End HIV/STI Oregon Statewide Planning Group (OSPG) Meeting Notes

February 21, 2024, 1:00 - 4:00 p.m.

Announcements

- The National HIV PrEP curriculum was recently released. This is a great resource for primary care providers, pharmacists, and anyone new to PrEP!
- The 2024 2SLGBTQ+ Meaningful Care Conference is March 27, 2024 at the Portland Airport Sheraton and online. Registration is open!
- The Oregon Primary Care Association's annual conference is April 17-19 in Portland. The theme is Cultivating Health Equity. Visit orpca.org to register!

End HIV/STI Oregon: Our Roadmap for Ending New HIV Transmissions in Oregon

Background

End HIV/STI Oregon is our roadmap for ending new HIV/STI transmissions in Oregon. The statewide plan is required by federal funders (CDC & HRSA) every five years. The current plan covers 2022-2026 and was developed with input from the OSPG; the Part A Planning Council; and other partners, including local public health authorities, tribes, community-based organizations, syndemic partner agencies, and community members. The Part B grantee (OHA) is responsible for developing, submitting, and monitoring the plan. Prevention, Surveillance, and Part A (Multnomah County Health Department) contribute to the plan, as well.

Though the plan is a requirement of our HIV grant funding, it takes a syndemic approach. A syndemic is a set of linked conditions; This includes HIV, STI, viral hepatitis, substance use, housing, and more. In the 2022-2026 plan, Oregon added STI in the title because 1) HIV/STI co-infection is common, 2) HIV and STI programs are co-located at OHA (viral hepatitis is not), and 3) Oregon has a separate viral hepatitis elimination plan and coalition.

Pillars, goals, and strategies

As shown in the table below, End HIV/STI Oregon has four pillars, as well as goals and strategies associated with each pillar.

End HIV/STI Oregon Pillar	Goals	Examples of Strategies
Diagnosis	• Increase the number of people who know their HIV status by 87%. • Eliminate racial/ethnic disparities in HIV testing. Ensure that at least 70% of all groups test at least once. • Increase the number of people linked to medical care within 30 days of HIV diagnosis by 25%.	• Routine testing • Outreach/focused testing of priority populations • Linkage to care
Prevention	• Decrease new diagnoses of HIV to 150 cases/year. • Decrease new diagnoses of syphilis by 24% (to less than 1,000/year). Eliminate congenital syphilis. • Decrease new diagnoses of gonorrhea among youth 19 and under by 35% • Eliminate racial/ethnic disparities in new HIV and early syphilis cases.	• PrEP • Sexual health promotion • HIV/STI partner services • Harm reduction & drug user health
Treatment	• Increase the proportion of people living with HIV (PLWH) who are virally suppressed to at least 90% • Eliminate racial/ethnic disparities in viral suppression rates.	• Rapid ART start • Improving access to care • U=U
Responding to end inequities	• Eliminate racial/ethnic disparities along the HIV care continuum. • Increase the number of people in rapid transmission networks linked to care and services.	• Cluster & outbreak response • Partnerships that support a syndemic focus

Priority populations

Oregon's priority populations (which are not mutually exclusive) are:

- American Indian/Alaska Natives
- Black/African American people
- Gay, bisexual, and other men who have sex with men (MSM)
- Latino/Latinx/Latine people
- Native Hawaiian/Pacific Islanders
- People experiencing houselessness/unstable housing

- People who inject drugs (PWID)
- People who live in rural or frontier areas
- People who use methamphetamine
- Youth
- People with sexually transmitted infections, particularly syphilis and rectal gonorrhea
- Transgender, nonbinary, and gender diverse people, with a focus on transgender women

Resources

- End HIV/STI Oregon Strategy
    - Annual Progress Report
    - Ambassador Kit
    - Mini Grant Program
    - Data Dashboard
- OSPG webpage

Measuring progress toward our goals

The End HIV Oregon Dashboard shows Oregon's progress toward ending the HIV/STI syndemic. The dashboard includes information about testing, prevention, treatment, inequities, behavior and gender, stigma, and root causes of HIV transmission, as well as regional data. All of the HIV/STD/TB Section's dashboards now have the same look and feel. They are accessible to the public and allow data to be downloaded.

