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

September 17, 2025, 1:00 - 4:00 p.m.

Announcements

The 2025 HIV Continuum of Care Conference is a free, online conference that will take place October 21-22. Register here or sign up for a community table if your organization is interested in being a virtual exhibitor.

Federal Update & State of the State

Federal policy changes present huge disruptions to our systems in Oregon. In addition, the state budget is facing challenges, and there may be changes to the allocation of state general funds for public health. Sustaining critical prevention and care services that protect Oregonians across the HIV continuum of care is the top priority of the Oregon Health Authority (OHA), HIV/STD/TB Section (HST). HST is tracking federal changes to grants. The federal budget for fiscal year 2026 (which begins October 1) is not yet final and continues to be negotiated in Congress. If a budget is not passed by October 1, a continuing resolution will be needed to avoid a government shutdown. With a continuing resolution, funding would continue at the previous fiscal year's level until a specified date.

HST currently manages 9 federal grants (previously 10):

- The CDC ended the Medical Monitoring Project (MMP) grant in May. Oregon has administered this survey since 2007. This project provided valuable information about the needs of people living with HIV (PLWH). The data previously collected will continue to be useful for 2-3 years. Without this grant, HST will need to find new ways to obtain similar needs assessment data in the future.
- HST has funding to support National HIV Behavioral Surveillance—known as Chime In in Oregon. OHA has administered this grant since 2016. This grant provides valuable information about people at risk for HIV. HST has no current information from the CDC as to whether this grant will continue after December 2025.
- HST has received flat funding for its core HIV surveillance and prevention grant through May 2026. Due to increasing costs, flat funding really means less money year to year. This grant funds an array of services, such as public health HIV surveillance, case investigation, testing, outreach, condoms, outbreak assistance, training, and medical consultation. The future of this grant is unclear, as Congress

is currently working to approve the fiscal year 2026 budget, and current versions of this budget eliminate domestic HIV prevention.

- HST has received flat funding for its core STI grant through February 2026. This grant funds public health STI surveillance, outbreak response, testing and lab services, medical access programs, and training and medical consultation. The current budget markup in Congress proposes changing the current granting method to a consolidated block grant. At this time, it is difficult to tell what will be included in the block grant. It could include STI, tuberculosis (TB), opioids, infectious disease, and possibly Viral Hepatitis. This new granting method is expected to reduce funding for programs (except for viral hepatitis, which could see an increase in funding). It is unclear how this block grant will work, how funding will be split up, and who would receive the funds through OHA; These programs are currently administered by different departments within OHA.
- HST has received flat funding for its Ryan White Part B grant through March 2026. This grant supports the AIDS Drug Assistance Program (known as CAREAssist) and HIV case management services in the Part B jurisdiction. Part B is made up of 31 counties that are sometimes referred to as the balance of state. These counties are outside of the Part A jurisdiction which includes Multnomah, Clackamas, Washington, Yamhill and Columbia Counties (and Clark County, WA). Both the Ryan White Part A Grant (administered by the Multnomah County Health Department) and the Ryan White Part B grant (administered by OHA) are expected to provide HIV case management and support services in their respective jurisdictions. The current federal budget markup indicates flat funding for Part A and B.
- HST administers three competitive Housing Opportunity for Persons with AIDS (HOPWA) grants, which have different project periods. The current budget markup indicates flat funding for these programs. Since these grants remain competitive, there is no guarantee of future awards. The three HOPWA grants are described below.
    - HST has a competitive HOPWA grant that provides statewide supportive housing services to persons who also need behavioral health care, in partnership with Cascade AIDS Project (CAP). CAP serves the Part A jurisdiction and OHA serves the Part B jurisdiction. This grant is due to end in December, but HST submitted a renewal application to the U.S. Department of Housing and Urban Development (HUD) and expects to receive a new award by the end of year.
    - HST has a competitive HOPWA grant that provides statewide supportive housing services to persons exiting corrections, also in partnership with CAP. HST has grant funds through November 2026 and hopes to receive a renewal application sometime next summer.
    - HST has a three-year, statewide HOPWA Special Projects of National Significance (SPNS) grant that is in the early stages. This grant involves a partnership with CAP, HIV Alliance, EOCIL, and the Department of Corrections. This grant funds a release planner and navigators to assist

people in quickly transitioning from correction into housing, medical care, and other support services. The grant is not expected to be renewed.

