let us Remember why we are here today. Let us have the strength to make the decisions that

will improve the care of those we serve. Let us be thankful for what we have accomplished to date.

III. Acceptance of Excused Absences: Kristina Rowe.

IV. Acceptance of February 22nd, 2021, CARE Council Meeting Agenda
Prior to accepting the Meeting Agenda two items were added via Consensus (no vote by quorum needed) under New Business
A. Care Council budget was added as Item A under New Business by Consensus.
B. Financial Assistance to attend HIV Conference

V. Acceptance of the January 25th, 2021, CARE Council Meeting Minutes: There was No quorum, so the Minutes could not be approved.

VI. Comments by the Chair: The Chair, Kim Enright, took a moment to remember John Foley, a member of the Ryan White staff, who died recently. John was one of the first people to join the RW staff and worked there for over 20 years. He was deeply involved with RW and the HIV community. She is saddened by his passing.

VII. Public Comments: To improve in-person attendance and facilitate meeting quorum, Mary Kannel recommended the use of a county building like the Business Center on Jog Road for safer, socially distant in-person committee meetings. The building has 10-12 spaces that are divided by Plexi-glass and can hold large audiences. This may help HIV + members and others who are concerned about COVID feel more comfortable.

The Chair thanked her for the recommendation and said we'll look into it.

VIII. Educational Moment: Update on Ryan White Clients housed by non-Ryan White Programs in GY-2019: A Review of data, processes, and proposed solutions by Dr. Daisy Wiebe and Dr. Casey Messer. (Kieanna Pear Lewis from Human Services also worked on this project but was unable to attend today's meeting. James Green was the project sponsor.)

Dr. Messer said that quality improvement and continuous quality management are huge components of the RW program. Housing has been a huge barrier to success for People with AIDS in PBC. Over the last 4 months the Recipients' Office participated in a Green Belt Training for Lean 6 Sigma. They worked in partnership with the Human Services Division of Community Services and the Continuum of Care Housing Providers.

Today's presentation includes framework analysis, specific barriers identified as preventing success/preventing PWHIV achieving optimal health outcomes, financial components of both opportunities for improvement and cost to the system of inefficiency in providing quality services, and recommendations.

The study was framed through the Lean Six Sigma Process: BDMAI.

B: Background, **D**: Define, **M**: Measure, **A**: Analyze, **I**: Improve

Dr. Wiebe provided the project overview: Human Services provides homelessness prevention and housing services for homeless individuals and families. RW Part A Program provides services for PWHIV and provides safety net healthcare and a variety of supportive services including emergency housing. RW & HS have different funding sources and databases and although they are in the same department and administration in the same building, they often operate in silos.

Chris Dowden asked for the definition of homelessness. Dr. Wiebe explained that the study looked at 4 specific housing category subtypes in the RW Provide database. The main category was 'place not meant for habitation but emergency shelter or transitional housing for homelessness or temporary safe-haven.' PBC has 21 categories, anything ranging from staying with family or friends on a permanent or temporary basis, or day by day, or stable or unstable rental. But for experiencing homelessness there are 4 categories. If the client is in a hotel that is being paid for by RW or the Lottery, or a public program, that is also considered being homeless. Areas not meant for habitation like outdoors, shelters, under bridges, also qualify as examples of homelessness.

Couch Surfing: A question arose about whether couch surfing was considered homelessness. Dr. Wiebe stated that couch surfing—staying with family or friends temporarily—was the most common category, but that does not qualify as experiencing homelessness. To meet the qualification of the 4 categories the person would need to have been kicked out or have had a lease in their name.

Failure to recognize couch surfing as experience of homelessness is one of the major gaps in the current system. Many clients fail to disclose that they are on the verge of homelessness via couch surfing or if living in a hotel paid for by RW or other program. Lack of disclosure impacts their eligibility and lowers their prioritization for homeless services.

Dr. Messer stated that the guidelines from HUD fund our housing program and we know that the definition and needs of PWHIV may be different from HUD's definition, but those gaps exist.

