HIV Integrated Planning Group

STRATEGIC PLANNING FRAMEWORK,
DATA SUMMARY,
AND ROAD MAP FOR TODAY’S MEETING

APRIL 18, 2012
SALEM, OREGON
Strategic Planning Process Review

- **Step 1: Get Organized**

- **Step 2: Take Stock**
  - Review Goals & Strategies, Examine Data, Begin to Identify and Discuss Priority Areas and Potential Action Steps

- **Step 3: Set Direction**
  - Develop the Strategic Plan: Choose Priorities and Flesh out the Action Steps

- **Step 4: Adopt & Refine the Plan**
Step 2: Taking Stock

- **Review Goals of Each Committee**
  - Note relationship to National HIV/AIDS Strategy

- **Analyze Available Data**
  - Review answers to data questions generated by IPG membership
  - Identify data gaps

- **Identify Ways to Address Establish Strategies**
  - Use data to guide discussion around range of action steps
Oregon HIV/AIDS Strategies

- Reduce new HIV infections and co-occurring STI and VH
- Increase access to prevention and care services
- Improve coordination of HIV, STI, and VH care and prevention services
- Reduce HIV-related health disparities
Reducing New Infections

- Intensify prevention efforts in communities where HIV and co-occurring STI and VH is most heavily concentrated.

- Expand targeted efforts to prevent HIV (and co-occurring STI/VH) using a combination of effective, evidence-based approaches.
Reducing New Infections

- Educate all Oregonians about the threat of HIV, VH, and STI and how to prevent them.

- Adopt community-level approaches to reduce HIV and co-occurring STI/VH in high-risk communities.
Increasing Access to Prevention & Care

- Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.

- Take deliberate steps to increase the number and diversity of available providers for clinical care and related services for PLWH and those with co-occurring STI/VH.
Increasing Access to Prevention & Care

- Support HIV+ people living with co-occurring health conditions like VH and STI and those who have challenges meeting their basic needs, such as housing.

- Reduce HIV-related mortality in communities at high risk for HIV infection.
Improve Coordination of Care & Prevention Services

- Increase the coordination of HIV, STI, and VH programs across and between federal, state, territorial, local, and tribal governments, as well as private providers.

- Develop improved mechanisms to monitor and report on progress towards achieving Oregon’s goals.

- Reduce stigma and discrimination against PLWH.
Specific Tasks for the Next 3 Meetings

- **Meeting 2 (today):** Brainstorm wide range of critical issues that need to be addressed to achieve committee strategies.
  - Pie in the sky is OK for today.
  - Identify approaches that exist now as well as those that do not exist.

- **Meeting 3 (July):** Prioritize areas of focus and action steps to be taken in Oregon.
  - Reality sets in...

- **Meeting 4 (October):** Finalize action steps, responsibilities, and timelines.
  - Content for IPG Plan should be set at end of Meeting 4.
**Step 1: Intensify prevention efforts in communities where HIV and co-occurring STI and hepatitis is most heavily concentrated.**

**1.1 Specific way we will accomplish Step 1—e.g., “Increase prevention efforts targeting XYZ community.”**

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<thead>
<tr>
<th>Actions Needed</th>
<th>Lead Agency/Partners Involved</th>
<th>Timeframe</th>
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<tr>
<td>Begin Xxxxxx</td>
<td>Public Agency X (Key Contact: Joe Blow)</td>
<td>Jan 2013-Mar 2013</td>
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Oregon benchmarks will correspond to NHAS benchmarks: (Examples from NHAS, July 2010)

- By 2015, lower the annual number of new infections by 25%.
- By 2015, increase the proportion of newly diagnosed patients linked to clinical care within 3 months of their HIV diagnosis to 85%.
- By 2015, increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%.
Data Review

SOME THINGS TO CONSIDER
AS WE DEVELOP OUR ACTION STEPS
Data Review: Five Key Questions

- Which communities in Oregon are most heavily burdened by HIV, and co-occurring STI and VH?

- What are the strengths and gaps in Oregon’s continuum of HIV care and prevention services?

- What interventions and services can be used to meet the needs of the most marginalized and highest risk groups?
Data Review: Five Key Questions

- What are evidence-based approaches to reduce HIV and co-occurring STI and VH?
- What partnerships exist in Oregon to address the identified service and prevention needs and gaps? What partnerships are lacking?
Key Question 1

Some critical issues...