- HST has a HOPWA Formula grant that only serves the Part B jurisdiction. HUD informed OHA that it no longer meets eligibility based on changes to the case number definition and that this grant will end. To adjust to the loss of these funds, HST will be exploring ways to support 94 households with other possible funding sources and has slowed its wait list. This issue does not impact the Part A jurisdiction as the City of Portland receives its own HOPWA Formula grant and continues to be eligible.

HST is working closely with the National Alliance of State and Territorial AIDS Directors (NASTAD), the National Coalition of STD Directors (NCSD), and other states to stay current on issues that impact funding in Oregon. HST has been educating OHA leadership, and OHA is part of a federal response team responsible for reviewing impacts across the state and providing direction to programs.

At this time, there have been no changes to health benefits programs managed by Oregon, including the Oregon Health Plan (OHP), Healthier Oregon, and CAREAssist. Healthier Oregon serves people of any immigration status. In January, Oregon stopped sharing immigration status data with the U.S. Centers for Medicare & Medicaid Services (CMS). In July, Oregon led a lawsuit against the U.S. Department of Health and Human Services (HHS) to stop the federal government from sharing confidential Medicaid records with immigration enforcement officials. HST does not collect any information about immigration status or country of birth.

Oregon law protects gender-affirming care and prohibits discrimination based on gender identity in employment, housing, and public accommodations.

HST leadership is grateful for OSPG members' commitment and critical input—and for the experienced team of professionals on the HST leadership team.

<u>Discussion</u>

- Q: What kind of cuts are we looking at for housing over the next 1-2 years?
  - A: We are waiting to learn more about HOPWA funding on October 1 when the final budget is available. In the president's budget, there is no funding. In the House version, there is flat funding. Negotiations are still taking place. HST will continue to compete for other funding. The loss of the HOPWA grant serving Part B (approximately $750,000 annually) is significant and impacts nearly 100 households. OHA is exploring cost containment strategies and ways to support households with other funding streams.
- Q: When does MMP data become too old?
  - A: MMP data will be very useful for at least two years. In the future, HST will need to figure out how to replace those data.

- Q: The administration submitted some anomalies to support a clean continuing resolution. What areas of funding would these anomalies affect?
    - A: We are hopeful that Oregon's programs would continue at the current funding level at least through the end of the continuing resolution period. The anomalies seem to be outside of the health and human services realm.
- Q: Would you consider this planning process a point-in-time needs assessment?
    - A: MMP was a point-in-time needs assessment. It provided information about medical services, housing, social support, and more. We will use MMP data for planning purposes this year. We also have many other data sources that provide information about PLWH and people at risk for HIV.

Integrated Planning for Ending the Epidemics in Oregon

Federally funded HIV programs are required to submit an Integrated Plan every 5 years. In Oregon, our Integrated Plan is known as the End HIV/STI Oregon Strategy or End HIV/STI Oregon Initiative. The five-year plan is our roadmap for ending new HIV/STI transmissions in Oregon. It reflects community priorities; considers local data, systems, and contexts; and defines goals and objectives (using metrics to track progress). The plan is developed with input from planning groups and the broader community, and it reflects our collective efforts to end the syndemics. While the full plan is more than 100 pages, the executive summary (available at endhivoregon.org) is only 10 pages in length, includes images, and is available in English and Spanish.

OHA publishes an annual report (available at endhivoregon.org) and updates its End HIV Oregon data dashboards on World AIDS Day (12/1) every year. The annual report includes key metrics and highlights some work of OHA and community partners. It is not exhaustive.

The Integrated Plan is required for health departments that implement the following federally funded HIV programs:

- Ryan White Part A: In Oregon, this program is managed by the Multnomah County Health Department and serves the Portland metropolitan area, including 5 Oregon counties and Clark County, Washington.
- Ryan White Part B: In Oregon, this program is managed by OHA and serves the balance of state (31 Oregon counties).
- Statewide HIV prevention programs: These programs are managed by OHA.

In Oregon, we have chosen to submit one integrated plan since 2016. This approach helps avoid duplication of effort and can help promote a status-neutral and less siloed approach. The plan is an "integrated" plan because it includes Part A, Part B, and the HIV Prevention Program. The OSPG and the Part A Planning Council must vote to submit votes of concurrence, non-concurrence, or concurrence with reservations.

