



January 30, 2019

Oregon Office on Disability and Health
707 SW Gaines St
Portland, OR 97239

Institute on Development and
Disability
Oregon Office on Disability and
Health

tel 503 494-4858

livaudai@ohsu.edu

www.ohsu.edu/oodh

Mail code: CDRC
707 SW Gaines St
Portland, OR 97239

Dear PartnerSHIP and OHA Public Health Division,

The Oregon Office on Disability and Health (OODH) would like to thank you for the opportunity to offer input on the 2020-2024 SHIP priorities. We envision a future where entire communities are accessible, welcoming and inclusive of all Oregonians.

OODH is housed in the Institute on Development and Disability at Oregon Health & Science University and has been funded by the Centers for Disease Control and Prevention since 1994. Our mission is to promote the health and wellness of people with disabilities in Oregon. We fulfill this charge by analyzing data to educate and inform key community, county and state partners and policy makers on the importance of inclusive policies, systems and environments that promote the health of Oregonians with disabilities.

Of the 14 priorities identified by the PartnerSHIP, OODH has prioritized the following five:

- Safe, affordable housing
- Access to mental health care
- Tobacco
- Access to care
- Food Insecurity

Of these five, we have analyzed data from the Behavioral Risk Factor Surveillance System (BRFSS) to directly support the need for improving access to mental health care and tobacco cessation. For the other priorities, we offer an informed position based on our work directly with the disability community in Oregon and our familiarity with national research on these issues.

1. Safe, affordable housing

Safe, affordable, and accessible housing for the disability community is rare in Oregon, especially in the Portland metro area.

When low-income individuals/families with disabilities are forced out of the metro housing market because available units are inaccessible or accessible units are occupied, they are forced into inferior housing options, isolated locations, and/or assume leases and transportation costs that squeeze their resources. Additionally, housing and transportation costs for people with disabilities are often correlated, especially for those who cannot drive. The

farther away from the metro center they must go to find affordable housing, the greater the burden and cost of transportation. They also face education and economic opportunity-costs by being removed from metro-centers, as well as barriers to care.

QUAD Inc. in Portland, OR is a non-profit supporting individuals with severe disabilities who are seeking housing. The waitlist for an available unit is several years long. According to the QUAD Inc. web site the options for an individual with a severe disability who wants to live independently are few.

They can live in a nursing centers or in adult foster care. These facilities can meet an individual's physical care needs, but most don't offer choices in care routines, scheduling flexibility or any services encouraging self-reliance and self-sufficiency.

The can live with family members. This option might work for some people, but physical barriers and the pressures on families responsible for 24-hour care can cause tremendous strains on relationships.

Alternatively, an individual can employ an in-home personal care attendant. "Some people with disabilities hire aides to assist them with daily activities, but realize that finding and keeping dependable caregivers is a vast and ongoing hurdle." (<https://www.quadinc.org/about/stats-faqs/>)

The Oregon Office on Disability and Health recommends supporting the development of more affordable, accessible units like those of QUAD Inc., which is a unique model of affordable, accessible housing combined with dependable, shared personal attendant care. More broadly, we recommend that all new affordable housing developments be 100% accessible. With the passage of ballot measure 26-199, there is an opportunity to make all new construction, including living units, accessible. The adoption of a policy ensuring that all new affordable living units are accessible would support health equity at the most fundamental level.

2. Access to mental health care

Access to mental health care is important for all Oregonians, but it is critically important for Oregonians living with a disability. The percentage of Oregon adults with disabilities who have depression ranges from 30-70% depending on type of disability, compared to 18% of adults without disabilities.

Women with disabilities are more than twice as likely to be depressed as women without disabilities (61.8% versus 25.7%). Men with disabilities are more than three times as likely to be depressed as men without disabilities (38.8% versus 11.8%). (**See attachment "Depression Among Oregonians with Disabilities"**).

Additionally, more than 1 in 4 Oregonians with a disability, or 26.7%, reported experiences of memory loss in comparison to only 4.8% of Oregonians without a disability. In other words, Oregonians with a disability are 5.6 times more likely to have memory loss than Oregonians with no disability. Among those

with a disability and cognitive decline, 40.7% said that they have given up day-to-day household activities (such as cooking, cleaning, taking medications, driving, or paying bills) because of their memory loss. Furthermore, 52.2% of Oregonians with a disability need assistance with day-to-day activities because of their memory loss in comparison to only 17.2% of Oregonians with no disability (**see attachment “Cognitive Decline Among Oregonians with Disabilities”**).

The Oregon Office on Disability and Health recommends prioritizing access to mental health care for people living with disabilities by ensuring services are affordable, clinic spaces are accessible, clinicians are trained and utilize culturally specific, trauma informed practices that are aware of disability etiquette, and transportation to services is accessible, convenient, and affordable. We also recommend supporting telehealth for mental health services, where it is appropriate, which will improve access for those in rural areas and those who do not have access to transportation.

3. Tobacco

The percentage of Oregonians with disabilities who smoke is 25.6% – nearly twice as high as the percentage of Oregonians without disabilities who smoke (13.1%). We found that Oregonians with disabilities are not only more likely to smoke, but they also smoke more cigarettes per day than adults without disabilities. On average Oregonians with disabilities smoke 15.7 cigarettes per day, whereas adults without disabilities smoke 13.1 cigarettes per day.