- HIV prevalence
- Disproportionate impact
- Delayed diagnosis
- Engagement with HIV medical care
- Co-infection with STI/VH

• Which communities in Oregon are most heavily burdened by HIV, and co-occurring STI and VH?
Men who have sex with men (MSM):

- Gay & bi men = 2 – 4% of Oregon’s population, but 61% of all new HIV infections in OR.
- An additional 9% of men report MSM/IDU risk.
- MSM cases more likely to receive HIV medical care; less likely to have delayed diagnosis.
- Co-occurring STI is common among HIV+ MSM.
  - 1 in 5 syphilis cases in Oregon were MSM with HIV.
Black/African American Men & Women

- 2% of Oregon’s population and 6% of PLWH.
- New diagnosis rates 3.5 times higher than for whites.
- 1 in 3 Black/African American cases is foreign-born.
- Black/African American men less likely to identify as MSM than white men (59% vs. 72%)
  - More likely to identify as high-risk heterosexual (20% vs. 2%)
- Less likely to be in HIV medical care.
Latinos and Latinas

- 12% of Oregon’s population and 11% of PLWH.
  - But new infections are increasing: rates of NEW diagnosis are 1.2 times higher than for non-Hispanic whites.

- About 1 in 3 new HIV cases among Hispanic men report no likely transmission category.
  - Lack of identified risk factor more common among male and female Hispanics.

- More likely to be diagnosed with advanced disease and less likely to be engaged in HIV medical care.
People who Inject Drugs

- Unknown how many people in Oregon inject drugs; 19% of Oregon HIV cases have IDU risk.
  - IDU-related HIV cases have declined substantially since 1997.

- HIV+ people who inject drugs:
  - More likely to have delayed diagnosis
  - Less likely to be engaged in HIV medical care
  - Have shorter survival times
  - Have high rates of HCV co-infection—about 1 in 3 HIV+ male IDU and 1 in 2 HIV+ female IDU are HCV co-infected
Some populations may not represent large or disproportionate numbers in the local epidemic, but may merit special attention.

HIV Statewide Planning Group (SPG) identified two “hidden populations” of concern in Oregon:
- Migrant workers
- Transgender people

Both of these groups are diverse.
Migrant Workers

- No prevalence data, but issues identified among Latinos are relevant (e.g., delayed diagnosis, less likely to be in medical care).

- Structural and cultural barriers identified:
  - Language
  - HIV-related stigma
  - Beliefs about health, illness, and masculinity
  - Lack of insurance and financial resources
  - Concerns about documentation status
  - Negative experiences/lack of trust with providers
Transgender People

- National literature shows very high prevalence among trans women (12 – 28%)
  - But most of these studies included samples of trans women engaging in survival sex and sex work.

- Trans men have lower rates (2 – 3%) in 2 needs assessments, but most studies don’t include them.
  - Trans MSM may be at particularly high risk (programs in Ontario and San Francisco to explore prevention needs).

- Speak Out survey in Portland found 0% trans respondents HIV+ vs. 18% males, 4% GQ, and <1% female respondents.
Overall Data: Co-Occurring HIV/STI/VH

- Rates of STI much higher among PLWH, particularly male PLWH.
  - Syphilis rates: 116x higher
  - Gonorrhea rates: 450x higher

- Prevalence estimates of HIV/HCV co-infection vary, depending on data source:
  - 7% (Epi Profile) to 11% (CAREAssist) to 21% (MMP)

- 5% of PLWH in Oregon estimated to have HIV/HBV co-infection.
Key Question 2

Some critical issues...

Access to HIV medical care

Access to HIV testing

Access to other essential services, like housing

• What are the strengths and gaps in Oregon’s continuum of HIV care and prevention services?
Access to HIV Medical Care

- Local data indicate that HIV medical care in Oregon fairly accessible once people are ready to access it:
  - 95% of MMP participants* began HIV medical care within 3 months of diagnosis; 5% entered within 12 months.

- Assessment among newly reported HIV+ Hispanics didn’t reveal systemic barriers to testing or to HIV care, once +.

- Part B assessment in 2011: nearly all participants reported being out of care at some point; barriers mainly individual-level, rather than systemic.
Reasons Given for “Out of Care”

- Reasons given by PLWH in Part B Oregon, 2011:
  - Denial and depression
  - Side effects of HIV medicines/fear of starting ART
  - Alcohol and drug abuse

- Findings consistent with national, scientific literature on why PLWH are out of care.

- 2 main reasons for entering or returning to care:
  - Illness
  - Connected via efforts of concerned family, friend, or other
Who is Out of Care in Oregon?

- About 25% of PLWH/A may be out of care.

