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

FULL MEMBERSHIP MEETING
Date: April 1, 2015
Number of voting members present: 26
Number of others/non-voting members present: 6
Number of guests present: 1

<table>
<thead>
<tr>
<th>Agenda Item/Topic</th>
<th>Key Themes in Discussion</th>
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| Announcements                        | • The lighting of candles is a tradition that has existed for many years. Please consider how an observance can be done that may be different than what the committee is doing now.  
• Four new members have joined the IPG. There have been two resignations. The current membership committee terms will end on April 30. Terms for new membership committee persons will begin on May 1. Six volunteered to participate on the membership committee.  
• Need help for icebreakers which occur at each meeting. Please let one of the co-chairs know if interested.  
• Cascade AIDS Project has a job opening in the HRSA navigation program as well as an opening in CareLink services. The purpose of these positions is to ensure that those who are HIV positive and know their status are linked into care, retained in care, and taking their medication regimens.  
• CAP is hosting its annual art auction in May. The event will be at Montgomery Park on Saturday, May 2. Tickets are $50.00. This is the largest fundraising event for local HIV services.  
• Dine Out for Life will occur on April 23. Proceeds from participating restaurants go to the Partnership Project.  
• On June 7, there will be a barefoot soccer tournament. This is an opportunity to teach kids about HIV and AIDS through soccer. |
| HIV testing data: What do we know?   | • The IPG was surveyed about routine testing, targeted testing, and partner services.  
• 80% of those who responded say they have a fairly good understanding of routine and targeted testing but not so much about partner services.  
• In upcoming meetings, there will be more focused data tailored towards the topic of that particular
meeting with small group discussions in the afternoon to gather ideas with the ability to be able to collect more data based on committee feedback.

- The HIV Care Continuum is a visual that has been used for approximately five years. This helps to better understand what is happening through the whole range of the epidemic from testing through treatment. Based on the information presented, there is a lot of work yet to do.
- Challenges include an infected person being open to care and staying in care,
- The number of deaths of people with HIV was 338 in 1994. In 2012, it was 75.
- The undetectable is a lot lower than it should be. There is also a large gap between dates of infection and diagnosis.
- The care continuum has been calculated between urban versus rural areas of the state.
- We are doing better than most of the country.
- The systems that have been built up do well at identifying diagnosis and getting people into care.
- Need to think differently about how services are getting out to populations that are missing.
- 39% of those infected have been diagnosed in the first 12 months.
- There are cases where persons who are very active in managing their HIV may only be asked for a viral load check every two years.
- 40% are diagnosed late. The highest number of transmissions were among those who did not know their status.
- Older people tend to have late diagnosis. This is also true in the Latino population.
- Another reason for getting a late diagnosis is due to not being tested because of active substance abuse.
- Native Americans need to be included in demographics data.
- On the Statewide Health Improvement Plan, there are testing guidelines for some STD’s but not HIV or Hepatitis C.
- Testing needs to be included as part of the metrics so that agencies like Medicaid will pay for the tests. It is covered but not required.
- Coordinated Care Organizations (CCO’s) have a community advisory council. This could be another way to educate and advocate for routine testing.
- People who do not think they are at risk is the number one reason for not getting tested.
- Women should be included in targeted testing.

### Prevention strategies: What are we doing?

- In 2012, the HIV Prevention program went from funding 21 counties down to seven.
- The seven counties are Jackson, Deschutes, Lane, Marion, Multnomah, Clackamas, and Washington.
- These programs are funded to do targeted testing, comprehensive prevention with positives which includes testing to diagnosis to connections with health services and treatment.
The state HIV Prevention Program has developed relationships with the manufacturers of rapid test kits. Price agreements have been established that can be used by any of the funded health departments for purchases of tests. In addition to federal grant funds, a small portion of state general funds have been distributed for those programs that have syringe services. Federal grant money cannot be used to purchase syringes and equipment. The amount has been consistent for several years. In 50 states that support public health infrastructure, Oregon ranks 47th. The biggest challenges include finding people who have never been tested and people who are in a high-risk category to continue testing. Funds are provided to the Oregon State Public Health Lab for counties who are not funded so they can submit their HIV tests. Content is always being updated and added to the state website. The Condom Distribution Plan is in place. Training opportunities will be increasing through the use of webinars. This is in response to the challenges that staff are not able to attend a training and be away from the office or clinic. Partner service is focused around sexually transmitted infections. Disease Intervention Specialists (DIS) are very good at establishing relationships with clients. The current role of DIS is to help increase the capacity of local health departments. Others that are doing the work are communicable disease nurses and community health workers. Casework, partner services, education, and testing can be a part of a community health worker’s role. The chances of rural areas in Oregon getting funding from CDC is very small, if that. Targeted populations for testing include men who have sex with men (MSM), persons who inject drugs, and partners of people who are living with HIV. These were initially approved by the Statewide Planning Group (SPG), and adopted by the IPG in both its Comprehensive and Jurisdictional Plans. It is not possible for lesbians to be considered a priority population as there is little to no prevalence to support their inclusion as a priority population. Another challenge is making sure that those who do not identify are able to access the same services. Work is continuing to have routine HIV testing as well as addressing stigma. Routine testing would be a part of regular testing just as one would be tested for glucose or monitoring blood pressure. The public health standard is for everyone to be tested once in a lifetime between the ages of 15 - 65. If a communicable disease nurse, community health worker, or DIS talks to someone about talking
to their partners, the role that a person can take either through consultation and support while they contact their partner(s) or offering to do it for them. If a person opts not to contact their partners, the worker can do so and will NOT divulge any name or any person that has referred to them as a contact who has possibly been exposed to HIV.