According to 2016 Oregon data, adults with disabilities in every age group were more likely to smoke than adults without disabilities in the same age group. Men with disabilities were more likely to be current smokers than women with disabilities. About 28.5% of men smoke in comparison to 23.4% of women. The percentage of adults with disabilities who smoke also varies across the state. Smoking is most common along the Oregon coast, in Columbia and Multnomah counties, and in central Oregon. In counties such as Douglas, Coos, Curry, and Josephine about 3 of every 10 adults with disabilities currently smoke (**see attachment “Tobacco Consumption Among Oregonians with Disabilities”**).

The Oregon Office on Disability and Health recommends a coordinated strategy across state and local entities, including all disability service providers and health care providers, to increase the awareness and availability of tobacco cessation services. We also recommend offering additional training and technical assistance to Oregon Tobacco Prevention and Education Program (TPEP) coordinators to reach the disability community. The Oregon Office on Disability and Health would be happy to assist with those efforts.

4. Access to care

People with disabilities in Oregon are more than twice as likely as people without disabilities to say they needed to see a doctor but could not because of cost. According to BRFSS data, almost 1 in 5 (19.5%) of adults with disabilities in Oregon said that was the case compared to 9.5% of adults without disabilities. Additionally, many people with disabilities encounter transportation barriers and onsite barriers to accessing healthcare. Onsite barriers include lack of adjustable height exam tables, lack of wheelchair accessible scales, challenges with obtaining sign language interpretation services, and difficulty obtaining written information in alternate formats.

As a result of barriers, people with disabilities may not receive clinical preventive services as often as recommended. For example, multiple studies at the national level have found that women with disabilities are significantly less likely to be up-to-date with breast and cervical cancer screening, compared to women without disabilities in the same age range.

The Oregon Office on Disability and Health recommends prioritizing full compliance with the Americans with Disabilities Act and the U.S. Access Board's Standards for Accessible Medical Diagnostic Equipment (<https://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking/final-standards>). We also recommend clinician training and reminders to ensure that people with disabilities receive all preventive services prioritized by the U.S. Preventive Services Task Force within the recommended timeframes.

5. Food Insecurity

Prior studies both in Oregon and nationally have found that people with disabilities are more likely to experience food insecurity than people without disabilities. The difference may be partly explained by the fact that people with disabilities are much more likely to have low income. According to 2016 BRFSS data, 21% of adults with disabilities in Oregon have a household income of \$15,000 or less per year, while only 4.9% of adults without disabilities have a household income that low. However, income alone does not explain all of the difference. People with disabilities may have additional medical and other expenses that leave them less food secure than people without disabilities at the same income level. Food insecurity may also extend to other members of households that include a person with a disability (**see attachment "Food Insecurity, Hunger, and Obesity among Informal Caregivers"**).

The Oregon Office on Disability and Health recommends screening for food insecurity during medical appointments, particularly for individuals with disabilities and family members of individuals with disabilities. We recommend that all food banks be fully accessible to people with disabilities, and we recommend targeted outreach to individuals and households experiencing disability to ensure that they are aware of local resources to help with food insecurity.

We appreciate the opportunity to provide feedback on these critical priorities and look forward to continued partnership in advancing the health of all Oregonians.

Sincerely,

Oregon Office on Disability and Health

From: [Moseley Katarina](#) on behalf of [Public Health Policy](#)
To: [HUDSON Christy J](#)
Subject: FW: Feedback on 2020-2024 SHIP Priorities
Date: Thursday, January 31, 2019 11:09:59 AM
Attachments: [image001.jpg](#)

From: Katherine McGuiness <Katherine_McGuiness@co.washington.or.us>
Sent: Thursday, January 31, 2019 11:06 AM
To: Public Health Policy <PublicHealth.Policy@dhsosha.state.or.us>
Cc: Tricia Mortell <Tricia_Mortell@co.washington.or.us>; Rachel Schutz <rschutz@bgcportland.org>; Sebastian Lawler <sebastianlawler@gmail.com>; Kathleen Johnson <Kathleen_Johnson@co.washington.or.us>
Subject: Feedback on 2020-2024 SHIP Priorities

To the Oregon Public Health Division,

The Washington County Public Health Advisory Council (PHAC) is excited for the opportunity to provide feedback on the potential priorities for the 2020-2024 SHIP.

The PHAC is appointed by the Washington County Board of Commissioners and advises the Board in its role as the Board of Health for Washington County, and makes recommendations to the Board and the Public Health Division manager on matters relating to public health.

When reviewing the list of potential SHIP priorities, PHAC members were happy to see that there are many areas of overlap with work happening in Washington County, including ACEs and Trauma, Systemic Bias, Climate Change, Food Insecurity, Access to Care and Mental Health, Tobacco, Obesity, Suicide and Substance Abuse.

While Washington County Public Health does not currently focus on Safe and Affordable Housing, Living Wage, Incarceration or Violence, it recognizes that these issues are important and play a large role in the health of individuals and their communities. We encourage the Oregon Public Health Division to intentionally and visibly support partners and other state agencies leading this work. We believe these partnerships will create opportunities to continue to integrate and operationalize a culture of health framework into the public health work at the local, state and federal level.

The priorities that the Washington County PHAC would want to partner with the Oregon Public Health Division on most through the SHIP are Climate Change, Suicide Prevention, Tobacco, Systemic Bias in Public and Private Institutions, and Access to Physical and Mental Health Care.

Thank you for the opportunity to provide feedback, and we look forward to hearing what the next steps in the development of the 2020-2024 SHIP are.

