

# IPG Meeting Notes

February 16, 2022, 1:00 - 4:00 p.m

## Announcements

- Please welcome Myriam as the new IPG co-chair. Myriam is the CAREAssist Program Coordinator and has worked for CAREAssist for more than 8 years.
- Josh will be leaving OHA in April. We wish him all the best!

## Integrated planning 201

Oregon's Integrated HIV Prevention and Care Plan is also known as the End HIV Oregon Strategy. It's a roadmap for achieving the goals of the End HIV Oregon initiative. The Part B grantee (OHA) is responsible for developing and submitting the plan every 5 years. Part A (Multnomah County Health Department) has chosen to partner with OHA to develop the plan. Partners and stakeholders contribute to the plan through the IPG, the Part A Planning Council, and other opportunities. The current plan (2017-2021) includes many achievements (e.g., a mail-order condom distribution program, a shift to needs-based syringe exchange programs in Part A, the implementation of Early Intervention Services and Outreach), as well as some initiatives that remain works in progress and some that are no longer priorities. Our next plan will cover 2022-2026.

The planning process results in two documents:

- The Integrated HIV Prevention and Care Plan (the End HIV Oregon Strategy); and
- The Statewide Comprehensive Statement of Need (SCSN).

These documents are due to HRSA and CDC on December 6, 2022. IPG members and partners will have opportunities to review and comment on these documents from March - November 2022 via Google Docs.

## How does the plan fit with the End HIV Oregon initiative and other plans?

The End HIV Oregon initiative and its four pillars are based on the Integrated HIV Prevention and Care Plan (the End HIV Oregon Strategy) and the Statewide Comprehensive Statement of Need (SCSN). Oregon's updated plan will also be informed by national plans to address HIV, Viral Hepatitis, and STIs, as well as surveillance data that are collected on an ongoing basis.



The proposed End HIV Oregon 2.0 goals are: 1) diagnose, 2) prevent, 3) treat, and 4) respond (to end inequities). OHA is beginning to use “inequities” instead of “disparities” to better emphasize that observed differences are driven by inequitable systems.

Discussion:

- It seems like the Ending the HIV Epidemic plan and the National Strategy are more about coordination than equity. Should we consider equity as the lens with which we lead the work, rather than a pillar?
  - OHA Response: That’s a great point. In the past, members requested we address inequities as a pillar to emphasize health equity as a priority.
- Coordination in our efforts to address HIV, Viral Hepatitis, and STIs is an important part of the Respond pillar.

## What’s the IPG’s role?

Every IPG member and every IPG meeting contribute to the planning process. IPG members vote on the final plan and write a letter of concurrence (or non-concurrence). All members and partners are encouraged to fully participate in the planning process, but only voting members can vote. This year, IPG members will have opportunities to share input via meetings, emails, Google Docs, listening sessions, and topic-specific workgroups.

OHA is interested in gathering more information about practices to engage populations experiencing health inequities, as well as supporting topic-specific workgroups (e.g., Rapid ART starts, PrEP, youth-focused interventions). If interested in joining a workgroup, please contact Linda.

Discussion:

- Can we explore ways to better integrate HIV, STIs, HCV, and substance use? Could this be a workgroup?
  - OHA response: Yes.

## Operations Committee update

### What is the Operations Committee?

The Operations Committee is a group for IPG members who meet with OHA and CivCom staff to help plan meeting agendas, review feedback from meeting evaluations, review any new member applications, and recommend changes to policies and procedures as needed.



## Membership data

Each year the Operations Committee examines who attended at least 1 IPG meeting in the previous year, which groups are represented, and where we have gaps in representation. Last year, the IPG had 63 people attend at least one IPG meeting. This includes guests, partners, presenters, and 29 voting members. We've done a lot to advance representation. For example, one quarter of IPG members identify with a racial/ethnic group other than white, which matches the proportion of PLWH in Oregon who identify as people of color. However, we still have some gaps and areas to expand representation, so the Operations Committee voted to expand our priority populations for IPG membership. Our priority populations for recruitment this year are people who are:

- Black, African American, or African immigrants;
- Hispanic or Latino/a/x;
- American Indian, Alaska Native, or members of tribal communities;
- Transgender or non-binary;
- Young (ages 18-29); and
- People of color who are living with HIV.

If you'd like to help with recruitment, you can refer people to the IPG website ([healthoregon.org/ipg](http://healthoregon.org/ipg)), which includes a membership application.

## Group name

Members of the Operations committee noted that the IPG acronym and the full name of the group (Oregon HIV/Viral Hepatitis/Sexually Transmitted Infection Integrated Planning Group) can be confusing and can be barriers to recruitment. Members have suggested that we rebrand the Group as the End HIV Oregon Advisory Council, a name that reflects the group's primary goal and the branding of our statewide initiative.

