Meeting Minutes

Oregon HIV/Viral Hepatitis/Sexually Transmitted Infection
Integrated Planning Group (IPG)

FULL MEMBERSHIP MEETING

Date: March **26, 2014**

Number of voting members present: 24

Number of others/non-voting members present: 6

Agenda Item/Topic	Key Themes in Discussion	**Outcomes** (Decisions or Next Steps)	**Responsible Party**
Introduction	• There are four objectives for today's meeting: Share information relating to the IPG Implementation Plan process, to obtain community input to develop resources around cultural sensitivity, identify how OHA surveillance data can help meet local needs, and develop some talking points around viral hepatitis. • Two new members have joined the IPG. Three others have completed their 2-year membership term. A fourth person (OHA staff) has retired.		
Announcements	• Changes have occurred in what has been called the Quality Management Task Force. After determining that with all of the different funding sources, it is difficult to come up with a project that can be worked on. It was useful to get together and find out what everyone is doing in their respective programs. The group is being re-designed to become more of a quality improvement collaborative. People are welcomed to join. It is a place to come and talk about issues and projects that are in progress. • The TB Control and HIV Community Services programs have merged. The two programs are working together		

	to integrate services. • The STD prevention program is now under the same management as the HIV Prevention program. • The downtown clinic is the only specialty facility and there is a need for Hep. C mono infected patients. A Hep C clinic has been started starting next year. There is an internal arrangement with Multnomah County providers to refer mono Hep. C patients since there is more experience than in the general clinics. • Annual art auction is occurring at Cascade AIDS Project (CAP). Tickets are still available. • If there is anyone who has not made the transition for insurance, please have them call their case managers. • The Meaningful Care Conference begins on Thursday, March 27. This is a bi-annual event and is designed to build cultural competency skills for providers working with LGBTQ – identified persons throughout the regions. A few events have been added. A provider networking event is scheduled from 6:30 – 8:30. There will be a speaker about HPV who will provide information on vaccination and treatment and care guidelines. • The CAREAssist Program has finalized its emergency preparedness plan. Working with the Emergency Preparedness program within the Public Health Division, to make sure that people are able to access their medication in the event of a statewide emergency. Going to start the outreach communication plan. • Focus is being increased on people knowing their status through peer educators as well as providers testing more. Did get a new positive Hep C at one of the institutions. Also looking at care outside of the corrections system. Also doing drug-based therapy as well as implementing activities into case management. • Working on bi-regional meeting focused on identifying sexual health services for MSM in health delivery		

	systems in the era of the Affordable Care Act implementation. First meeting is scheduled for May 30. • The Multnomah County clinic has served almost 1,300 people. • From the last meeting, there has been conversation around member engagement and member support. A couple of decisions made include the membership committee is going to put together an exit interview for those leaving IPG. Want to make sure that consumers who don't work in the field feel supported and can keep up with what's going on. A conference call may be scheduled for consumers to see what is going on. The membership committee is always looking for new members. Members are encouraged to join the membership committee. Duties include reviewing membership applications, updates to policies and procedures, and the development of an exit interview process. It is difficult to find a time when everyone can meet. A document is posted on the IPG website that shows the membership and what is needed. • The Centers for Disease Control & Prevention (CDC) and the Health Resources Services Administration (HRSA) have embraced integrated planning. A joint letter from both agencies was sent addressing due dates for reports to both agencies. The goal in the near future is to have all reports for both agencies be due at the same time which will be September, 2016. This will include a single integrated plan that will meet the requirements of both agencies.		
IPG Implementation Plan Update	• In 2012 when the IPG was formed, committees were developed to create and incorporate a piece of the IPG Strategic Plan. The goal was set to create a document that contained both broad and specific recommendations. Oregon Health Authority (OHA) staff created the IPG Implementation Plan based on the Stretegic Plan. The recommendations were used to		

	create specific activities that included timelines and staff who would take the lead. The Implementation Plan has activities that cover 2013 through 2015. An updated Plan has been sent out. • The Implementation Plan is a way to check that the work that is being done reflects recommendations. • OHA continues to support client training throughout the 31 counties with providers. This includes a positive self-management training which is a seven week course designed for those living with HIV, partners, and family members. Other smaller trainings were also conducted. • For 2015, the hope is to have more webinars available to reach more people. • Another goal is to improve marketing around client training. Case managers were not receptive to initial ideas. If interested, IPG members can join an ad-hoc group that will talk about client outreach. • The Oregon Health Authority has been active in Oregon Administrative Rule revisions around consent for HIV testing. • Prior to 2012, a separate consent was required for HIV testing. It was felt that it was there was an administrative burden and promoted stigma. • In 2012, the Legislature passed a Bill that said HIV testing consent can be part of the general consent process and not something unique or set apart and that the client has the right to refuse. • There may be more stringent processes between health systems in Oregon. • In 2012 – 2013, the Administrative Rules were revised to fall in line with the new Bill. • This process involved working with the State Attorney General's office and representatives from various health systems and other agencies. • CAREAssist is looking at issues relating to dental care. The goal is to support the purchase of dental insurance.		