Sincerely,

The Washington County Public Health Advisory Council
Rachel Schutz, Chair Sebastian Lawler, Vice-Chair

Katherine McGuiness, MPH, MSW | Senior Program Coordinator

Public Health Division, Health Equity, Planning and Policy
Washington County Dept. of Health and Human Services
155 N. First Avenue, MS 5a | Hillsboro, OR 97124
Temporary location: 20655 SW Blanton Street, Aloha
503-846-4921 desk

www.co.washington.or.us/hhs/ [Facebook](#)

[Take our brief survey](#) and tell us how we are doing!





To the Oregon Health Authority's Public Health Division,

We, the undersigned, are writing you to provide community feedback regarding the 2020-2024 State Health Improvement Plan in order to speak to the plan's priorities. As the Leadership Group of the Central Oregon Suicide Prevention Alliance, we believe it is vital that suicide be included as a priority.

Suicide is one of the leading causes of death in Oregon. In our Central Oregon Region, 31, 22, and 17 people die by suicide annually in Deschutes, Crook, and Jefferson Counties respectfully.¹ Suicide is the tenth leading cause of death in the United States with one suicide occurring on average, every 13 minutes.² Suicide rates have been increasing in the past decade nationally, statewide and in the Central Oregon region.^{1,3} Moreover it is estimated that the average cost of one suicide is \$1,329,553, which includes medical costs for individuals and families, lost income for families, and lost productivity to employers.⁴ In addition to financial costs, the emotional toll to families and communities cannot be quantified. Suicide is a death like no other in that its human impact has a far-reaching ripple effect.

Though these facts and figures are alarming, we also know that suicide is the most preventable form of death.^{5,6} We, as a Central Oregon Suicide Prevention Alliance Leadership Group, know that comprehensive suicide prevention is an investment that saves dollars, and more importantly, saves lives. Comprehensive suicide prevention at the local level can be extremely effective when aligned and supported statewide. Prioritization allows for effective and sustainable collaboration, increased resources to execute the work comprehensively, and matched prioritization among local organizations and agencies who look to the Oregon Health Authority as the leader in prioritization of public health issues.

The Central Oregon Suicide Prevention Alliance Leadership Group believes it is vital that the Oregon Health Authority include suicide as a priority for the 2020-2024 State Health Improvement Plan. Through prioritization and a comprehensive public health approach that includes multi-sector partnerships, we as a collective state can work to save lives. Suicide prevention is a priority of the Central Oregon region, and given the rising suicide rates as a state, should be a priority of the Oregon Health Authority's 2020-2024 State Health Improvement Plan.

Respectfully,

Central Oregon Suicide Prevention Alliance Leadership Group

Whitney Schumacher, MPH

Suicide Prevention Coordinator for Deschutes County

Cheryl Emerson, MS, NCC, LPC

Private Therapist

Paige E. Farris, MSW

Community Research Program Administrator for the OHSU
Community Research Hub

Dr. Mike Franz, MD, DFAACAP, FAPA

Medical Director of Behavioral Health for PacificSource

Holly McCown Harris, M.Ed., LPC

Crises Services Program Manager for Deschutes County

Martha Hinman, MA

Executive Director of Student Services for Redmond School
District

Dee Ann Lewis

Executive Director of the Family Resource Center

Donna Mills

Executive Director of the Central Oregon Health Council

Dr. Laura Pennavaria, MD, FAAFP

Chief Medical Officer of St. Charles Medical Group

Sean Reinhart, MS

Executive Director of Special Programs for Bend-La Pine Schools

References:

1. Crude rate per 100,000, rounded to nearest whole number. Source: Oregon Public Health Assessment Tool, 2017.
2. Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from <http://www.cdc.gov/injury/wisqars/index.html>.
3. Peterson C, Stone DM, Marsh SM, et al. Suicide Rates by Major Occupational Group — 17 States, 2012 and 2015. *MMWR Morb Mortal Wkly Rep* 2018;67:1253–1260. DOI: <http://dx.doi.org/10.15585/mmwr.mm6745a1>
4. Shepard, D. S., Gurewich, D., Lwin, A. K., Reed, G. A., Jr., & Silverman, M. M. (2015). Suicide and suicidal attempts in the United States: Costs and policy implications. *Suicide and Life-Threatening Behavior*.
5. U.S. Office of the Surgeon General, National Action Alliance for Suicide Prevention. *2012 National strategy for suicide prevention: goals and objectives for action*. Washington, D.C.: HHS; 2012.
6. World Health Organization. *Suicide prevention: a global imperative*. Geneva, Switzerland: WHO Press; 2014.



January 28, 2019

Submitted via: publichealth.policy@state.or.us.

PartnerSHIP
c/o Lillian Shirley, Director
Oregon Public Health Division
Public Health Division
800 NE Oregon Street
Portland, OR 97232

Re: 2020-2024 State Health Improvement Plan

Dear Director Shirley:

ViiV Healthcare (ViiV) appreciates the opportunity to submit comments regarding the State of Oregon's proposed 2020-2024 State Health Improvement Plan.

ViiV is the only pharmaceutical manufacturer devoted exclusively to the treatment of HIV with a singular focus to improve the health and quality of life of people affected by HIV. As a manufacturer of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition.