Discussion:

- Four members voiced support for this change.
- Two members voiced concern that VH and STIs would not be included in the name.

Comments:

- We cannot end HIV without addressing VH and STIs.
- Other integrated groups, such as the one in San Francisco, have changed their names to End the Epidemics. NIH and CDC are recognizing these interesting epidemics as a syndemic.
- Should we use person-centered language rather than disease-centered language in our name?
- Other suggestions or a group name include:
  - Ending the Epidemics Advisory Group.
    - Three people voiced support for this suggestion.



- End HIV and the Epidemics Planning Group
- End the Endemics Coalition
- Syndemic Advisory Group (SAG)
  - One member commented that “syndemic” is not a word most people know.

Next steps:

- CivCom and OHA will share a survey or a poll to get additional input.

## HIV testing & linkage to care

### The status of testing and linkage in Oregon

- While Oregon is considered a low incidence state, inequities remain.
  - Rates of new HIV diagnoses in Oregon are higher among Blacks/African Americans, American Indian/Alaska Natives, Native Hawaiian/Pacific Islander, and Hispanic/Latinx populations compared to whites.
- Only 42% of adult Oregonians have ever tested for HIV. Our goal is to reach 70%.
  - Testing rates are highest among Blacks/African Americans (54%).
- At-home testing is reaching diverse communities.
  - We don't know how many people are testing from kits they purchased, but we do know the demand for home test kits through OHA's at-home testing program is high; 913 test kits were distributed, and 0.8% were newly diagnosed.
- The CDC recommends HIV screening (at least once) for everyone between ages 13-64 as part of routine health care. As of 2019, 94% of Oregonians were insured.
- Sexually transmitted infections (e.g., Gonorrhea, Syphilis) in Oregon have continued to rise. HIV and STI co-infection is common. Integrated testing and Partner Services are effective interventions; EISO remains important.
- Oregon has made notable progress with linkage to care.
  - In 2019, 87% of people newly diagnosed with HIV in Oregon were linked to care within 30 days, compared to 69% from 2012-2016.
  - Rapid ART Start Programs are becoming more common.

Discussion:

- Can we look at HIV screening in medical records? BRFSS has limitations as the data are self-reported.
  - OHA response: Yes, the BRFSS data may be an underestimate. OHA looked at the all payers/all claims database a few years ago, but it only captured recent testing, not lifetime testing rates. Assessing lifetime testing is challenging.
- Does OHA get data on testing in jails and prisons?
  - OHA response: OHA has started receiving data on HIV testing in Department of Corrections facilities.



- What is considered publicly funded testing?
  - OHA funds 7 county health departments, and those health departments can fund community-based organizations.
- Can doctors require STI tests?
  - Response: STI testing is recommended, but not required.

## Small group discussions

### Group 1: Increase awareness of HIV, especially among priority populations

What kinds of activities are already happening in Oregon related to these strategies & who is doing them?

- Community health workers are offering testing on site in the houseless camps
- We are offering rapid HIV, HCV and syphilis tests in our local jail
- Our Harm Reduction program is offering free testing at syringe exchange
- Testing in STI and Family Planning Clinics
- Educating our communities about U=U
- Testing at detox centers
- Aging Well program

What activities have not been done but should be started and prioritized?

- What about testing at school based health centers?
- Culturally specific outreach strategies to connect with populations experiencing inequalities who historically won't get testing or PrEP
- More cross training (HIV testing staff) integrated between CAP and other testing sites and CBO's
- Opt-out testing at FQHC level
- Highlighting organizations state and all around that support our communities' people can reach other people in other states
- HCV treatment in primary care
- Mobile rapid testing with an RN who can also treat
- Me Cuido, Te Cuido: Familias en Acción, Culturally Specific HIV Prevention Education for the Latinx community (entering Year three of three-year contract with OHA)
- We need more Latinx outreach for testing
- Partnering with Wallace Medical/ Neighborhood Health Center to improve awareness and access to PrEP for Latinx community in Portland Metro
- More outreach/educational materials in Spanish in order for Latinx outreach to be effective
- More partnerships with local tribal organizations
- Integrating trainings for folks who are already out in the community supporting folks on their own

- Let's look at engaging the drag queen/king community or other popular opinion leaders that are seen as role models and credible sources of information.
- More community health workers to help people navigate the system for PrEP
- Want to see electronic health records that flag when someone hasn't had an HIV test ever or in a certain number of years.
- Want to see more HIV testing at health fairs that already offer blood pressure screenings, etc.
- Conferences, letting our communities know what educational conferences may be available to folks like AIDSWatchConferences, letting our communities know what educational conferences may be available to folks like AIDSWatch
- Would love to see more input from high needs communities
- Partnering with culturally specific faith based organizations
- Providing tools for folks to have the knowledge and awareness of local and national advocacy events

Designing for equity, which populations should be prioritized? Are there any unintended consequences we should consider?