Notable data from the dashboard includes:

- Most Oregonians have never tested for HIV.
- More than 1 in 8 people with HIV in Oregon are unaware of their status.
- HIV diagnoses in Oregon and the United States declined from 2012 to 2020. However, in 2022, new HIV diagnoses in Oregon increased. Due to the impact of the COVID-19 pandemic, data for 2020 and 2021 should be interpreted with caution.
- In 2022, 24% of people diagnosed with HIV had a prior STI diagnosis (syphilis, gonorrhea, or chlamydia) within 2 years.
- There are more Oregonians who could benefit from PrEP than currently receive PrEP prescriptions.
- Viral suppression in Oregon (77%) remains higher than national estimates yet still falls short of our End HIV Oregon goal (90%).
- People living in rural/frontier areas, diagnosed in correctional facilities, American Indian/Alaska Native, Multi-racial, and Black/African American people, and those aged 25-44 years experience lower proportions of viral suppression.
- New HIV diagnoses have decreased among most groups, with notable exceptions for Native Hawaiian/Pacific Islander and American Indian/Alaska Native males. HIV rates are comparable across sexes for American Indian/Alaska Native people.

Black and American Indian/Alaska Native people across sexes and Latinx and Native Hawaiian/Pacific Islander males continue to face elevated rates of HIV, likely linked to systemic barriers denying health opportunities.
- New HIV diagnoses have increased most dramatically in frontier regions.
- People facing housing instability have been disproportionately affected by HIV given their share of the population.
- People living in rural/frontier areas, diagnosed in emergency departments, Native American/Alaska Native and Asian people, and older adults (45-65+ years) experience higher proportions of late HIV diagnoses compared to the Oregon average (22%).
- Awareness of U=U among people living with HIV in Oregon increased from 2018 to 2020. There were no changes in awareness in 2021 compared to 2020.
- The proportion of people living with HIV who reported injection drug use increased in the past decade.

Keep in mind that racism, misogyny, transphobia, homophobia, stigma and discrimination—not race, gender, or sexual orientation—drive inequities in HIV and STIs. Not all communities have equal access to opportunities to maintain or improve health.

Do you have feedback about a dashboard? Email prevention.info@dhsoha.state.or.us or complete this survey.

Discussion
- I love the dashboard and use it regularly.
- On the statistics page, there are links to two different dashboards with different years. A link may need to be updated.
- Q: When will 2023 data be added to the dashboard?
    - A: OHA expects to add 2023 data by World AIDS Day.
- Q: What is considered a frontier area?
    - A: Frontier areas are determined based on population density. A map showing Oregon's frontier areas can be found on the Regional Data tab.
- Notably, many frontier communities have health care provider shortages.
- Since frontier areas have smaller populations, even two cases of HIV can impact the area's HIV case rate.
- Frontier communities may lack providers/CBOs/workers who are culturally specific, gender diverse, etc.
- Rural/frontier areas have unique strengths too.
- Q: Does the dashboard include information about who is and is not receiving Ryan White services?
    - A: The dashboard includes data about Part B services. There is also a separate CAREAssist dashboard.
    - There is CAREAssist, OHOP and Part B data on OHA's Care dashboards. Part A develops Scorecards which are on HGAP's website.
    - View OHA's new Care and Treatment Dashboards.

Oregon's New PrEP & PEP Laws

HIV Post-Exposure Prophylaxis (PEP) is the emergency use of antiretroviral drugs after a one-time confirmed or suspected exposure to HIV to prevent infection. PEP must be taken within 72 hours and is most effective when started immediately after exposure. PEP should be taken daily for 28 days post-exposure. Most individuals seeking PEP go to a local emergency room or urgent care. HB 2574 seeks to ensure that all Oregon hospitals can, at minimum, provide an immediate 5-day starter pack of HIV PEP to patients in need.

HB 2574 went into effect January 1, 2024, and the related OAR was finalized January 29, 2024. OHA sent out an announcement about the new requirements, including a resource packet for hospitals, HIV prevention partners, and patients on January 30.