ViiV greatly appreciate the efforts of the PartnerSHIP to identify strategic issues using the following criteria:

*"... magnitude (issues that affect a large number of people), severity (are associated with death or disability), disparities (disproportionately affecting specific communities) and upstream determinants (root causes of downstream health effects)."*¹

However, ViiV is disappointed to see that the focus on communicable diseases, particularly HIV, was not carried over from the 2015-2019 SHIP.² HIV continues to affect approximately 6,598 people living with HIV in Oregon,³ and there were 221 new HIV diagnoses in 2016 (the most recent year for which data is available).⁴

With that in mind, ViiV offers the following comments on three specific, strategic issues that ViiV hopes will be prioritized and included in the proposed 2020-2024 State Health Improvement Plan.

1. Substance Use

ViiV applauds the state's focus on alcohol and substance use⁵ as a strategic issue identified for inclusion in the proposed 2020-2024 State Health Improvement Plan and encourages the PartnerSHIP to consider the intersection of substance use and HIV within the state of Oregon.

¹ <https://www.oregon.gov/oha/PH/About/Pages/ship-process.aspx#meetings>

² <https://www.oregon.gov/OHA/PH/ABOUT/Pages/ship-communicable-disease.aspx>

³ AIDS Vu, Oregon, <https://aidsvu.org/state/oregon/>

⁴ AIDS Vu, Oregon, <https://aidsvu.org/state/oregon/>

⁵ <https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/Mini%20grantees%20-%20strategic%20issues%20docs/Substance-Use.pdf>

For people living with HIV (PLWH), substance use can hasten disease progression, affect adherence to antiretroviral therapy (ART), and worsen the overall consequences of HIV.ⁱ PLWH who use substances are less likely to take medications as prescribed due partially to effects from interactions between some prescribed drugs and illicit drugs. Not taking ART as prescribed can worsen the effects of HIV and increase the likelihood of transmission.

Currently, the opioid epidemic represents a significant public health crisis in the United States, with an estimated 2.1 million Americans having an opioid use disorder in 2016.^{ii,iii} According to the Centers for Disease Control and Prevention (CDC), drug overdose is now the leading cause of death among individuals under 50 years of age.^{iv} The CDC estimates that over 115 people die per day from opioid overdose.^{v,vi} The economic impact of misuse is \$78.5 billion per year in the United States.^{vii} As HIV advocates, policymakers, and public health officials work towards the goal of “Ending the HIV Epidemic,” the ongoing opioid epidemic and its impact on these efforts must be considered.

The opioid epidemic also indicates an increased risk of HIV transmission. While many individuals with opioid use disorder start with pills, an estimated 10-20 percent of people who abuse prescription opioids move on to inject opioids or heroin.^{viii,ix} Substance misuse can lead to increases in risky behaviors for disease transmission, and injection drug use in a population can fuel transmission of blood-borne infectious diseases such as HIV.^x The CDC estimates that 19 percent of the more than 1 million people living with HIV in the United States are injection drug users,^{xi} and injection drug users accounted for 9% (3,425) of new diagnoses of HIV in the United States in 2016.^{xii} Individuals who inject drugs intravenously in their lifetime are over 30 times as likely to have HIV/AIDS.^{xiii} In 2015, there was an increase in new HIV diagnoses among injection drug users for the first time in two decades.^{xiv}

The CDC has published data identifying 220 U.S. counties with the highest potential for HIV and other infectious disease outbreaks due to the opioid epidemic.^{xv} Health officials in some states and regions have reported increased HIV transmissions as a result of the opioid epidemic.^{xvi,xvii,xviii}

As a scientific company dedicated to the treatment of HIV, ViiV encourages both federal and state policymakers to consider the intersection of the HIV and opioid epidemics by promoting education and awareness of the transmission of infectious diseases like HIV; facilitating the identification of new infections through routine testing and screening; and ensuring access to HIV treatment and appropriate medical care for PLWH.

HIV testing is a vital yet overlooked part of substance use treatment efforts. The CDC recommends routine opt-out HIV screening for all adults, adolescents, and pregnant women in health care settings as a normal part of medical practice, but those with specific risk factors for the disease (such as injection drug users) should be tested more frequently.^{xix} It is possible that many new HIV infections are not being detected due to a lack of routine testing for those at risk due to the opioid epidemic. Some individuals may not be aware of the highly increased risk factor for HIV due to substance misuse.

HIV testing as a part of interventions targeting those with opioid use disorder represents an important public health opportunity for both the health of PLWH and for those at risk for the disease. Studies show that the earlier a person is diagnosed and treated for HIV, the better their health outcomes. Early initiation of antiretroviral therapy significantly improves survival, as compared with deferred therapy.^{xx} Effective HIV treatment can help people living with HIV to live longer, healthier lives.^{xxi} When treated effectively, HIV disease can be managed similar to a chronic disease.

Effective HIV treatment can also prevent the transmission of the disease. According to the CDC, PLWH who achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to others.^{xxii} Despite these treatment advances, only 48 percent of all PLWH are retained in care and only 49 percent of all people living with HIV are virally suppressed.^{xxiii} Achieving viral load suppression can only occur if PLWH are diagnosed, have access to medical care, receive treatment, and remain adherent to their prescribed therapy.

For these reasons, ViiV encourages the specific inclusion of provisions related to HIV counseling and education for individuals being treated for SUD in order to promote awareness and prevention of the disease. ViiV also encourages HIV testing for patients at intake, consistent with ASAM and CDC guidelines, so that those individuals living with HIV may be connected with care and treatment.