The plan uses more than 30 data sources. The OSPG and Part A Planning Council engage in continuous cycles of both reviewing data and programs and providing input on data and programs. There are additional efforts to gather community input during planning years—when the five-year plan is being developed or updated. This year, there will be four town halls to discuss Ryan White priority services, including two for clients (one in English and one in Spanish) and two for providers (one for Part A and one for Part B). There have also been discussions about additional data collection efforts—leveraging existing programs to get client input from special populations, such as people who are unstably housed or incarcerated.

Community input has played an important role in shaping services. For example, HIV Early Intervention Services & Outreach (EISO) was identified by OSPG and other partners as a critical priority for Oregon in the 2017-2021 plan. OHA allocated program income to fund EISO in counties with the highest HIV prevalence. Services were evaluated over time and the model was honed. EISO is shown to improve linkage to care & viral suppression within 90 days of HIV diagnosis. In 2025, the EISO model extended to all Oregon counties. It is now called HIV/STI Statewide Services (HSSS).

Key dates:

- Oregon's new integrated plan will cover 2027-2031.
- OSPG meetings in November, February, and April will be used to collect input.
- A full plan will be available online for review and comment from May 1st - 22nd.
- During the June 3rd OSPG meeting, the group will review final changes and members will vote.
- By June 30, 2026, OHA and the Multnomah County Health Department will submit the joint plan to the Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC).

Discussion

- The Integrated Plan offers a roadmap for both the state and the TGA (the Portland metro area). This is an important time to share input.

Syndemic Landscape Mapping

Syndemic refers to the synergistic epidemics of HIV/VH/STI, substance use disorder (SUD), and mental health conditions that lead to exponentially poorer health outcomes for people than any one condition alone. A syndemic is not simply co-morbidity; one thing significantly increases the probability of another one.

A field scan is part of a larger landscape analysis that focuses on specific networks of identified service within a given context (syndemic infrastructure across Oregon communities). For example, behavioral health organizations represent a syndemic network.

Our infrastructure includes:

- HST has well established partnerships with CLHO, Tribal Governments, OHSU, local public health authorities (LPHAs), Ryan White, the AIDS Education & Training Center (AETC), SPG, CBO, Centers for Independent Living, CAP, Oregon Department of Corrections, VH, syringe services programs (SSPs), harm reduction programs
- OHA has well established partnerships with CMHA, Tribal Governments, OTPs, public and private SUD providers, Dual Dx providers, private providers, OSH, CBO, ASOs, Centers for Independent Living, M110 funded BHRNs, FQHC and CCO partners, educational districts
- The Viral Hepatitis Program has well established partnerships with many of the partners listed above, as well as the Oregon Viral Hepatitis Collective.

Discussion

- Who are your key partners for syndemic work?
    - LPHAs, CCOs, SUDs, schools, universities, FQHCs, health care providers and clinics, rural health clinics, BHRN partners, LE, food banks, housing developers, affordable housing organizations, social services organizations
    - EOCIL, CAREAssist
    - Outside In
    - CARE Oregon
    - Unity
    - Riverfront District Navigation Center works with Cascadia and OHSU
    - Portland State University Student Health and Counseling (SHAC)
    - Legacy Health has syringe exchange vending machines
- What is the overarching goal of this project?
    - The goal of this project is to be a resource for anyone doing syndemic work in Oregon. This will be a living document that we can use to help identify new partners in order to meet client needs.
- Will this be like a directory of people and organizations?
    - It's a bit like a directory of organizations, but from your perspective. We are specifically looking for HIV/VH/STI, SUD, and MH priority clients and services for them.

Next steps: OSPG members will receive a survey inviting them to share additional information.

Update on Outreach Services Contracts

Outreach Services were initially prioritized by the OSPG and in the End HIV Oregon 2017-2021 five-year plan. Since 2020, HST has funded outreach services with HRSA HIV Ryan White program income. HRSA defines outreach as activities "to identify people living with HIV who do not know their status, or people with known HIV who are out of care and link those people to services."

Outreach services have been funded through 1) contracts with eight LPHAs for HIV Early Intervention and Outreach Services (HIV EISO), 2) contracts with the Confederated Tribes of the Siletz Indians for HIV EISO, and 3) contracts with community-based organizations (CBOs) to deliver statewide outreach services.

CBO-delivered outreach services were issued with non-competitive awards. OHA has three contracts with CBOs to serve regions across the state. Contracts were amended for one additional year to complete an evaluation. They will expire 12/31/2025.

