Meeting Minutes

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

Committee: IPG Full Committee
Date: June 24, 2015
Number of voting members present: 19
Number of others/non-voting members present: 6

Agenda Item/Topic	Key Themes in Discussion		
Announcements	• In addition to the IPG Implementation Plan, another report that the committee is involved in is the Jurisdictional HIV Prevention Plan. Originally developed in 2012, addendums have been made over the last few years since then. An update to the plan is due in September. The addendum will be e-mailed to the committee for review and input. • The Part B case management survey will be sent out soon. • A community-based RN position is open at Our House. • Registration is open for AIDS Walk Portland on Saturday, September 12. A variety of teams will be participating. This is the largest fundraiser for several organizations in the area. • A new board member has been appointed to Cascade AIDS Project. • A new viral hepatitis website has launched. • The viral hepatitis Epi Profile is almost complete. • Currently hiring a black services case manager position as well as a CARELink navigator. • A^6 is hosting a community forum on September 29. The topics include sexuality, HIV, and hepatitis C. • HIV Alliance is almost ready to launch a pharmacist's telehealth program where pharmacists contact people in rural areas. The pharmacists are going to enter into a collaborative practice agreement with		

	a doctor who specializes in HIV in southern Oregon. The outcome is to be able to prescribe and order lab tests
Co-infection among PLWH: What do we know?	• A person living with HIV is three to five times likely to pass on an infection to their partner who is not infected. • An STI can decrease your CD4 count and increase viral load. • Certain STI's break the skin barrier which makes transmitting body fluids easier. • Many people living with HIV are not at risk for STI's. • Data from the Medical Monitoring Project (MMP) suggests that one in three men and one in two women receiving HIV care in Oregon are not sexually active. • A small portion of people living with HIV is at high risk for STI's acquisition or transmission. • About one in 10 people receiving HIV care in Oregon reported having 10 or more partners in the past year. • Among those who are sexually active, one in eight reported having unprotected sex with partners who were HIV negative or of unknown status. • One in nine are diagnosed with syphilis, gonorrhea, and/or chlamydia. • The agencies who fund the HIV and STD Prevention programs recommend a full screening of STI's at the beginning of HIV care. Screenings should be done every year. • For those at higher risk, screenings for STI's are recommended every three to six months including those who have multiple and/or anonymous partners. • The US Preventative Task Force which made recommendations are followed by most of the health care systems. • For those living with HIV and STI co-infection, the rate is much higher than that of the general populations. • From 2008 – 2012, the average annual rate of syphilis was 272 times higher among people with HIV. The average annual rate of gonorrhea 45 times higher among people with HIV than the general populations. • Certain groups of people living with HIV tend to have higher rates of STI's. These include HIV positive men versus HIV positive women, people in urban versus rural areas, younger people between the ages of 18 – 25, and HIV positive persons without an AIDS diagnosis.

	• Data from the MMP STI screening rates among persons living with HIV receiving HIV care are one in three. • Oregon is eighth in the country for syphilis (6.8 per 100,000). In 2011, Oregon was 31st, and in 2012, Oregon ranked 10th. • In 2013, 50% of those diagnosed with infectious syphilis were also HIV positive. In 2014, the number went down to 39% of early syphilis cases although the overall proportion of people with HIV who have syphilis is still high. It is not known why there was a decline in cases between 2013 and 2014. The hope is that it is due to increased screening. • Since December, 2014, Oregon, California, and Washington have all experienced an increase in ocular syphilis cases. This is due to bacteria impacting the eye and ocular nerve. • The number of acute hepatitis C cases in the United States is increasing. The current estimate is that close to 30,000 people who have been infected with new hepatitis C. • In the United States, there is an estimated 2.7 million people infected with hepatitis C. • The highest prevalence group are those born between 1945 – 1965. • Two-thirds of people will go on to develop chronic liver disease. 20% - 25% will develop cirrhosis which is a hardening of the liver. !% - 5% will develop liver cancer. • The populations that the state hepatitis program works with are those born between 1945 – 1965, people with current risk, and people with past risk. • Hepatitis C is contracted through blood. • Those that have been incarcerated have a higher risk of being exposed to hepatitis C. • CDC released a report which states that 19,368 people were reported to have died from complications that are hepatitis-related in the US in 2013. • The total chronic cases of hepatitis C in Oregon by 2013 is 45,435. • Between 2009 and 2013, there were 616 cases of liver cancer related to hepatitis C which made up 40% of all liver cancer cases in Oregon. • There are approximately 300 new hepatitis C cases each year. • Injection drug use is the leading cause of hepatitis C in Oregon. • in 2012, Oregon had the highest rate of non-prescription pain reliever use in the country.