2. Access to Care

ViiV applauds the state's focus on access to care⁶ as a strategic issue identified for inclusion in the proposed 2020-2024 State Health Improvement Plan, particularly that:

“People need equitable access to health care, including physical, mental, behavioral and oral health care services. Access depends on having health insurance coverage, a doctor or dentist that provides culturally responsive care, and transportation to visit a provider. Many people across Oregon report difficulty accessing health care.”⁷

Access to high quality health care is very important for PLWH. ViiV urges the state ensure PLWH in Oregon have access to all Ryan White providers, who play a vital role in treating HIV. The Ryan White HIV/AIDS Program provides direct health care and support services for over half a million PLWH nationally— more than 50 percent of all people living with diagnosed HIV in the U.S.^{xxiv} Ryan White providers are designated as essential community providers (ECPs) by the federal government because of the role they play in caring for and treating medically underserved and low-income people with HIV/AIDS.

ViiV further encourage the PartnerSHIP to prioritize HIV-specialized and HIV-experienced care providers in the state who may not be Ryan White providers. Since the beginning of the HIV epidemic, providers from a variety of specialties (such as infectious disease specialists, family medicine practitioners, internists, and general practitioners,) and licensures (physician's assistants, nurses, nurse practitioners) have focused in HIV care and treatment and served this vulnerable population. While there is no specific board certification for HIV medicine, several professional organizations and other states have proffered criteria for the designation of HIV specialists.^{xxv, xxvi, xxvii} Medical care providers who are specialized and experienced in the care and treatment of HIV – even some Ryan White providers – may not necessarily be designated as specialists. Conversely, some infectious disease specialists may lack advanced training and experience in HIV treatment.

PLWH depend on access to experienced medical providers with HIV expertise for effective management of their disease. These providers are experienced in aiding patients with the many medical complexities that arise from living with HIV including comorbidities with other diseases, adherence, drug interactions, and drug resistance. Studies show that individuals with HIV whose care is managed by an experienced HIV medical provider are more likely to be retained in care, virally suppressed, and to receive more cost-effective care.^{xxviii xxix}

Patients retained in active medical care often have long-standing, trusting relationships with their medical provider, which is a key piece of the successful management of HIV. Exclusion of these providers from coverage networks can lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations. Achieving control of the virus requires uninterrupted access to regular access to a medical provider. Gaps in HIV treatment of days to weeks can reverse viral suppression, increase risk of transmission to others, and lead to serious complications, including development of a virus that is drug resistant, and more difficult to treat.^{xxx} ViiV urges the PartnerSHIP to require broad access to all HIV care providers in the state, including but not limited to Ryan White clinics, for all PLWH in the program.

3. Institutional Bias Across Public/Private Entities

⁶ Oregon SHIP, Access To Care, <https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/Mini%20grantees%20-%20strategic%20issues%20docs/access%20to%20care.pdf>

⁷ Oregon SHIP, Access To Care, <https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/Mini%20grantees%20-%20strategic%20issues%20docs/access%20to%20care.pdf>

ViiV applauds the PartnerSHIP's focus on institutional bias in health care, particularly as it pertains to racial bias, sexual orientation, and gender identity in terms of access to healthcare, and stigma.

Minorities are disproportionately affected by HIV. In the State of Oregon, the rate of Black males living with an HIV diagnosis is 3.0 times that of White males. The rate of Hispanic/Latino males living with an HIV diagnosis is 1.2 times that of White males. The rate of Black females living with an HIV diagnosis is 12.5 times that of White females. The rate of Hispanic/Latina females living with an HIV diagnosis is 1.7 times that of White females.⁸

ViiV urges the PartnerSHIP to also focus on stigma related to gender identity, and sexual orientation. There is a particularly high burden of HIV among Black gay and bisexual men. However, HIV highly impacts gay, bisexual, and other men who have sex with men of all races and ethnicities, and transgender women.⁹ Some studies have found that as many as 30 percent of transgender individuals are living with HIV infection.¹⁰ Diagnoses of HIV infection are increasing in young gay and bisexual men, particularly.¹¹

The National HIV/AIDS Strategy identifies stigma as a key issue saying its vision is that PLHW should have access to high quality, life-extending care, free from stigma and discrimination.¹² ViiV shares this vision and urge the PartnerSHIP to expand the focus on bias towards gender identity, and sexual orientation within public and private entities within the state.

Conclusion

ViiV is committed to working with policy makers and health officials to prevent HIV transmission, to support HIV education and ensure access to HIV treatment for those living with the disease. ViiV appreciates your consideration of these comments.

Please feel free to contact me at kristen.x.tjaden@viivhealthcare.com with any questions.

Sincerely,



Kristen Tjaden
Government Relations

⁸ AIDS Vu, Oregon, <https://aidsvu.org/state/oregon/>

⁹ NATIONAL HIV/AIDS STRATEGY

for the UNITED STATES: Updated to 2020 <https://files.hiv.gov/s3fs-public/nhas-update.pdf>

¹⁰ Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS Behav.* 2008; 12:1–17. doi: 10.1007/s10461-007-9299-3

¹¹ Centers for Disease Control and Prevention. HIV Surveillance Report, 2013. February 2015; 25. <http://www.cdc.gov/hiv/library/reports/surveillance/>

¹² NATIONAL HIV/AIDS STRATEGY

for the UNITED STATES: Updated to 2020 <https://files.hiv.gov/s3fs-public/nhas-update.pdf>