Beginning Fall 2023, HST began a strategic analysis of its HIV/STI prevention and linkage to care service delivery system. The goals were to develop a service system that 1) is more coordinated, structurally integrated and efficient, 2) is aligned with national efforts to end HIV/STI, 3) reflects best practice interventions and approaches, and 4) serves Oregonians in every county across the state. The HIV/STI Statewide Services (HSSS) model was an outcome of this analysis. The HSSS model is a status neutral, integrated approach to prevent new infections, link people to care and treatment, and improve health outcomes. The model includes activities such as targeted outreach, integrated testing, case investigation and partner services, rapid linkage to care and treatment for persons testing positive and living with HIV. Moreover, HSSS expands on the successes of HST's funded HIV EISO.

To inform decisions about future design/delivery of CBO-delivered outreach services in Oregon, HST conducted an evaluation of CBO-delivered outreach services (March - June 2025). Methods used include semi structured facilitated interviews with LPHAs, semi structured facilitated interviews with key HST prevention and care staff, one-on-one interviews with CBO outreach staff, and a review of reported quantitative and qualitative data. The evaluation found that CBO-delivered outreach services have unique benefits and challenges. CBOs were able to increase reach into specific populations and improve relationships with community organizations, and they often have more flexibility than LPHAs. At the same, CBO-delivered outreach resulted in some duplication of services and role confusion between CBO and LPHA staff. In addition, some CBOs have large service areas and are not truly able to serve all areas of the state.

There was little consensus about priority activities. Contracts had different areas of focus. Activities ranged from community testing, PrEP and PEP navigation, education, benefits/insurance navigation, and support for PLWH not in care.

A wide range of populations were served:

- People in specific locations (e.g., people who are unhoused, who use alcohol and drug treatment centers, or who live in rural communities)
- People in specific cultural communities (e.g., people who are Latine/Hispanic, Pacific Islander, Native American, men who have sex with men).
- People without insurance.

This evaluation resulted in the following recommendations:

1. Realign/restructure any future CBO-delivered Outreach Services.
    - Articulate a clear vision for services and how they fit into the statewide HIV status neutral continuum and HSSS approach.
    - Ensure services delivered are in alignment with funding used.
    - Improve coordination and reduce duplication.
    - Establish clear roles and responsibilities.
    - Improve distribution of services across the state or prioritize geographic areas.
2. Leverage existing funding, contracts and services to eliminate duplication.
    - Use HST's existing media contract to meet statewide social media and digital advertising needs.
    - Allow HST CBO-delivered Outreach Services contracts to expire on 12/31/2025 and leverage funding available through the OHA Public Health Equity Grant for CBOs. These grants allow outreach & related activities (e.g., testing, PrEP navigation). Since they are supported by state general funds, there is more flexibility to address local needs. Awards are for an 18-month period. The next cycle begins 1/1/2026. Administration and oversight of these funds fall outside of HST purview; HST staff can offer technical support to HIV/STI funded CBOs as needed.
3. Support the broader HIV status neutral and HSSS delivery system.
    - Expand tribal work to address HIV/STI among American Indian/Alaska Natives.
    - Continue encouraging LPHA subcontracting with CBOs under HSSS for outreach and other allowable activities.
4. Identify priority service areas and populations as part of statewide integrated planning in 2025-2026 and direct future funds accordingly.
    - Determine the best way to meet statewide needs.
    - Consider statewide outreach to reach specific communities.
    - If funded by HST in the future, facilitate a competitive request for proposal (RFP) or grant application process.

Discussion

- I appreciate the focus on tribal engagement. In addition to working with tribal governments, will there be a focus on urban natives, as well?
    - A: OHA has government to government relationships with the nine federally-recognized tribes and the Urban Indian Health Program. Tribal governments have expressed interest in building their own capacity to

deliver communicable disease prevention services, and OHA has directed resources to support this multi-year effort.
- The HSSS model includes targeted outreach, so this remains a best practice.
- What is the timeline for assessing priority populations? Will there be opportunities to continue conducting targeted outreach?
    - We expect to have some decisions made by the end of May 2026. Community input will be an important part of the process. These decisions will also be data driven.
- Q: If state resources will be used to target specific populations, does this mean that less funding would be available for CBOs?
    - A: Not necessarily. The Plan is used to identify priority populations and activities to end HIV/STI in Oregon. OSPG does not make decisions about funding allocations. How services are delivered and who delivers them are decisions made based on many factors, including what the need is, who can best meet the need, and what funding source is being used/any limitations on the use of available funds.