- African Americans
- African women
- Tribal Communities
- Outreach, especially in rural areas
- The approach taken needs to match the culture of the specific population and include that population in planning and execution of activities
- There are populations who will not access services or care because of the stigma
- More peer led groups
- Houseless populations
- Women and youth
- MSM who are at high risk need easily accessible/frequent/on demand testing/treatment
- Include negative partners and children of PLWH; their voices need to be represented.
- Trans youth
- Provide information and education around changing policies and being heard
- Hispanic/Latinx/Spanish speaking populations, including women
- People with HIV need social support and can provide invaluable input into our programs
- People who inject/use drugs
- Substance use treatment programs
- Providing support for families who are affected and impacted
- Unintended consequences might include:
  - Specific groups feel targeted instead of supported
  - People perceive they are being told what to do instead of being asked how we can help
  - Domestic violence situations for women in specific cultures if they are found to be accessing services or care

What other information do we need to do good planning for this objective?

- Education about HIV and transmission methods (voiced by 3 members)
- Input (e.g., surveys) from the populations we seek to serve regarding their priorities and service needs. This suggestion was voiced by three people.
- Speakers in schools programs statewide. Efforts to increase awareness of HIV in youth.
- Culturally appropriate materials and approach
- Knowledge if approaches that are working
- Include HIV prevention/trainings as part of the scope of work and services provided by Community Health Workers
- HIV, STI and Viral Hep should be integrated from the top down, with integrated funding
- Updated data around women and youth
- Integrate more peer support specialists
- Bilingual DIS workers are so amazing to have
- community input- What are community members greatest barriers to access testing? (transportation, stigma, fear of repercussions from partners, etc., for example)
- Outreach for schools - speakers etc
- What proportion of symptomatic/empirically treated STI cases presenting to an urgent care or ED were also tested for HIV?
- What would incentivize private providers to offer HIV, STI and VH Hepatitis prevention education and interventions?
- Educate ER departments and hospitals to reduce stigma for folks needing treatment
- Provide additional ways for people to be tested

Who else should be involved in conversations about this?

- Folks who would like to participate, especially targeted populations
- Negative populations who are directly affected and impacted
- Youth
- Trans community
- Families
- Folks who are ready to advocate and share in our communities

**Group 2: Increase testing in medical settings**

What kinds of activities are already happening in Oregon related to these strategies & who is doing them?

- Currently training occurs through AETC with medical providers.
- ORAETC offers provider education on the importance of 3-site screening and distributes 3-site testing instruction posters.
- OHSU has increased testing in the ED over the past year through a Gilead grant.

What are the barriers?



- There is not enough screening in urgent care settings, and there is limited or no follow up.
- Time, comfort, training, prioritizing preventative health for people who are uninsured.
- Limited number of providers in rural Oregon.
- Providers forget Hepatitis C testing in the STD panel.

#### What are some possible solutions?

- Advocacy with Oregon Primary Care Association and other medical associations to socialize the need for HIV testing and how to access linkage to care resources. We can certainly work on hospital to hospital but bigger system wide effort is needed
- Testing prompts
- Provider education on importance of testing and guidelines
- Policies requiring testing (i.e., CCO systems)
- Partner with primary care associations or other ED-related associations to identify solutions
- Promote routine testing and teach providers how to feel more comfortable with sexual health questions

#### Designing for equity, which populations should be prioritized? Are there any unintended consequences we should consider?

- Populations:
  - People who use substances
- Solutions:
  - Do more community outreach like health fairs or events in community centers. Go out to communities that have health inequities with certain groups.
  - Routine testing helps reduce stigma.
  - Incorporate peers and community health workers in outreach efforts.
  - Get more creative about how we offer testing. Home test kits are a bridge. Incentivize testing.

#### Who else should be involved in conversations about this?

- Primary care and ED associations. It's difficult to work with each health system individually.