Denise Brown said that failure to recognize couch surfing as a precursor to homelessness is shortsighted as clients who couch surf are often thrown out onto streets when they can't contribute financially to family or friends who they're staying with. She recommended that we suggest to RW clients that if they are getting a room from a family member or friend, perhaps they could get a letter from that person saying they rented one of the rooms, or perhaps they should see if they can get on the lease. They must show that they receive mail at that address; this can help to show their transition from having a home to then being in an unstable/homeless situation. She added that people shouldn't have to be on the street to be defined as homeless and that we need to address issue before it gets to that point. We need to come up with new strategies to decrease homelessness.

Dr. Wiebe agreed but explained that the presentation is just describing the current

definition used by Human Services and the Continuum of Care for Housing in PBC, which follows the HUD qualification. The definitions are qualifications for their programs, not RW's. Other problematic requirements for being defined as homeless in PBC include that the person must have become homeless while living in the county.

Dr. Messer said the goal of this presentation is to walk through the processes and barriers, see what's not serving our clients and then propose solutions that will better serve them. We want to prevent homelessness, not react to it.

The presentation reviewed project objectives, theme indicator/key outcomes, strategic alignment, stakeholders and needs analysis and the gaps in service. **Gap: RW clients experiencing homelessness served by Human Services or CoC for GY2019 (March 1st, 2019-Feb. 2020) was 15.5%. Goal for 2021 is 24.7%.** The goal is to eliminate this 9.2% disparity, which is also the disparity between RW clients served by HS or CoC and the percentage of the general population.

Cost of Poor Quality: The report looked at the costs and negative impact of not serving RW clients/PLWHIV at the same rate as the general population. **Annualized financial cost of poor quality: $262, 426. That is the cost to close the gap** and bring PLWHIV up from 15% served to 24.7% of service similar to the general population. It's costing the system more to not provide quality service, by continuing to not serve almost 10% of clients—the gap between 15 and 24.7%--it is costing us that much more per year. (See report for breakout of costs and impacts).

Dr. Wiebe reviewed the Flow Chart looking at how clients receive services, how they get linked and identified, and the coordinated points of entry, etc.; the importance of access points, Vi-spdat assessment tool, and length of homelessness in prioritizing level of homelessness were also discussed; and the 8 Wastes in Lean 6 Sigma—potential causes of waste in the process in terms of getting clients housed—were also reviewed. (See presentation for breakout.)

The biggest gap is that clients weren't linked to services. Many didn't even make it over from RW to Housing services. The next gap is when some made it over, they were missing the assessment that helps determine priority level. Takeaways: of the individuals that we knew were homeless in RW program, 1/3rd didn't make it to the housing provider; of those who made it and were linked to housing provider, 20% were not assessed; That accounts for 50% of the challenge.

The Chair said we know the how, but she would like to know the 'why'. Dr. Messer explained that the Fishbone analysis included in the presentation explains the why, and we are also working on a Needs Assessment which will tell us the why. He requested feedback from members regarding if they had experienced clients being sent back to them. He said this was something the team had heard about but didn't know how widespread the practice was.

Dr. Wiebe said that we are going to present this report to the Homeless and Housing Alliance. She added that clients being sent back is one issue, but she thinks that clients having to collect all the documents and being able to make it to the appointment, are

among the 5 common reasons for what's happening.

Dr. Wiebe said **there's no question in the assessment that asks, *'Are you living with HIV?'* and that** impacts prioritization. **Clients not identifying as such**, and not answering other questions because they think it may impact their housing opportunity negatively—issues of domestic violence, mental health, substance abuse, etc.—**is probably lowering their prioritization score.**

The study reviewed the Root Cause Verification Matrix—**potential root causes why the problem is happening. The biggest problem we think is that RW is not a player in the housing coordination system.** Important takeaways include inefficiencies in the process, including barriers in referrals and in access to services for PLWHIV. Dr. Messer was surprised by the number of PLWHIV who do not disclose their status, which would have helped to improve their prioritization score.