- ⁱ “HIV and Substance Use in the United States” Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, CDC.gov; last updated: March 6, 2018 <https://www.cdc.gov/hiv/risk/substanceuse.html>
- ⁱⁱ Kaiser Family Foundation HIV and the Opioid Epidemic: 5 Key Points <https://www.kff.org/hiv/aids/issue-brief/hiv-and-the-opioid-epidemic-5-key-points/>
- ⁱⁱⁱ SAMHSA. 2016 National Survey on Drug Use and Health. <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf>
- ^{iv} Hidden Casualties: Consequences of Opioid Epidemic on the Spread of Infectious Diseases. HIV.gov. Published: November 20, 2017 <https://www.hiv.gov/blog/hidden-casualties-consequences-opioid-epidemic-spread-infectious-diseases>
- ^v Opioid Basics, “Understanding the Epidemic,” CDC, <https://www.cdc.gov/drugoverdose/epidemic/index.html>
- ^{vi} Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at <http://wonder.cdc.gov>.
- ^{vii} Florence CS, Zhou C, Luo F, Xu L. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Med Care*. 2016;54(10):901-906. doi:10.1097/MLR.0000000000000625
- ^{viii} Peters, P., et al. (2016). “HIV Infection Linked to Injection Use of Oxycodone in Indiana, 2014–2015.” *New England Journal of Medicine*. 375:229-239.
- ^{ix} Van Handle, M., et al. (2016). “County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States.” *Journal of AIDS*. 73:3, 323-331
- ^x “Drug Use and Viral Infections (HIV, Hepatitis)” National Institute of Drug Abuse, NIH, April 2018 <https://www.drugabuse.gov/publications/drugfacts/drug-use-viral-infections-hiv-hepatitis>
- ^{xi} The National Survey of Substance Abuse Treatment Services (N-SSATS) Report: HIV Services Offered by Substance Abuse Treatment Facilities. <https://www.samhsa.gov/sites/default/files/hiv-services-offered-by-sa-facilities.pdf>
- ^{xii} CDC, HIV Among People Who Inject Drugs, <https://www.cdc.gov/hiv/group/hiv-idu.html>
- ^{xiii} Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (December 1, 2010). The National Survey on Drug Use and Health (NSDUH) Report: HIV/AIDS and Substance Use. Rockville, MD. <https://www.samhsa.gov/sites/default/files/hiv-aids-and-substance-use.pdf>
- ^{xiv} Kaiser Family Foundation HIV and the Opioid Epidemic: 5 Key Points <https://www.kff.org/hiv/aids/issue-brief/hiv-and-the-opioid-epidemic-5-key-points/>
- ^{xv} J Acquir Immune Defic Syndr. 2016 Nov 1 “ County-Level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections Among Persons Who Inject Drugs, United States.” <https://www.ncbi.nlm.nih.gov/pubmed/27763996>
- ^{xvi} Northern Kentucky Health Department. Press Release: “Health Officials See Increase in HIV Infection Among Individuals Who Inject Drugs.” January 9, 2018. <https://nkyhealth.org/2018/01/09/health-officials-see-increase-in-hiv-infection-among-individuals-who-inject-drugs/>
- ^{xvii} Massachusetts, Department of Public Health, MDPH Clinical Advisory, HIV Transmission through Injection Drug Use, November 27, 2017 https://hmcrcg3.org/wp-content/uploads/sites/90/2017/12/112707ClinicalAdvisory_HIV.pdf
- ^{xviii} Morbidity and Mortality Weekly Report (MMWR), “Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxycodone — Indiana, 2015” May 1, 2015 <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6416a4.htm>
- ^{xix} CDC. Revised Recommendations for HIV Testing of Adolescents, and pregnant Women in Health-Care Settings. MMWR 2006; 55 (No. RR-14). Accessible via the web at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>
- ^{xx} Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med*. 2009 Apr 30 National Institutes of Health; US National Library of Medicine <https://www.ncbi.nlm.nih.gov/pubmed/19339714>
- ^{xxi} Severe P, Juste MA, Ambrose A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201
- ^{xxii} CDC. Dear Colleague: September 27, 2017. <https://www.cdc.gov/hiv/library/dcl/dcl/092717.html>
- ^{xxiii} CDC, Understanding the HIC Care Continuum. July 2017. <https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf>. Accessed September 6, 2017.
- ^{xxiv} Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2016 <https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2016.pdf> Accessed: 11/29/2017
- ^{xxv} HIV Medicine Association (HIVMA), American Academy of HIV Medicine (AAHIVM), and Associations of Nurses in AIDS Care (ANAC). The AAHIVM has a credentialing process for HIV physicians, nurse practitioners, physician’s assistants and pharmacists. ANAC created the HIV/AIDS Nursing Certification Board for certification of registered nurses and nurse practitioners in HIV nursing.
- ^{xxvi} Florida Agency for Healthcare Administration, Medicaid Managed Care Contract, The HIV/AIDS Specialty Plan, Attachment II, Exhibit II-C, HIV/AIDS Specialty Plan, November 1, 2015, https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-C-HIV-AIDS_2015-11-01.pdf
- ^{xxvii} Centers for Medicare & Medicaid Services, Core Quality Measures Collaborative, *HIV/Hep C Core Measures*, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/HIVHep-C-Core-Measures.pdf>
- ^{xxviii} Kitahata MM, Koepsell TD, Deyo RA, Maxwell CL, Dodge WT, Wagner EH. Physicians’ experience with the acquired immunodeficiency syndrome as a factor in patients’ survival. *New Engl J Med*. 1996;334:701–7. [PubMed]
- ^{xxix} Gallant, Joel E. et al. “Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition.” *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America* 53.11 (2011): 1043–1050. *PMC*. Web. 20 Dec. 2017.
- ^{xxx} Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf> [Discontinuation or Interruption of Antiretroviral Therapy].