### **Group 3: Increase testing among youth**

#### What kinds of activities are already happening in Oregon related to these strategies & who is doing them?

- School based health clinics (SBHCs) offer HIV/STI testing
- empowering youth with information to make healthier choices
- We are exploring outreach on TikTok





- Oregon policy around sexual health in schools -- statewide policy/implementation?
- The Living Room in Gladstone, Q Center in Portland, SMYRC, GSA Summit (this weekend) & others all have programs and groups focusing on youth that focus on prevention education
- EOCIL offers prevention gift bags with testing messaging, Partners with Rave organizers to provide testing and gift bags, and has a Freedom 2 Express support group with access to testing and prevention services.
- Portland Public Schools -- CDC grant to address STI & HIV?

What activities have not been done but should be started and prioritized?

- Testing days on college campuses
- Messaging targeting youth STI/HIV/Sexual Health via media, outreach, social media
- Youth-focused CBO Equity Grants
- Testing in LGBTQIA youth groups
- Work with health care providers who focus on teens and young adult ages
- Mobile vans
- Word of mouth to reach youth
- School-based services that support youth to test off-campus, with support?

Designing for equity, which populations should be prioritized? Are there any unintended consequences we should consider?

- People with inject drugs or engage in chem sex
- young MSM, young MSM of color, young trans folks
- young people who use meth
- Homeless youth
- Sex workers
- folks diagnosed STI -- syphilis, rectal GC
- young heterosexual folks of color -- Black/African American, specifically, other youth of color
- People who are institutionalized or in other closed settings
- People with disabilities (mental health and other)
- Migrant and BIPOC communities
- To avoid unintended consequences, we can provide services in a manner that:
  - Does not perpetuate stigma/stereotypes
  - Is empowering and not anxiety producing

What other information do we need to do good planning for this objective?

- Youth involvement, input, and data
- More youth-led education
- Peer-led training and education
- partnering with organizations
- Paid youth involvement (e.g., youth councils, youth focus groups, peer programs)



- Elder-youth mentoring/partnership?
- Better understanding where young people receive information and influence: social media! (Instagram, TikTok, etc., Not Facebook)
- learn from community members & partners who are doing this work
- Academia actionable research and analysis (including root-cause analysis)
- Juxtapose of OHA agencies state plans and incorporation of strategies from State Health Improvement Plan when appropriate

Who else should be involved in conversations about this?

- Schools and colleges
- New Avenues for Youth, Outside In, SM
- Straight-Gay Alliances
- PFLAG
- Tribal leadership
- We need clearer guidelines from the state around distributing safer sex supplies and safer use supplies (works) to youth. When you leave this to individual agencies, we operate more defensively.
- CBOs serving youth (e.g., CAP)
- Peers/people with lived experience
- People who work with youth, like counselors
- DHS agencies (vocational rehab, SILC, DOE)
- ODHS' My Future My Choice Teen Advisory Board (has high schoolers who teach sex ed to middle schoolers & do other sexual health related projects)
- Legislative representation
- Latino Network's youth sexual health program

**Group 4: Improve linkage to care**

What kinds of activities are already happening in Oregon related to these strategies & who is doing them?

- HHSC rapid start clinic
- HIV case investigation and follow-up at LPHAs
- EISO

What activities have not been done but should be started and prioritized?

- Partner more with clinics who have case managers/social workers or who have the capacity for follow-up
- Replicate rapid start across the state, especially in rural areas
- Integrate peers into rapid and other linkage activities

Designing for equity, which populations should be prioritized? Are there any unintended consequences we should consider?

- Review data on who is least likely to be linked to care in 30 days
- Trans Women
- Black/Latinx/Indigenous
- People who engage in sex work
- People using substances
  - If we prioritize substance use more generally, we may be unintentionally de-prioritizing people who inject drugs or use more/more frequently.
- People who are primarily using ED for care and do not have other regular touchpoints s/a medical home
- Community partners we have not historically worked with
- People involved in the carceral system
- Homeless populations experiencing behavioral health issues
- Epi data suggest Black African American and American Indian/Alaska Native people need to be prioritized. How can we partner with health care providers serving those communities to get HIV on their 'usual screening' radar?

What other information do we need to do good planning for this objective?

- Data on who gets lost in the diagnosis-to-linkage journey
- How can the HOPE peers model apply to HIV?
- Linkage from emergency to primary care, and where these differences are (may vary across the state)
- Who is not getting referred to Ryan White case management?
- Which PCPs know or do not know where to send people and how do we increase education?
- In which areas of the state is linkage not happening?
- How to support people to get medical care when they are not ready to engage with Ryan White case management? Peers may support this!
- PRIME+ and other harm reduction peers have opportunities to work with PLWH who are newly diagnosed

Importance of Rapid Starts and Partner Services. Benefits of including peers. Prioritizing trans people, behavioral health populations, people of color needed to address inequities. We need more provider education on linkage and referral practices.