Dale Smith commended Dr. Wiebe and the team and stated that he'd like to be a part of the process because he has been on both sides of the issue. He believes he can provide valuable information regarding the discrepancies and discrimination. He believes the root causes are bigger than what's mentioned, i.e., the point of entry being messed up. He says he lost his home, and no one was able to help him, neither social service organizations nor family. He believes we need to have contingency funds in case someone on the board experiences anything like that, so we can help them out. He gave an example of problems with the Point of Entry, saying that when a client goes for housing services and is told they need to get a Housing Declaration, many clients may be unfamiliar with the terminology or documentation, but there's no one there to explain it to them. He says when he was told that he needed a Housing Declaration, no one told him what that was, which delayed the process for weeks. He kept asking for some literature to read about it but received nothing. He said that PLWHIV will disguise the way we ask the questions, so we go through the process on eggshells, wondering if we disclose certain information, it will negatively affect our chance of getting housing. He said he had to make a call to someone who'd been in the process to ask them how to answer certain questions. Another problem he cited is that individuals who are supposed to be helping the client get housing services, aren't 'user-friendly,' and don't help to make the client feel comfortable and reassured that things will be okay.

James Green thanked Dale Smith for his feedback and said it was extremely valuable and that he wants to integrate Dale and his lived experience into the process so that he can help us make the necessary changes to improve the system of care. He added that he'd be reaching out to Dale after the meeting and that he believed his feedback will be helpful for the Homeless Housing Alliance.

Denise Brown said she was under the impression that when her organization brought a client to an organization that provides housing services, RW was involved. She's surprised and disappointed to learn that RW is not collaborating with those organizations.

Dr. Messer said the gaps in the system were the impetus for this project. She highlighted the Counter Measures we are proposing; how to minimize inefficiency and

ineffectiveness; avoid duplication; Barrier AIDS Analysis and our very aggressive Action Plan. We want to present it to CoC in March.

This presentation is an initial step, and if we can get initial approval form the CoC to consider some of the recommendations, particularly for us to become a coordinated entry site, then we can move forward with some of the other steps of becoming a member and getting access to the databases and getting trained on how to use it. **Our vision is to have one case manager assisting the client with all his/her/their needs.**

Other topics discussed: the demographic makeup of PLWHIV/clients needing housing is primarily single men and women, while most housing and homelessness prevention program prioritize families, children, or single women with children. The average length of time that a person in PBC is homeless before they receive services is over a year. This illustrates the low priority that will be assigned to newly homeless.

All these issues make it complicated because there are more people in need of services, than the number of housing slots we have available. So, we are not talking about fixing the system, given that the need is so great, we are just talking about preventing the disparity in service for PLWHIV v. the general population.

Kenny Talbot noted that if someone is couch surfing and they mention it in their interview they'll probably be dinged, as that is not considered as being 'homeless,' so they probably shouldn't couch surf as they'll no longer be considered homeless.

Neeta Mahani asked if the Homeless/Housing Ad Hoc Committee that we are trying to create will only be for Ryan White clients and said perhaps we can start in March. Dr. Messer said he thinks we should get it started but the committee must be a voice of the community and that we need individuals like Dale on it.

There was a brief discussion of the issuance of NOFOs for Emergency Housing and CARES Act Housing, which did not get a lot of people interested, perhaps because of the pandemic. We need to bring individuals with specialized knowledge in housing to participate in the Ad Hoc Housing committee.

Return on Investment. Cost v. Benefits. We see that for every dollar we invest in improving programs there's a return of $2.70, so that furthers our motivation for reducing the gap.

Dr. Messer asked if there were any questions. He asked the committee what we think about Ryan White or the HOPWA program being an Entry Point for referring clients elsewhere? Response from some members of the committee was that it sounds like a good solution, but is it achievable?