- People more likely to have no CD4/VL testing:
  - People with AIDS (vs. HIV)
  - Hispanics, Native Americans, and Black/African Americans (vs. white, non-Hispanics)
  - MSM/IDU or IDU males (vs. MSM only) and IDU females (vs. females w/ heterosexual transmission risk)
  - Rural (vs. urban)
  - Foreign-born (vs. native born)
Housing

- Even among PLWH in medical care, ~1 in 10 report unstable housing.
  - 11% of MMP participants moved more than once in past year.
  - 6% reported past-year homelessness (MMP)
  - 4% reported past-year incarceration (MMP)
  - 13% of CAREAssist clients homeless in past 2 years (2009 data)
Transportation

- About 2 in 3 MMP participants travel 30 minutes or less each way to get to HIV medical care.
  - Distances vary greatly, from 1 – 300 miles each way
  - About 1 in 9 said travel to HIV medical care is difficult: 10% said “somewhat difficult” and 4% said “very difficult”.

- Rural clients report ongoing barriers to staying in HIV medical care because of long distances between home and doctor, dentist, and other providers.
  - Also report stigma and lack of culturally competent providers in local communities.
Key Question 3

Some critical issues...

People who are HIV+ but don’t know status
Delayed diagnosis
Perceptions of risk
Incarceration

• What interventions and services can be used to meet the needs of the most marginalized and highest risk groups?
Delayed Diagnosis

- About 20% of HIV+ people don’t know their HIV status.
  - Knowledge of HIV status correlated with safer behaviors.

- In Oregon, 40% of recent diagnoses were delayed; may provide clues:
  - Hispanics (vs. non-Hispanic whites)
  - Men with IDU or unknown transmission risk (vs. MSM)
  - Rural residence (vs. urban)
  - Older people—age 40+, with relative risk highest among age 60+ (vs. people < age 40)
Why Don’t People Test?

Five recent studies on reasons for delayed diagnosis found people didn’t test for HIV because they didn’t think they were at risk:

- Samples included people with delayed diagnoses from NYC, San Francisco, the Southeastern U.S., the UK, and MSM in Seattle.

- Other barriers were fear of illness and dying, stigma, and beliefs that their behaviors kept them safe.

- Two studies also looked at access—access to care was not the main cause of delayed diagnosis.
1 in 10 MSM surveyed reported unprotected anal sex with man of opposite or unknown HIV status.
- High number of casual & anonymous partners
- Mixing of social and sexual networks

Lack of communication fueled confusion about HIV status and indecision about condom use.
- Both HIV+ and HIV- men often believed they were serosorting in the absence of any evidence that they were doing so.

Highest risk men held personal narratives that let them believe: 1) their behavior was safe or 2) safer sex responsibility of other person
Incarceration, Briefly

- Prevalence among incarcerated about 3x higher than general U.S. population.
  - In 2008, 1.5% of male inmates and 1.9% of female inmates in state or federal prisons were HIV+.
  - Estimated that nationally, about 25% of PLWH cycle in and out of jail or prison each year.

- About 4% of MMP participants reported past-year incarceration.

- Incarceration is disruptive: HIV treatment, insurance, housing, employment, social relationships...
  - Re-entry can be dangerous and stressful time.
Key Question 4

Some critical issues...

Syringe exchange
Outreach models
Interventions addressing stigma

• What are evidence-based approaches to reduce HIV and co-occurring STI and VH?
Syringe Exchange

- Many studies show that access to clean needles is key:
  - Includes policies that promote wider distribution, secondary exchange, peer outreach models
- Clean syringes available through Oregon pharmacies:
  - Barriers exist, including pharmacist refusal to sell without prescription, cost/packaging, stigma/fear
- Syringe exchange programs may serve different populations of PWID:
  - Studies indicate that PWID who don’t use SEP may have riskier behaviors.
Outreach Models

- Shown to increase engagement and retention in HIV medical care.
  - Labor-intensive, many are costly.

- Peer-based programs show promise for improving access to care, as well as for promoting HIV prevention among PWID.
  - Can be administratively complex, costly, may require shift in thinking/political acceptance.
HIV and Stigma

1,368 articles came up in recent Medline search; wide variation in how stigma defined.

High levels of HIV stigma correlated with:
- Low social support
- Poor physical health
- Poor mental health
- Younger age
- Lower income
- Lower likelihood to disclose HIV status
HIV and Stigma: What to Do?

- Only 2 studies out of hundreds described quality, evidence-based interventions that were effective in reducing HIV/AIDS stigma.

- Strategies to reduce stigma include:
  - Informational approaches
  - Skill-building
  - Counseling/support
  - PLWH/A testimonials
Key Question 5

Who is at the table?

What other voices need to be included?

Who can help accomplish our goals?

- What partnerships exist in Oregon to address the identified service and prevention needs and gaps?

- What partnerships are lacking?
Key Partners Identified in NHAS

- Department of Health & Human Services
- Department of Housing & Urban Development
- Department of Justice
- Department of Labor
- Veteran’s Administration
- Social Security Administration