What is now required of hospitals?
For any patient evaluated at the hospital within 72 hours of a possible occupational or nonoccupational exposure to HIV, a hospital shall ensure that:

- Hospital personnel dispense to a patient at least a five-day supply of HIV PEP unless medically contraindicated; and
- Information on the importance of starting and completing the medication regimen, as well as resources to ensure access to the full medication regimen, is provided to the patient at the time the first dose of the five-day supply is dispensed.

What is now required of OHA?
OHA will provide small rural hospitals with one 30-day supply of PEP medications once per year. This is to help ensure that these hospitals can stock PEP.

- People living in rural and frontier Oregon are a priority population in Oregon's End HIV/STI Strategy because they experience inequities at multiple points in the HIV prevention and care continuum, including prevention, diagnosis, linkage to care, and viral suppression.
- Many parts of rural and frontier Oregon have seen recent increases in new diagnoses of HIV. Rural Oregonians also face additional barriers to accessing PEP medications.

PEP availability
Some pharmacies do not stock medicines for PEP, meaning that individuals may experience barriers to finding time-sensitive, urgently needed medications. Delays mean people may not be able to access PEP in time to prevent infection. Few pharmacies in rural Oregon stock PEP medication. The Oregon AETC, OHA, and the Oregon Pharmacy Association are working together to help expand access to PEP.

Pharmacist-prescribed PrEP/PEP

Oregon pharmacists can play a key role in ensuring people have access to PrEP and PEP, thanks to key legislation passed in 2021 (HB 2958). Pharmacists may prescribe and dispense PrEP and PEP in accordance with Oregon Board of Pharmacy protocols. Pharmacists may conduct HIV tests and order / interpret other lab tests needed for PrEP prescribing.

Insurers must reimburse pharmacists for prescribing PrEP and PEP at the same rate as any other provider. Insurers must cover at least one form of PrEP without prior authorization and regardless of whether the pharmacist is in-network (some providers, such as Kaiser Permanente, are exempt from this prohibition on network restrictions).

While HB 2958 and the Oregon Board or Pharmacy PrEP and PEP protocols created a pathway for pharmacists to prescribe PrEP and PEP, The decision to prescribe, however, is an opt-in decision. Relatively few pharmacists in Oregon are doing so.

To prescribe PrEP and PEP, the Oregon Board or Pharmacy requires that pharmacists complete "a comprehensive training program related to the prescribing and dispensing of HIV prevention medications, to include related trauma informed care." It is up to pharmacists to determine if a training program meets these criteria.

Resources:

- Oregon pharmacies that offer PEP (AETC webpage)
- PrEP provider list (AETC webpage)
- OHA's Health Facility Licensing & Certification is responsible for processing complaints if hospitals are not in compliance with the law.
- OHA factsheet on PrEP/PEP Prescribing Training Options for Oregon Pharmacists
- OHA announcement about the new requirements, including a resource packet for hospitals, HIV prevention partners, and patients.
- Pharmacist prescribed PrEP/PEP factsheet

Discussion

- Q: Are other states allowing pharmacist-prescribed PrEP?
    - A: Oregon is an early adopter, but not the only state.
- Oregon's work with PrEP is brilliant. I'd like to see it replicated in other states.
- Q: Who has the responsibility to follow-up with patients who are prescribed PrEP or PEP in a hospital?
    - A: The law requires hospitals to not only prescribe a 5-day supply, but to offer information and resources. Ideally, this includes information about pharmacies that can fill the full prescription, as well as medication assistance programs.
- One of the things we (Immunization folks) learned with pharmacy provision of non-usual services during peak-of-COVID19 times, is that relationships are key to engaging and supporting rural and frontier pharmacies. If they are large corporation pharmacies (Kroger, BiMart), there can be corporate decisions that will