LGBTQIA Listening Session Summary

November 5th, 7th and 8th



Our mission

Working together to provide quality, cost-effective healthcare for our communities.

Our promise

Changing healthcare to work for you.



Background

AllCare had two staff participate and graduate from Oregon Health Authority's Developing Equity Leadership through Training and Action (DELTA) program. DELTA is a health equity and inclusion leadership program that includes training, coaching, and networking to health, community, and policy leaders in Oregon. This nine-month program trains 25 members committed to advancing health equity and diversity throughout Oregon.

Through this training, the staff were exposed to and trained in Multicultural Listening Sessions.

Multicultural Listening Sessions

Multicultural communities often convey health information and knowledge qualitatively – through sharing stories – while professionals tend to rely more upon quantitative methods – such as data collection – to gather information. Storytelling and other qualitative methods can help professionals understand and determine the meaning behind the numbers, which is key to effective policy and program development. In addition, sharing a personal story has the added benefit of empowering the storyteller and, if applicable, can also help with his/her healing process. This is especially true when the story is heard by those in leadership positions who can influence positive changes to address elements shared within the story.

https://www.youtube.com/watch?v=2IR_HVljagE&feature=youtu.be

Background

Provider offices that participate in AllCare Health's Alternative Payment Models (APM) are surveyed annually to determine patient satisfaction with access to care and their provider. In an effort to make the program more equitable the following question was added to the survey:

Do you feel that you were treated differently from other patients because of any of the following? (Check all that apply) Insurance Type, Race, Gender, Age, LGBTQ, Disabled, Language, Other

LGBTQ continues to be checked as one of the most common reasons that members feel they are treated differently. Through AllCare's Community Advisory Council in each county those that identify as transgender continue to voice concerns of discrimination, as well as, verbal and physical abuse, according to feedback from AllCare's Community Advisory Councils in Josephine, Jackson and Curry counties.

Planning Committee

AllCare has an internal committee called the Health Equity and Inclusion Action Team. This team was developed to look at AllCare's internal policies and procedures along with ways to influence the provider network to better address the cultural and linguistic needs of our members.

As part of that committee a sub-committee was formed. To ensure cultural responsiveness of the session, the committee for final decisions regarding the sessions will consist of 71% LGBTQ members. This was tracked through a survey given anonymously to the committee.

Sessions

There were four (3) sessions held in the Fall of 2018. One in each county Jackson, Josephine, and Curry County.

Participants were not limited to AllCare health plans. The general public was invited.

Caterers that were identified as LGBT were given preference for selection at each event.

Participants were given a \$25.00 gift card for participating.

Survey questions

As participants entered, they were asked to answer the following questions:

QUESTION	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
I feel comfortable with my doctor.					
I feel comfortable with the staff at my doctor's office.					
I am not treated differently in my doctor's office.					
My doctor understands my health care needs.					
I have access to the care I need.					
I feel comfortable in the community I live in.					

Session Slides

Welcome

- Complete Survey
- Sign In
- Restrooms
- Food
- Introductions

Why are we here today....

To hear your stories about healthcare in the community. This valuable information will help us understand how to better meet your healthcare needs.



Other factors of health



Group Discussion.....

- A question will be put up on the screen.
- Each group will discuss the question.
- One person will guide the conversation.
- One person will be a note taker.

Group Work Agreements

- **Everyone Participates** – stay present and engaged, one conversation and active listening.
- **Speak Your Truth** – do not be afraid to share your personal “story” and life experiences.
- **Different Opinions Are Welcome** – acknowledge the views, experiences and opinions of others that differ from your own with respect and dignity.
- **Maintain Confidentiality** – personal experiences, opinions and stories shared do not leave this room without permission.

When you or your family is sick where do you seek care?



When you seek care what is your experience?



What happens next.....

- We will create a report based on the topics discussed today.
- We will develop a plan to help providers better meet your needs.
- Keep in contact with us. We plan to report back to all of you in the next year.



Next Steps and Q&A

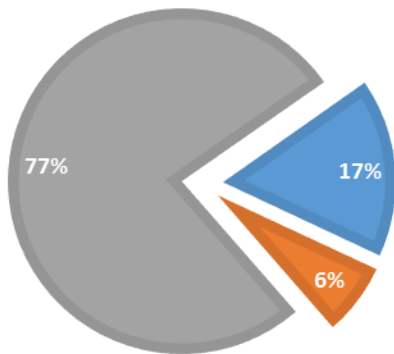
Sample of Responses Received



Survey questions

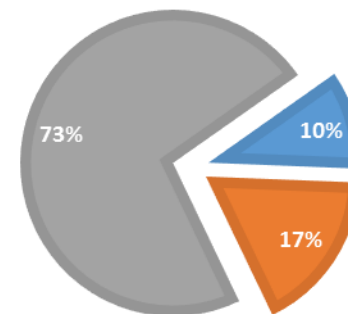
I FEEL COMFORTABLE WITH MY DOCTOR

■ Negative ■ Neutral ■ Positive



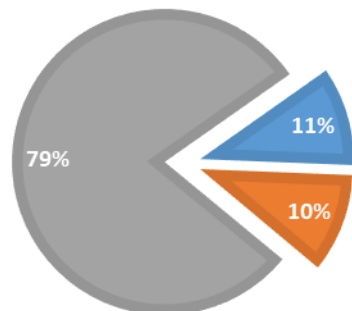
I FEEL COMFORTABLE WITH THE STAFF AT MY DOCTORS OFFICE