	• How much and what will happen has yet to be determined. An additional issue is that with the expansion of Medicaid and the inclusion of dental services, there are challenges related to availability of services. • Feedback is coming in relating to challenges clients have had. • Multnomah county is developing materials around being tested at dental care sites.		
CAREAssist Update	• The AIDS Drug Assistance Program is also known as CAREAssist. • CAREAssist has had an insurance model in providing services since 1997. This meant that when someone needed service, they could be referred to an insurance carrier. This was possible through a high-risk insurance pool. • With the Affordable Care Act (ACA), it has been a challenge to get insurance people were in to a different insurance. • Part of the ACA was an expansion of Medicaid. At some point,55% of those served by CAREAssist will be covered by the state Medicaid program. There may be services that are not available through Medicaid that people can still get through CAREAssist. • On a given year, CAREAssist services approximately 3,600 people. • For the 45% clients not covered through Medicaid, they may have a group policy through their employer or other policy. There are people who are not eligible for Cover Oregon. Those not eligible are directed to a private insurance carrier. • 1,600 people have had changes in their insurance type. Some were automatically transferred to another type of insurance. • There are about 150 people whose insurance status is unknown. There may be as many as 30 people who		

	may not be eligible for the Oregon Health Plan. They may be those that are not responding to CAREAssist. • For April through December, a level of service will be provided for those who "show up". These people will be a part of the CAREAssist formulary. The goal is to get them to the next open enrollment period. • Several years ago, work began with Program Design and Evaluation around needs of people who were, are, or are interested in quitting smoking. This is due to a recent statistic says that 42% of clients indicated they are current smokers. CAREAssist has been providing quit smoking services that have been underutilized. • On March 26, client eligibility reviews are being printed that will have three questions devoted to tobacco. If a person responds that they want to quit within the next 30 days, they will be contacted and referred. Over-the-counter nicotine replacement therapy will also be available through the contracted mail order pharmacy. An outreach and marketing plan will also be launched. • Will be looking for feedback throughout this process. • The goal is to have on-going support to help people quit smoking. HRSA has expressed an interest in smoking cessation programs.		
Cultural Sensitivity Breakout Discussions	• The IPG membership has expressed interest in how cultural sensitivity issues can be addressed. • Cultural acumen is defined as understanding the culture of your agency as well as the culture that is being served. • Workgroups around MSM and persons who inject drugs have met. • Materials are being reviewed based on core cultural issues. • The exercise was very successful. A lot of information was shared. There were similar themes.		
OHA Surveillance Data:	• Since the group has been meeting for a couple of		

How can we meet your needs?	years, in determining the topic for discussion, it was decided to discuss the inventory of sources that can be used for public health purposes related to HIV prevention or treatment. • HIV and other sexually transmitted infections (STIs) are among 30 communicable diseases that must report in Oregon. • Laboratories have to report results that are specific for a reportable disease. • In the case of HIV, the reporting is shared between local health departments and the state health department. States are different in their reporting mechanisms. • Doctors have to report when they recognize a new case of a reportable condition which includes certain kinds of cancer. • Clinical labs are required to report every CD4 and viral load they process. This has been the process since 2006. • Mortality data from the federal and state levels are examined to identify cases that happened to people who have passed away. • Data is available at the county level based on categories such as age and risk factor. • An Epidemiological Profile is developed annually. It does take time from when the cases are reported to when the results are published. The average is about a year. • A report is also sent to CDC on the number of HIV cases that were reported and how many were linked to services. • Factsheets are developed and updated every year. • Lab reporting is closely related to case reporting. Results from Viral Load and CD4 counts come to the state health department electronically from the Lab. Software has been developed to review tests.		

	• This kind of data is used for estimating the number of people who have HIV and not getting care. • Data sources can be cross-linked. • 90% of tests from medical monitoring project (MMP) charts were reported to the Health Lab. • A project is underway with Multnomah, Lane, Jackson, and Douglas counties where those who have not had a laboratory test in the last 18 months. The question is whether these people can be found. Looking for these people included calling other states. All but 150 out of 4,000 can be determined to be out of care. This may be a routine practice on an annual basis. • There is an AIDS Research Group based in Seattle that is trying to standardize the definition of "out of care" and how to find someone. • The Medical Monitoring Project (MMP) has been going since 2007. Staff from Program Design & Evaluation (PDES) do most of the data collection. The project consists of interviews and chart reviews of up to 400 people per year. These people are receiving healthcare. Persons are selected by identifying who are HIV proficient healthcare providers. This would include those who collect HIV test results and prescribes antiretroviral medicines. Then estimates are made of how many patients are in their care. Providers are asked for a list of who has been seen between January through April. MMP data is used for needs assessments, develop factsheets and special projects. • Starting in 2015, MMP information is going to be drawn from the surveillance data set. For all reported cases, that is where the persons will come from that could participate in the project.		
Hepatitis C Update and Talking Point Development	• The National Health and Nutrition Examination did a survey looking at prevalence between 1999 through 2012. 5,000 people took part in random samples per year.		