void local efforts. Focusing on smaller, community specific pharmacies can make a difference.
- Safeway/Albertsons has also been supportive of PrEP/PEP access and said they will stock in communities where we have concerns about access. This could help rural Oregonians.
- It is up to the hospital receiving support from OHA as to whether they dispense a 5-day supply or a full supply of medication.
- Q: What about collaboration with county health departments. to expand PEP/PrEP access?
    - A: County HDs can play a key role in supporting PrEP as part of a comprehensive HIV prevention strategy, whether through increasing awareness of PrEP, delivering PrEP at county health clinics, or supporting local infrastructure for PrEP provision. Most LPHAs receiving HIV funding in Oregon (e.g., EISO) do provide education about PrEP and PrEP referral/navigation. Depending on geography, some LPHAs also offer PrEP directly via a county health clinic.
- The reality is that it's still not easy to get PrEP. PrEP navigators would be helpful, especially for people who may face additional barriers, who don't speak English, or who are uncomfortable advocating for themselves. How do we ensure PrEP is advertised correctly and that people can get co-pay assistance through Gilead?
- Q: Most tribal clinics stock PrEP and PEP. Can we update the PrEP map so that they are included?
    - A: OHA will explore updating the maps.
- There is still discomfort with prescribing the medications. Providers need training.

Addressing the HIV/STI Syndemic

HIV Early Intervention Services & Outreach: Phase 1 Evaluation Results

HIV Early Intervention Services and Outreach (EISO) are an important and effective investment and have been identified as a priority by the OSPG. EISO is currently in Phase 2 and has results from Phase 1.

From 2018 - 2022 (Phase 1 of EISO), OHA awarded $29 million in contracts to 6 local public health authorities to serve 12 Oregon counties (Multnomah, Clackamas, Washington, Marion, Lincoln, Benton, Linn, Lane, Deschutes, Crook, Jefferson, and Jackson) and the Confederated Tribes of Siletz Indians.

Early Intervention Services (EIS) quickly link people with HIV to care and treatment. EIS activities include HIV testing, linkage to care, referral services, and health education. Outreach (O) identifies PLWH who do not know their status or who are out of care. Outreach focuses on priority populations and on places with a high probability of finding new HIV cases.

Because Oregon has high rates of HIV/STI co-infection, integrated testing (for HIV, syphilis, and gonorrhea) is a priority.

- 67% of people newly diagnosed with HIV were tested for other STIs (syphilis and gonorrhea). Of those who tested positive for HIV, 17% also tested positive for syphilis, and 16% tested positive for gonorrhea.
- 55% of people newly diagnosed with early syphilis (not known to be HIV+ at the time of diagnosis) were also tested for HIV. Of those tested, 4% had an HIV-positive test result.
- 60% of people newly diagnosed with rectal gonorrhea (not known to be HIV+ at the time of diagnosis) were tested for HIV. Of those tested, 4% had an HIV-positive test result.

During Phase 1 of EISO, 84% of all people newly diagnosed with HIV were linked to care within 30 days, and 72% achieved viral load suppression within 6 months of their diagnosis.

From 2018 - 2022, 1 in 5 people who received EISO services were infected multiple times, and 1 in 5 received EISO services more than once. Notably, 10% of clients with multiple enrollments and not known to be HIV-positive at the time of their STI diagnosis seroconverted.

PrEP referrals were low:

- 36% of people newly diagnosed with early syphilis received a PrEP referral.
- 32% of people newly diagnosed with rectal GC received a PrEP referral.
- PrEP referrals were given at 42% of visits with people who had multiple EISO enrollments for rectal gonorrhea or syphilis and who later tested positive for HIV.

EISO staff will be discussing these findings and how to address them.

STI data dashboards: Measuring STI in Oregon

OHA's updated STI dashboards reveal that both 1) integrated HIV/STI testing and 2) PrEP referrals for people diagnosed with an STI are very important. People with STI, particularly those with multiple occurrences, are at very high risk of HIV seroconversion. People with STI continue to be a priority population for ending new HIV transmissions.

