	Regional Advisory Committee (RAC) **Meeting Minutes** **September 14, 2009** **4:30 p.m. - 7:00 p.m.** **NEBO**	
Agenda Item	**Discussion**	**Decisions/Follow-up**
Welcome • Introductions	• Carolyn Massey welcomed everyone and introductions occurred.	N/A
Meeting Framework Overview of RAC Meeting Purpose	• Carolyn Massey and Karen Bellesky gave an overview of RAC and explained the purpose of the meeting. • Karen also reviewed the evaluations and May's meeting minutes. She encouraged meetings attendees to fill out evaluations at all meetings.	N/A
IDEHA Overview Heather Hauck, Director	• Heather Hauck, Director of IDEHA introduced the new collaboration between the Maryland AIDS Administration and the Community Health Administration. IDEHA, Infectious Disease and Environmental Health Administration is the same services and program areas the AIDS Administration always had, in addition to other disease threats and environmental health issues. • IDEHA is meant to strengthen the programs by offering a more coordinated approach, introducing an overall common health protection message, provide greater collaboration within departments, as well as increase the DHMH ability to monitor the quality of health care provided to affected individuals and communities.	N/A
Legislative & Policy Update William Honablew Jr.	• William Honablew Jr. gave an overview of the re-authorization of the Ryan White Treatment Act last done in 2006. On October 1st of this year it will no longer be active. The act has four provisions that need to be revised and William hopes the re-authorization can last for at least 3 years. This will entail working with congressional partners to make sure this act continues. • The provisions already underway with the Ryan White Act are: the re-authorization period, continued protection for states with maturing HIV case data, extension of hold harmless provisions, ADAP Rebate Dollars, and un-obligated funds. • See handout for more information.	

The Role of the RAC Co-Chair	• Donna Devonish explained the roles of the RAC Co-chair and announced that the voting for the new Co-chair will begin in October.	
Community Dialogue • Overview • Small Group Discussion • Report Back/ Large Group Discussion	1. "Tools for Advancing Community Change" a. If you attended the training on "Tools for Community Change," what specific actions have you taken toward influencing decision-makers to change specific policies or programs? b. What specific follow up actions are you planning to take over the next few months related to advancing community change? OR If you had not initiated any, what specific actions are you planning to take to advance community change over the next few months? Which decision makers are you planning to influence? 2. HIV Care Services a. How has the economy had any impact on your ability to get HIV care (or provide care)? b. What recommendations do you have to improve health services? 3. The Infectious Disease and Environmental Health Administration a. How can the Infectious Disease and Environmental Health provide better care to the community? See table below.	
Wrap Up • Announcements	• 52 attended today's meeting. • Karen Bellesky commented on the meetings larger turnout. • Mobile Feast is Thursday September 17, 2009. Meeting goers were encouraged to go out to eat to support the charity.	

Community Dialogue

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
• Appropriate nursing home and assisted living impact—waiting lists (e.g. adult day) • Supportive services who are really ill are not there. • Primary care=no impact • Paying rent and just living • Recommendations: $ to fill gap (medicare assisted living and adult day), Finding services for mental health and substance abuse-dual diagnosis • E.g. drug abuse effects heart regimen • More $ for housing • Cap on MADAP should be raised • Working Well? : primary care- more funding for meds not on formulary = gap (e.g. allergy meds, some over the counter) • Direct observed therapy is working , but waiting lists (GAP) • Housing- one of the top priorities • Working: moveable feast- transitional/ • permanent house =	• Transportation in Carroll County and no public transportation-difficult to get to the Dr. must move back to Baltimore. • Insurance coverage? Has that changed? • Carroll County cut nursing hours-have been cut furlough drays have impacted services and must be prepared and organized. • Groups are smaller in numbers. Addictions/HIV/support Groups • If you are not providing treatment (physicians) then you cannot provide the groups. Priorities have shifted-more impact to have a job/training for job • Services seem to be working well mental health/transportaion education in Harford County • However in Carroll County one pre-plan if you have an	• Economy's impact on care • Long wait time at appointments/ transportation schedule not flexible • MCO-has changed formulary medicines. Dropped medication-make funding available for OTC meds manage-side effects • Not noticed changes in care • Providers have no cut services • Change in access to social worker (change to appts. Only) • Return to drop-in walk-in access. • Continuity in staffing lost (furlough days alternating schedules) • Access to live staff via phone • Clinicians reserve blocks of time "for urgent" same day appointments • LHD clinic closed-had to transfer providers • Access-"off hour's clinics" weekends –	• Economy & Care – Reduction in # of days staff available at local health dept. • Interview new pts. • Assist current pts. • Great need- housing asst. sec 8 housing with no longer accepting applications • Payment of copays • Loss of insurance for services and meds	• Increase in request for services, using RW funds faster—change in job status, transportation issues, less money for copays • Testing programs finding more people PLWHA • Long term clients now need $ help—rental assist, utility, copays • How many bus tokens do we provide? • Increase with clients with other life threatening diseases (non HIV/AIDS) • Issues with funding received charitable giving is down • Concerns about Hep C co-morbidity • Increase housing opportunities can be a barrier to tx adherence • Mental health tx services • More substance abuse • Transportation is a barrier to access esp. in suburban and rural areas medically fragile individuals • For 1 person we help	• Howard County (DOH) no longer have C. Mgt. Svcs • No part B funding; sm. Part a (limited) • Clients impacted by economy but must communicate with their C. mgrs. • C. Mgrs. Must have resources to (share) communicate with clients Strong referral and follow up processes and formal linkage agreements • Capturing qualitative data throughout the continuum of care • Assure that non-medical as well as medical case management continues • Support services is now working pretty well • Basic life mgt. skills • Case management training