■ Negative ■ Neutral ■ Positive



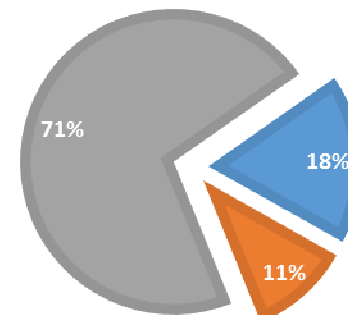
I AM NOT TREATED DIFFERENTLY IN MY DOCTORS OFFICE

■ Negative ■ Neutral ■ Positive



MY DOCTOR UNDERSTANDS MY HEALTH CARE NEEDS

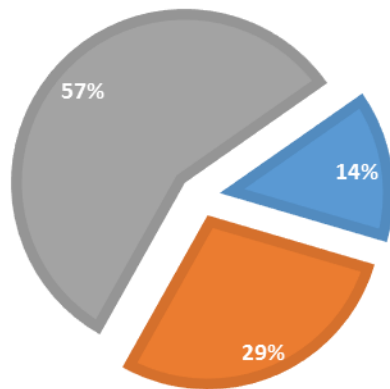
■ Negative ■ Neutral ■ Positive



Survey questions

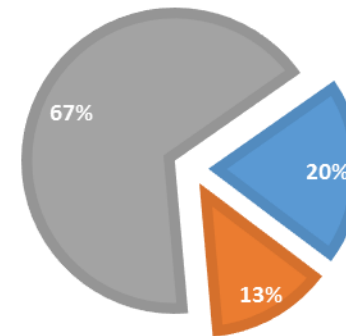
I HAVE ACCESS TO THE CARE I NEED

■ Negative ■ Neutral ■ Positive



I FEEL COMFORTABLE IN THE COMMUNITY I LIVE IN

■ Negative ■ Neutral ■ Positive



In summary

Access

- Appointments are too far out
 - Everyone wants to go to Primary Care if they can get in
- Alternative ways to seek advice on care greatly helps in emergencies
 - Nurse Help Lines
 - Crisis Lines
 - Suicide Hotlines
 - Mental Health Crisis Lines
- Patient Portals are great and the participants loved that they could use them instead of worrying about discrimination when going in to the office in person. Follow-through on the provider side is important. Participants had the following frustrations
 - No response to emails through Portal
 - Labs were not posted

Access

- Most providers in the region are great, especially Nurse Practitioners.
- Many barriers happened with gatekeepers:
 - At the specialist office
 - Receptionist
- Stigma seemed worse with other factors
 - Hearing loss
 - Ageism
 - Weight of the individual
- In the rural areas transportation is big barrier.
 - Individuals are still traveling to Eugene because of more Culturally Competent Care
 - Specialists
 - Hospitals
 - HIV Testing
 - Gender identity is on some forms at some hospitals but no Cultural Competency training to ask the questions
 - No Sexual Orientation Questions

Culturally Competent Care

- Providers that have completed Sexual Orientation and Gender Identity training makes for a more welcoming environment.
- There is a lot of dismissal of Sexual Orientation and Gender Identity being a factor in one's healthcare.
 - Individuals that identify as Lesbian being forced to take pregnancy tests before procedures.
 - A Transgender Male was forced to explain to front desk staff at the lab why they needed to complete a BRCA gene test.
- Therapist took gender dysphoria off of diagnosis and the individual had to explain to provider why it was important.
- Education happening from the LGBTQIA population to the provider community on the care that is needed.

Culturally Competent Care

- STI discussions need to happen in a more Culturally Appropriate way.
 - No PrEP education in area
 - Using the wrong STI test on partners that are negative for HIV with HIV positive partners.
 - Provider thought that a Lesbian partner would not need to be tested during an STI scare for one woman.
- LGBTQIA individuals are very vulnerable in the medical setting.
 - Advertising that you welcome LGBTQIA individuals
 - Rainbow flags in waiting rooms would be nice
 - Be humble about mistakes made and apologize
- Cultural Competency for Gender Identity is needed greatly
 - Transgender male's wife was asked to undress for mammogram
 - Wife was also asked if "felt safe" with this individual in front of the partner.

Do not reinvent the wheel

There are many resources and tools available to guide you through this process.

Minnesota Public Health:

<http://www.minneapolismn.gov/health/toolkit/multicultural>

https://www.youtube.com/watch?v=2IR_HVljagE&feature=youtu.be

<http://www.minneapolismn.gov/www/groups/public/@health/documents/w ebcontent/wcms1p-115951.pdf>

Oregon Health Authority:

<http://www.oregon.gov/oha/OEI/Pages/index.aspx>

DELTA Program:

<http://www.oregon.gov/oha/OEI/Pages/DELTA.aspx>

AllCare Health:

Stick Crosby

Contracts Manager

Phone +1 (541) 471-4106

Email

Stick.Crosby@allcarehealth.com

Natalie Case

Quality Analytics Specialist

Phone +1 (541) 471-4106

Email Natalie.Case@allcarehealth.com

Will Brake

Chief Operating Officer

Phone +1 (541) 471-4106

Email Will.Brake@allcarehealth.com





Next Steps and Q&A