	• When there is a co-infection with HIV, the progression increases for hepatitis C.
Current efforts to address co-infection: What are we doing?	• There is a functional cure for hepatitis C. • An Epidemiological Profile for hepatitis C will be published soon. • Recommendations fall into three categories: assessment, policy development, and assurance. • Some recommendations for co-infections with HIV include monitoring trends, monitor liver cancer and mortality, identifying health disparities, identifying policy for those having hepatitis C and linking them to treatment with an emphasis on people with increased prevalence and immediate risk of advanced liver disease. • An additional recommendation is to look at efforts to reduce opiate dependency and prevent people from progressing to injection drugs. • Looking for input on strategies to increase screening and re-screening among people who are living with HIV. Please send any questions around co-infection. Understanding what questions are coming from the community is very important. • Get involved with community advisory councils that are associated with Coordinated Care Organizations (CCO's). • Volunteer at a community-based organization. • Join community coalitions and groups. • In January, 2014, representatives from CDC came to work with the Oregon STD program and Multnomah County around syphilis. The work consisted of conversations with stakeholders and clients as well as revieweing medical records. Findings indicate high rates of serosorting. • There was an overall belief among HIV positive and negative men, medical providers, and others that sex without condoms is widespread – particularly among HIV positive men who have sex with men. • Groups interviewed reported that the risk of syphilis is often minimized if it is brought up. • Recommendations include educating more MSM – especially those that are HIV positive about health consequences of untreated syphilis. • The rates of syphilis screening for people living with HIV / AIDS tended to be lower in the private setting, health maintenance organizations and medical centers than in public health HIV clinics. • CDC is considering allocating money for a public information campaign including billboards, bus stops, and train ads.

	• Want to encourage private health systems to pair routine STI screening with CD4 and viral load testing. • CAREAssist provides coverage for co-pays for testing and treatment drugs. • The Oregon Reminders system can be used to provide testing reminders. • Partnering with care oriented groups like the AIDS Education and Training Center to assess best ways to promote current clinical recommendations including STI's and viral hepatitis among HIV clinical care providers. • Condom distribution is still being done through the state HIV and STD prevention programs. • On-going technical assistance with providers including those involved with HIV clinical care.around testing and treatment of sexually transmitted infections. • Working on a rectal gonorrhea project in Multnomah, Washington, and Lane counties. An added benefit is the project is allowing the Oregon State Public Health Lab to do a validation process for self-collected rectal samples. • Training and technical assistance including the role of sexually transmitted infections testing for people newly diagnosed
Themes from group discussions	**Sexual Health Messages for PLWH** • Reviewed the Medical Monitoring Project information that was provided earlier in the meeting. • Suggestions from surveys submitted before the meeting were compiled into themes. They include messages that are sex positive, reduce stigma, risk reduction, medication adherence, lower viral loads, the importance of HIV care, STI awareness, HIV and STI transmission information, and STI testing. • Additional messages that were suggested include current medications still do not cure HIV, know what you have been tested for, have the STI conversation with your doctor, your health starts with you, sexual health is a part of overall health, numbers are increasing – it is a big deal (about syphilis), STI's do not discriminate, talk to your sexual partners, sero-sorting will not protect you from other STI's, make sure you are clear about bare-backing, cultivate non-penetrative intimacy, an informed you is a sexier you, a healthier you is a healthier community, effective treatment could be here today and gone tomorrow, inform yourself, protect your community, are you caring about what you are sharing, love yourself enough to protect yourself, HIV does not define you, • All agreed that there should not be any ads separating out other STI's

	• Avenues for messaging include t-shirts, phone apps, and encourage anonymous conversations. **Increase STI Testing among PLWH** • Encourage health systems to include STI screening, increasing routine opt-out screening, making STI screening a performance metrics for the community care organizations, patient education efforts, increasing general access to STI testing, providing testing in the community, testing in areas where people meet for sex, and work with CAREAssist in some kind of messaging to clients around screening for STI's or adding something to the re-certification process. **Increase hepatitis C screening among PLWH** • A question that came up is whether screening for hepatitis C is actually a problem in Oregon? The general consensus is that no one knows. • Ideas include asking providers if they are screening and re-screening, review charts, have a metric for hepatitis A and B vaccines for people with HIV, a way to have HCV screening regularly scheduled similar to STI screening for people with HIV, determine what automatic routine panel could hepatitis C screening be connected to, need state funding for a mobile unit for street type of health work where HIV and hepatitis C screenings can be done with syringe exchange services, adding HCV screening to Oregon Reminders, need to engage with payers to make sure they will reimburse for hepatitis C screening, do some kind of letter to patients and/or colleague providers to provide care for people living with HIV, work with insurance companies that are also providers to be prompted on lab tests, engage with community health workers to support patient navigation for hepatitis C treatment, connect with people who have had traumatic experiences with healthcare, messaging through social media, raising patient and community awareness around HIV and hepatitis C, databases need to be set up to communicate better, how to get hospital emergency rooms to communicate with community-based service providers when someone goes into an emergency room, how to get support for HCV care coordination, and how to get CCO's to pay for navigators. • Constant theme after all three groups is to normalize sexual health services and messages as part of a broader health transformation. • All input will be compiled and included in the next IPG Implementation Plan. • Utilizing technology which is being emphasized by the state is great.