The Chair said that in a perfect world would the client be able to go to their case manager and have the case manager get them into the system.

Dr. Messer said that currently the RW case managers are collecting all the info and documentation but then they have to refer the client elsewhere to be able to access housing. We want to eliminate that. In fact, at present, RW case managers don't even know the status of the client, if they got a Vi-spdat, or if they've been housed or offered an appointment. There's no communication.

Kenny Talbot added that a lot of clients won't even call a case manager because they don't want to tell them that they are homeless or facing homelessness.

Dr. Messer said there are red flags that indicate housing instability and likelihood of impending homelessness. Those include, a client seeking help with utilities; seeking emergency financial assistance this one month; job loss, or lower income over the past month. We need case manager to pay attention to these red flags so that we can act before the person becomes homeless.

With the new HOPWA program, we are hoping to be able to intervene much sooner to prevent that from occurring, so that clients can have a smooth transition. The goal is to have one case manager/dedicated support specialist that the client goes to for all their needs, whether it's a medical or non-medical case manager, rather than having a care coordinator, housing case manager, mental health manager, etc.

The Chair said that this was an important conversation and discussion would continue at a further meeting, but that we would more forward to other agenda items. She thanked everyone for their contribution to the dialogue. She said we talked about getting up a housing committee and that we'll have to figure that out. Neeta Mahani said that we should have the committee by this month.

Denise Brown asked for a copy of the data/presentation. Dr. Messer said we would send out the draft, but that it still has to be finalized.

VIII. Unfinished Business and General Orders:

The Chair said as we do not have any unfinished business and General Orders we would go straight into the P&A discussion.

IX. Old Business: The Chair stated that we won't be voting on these items

A. P& A Committee Recommendations on the table: The Chair stated that we won't be voting on these recommendations. We have given authority to the Recipients to handle, but they need to tell us what they are doing. She turned the meeting over to Kenny Talbot to give the P&A update.

Kenny Talbot stated that we didn't have quorum at the last P&A, so we had to turn the items back to the Recipients' staff to do the best they could.

Dr. Messer pulled up a slide spreadsheet for PBC RW July 20th for the current grant year. He reviewed underspending in the various categories.

Kenny Talbot said that we discussed prioritizing core services as a primary objective and what we were going to do with whatever's funding's left over. We were mainly

looking at direct services for clients. Maria Corona went over the slide presentation and explained the breakdown of what was going on right now. She explained that we underspent by $98,420 and we need $102, 281.

The Chair asked if there were any questions. Kenny stated that as it's the end of the GY, the P&A Committee decided not to make any decisions in the meeting. They decided to leave it up to the Recipients' staff to handle the budget.

The Chair said we can discuss, but not vote. Dr. Messer said the intent from the Recipients' Office was that we will bring it back for ratification at a later meeting. The Chair asked if there was anything else from P&A.

Kenny Talbot asked Neeta Mahani to start scheduling P&A meetings at the Frederick Building to see if people will feel more comfortable about showing up in person so that we can make quorum.

B. Approval of LGBTQ+ BROCHURE

The Chair said we'd discussed approval of **the LGBTQ brochure** at the last CARE Council meeting, and we hadn't had quorum either then**, so we'll have to table it till the next meeting since we don't have quorum today either.** She said she believes the same thing holds for the 3 other items.

Helene Hzvid said she did not believe the brochure needed approval of the CC via vote and that Consensus could be used instead.

The Chair said she'd be happy to move forward as the brochure has been under discussion for a while. She asked if we could take a vote by Consensus. Helene Hzvid said the idea would be to go ahead and ask if there were any objections to the brochure, and if there weren't any, we would just ask members to vote by Consensus to authorize its distribution. It's not an item that's in the Bylaws or any of our policies to be voted on.

The Chair asked Neeta to pull up the brochure created by the LGBTQ+ Health Equity Sub Committee of the CARE Council. It is information to be distributed to health care providers and sub recipients and other places in the community that can benefit from LGBTQ info.

