IPG Meeting Notes

March 31, 2020, 1:00 - 4:00 p.m

COVID-19 Update

As of this morning at 9am, 690 cases of COVID-19; 18 deaths. 14,000 people have been tested—a big increase as commercial labs joined the State lab in testing. There have been 213 hospital admissions—40 required ventilator support. Most people infected with COVID-19 are not hospitalized. People aged 40-69 have the highest infection rate, evenly split between males and females. We know of 3 people living with HIV who have COVID-19; all 3 had undetectable VLs and are doing well. OHA developed an HIV & COVID-19 FAQ. There are some social media posts related to sex in the time of COVID. OHA also started home-based HIV testing. As of this meeting, it's been open 12 hours and people ordered 109 tests! OHA also released a FAQ on COVID-19 and harm reduction.

Discussion

Q: Are PLWH at higher risk if they are virally suppressed?
A: For PLWH: Acquisition is not higher for PLWH than for others. It appears that PLWH who are virally suppressed should be able to do as well as others. However, PLWH in Oregon are older; risk of severe disease is higher among those who are older and have other comorbid conditions (a lot of older PLWH have comorbidities).

Q: Are ARTs protective against COVID-19?
A: Probably not. They did some testing during the SARS and MERS outbreaks—didn't seem to do much. These data are from mouse models, so not a lot of human data.

Q: where can people order the home test kits?
A: takemehome.co (we'll send additional messaging)

Q: What about chloroquine?
A: It's being used on a compassionate care basis for people with severe disease but is not available for more general use.

Q: what bodily fluids can transmit COVID-19?
A: Respiratory secretions and saliva (e.g., spit, airborne droplets). However, COVID is also found in human stool; not sure if it is viable. Urine is not a known source of transmission.

Public comment

No guests signed up to provide comments. There was an acknowledgment about the similarities of COVID-19 and the early days of HIV, and how this may trigger some trauma responses, particularly for long-term survivors.

HIV detection & response

Dr. Menza discussed public health data collection and HIV data analysis, including new techniques we are able to use, like molecular surveillance. He used the example of COVID-19 as a real-time use of data collection, analysis, and policy development (e.g., the Stay Home, Save Lives executive order, designed to "flatten the curve" and save lives).

Dr. Menza explained how HIV genetic data are collected through HIV drug resistance testing (e.g. molecular surveillance). Molecular surveillance has been used in surveillance of other diseases; its use in detecting HIV clusters is newer. This tool helps with outbreak detention and response, particularly by identifying connections between people who might otherwise seem unrelated. We can't use this tool to determine directionality of infection.

Discussion
Q: Can people be infected with multiple strains of HIV?
A: The concept of a "supervirus" doesn't really seem to have legs and doesn't seem to be a common occurrence.

Q: Is U=U being used as a motivating message for adherence and treatment starts?
A: Yes.

Q: How can we get more providers to talk about U=U?
A: OHA is working on promoting this through social media posts, public health detailing, and other venues.

Q: Isn't testing as important for COVID-19 as it is for HIV?
A: Yes. Testing was restricted initially because it was unavailable.

HIV data trends: 2019-2020

Oregon has seen a decrease in HIV incidence over time; Oregon has about 200 new cases/year and this is slowly decreasing. People are living longer, so HIV prevalence has been stable. New diagnoses among men who have sex with men (MSM) have been decreasing, while diagnoses among people who inject drugs have increased. The proportion of people diagnosed with HIV who

are diagnosed with AIDS within 12 months has decreased substantially overall (25% in 2018). Some groups are more likely to have a delayed diagnosis than others, which is an important area to address for health equity. About 80% of people diagnosed with HIV are linked to care within 30 days; this is a major success.

Lea discussed the time-space HIV cluster detected among people who inject drugs in Multnomah County in 2019-2020.

Diagnoses among Blacks/African Americans are going up. Diagnoses among Latinx people also seem to be going up (we think the 2019 decrease may be a short-term artifact of less testing because of Public Charge and other social factors). We discussed partnerships and projects that OHA has initiated in response to these data.

A molecular cluster was identified in Fall 2019. It helped show the usefulness of molecular surveillance. Half of the cisgender men in the cluster had sex with transgender females. We don't have solid data on HIV among transgender females. OHA started to do some outreach to partners who work with the trans community (before COVID-19 hit) in order to find ways to facilitate HIV testing and services. At-home testing may be a resource.

Q: Do you have ideas why viral suppression rates are higher among older PLWH?
A: Younger people may be less engaged in care and may be more newly infected/less experienced with HIV treatment. Older people may be more stable in their lives and have longer-term relationships with their providers. Newer cases are trending younger and have drug use and/or housing instability, which may present a barrier to medication adherence.

Plans for 2020

OHA priorities

Linda provided a brief overview of how End HIV Oregon was developed and rolled out in 2016, and how the initiative connects to the formative work of IPG and other stakeholders to create the Integrated HIV Prevention and Care Plan (2017-2021). The four pillars/key components (testing, prevention, treatment, equity) map to 10 strategies. These strategies and activities work together/are not siloed, but offer a framework for organizing and communicating about our work:

- Testing: routine testing, targeted testing
- Prevention: PrEP, harm reduction/health education, STD prevention/screening/treatment
- Treatment: medical care access & retention, viral suppression support, wellness & healthy aging
- Equity: eliminating disparities, eliminating stigma

OHA and its many community partners work together and individually on these strategies. Each year, OHA chooses priority activities that map to these strategies and reports back on them to the

community. We'll get input from IPG and report back to IPG about these activities over 2020 and provide our 4th year progress report on World AIDS Day. Please see www.endhivoregon.org for the 2019 progress report.

IPG recruitment

The IPG Operations Committee reviews new member applications and discusses member demographics on a continuous basis. The committee determines priority populations for IPG membership based on gaps and epidemiologic data.

In 2019, the IPG grew quite a bit. We now have 46 voting members!That's in addition to 2 non-voting members, 2 support staff, and 31 IPG partners who do not have voting rights and do not receive stipends, but receive meeting invitations and information.

To improve engagement among under-represented groups, the Operations Committee decided it would consider new applications from the following priority populations:

- Black, African immigrants, and African American people;
- Hispanic or Latinx people;
- Transgender females; and
- People of color who are living with HIV.

If the committee receives an application from someone who is not a member of a priority population, they offer the applicant the option to become an IPG partner (to receive all IPG emails and meeting invitations). Only IPG members can vote and are eligible for stipends. However, the information shared at meetings and the opportunity to participate are not limited to any group. All meetings are open to the public.

Given the IPG's size, the committee decided to:

- Restrict the number of voting IPG members to 48 (2 seats are currently open)
- Consider further reducing the IPG's size to a maximum of 40 members over time, as people leave the group—while also considering who is leaving and the impact on representation.

The IPG membership application and list of priority populations can be found at www.healthoregon.org/ipg. Anyone can help recruit by directing people to the website or sharing a recruitment flyer (Dano can share the flyer upon request).