The syphilis, congenital syphilis, gonorrhea, and chlamydia dashboards show STI cases and rates by year, by county, and by race/ethnicity. Notable findings include:

- Syphilis: The rate of syphilis in Oregon has increased twelve-fold in the last decade. Most diagnoses have been among people assigned male at birth but the rate among people assigned female at birth has increased significantly. The highest rates of syphilis have been among those negatively impacted by social structures.
- Congenital syphilis: The rate of congenital syphilis increased over twenty-fold in the last decade. The highest rates of congenital syphilis have been among those

who have been negatively impacted by social structures. Pregnant people associated with a congenital syphilis case are more often diagnosed with unknown duration or late latent than early syphilis.
- Gonorrhea: The rate of gonorrhea had been on the rise from 2010 to 2020. The decrease in 2021 could reflect the impact of the pandemic on accessing healthcare services. People assigned male at birth and people 20-29 years of age have experienced higher rates of gonorrhea in the past decade.
- Chlamydia: The rate of chlamydia increased from 2010-2019. The decrease in 2020 and 2021 could reflect the impact of the pandemic on accessing healthcare services. People assigned female at birth and people 20-29 years of age have experienced higher rates of chlamydia in the past decade. Chlamydia is the most common STD reported in Oregon.

Discussion
- Q: How can we increase PrEP referrals and/or PrEP uptake and maintenance?
- I'd love to see the syphilis data with sexual orientation and gender identity (SOGI) data.
- Q: Is there a way to determine how many of the folks served in EISO have positive viral hepatitis B or C labs?
    - A: I'm not sure. We can explore Orpheus data.
- Q: What is the plan for EISO services moving forward?
    - A: EISO funding for Phase 1 and in Phase 2 has remained stable. Phase 2 began in 2023 and ends in 2026. Currently, we have 8 EISO sites.
- Q: Do we know how many PLWH are co-infected with hepatitis C?
    - A: We can explore this. This is a great topic for a future OSPG meeting.
- Q: When we look at sex assigned at birth for syphilis, are cases among males being driven by urban areas, and are cases among females concentrated in rural areas?
    - A: We are seeing syphilis cases among females in all areas.

Report from the Community: Prevention with Priority Populations

Both Cascade AIDS Project (CAP) and HIV Alliance have programs focused on priority populations, which are funded by a CDC grant (CDC PS21-2102, Comprehensive High-Impact HIV Prevention Programs for Community Based Organizations). These programs span a five-year period (July 2021 - June 2026).

Cascade AIDS Project

Core elements of CAP's program include:
- Finding new HIV diagnoses
- Reducing new HIV infections
- PrEP and nPEP referrals

- Rapid entry to HIV care
- Outreach and community engagement
- Improving health outcomes for PLWH
- A special focus on serving MSM of color
- Reducing HIV-related health disparities

As shown in the table below, CAP's goals for this grant support the four pillars of the federal Ending the Epidemic initiative.

Ending the Epidemic Pillar	CAP Goals
Diagnose people with HIV as early as possible	• 1,200 HIV tests among racial/ethnic minorities, with 75% among MSM • 12 new HIV diagnoses • 780 STI screenings
Treat people with HIV rapidly and effectively to reach sustained viral suppression	• 90% of newly or previously diagnosed people will be linked to HIV care within 30 days • 90% of newly or previously diagnosed people will be provided or referred to medication adherence support
Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs	• 891 PrEP referrals • 50,000 condoms will be offered to PLWH and to people at high risk for HIV • 1,080 people at high-risk for HIV will be provided or referred to prevention and support services
Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them	• Support local health departments with cluster response activities • Identify specific areas to engage hard-to-reach populations • Use available data to identify clusters and outbreaks • Social Networking Strategy: Recruit community leaders to refer their contacts to testing

HIV Alliance

HIV Alliance's grant focuses on serving people who inject drugs (PWID) who are Black, Indigenous, or People of Color (BIPOC) in Lane, Marion, Douglas, Josephine, Coos, and Curry counties. As shown in the table below, HIV Alliance's goals for this grant support the four pillars of the federal Ending the Epidemic initiative.