Communication & Outreach Needs and Resources

Coates Kokes is an integrated communications firm in Portland. Notable public health campaigns include the End HIV/STI Oregon campaign, the 988 Oregon campaign on suicide prevention, and previous tobacco and marijuana prevention campaigns.

End HIV/STI Oregon brand timeline:
- 2016: End HIV/STI Oregon brand/website launch
- 2022: EOCIL rural campaign in Eastern Oregon
- 2023: Brand and website refresh go live
- 2023: AntFarm/Clackamas County rural campaign
- 2023 - 2024: A6 campaign in Portland
- 2024: Rural campaign with HIV Alliance (in Southern Oregon and Linn County)
- 2025: Coos/Curry counties digital only campaign
- 2026: 10 Years of End HIV/STI Oregon!

The goals of the End HIV/STI Oregon campaign are to:
1. Increase HIV testing and conversations about sexual health among people living in Oregon (urban and more rural settings).
2. Reduce stigma around HIV/AIDS, STI and sexual health.
3. Boost knowledge about testing, prevention and treatment resources (e.g., in-clinic testing and home testing options, PreP/PEP, condoms and lube, CAREAssist).

End HIV/STI Oregon campaigns have been co-developed with partners and informed by listening sessions, focus groups, and ad testing/polling. Materials have been customized based on population and geography. Types of media utilized include billboards, transit, bus shelter ads, ads in pharmacies, bar/club posters, mirror clings, social media,

digital/display media, dating apps ads, terrestrial (AM/FM radio) ads, streaming audio, and print ads.

Campaigns (English and Spanish) have included the following messages:

- "HIV isn't just a big city issue."
- "We all have an HIV status."
- "HIV affects us all. Get tested. Help our community."
- "It sure feels good (to know your HIV status)."
- "Be sure with an HIV test."
- "An HIV test protects our whole community."
- "Protect yourself from HIV and STIs."

Coates Kokes offers technical assistance to partners (e.g., CBOs, LPHAs) around the state, including:

- Graphic design support
- Ad development, poster, stickers, social graphics, infographics
- Collateral materials
- Brochures and program one-pagers
- Content creation
- Newsletters and e-blasts
- Social media visuals
- Creation of new visuals and content
- Support boosting content/creating target audiences
- Video and photography
- Earned media (public relations)
- Story pitching, press releases, and interview coordination
- Media training and interview prep
- Rapid response to emerging situations
- Media planning and buying (Note: CBOs or LPHAs would pay for media buys)

Partners are encouraged to join upcoming training sessions with Coates Kokes.

There are many existing materials available in the partner tool kit (e.g., social media content, videos, brochures, logo files, a brand guide). To access the partner tool kit:

- Visit www.endhivoregon.org/partners.
- Scroll down to "Partner support." Click "Partner resource downloads."
- Password: HIVResources

Discussion

- Are there materials you wish you were seeing in your community?
    - Yes: materials with information about PrEP aimed at all Oregonians.
- We appreciate the support with graphic design!
- How do you evaluate the impact of the End HIV/STI Oregon campaign? Many social media posts have only a few likes.

    - Even on posts with relatively few likes, Coates Kokes can see how many people viewed the posts (often thousands), clicked on links, clicked on ads, etc.
    - For more targeted campaigns, Coates Kokes and OHA compile these data in campaign reports. They include data about reach and impact (e.g., increases in testing or condom orders). Here are some examples:
        - A6/End HIV Oregon Communications Campaign Final Report
        - EOCIL/End HIV Oregon Eastern Oregon Communications Campaign Final Evaluation
        - AntFarm/EndHIV Oregon Clackamas County Communications Campaign Final Evaluation
    - For local campaigns, CBOs and LPHAs play a big role in getting campaign messages out to the community.
    - Social media can reach people who programs may not otherwise reach.
    - Boosting posts for as little as $25 can help expand their reach substantially.
    - Although the regular media calendar reaches fewer people, it's important to keep the brand visible, so it can be activated and recognized when used for targeted campaigns, such as the ones in areas of the state where we have seen an increase in cases.
- We share lots of the materials in different ways (e.g., through social media, at tabling events). I've loved seeing the evolution of the branding over the last few years.

Please reach out to Lance if you have a suggestion or a request for technical assistance.