The Chair asked if there were any questions or comments.

Kenny Talbot stated that earlier this week a discussion came up about this and he wished he'd had to brochure. The Chair thanked Kenny for that comment and Helene for recommending that the committee move forward on distribution of the brochure by Consensus. Damion Baker said he thinks the brochure is smart and that he likes it.

The Chair asked all voting members of the CC to vote by Consensus, so all those in favor of moving the brochure forward for publication and dissemination please signify by saying 'Aye.'

The Motion passed by Consensus.

The Chair tabled the remaining three items under Old Business as we have no quorum.

C. Ratification of the Chair's Appointment for the Treasurer
D. Approval of Leave of Absence Requests
E. Approval of Three New Members of the CARE Council

X. New Business:

The Chair said we would discuss the 2 items that we have under New Business.

A. CARE Council budget.
B. Financial Assistance for an upcoming HIV conference.

Neeta shared the CC budget on the screen. **The Chair asked if the money that goes unspent is carried over.** Dr. Messer said that the CC budget is part of administration costs and any such costs that are not spent will go into the Carryover Services for clients.

The Chair had a request. **She said that Compass is doing a modified Pride Market on June 5th and that she'd like to host a table at the event** to educate the community. She made a formal request for us to participate. This would be considered outreach. She said that she and Neeta Mahani would discuss what's needed at the table. A discussion of how to use the excess funds in our budget continued. The Chair asked if there was anything else we needed to discuss regarding the budget. There was not.

Financial Assistance for HIV Conference:
Cecil Smith said that he'd spoken with Dr. Messer earlier regarding the possibility of getting financial assistance for an upcoming HIV conference.

Dr. Messer said that last year we did not have a travel conference, and that those funds are available and could be used to help PLWHIV attend, but that the CC can utilize funds to send reps to the conference, especially PWHIV. We just have to decide.

Cecil Smith asked what the process would be if someone wanted to go. Dr. Messer said the CARE Council could decide. The Chair asked if we have to vote on it. Dr. Messer said we don't have to vote on it today. Neeta told Cecil that he's at the top of the list. Cecil said he'll submit the information to Neeta so we can move forward.

Chris Dowden said he'd like us to address where we stand in our temporary Bylaws. There was a discussion. The Chair said she is going to activate the Bylaws Committee, chaired by Vice Chair, Felisha Douglas, and she'll ask all those who were on it if they are interested in returning, and others if they'd like to participate.

Helene Hzvid told the Chair that a quorum committee isn't required as long you have CC quorum to vote.

XI. Other Business: **NONE.**

XII. **Standing Reports:** The Chair asked if anyone had anything from their committee that They'd like to share with the CC today. As follows:

- **A. Legislative Update: None**
- **B: CPP Update: None**
- **C. Part B Report: Patient Care & 4BNWK Report: Brittany McClure**
- **D. HOPWA: Miguel Vazquez**
- **E. C.H.A.G. Report: Denise Brown**
- **F. Part A Report: Dr. Casey Messer**
- **G. Expenditure Report: Maria Corona**
- **H. LGBTQ: Kim Enright**
- **I. LPAP: Felisha Douglas**
- **J. Membership: Kim Enright**
- **K. P&A: Kenny Talbot**
- **L. QMEC: Lilia Perez**
- **M. Planning: Lysette Perez**
- **N. Community Awareness: Felisha Douglas**

XIII. **Announcement:** The Chair asked if there were any announcements. Neeta Mahani announced that she's been getting a lot of emails from schools and colleges asking for information, and about volunteering.

XIV. **Adjournment:** The Chair thanked the members for attending and there being no further announcements, **the meeting was adjourned at 4:55 pm.**

Snacks will be available

**Conflict of Interest*

A CARE Council member who has an identified conflict of interest must abstain from voting on issues related to that conflict. A member who does not abstain from voting on issues where a conflict is identified by the County's Commission on Ethics, a member may be removed from the CARE Council.