need.	emergency on e cannot get transportation as easily. • Cab services often you have to wait. • Harford County is more developed than Carroll? • Providers could provide more integration with services keeping up with records electronically/multiple records • Retention- • Communication with MADAP staff along with the providers so that there is not a lapse in services	medications on the weekends.		we turn 3 away • Door to door transportation is a necessity for these populations • Cab companies aren't always sensitive • Affects quality of care	
• IDEHA: better care? • Mobile health van to the people testing and meds on site • Integration: make a door where many people can walk into and can get services – ("STI door" and getting HIV testing services together • H1N1 has been a good teaching tool—becomes a disease prevention program. • Communication-flyers, post cards, email can be overwhelming at times	• Housing-does fall under HIV care services-if you go under DSS/or other administration under DHMH-How can IDEHA connect with SAMSHA? HUD? HRSA? • Using Maryland services locator! Very useful • The integration allows all to think of the person as a whole person as opposed to disease specific-more creative ways to	• IDEHA: what out of integration? (provider and consumer) • Education-holistic health impact of other diseases info on HIV e.g. HIV presentation to include info on T.B., Diabetes, hepatitis etc with mental health preventative health: yoga; exercise, diet, nutrition • Youth targeted education efforts • Senior targeted education efforts	• Try to reduce administrative burden for providers. • Simplify RW program within state • Single system for information needed for referral, services, MADAP, etc. • Advertise where to get services. • Address co –morbid conditions (HIV/Hep C/STI's) • Promote STI testing during CTR.	• With integration services provided can only get better • Concern that HIV/AIDs not become less important since no longer standing alone • HIV/AIDS still important, keep focus on epidemic • May help improve education/awareness • "AIDS Admin." Stood out, sent a message to the state • Since keeping same director, "AA" may not take a backseat • Go back to old name?	• Continue to consciously seek and use community input and their awareness of what is going on • Provider networking meetings (shared learning opportunities) • IDEHA sending info out that has been gathered by IDEHA from providers (give them feedback for their mgt. use)

• Eliminate duplication • Have a list/network to know who to call. Like a list of the agencies who to contact for what. (providers) • Regardless of funding source (Part A us. Part B) lets just give HIV money to those with HIV • Reports- so many • Reduce requirements and reports and reduce redundancy • Clients are asked the same question s by multiple providers (intake counselor, nurse, doctor) Burden on both client and provider	provide services • Data accessibility with the multiple diseases under IDEHA how does that impact my community? What is the incidence/prevalence of HIV/vector boune/sanolneilla? How can we access all that data?	• Improved (developed) referral across programs • Comprehensive resource guide to include mental health/transportaion /AID in maintaining communication. • Communication-resource directory-includes community resources/faith institutions-not limited to RW		• How does food inspection, etc. go with HIV/AIDs communities? • Do they really go together? • How does it look to PLWHA? • Separate entity at local gov'ts why not at state? • Keep same enthusiasm and emphasis as when "AA" • How do we get to know the other parts? • More collaborations (e.g. STI, viral Hep C) • Hopefully more service integration • Surprised of "middle child syndrome" • Continue the same lines of communication that already was in place • Keep letting us know HIV/AIDS is a major priority • Don't want to be inundated with email and info that is not AIDS/HIV specific but do want to be informed • RAC type mtgs make sure people can still get to website using Maryland AIDS Administration in search engines.	

Respectfully Submitted,

Chelsea Strength