The PrEP & PEP Landscape: What's Happening & What Is Needed

Non-occupational post-exposure prophylaxis (nPEP or PEP) is the use of antiretroviral medication to prevent HIV transmission in isolated exposures to potentially infectious body fluids that may contain HIV. Pre-exposure prophylaxis (PrEP) is an HIV medicine taken by people who do not have HIV that reduces the risk of getting HIV.

PrEP and PEP landscape updates

The CDC released updated nPEP guidelines this year. These guidelines outline three preferred nPEP regimens (two previous regimens were removed and two were added):

- Dolutegravir 50 mg (Tivicay®) once daily + TDF 300 mg/FTC 200 mg (Truvada® or generic) once daily
- Dolutegravir 50 mg (Tivicay®) once daily + TAF 25 mg/FTC 200 mg (Descovy®) once daily (newly added regimen)
- TAF 25 mg/FTC 200 mg/Bictegravir 50 mg (Biktarvy®) (newly added regimen)

New prescribing considerations:

- Because U=U (undetectable = untransmittable), PEP is not recommended when the source patient is living with HIV and has sustained viral suppression (<200 copies/mL for at least 6 months).
- For patients taking HIV PrEP in alignment with current CDC guidelines, HIV PEP is not recommended. Taking PrEP on demand, or 2-1-1 dosing, is considered outside current CDC guidelines.

New or emerging strategies to prevent HIV infection:

- An immediate transition from nPEP to PrEP might be beneficial for persons with anticipated repeat or ongoing potential HIV exposures. Up to 9% of patients who have taken nPEP acquired HIV after nPEP completion. Potential candidates to transition from nPEP to PrEP include:
    - Patients initially seeking PrEP who were started on nPEP due to exposure in the past 72 hours
    - Patients with repeat requests for nPEP over a short period of time (e.g. twice in 6 months)
    - Patients with potential for ongoing risk.
- "PEP-in-Pocket" (PiP) involves education and a 28-day supply of recommended HIV PEP medication regimens in advance to persons with low-frequency, high-risk HIV exposures who decline to use one of the available PrEP regimens. Providers may provide a full 28-day PEP supply all at once or, at a minimum, starter packs and a clear plan for how to obtain the rest of the course.

Yeztugo (Lenacapavir) is the first and only FDA-approved HIV prevention option that offers six months of protection. It involves two injections in a provider's office once every six months (following an HIV test). Insurance coverage is critical since this is an expensive medication. Late-breaking addition: On September 18, the CDC published new clinical recommendations for twice-a-year injectable Lenacapavir as an additional option for HIV prevention in the United States.

Because of Oregon House Bill 2292 (effective January 1, 2026):

- Insurance plans must cover a) FDA-approved HIV prevention and treatment medications and b) PrEP-related services including, but not limited to, office visits and recommended labs.
- PrEP coverage must be provided with no cost-sharing.
- Insurers may not require prior authorization for HIV PEP, PrEP, or treatment.
- Insurers may not restrict reimbursement for HIV PEP, PrEP, or treatment to in-network pharmacies.

PrEP and PEP resources

- AETC maintains a PrEP Provider List, which includes more than 400 providers (including nine pharmacies) in Oregon and SW Washington that prescribe PrEP.
- AETC maintains a directory of pharmacies that stock medications commonly prescribed for PEP. Folks are advised to call a pharmacy to confirm availability before visiting.

- All Oregon hospitals must provide, at minimum, an immediate 5-day starter pack of HIV post-exposure prophylaxis medications (PEP) to patients in need.
- As a result of HB 2574, OHA will provide small rural hospitals with one 30-day supply of PEP medications once per year. Of the 33 eligible hospitals, 10 opted in during 2024 and 3 have opted in so far during 2025.
- Hospital non-compliance complaint form
- National Clinician Consultation Center
- ORAETC Communities of Practice
- ORAETC Clinical Case Consultation
- HIV/STI Program Provider Mentoring

Statewide PrEP data

- PrEP use has steadily increased since 2012. More than 7,700 Oregonians had a PrEP prescription in 2024.
- However, more people can benefit from PrEP than are being prescribed PrEP. Only 12% of people diagnosed with HIV in 2023 reported ever taking PrEP.
- Persistence on PrEP is too low. Almost half (49%) of people who started PrEP from 2011-2020 discontinued it by 2020. There is evidence that some people have acquired HIV after discontinuing PrEP.
- There is higher unmet need for PrEP among Oregonians who are between ages 13-24, Black, Latinx, Indigenous, Native Hawaiian and Pacific Islander, assigned female at birth, and living in rural Oregon.
- AIDSVu
- End HIV Oregon data dashboards