Ending the Epidemic Pillar	HIV Alliance Goals

Diagnose people with HIV as early as possible	• 3,450 HIV tests administered to PWID over 5 years
	  ○ 750 each in years 1 & 2, 650 each in years 3-5
	  ○ 75% of clients tested will be both BIPOC & PWID
	  ○ Expected reactivity rate of 1% (about 10 per year)
	• Incentives will be offered for HIV testing, CEG, SNS referral
	• Testing will be offered at 100% of syringe sites
	• 100% of SSP clients will be offered testing
	• Hepatitis C and syphilis rapid tests will be offered along with HIV testing
	• Chlamydia and Gonorrhea testing will be offered when feasible (if restrooms are available)

Treat people with HIV rapidly and effectively to reach sustained viral suppression	• Linkage to HIV medical care for PWID newly diagnosed with HIV • Re-engagement to HIV medical care for PWID previously diagnosed with HIV who are out of care (using “Out of Care Lists” generated by OHA) • Referrals to Partner Services • Care coordination: medical adherence and viral suppression
Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs	• Refer HIV negative PWID to HIV Alliance PrEP Navigators. • 100% of HIV negative testing clients will be referred to PrEP navigation. • New SSP locations have been established in Eugene, Oakridge, Salem & Wolf Creek • Bilingual education presentations offered alongside testing at community partner sites • 20,000 condoms distributed at SSPs
Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them	• Strengthen partnerships with local health departments for partner notification, cluster detection and response. • Implement a Community Engagement Group (CEG) comprised of BIPOC PWID/PWID • Provide BIPOC and/or PWID clients space to build community and be heard • Increase the effectiveness and impact of the program through incorporating CEG feedback and planning

Challenges faced:

- Identifying and reaching Oregonians who are both BIPOC & PWID has been a constant challenge, due to high stigmatization
- Communities are often insular. Relationship building takes time. It's necessary to take a decolonial approach in offering service folks want/need.
- Loss of significant SSP sites.
- Attempting to use Social Networks Strategy referrals to increase engagement.
- Community-wide staffing shortages/turnover due to COVID-19.
- Training can be a lengthy process, which takes away from valuable time in the field.

Accomplishments:

- The client response to CEGs has been wonderful!
    - The CEG helps connect clients with existing services & opportunities
    - HIV Alliance has been able to offer new services in direct response to client requests, such as first aid-training, grief counseling, and stress management tips.
    - HIV Alliance is currently expanding this concept to host a similar affinity space for LGBTQ clients.
- Expansion of community partner relationships
    - HIV Alliance is receiving new referrals from southern Oregon tribal communities (from folks who want to test discreetly, without using a tribal clinic).
    - New SSP & testing sites (e.g., Great Circle Recovery, new White Bird location, testing at the Springfield jail for a period of time).
- Testing & education at Centro Latino has been popular.
- HIV Alliance has seen an increase in the number of tests among BIPOC PWID each year and is on track to see an increase again this year.

Outcomes:

- Year 1: 737 tests; 9 positive results
- Year 2: 725 tests; 11 positive results
- Year 3 to date: 521 tests; 4 positive results

<u>Discussion</u>

- Syndemic Lens: People leaving carceral settings have a 10-fold greater risk of overdose compared to the general population. Jails and prisons are important partners for overdose prevention. Many of the same folks are at highest risk for HIV, syphilis, and viral hepatitis.
- Linn County is working on building capacity to implement the Status Neutral HIV Prevention and Care approach outlined by the CDC in conjunction with EISO work.
- Q: Are there limitations on who can be tested with this funding? Is anyone turned away?

    - A: CAP and HIV Alliance do not turn anyone away, as they have varied funding sources for testing services.
- Q: I heard a great term earlier this week: "lived experience compensation program." An NGO provided compensation for the expertise of their community leaders.
- Q: Do either of your organizations provide at-home test kits?
    - A: CAP offers at-home test kits.
    - A: HIV Alliance has a supplemental CDC grant that involves subcontracts with organizations that distribute at-home tests.
- Q: Does CAP test for hepatitis C?
    - A: CAP offers hepatitis C testing on a case-by-case basis since it does not have a dedicated funding source for hepatitis testing.
- Q: Are these funds renewable?
    - A: Continued funding is not guaranteed and will likely be determined in 2026 through a competitive process.