- A Latino Information Sharing Workgroup is working on identifying resources around the state and compiling this information on a website where it can be accessed in a specific service area.
- While there are a lot of resources available, not all are translated into Spanish.
- Also working on finding resources that are in homeland countries.
- The African American AIDS Awareness Action Alliance (A^6) is a group who have representatives from a number of agencies. This group addresses issues around HIV and the African American / Black community. They will be holding a series of World Café events which provide an opportunity for communities to look at issues around HIV. The issue of stigma is being addressed. The turnout at these events has not been good. The group will look at ways to get back into the community, gain support, and then host a number of events where there will be active participation around where people are going, what some of the misconceptions around HIV are, and what services people would like to see.
- A Passport to Partner Services training is being conducted to help increase capacity. The first training will be in Eugene and the second one will be in Portland. There are introductory modules available on-line for people to view which take about three hours to complete.

Public comment: Modernizing Oregon’s Public Health Systems

- The reason this is occurring is due to a bill that was passed in the 2013 Legislative session (HB2348). This measure creates a taskforce to look at public health across the state and to make recommendations for legislation. A report to the Legislature was due by October, 2014.
- The taskforce on the future of public health services was focused on recommendations that created a public health system for the future, considers the creation of regional structures, enhances efficiency and effectiveness, allows for appropriate partnerships with regional healthcare service providers and community organizations, considers cultural and historical appropriateness, and are supported by best practices.
- Some foundational capabilities include critical knowledge, skills and abilities necessary to carry out public health activities efficiently and effectively; needing to identify and analyze public health problems and to address these problems through public health programs and policies; and is key to protecting and improving the community’s health and achieving effective and equitable outcomes.
- Examples of these capabilities include assessment and epidemiology, emergency preparedness and response, communications, policy and planning, leadership and organizational competencies, health equity and cultural responsiveness, and community partnership development.
- Foundational programs include basic areas of public health expertise and activity essential to
assess, protect and improve the community’s health.
- Program benefits must be available to everyone in Oregon.
- These programs are considered the baseline of services for the governmental public health system.
- Public health programs and activities implemented in addition to foundational programs will address specific identified community public health problems or needs.
- Additional programs can be one of two kinds: Enhancement or expansion of a foundational program or a new program to address a need not covered by a foundational program.
- Recommendations include foundational capabilities and programs be adopted in order for Oregon’s public health system to function efficiently and effectively, significant and sustained state funding be identified and allocated for proper operationalization of the foundational capabilities and programs, statewide implementation of the foundational capabilities and programs will occur in waves over a timeline to be determined, local public health will have the flexibility to operationalize the foundational capabilities and programs through a single county structure; a single county with shared services; or a multi-county jurisdiction, and improvements and changes in the governmental public health system be structured around state and local metrics established and evaluated by the Public Health Advisory Board which will report to the Oregon Health Policy Board.
- For the future of public health, this will mean better integration of governmental public health with a transforming health care system, improved coordination and clarity of roles between local and state, basic public health assurances in place for everyone in Oregon, local flexibility in determining additional public health services, and improved sustainability for governmental public health services over time.

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<th>Themes from group discussions</th>
<th>Promoting Routine HIV Screening: Incentives for coordinated care organizations (CCO’s) to implement and track screening with metrics, an automatic ordering process which would occur at a medical providers office to remind staff to ask about a routine screening, screenings in healthcare settings that may not be the first one to offer. Examples include dental clinics, federally qualified health centers (FQHC’s), substance abuse treatment facilities and school-based health centers. Consider focus on building partnerships.</th>
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<td>Improving Targeted HIV Testing: Normalize testing in venues where people convene. Identify areas that are popular gathering spots. Partner with non-traditional systems to offer HIV testing including women, infants, and children (WIC) programs, sporting goods stores, colleges and universities through promotional opportunities from fraternity houses or the athletic department.</td>
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<td>Improving HIV Partner Services: Using multiple location apps and technology to identify more partners. Local outreach from non-health department providers around what partner services are. Have other entities besides local health departments such as community based organizations do</td>
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- A document will be created that will have all of the feedback from each group in addition to feedback from the survey.