Discussion

- Q: Is the new 6-month injectable PrEP available now? If so, where is it available?
    - A: It has been FDA approved and should, in theory, be available now.
    - It is being offered at Prism Health and possibly at OHSU.
    - There is a lot of patient interest.
- Q: Are there opportunities to explore the inequalities in PrEP through a resilience perspective? What is working well? PrEP advertisements may be helping.
    - A: Years ago, OHA held focus groups with Black and African American people, and these groups included some questions about PrEP. There was fairly widespread mistrust about PrEP usage at the time. It would be great to learn more.
- I would encourage us to research and learn more about people who took PrEP but then tested positive
- Oregon PrEP trends mirror national trends.
- Huge congratulations on House Bill 2942! That is a big win for Oregonians! Thank you to everyone at OHA, OPCA, and CBO organizations that worked hard to get that passed and signed.
- It will be important to track medical mistrust among folks who have not used PrEP. It will also be important to track why people claim insurance was a barrier. Were

they unable to provide documentation of employment? Was PrEP not covered by their insurance?

- Q: Is there a problem with people not taking PrEP every day (non-adherence)?
    - A: Unfortunately, the data in this presentation do not tell us whether adherence was a challenge. We might have some valuable anecdotal information about PrEP adherence from CBOs that work with clients directly.
    - There are some helpful phone apps that offer medication reminders.
- I think having a broader survey on PrEP awareness for specific groups would be helpful. (Note: Chime In has PrEP awareness data for people who inject drugs, men who have sex with men, and "low-income heterosexuals" (these are the 3 survey groups defined by CDC). The survey is only conducted in the Portland metro area. We also have data from rural focus groups that showed virtually no awareness of PrEP among people who identified as heterosexual or LQBTQ+ and lived in a rural part of Oregon.)
- Q: I would love to see more PrEP data broken down by race, ethnicity, language, and disability.
    - A: The End HIV Oregon data dashboard contains more categories than AIDSVu (the data used for this slide set).
- Q: What is N of the slide on the left?
    - A: N = the total number of PrEP starts from 2011-2020: 6,067
- Q: Is the needle for Yeztugo injection huge?
    - A: No, it's not huge! The needle for Yeztugo injection is a 22-gauge, 0.5 inch long needle. For comparison, the needle used for Apretude injection is a 23-gauge, 1.5 inch long needle. That makes the needle used for Yeztugo slightly wider (a larger gauge number means a thinner needle) and significantly shorter. It is shorter because Yeztugo is a subcutaneous (under the skin) injection, not an intramuscular (into the muscle) injection like Apretude. Note that each dose of Yeztugo requires two injections given at the same visit.
- Q: Is there daily maintenance required if you take Yeztugo?
    - A: Yeztugo dosing starts with two 1.5ml injections and two oral Lenacapavir tablets on day 1. On day 2, an additional two oral Lenacapavir tablets are taken. After that, two 1.5ml injections are given every 26 weeks (+/- 2 weeks). No daily maintenance is required with Yeztugo once the initiation doses are complete.
- Q: With Yeztugo now available for PreP, is this option coming soon for us who are HIV positive?
    - A: Injectable Lenacapavir has been available for the treatment of multi-drug resistant HIV since 2022, under the brand name Sunlenca. When the FDA approved injectable Lenacapavir for HIV PrEP in June 2025, Gilead branded it "Yeztugo" to distinguish its PrEP application from its treatment application.

Meeting Evaluation Results

Of 21 in-person and online respondents, 100% agreed or strongly agreed with the following statement: “The information shared today was useful and relevant to the OSPG’s mission.”

Of 22 in-person and online respondents, 50% agreed that there were enough opportunities for discussion, and 50% felt neutral.

Of 10 online respondents, 50% said it was very easy, 40% said it was mostly easy, and 10% said it was somewhat difficult to follow what people in the room were saying.

Written comments from in-person participants:

- I look forward to planning group discussions this year to inform the statewide plan and hope we can bring out virtual flip charts to identify priorities in this landscape.
- More time for discussion or questions would be helpful.
- I would prefer fewer topics with more room for discussion. I appreciate the opportunity to meet in person.
- Highly relevant. A huge thank you for the work that goes into running this meeting smoothly.
- Thank you for a well organized meeting!