	• A Chronic Hepatitis Cohort Study occurred between 2006 to the present. This study occurred in multiple places across the U.S. including Detroit Michigan, Danville Pennsylvania, Portland Oregon, and Honolulu Hawaii. The study consisted of a population size of 1.6 million who receive care at four integrated institutions. 13,000 persons with Hepatitis C and more than 3,500 with Hepatitis B participated in the study. • Hepatitis C is the most common blood-borne infection in the U.S. Overall, the Hepatitis C prevalence is estimated to be 1.6% of the U.S. population – 4.1 million with 80% common carriers. In Oregon, there are an estimated 48,000 persons have chronic Hepatitis C. • Peak Hepatitis C prevalence is among persons born between between 1945 – 1965. 75% of U.S. cases and 67% of Oregon cases cases. Compared to other states, Oregon has a higher than average Hepatitis C prevalence. • Hepatitis C is the leading cause for liver transplants and liver cancer. • In 2010, the Federal Drug Administration (FDA) approved point of care tests for Hepatitis C. In 2012 and 2013, the Centers for Disease Control and Prevention (CDC) and the U.S. Public Task Force revised Hepatitis C screening recommendations. These include risk screening and one-time screening of persons born between 1945 to 1964. • Disease severity rises as people get older. Healthcare utilization and expenditures rise with disease severity. Common co-morbidities include Type 2 Diabetes, depression, and substance use and/or abuse. With a co-infection with Fibrosis, the progression is common and can progress rapidly among persons co-infected with HIV/ Hepatitis C. Those co-infected with HIV and Hepatitis C need close monitoring and consideration for Hepatitis C treatment.		

	• Among the participants in the Oregon Medical Monitoring Project (MMP), 15% reported ever having HCV and 20% ever having HBV. Between 2006 to 2010, 5% of deaths in HIV-infected persons also had chronic Hepatitis in Oregon. From 2007 – 2010, 21-26% of OR MMP clients co-infected with HIV/HCV were determined eligible for HCV treatment. • Hepatitis C is virulent and easily transmitted. Viral infectivity has been demonstrated for up to 63 days in syringe barrels and dead space, up to 21 days in water in plastic containers, up to 14 days on surfaces (cookers and injection surfaces), and up to 24 hours in filters and 48 hours in filters wrapped in foil. • Every piece of injecting equipment is a transmission vector for Hepatitis C which includes syringes, cookers, filter, rinse water, mixing water, alcohol swabs, tourniquets/tie-offs, and injection surfaces are primary transmitters. • Every injection event has many infection and contamination opportunities. These include preparation – surfaces, cooker, waters, filters, injection – fishing, post injection handling and storage of supplies. • Actions that can be taken include decreasing syringe sharing and decreasing injection risk behaviors and potential exposures • For the 2007 – 2013 Oregon High Risk Screening program, there were 23 participating counties (health dept, jail, or needle exchange site), targeted HCV testing based on increased risk for infection, free tests were provided to testers even though no funding was available for staff or administrative fees, and a one page questionnaire: age, race/ethnicity/sex, risk factors, whether homeless or ever incarcerated, drug(s) of choice. • The preliminary findings from the screening project include those testing positive 517/3067 (16.9%).		

	Among HCV positives, rates by ethnicity include white- 452/517 (87%) and Hispanic- 36/517 (7%). Injection drug users were made up of those who inject drugs- 492/517 (95%). Drugs of choice included Cocaine- 22 (4%), Heroin- 111 (21.5%), Methamphetamine/Speed- 344 (66.5%), and Other- 12 (2.3). 59% of cases (n=673) reported only injecting methamphetamine/speed, 17% (n=192) reported heroin as the main drug used, 3% (n=41) reported cocaine, 15% (n=174) reported injecting meth/speed in addition to other drugs such as: heroin, cocaine, speedball (cocaine + heroin), methadone, and morphine. • The Oregon Viral Hepatitis Epidemiological Profile includes goals to Improved health outcomes for people at-risk of or living with hepatitis B and C infection in Oregon through appropriate prevention, screening, evaluation, care coordination, and treatment. • This profile can be a catalyst for action. Possible activities and support include talking about who is impacted by Viral Hepatitis in Oregon; support the development of public policies to promote effective surveillance, prevention, screening, and access to care; assisting agencies, organizations, and health systems to focus their efforts on appropriate populations for screening, prevention and linkage to care activities. • Draft talking points and messaging to the public that can include that Hepatitis B and C are common in Oregon, Hepatitis B can be treated, Hepatitis C can be cured, Risk factors for Hepatitis B and C, and where to get tested and treated. • Draft talking points and messaging to health system partners can include Hepatitis B and C are common in Oregon, Hepatitis C treatment has become much simpler and more effective, Hepatitis C screening and treatment are cost effective, and identify at-risk populations and their respective screening		

	recommendations • Draft talking points and messaging to policy makers can include that Hepatitis B and C are common in Oregon, Hepatitis C treatment has become much simpler and more effective, and there are significant cost benefits for prevention, screening and early treatment.		