



# Meeting Minutes

Oregon HIV/Viral Hepatitis/Sexually Transmitted Infection  
Integrated Planning Group (IPG)

Date: **July 13, 2016**

Number of voting members present: 15

Number of others/non-voting members present: 10

Agenda Item/Topic	Key Themes in Discussion
<b>Announcements</b>	<ul style="list-style-type: none"> <li>• A moment of silence for the shooting victims in Orlando, Florida, Jack Cox, and Heidi Eidler.</li> <li>• Annick Benson-Scott is the new section manager for the Oregon Public Health Division HIV / STD / TB (HST programs).</li> <li>• AIDS Walk Portland will be held on September 10. This is the biggest fundraiser for Cascade AIDS Project as well as HIV Alliance. Everyone is encouraged to sign up and participate. The website is <a href="http://www.aidswalkportland.org">www.aidswalkportland.org</a>.</li> <li>• Thank you to the current community co-chair for his years serving on the IPG.</li> <li>• Objectives and strategies work from the March and May meetings were sent out which focused on Care and Prevention. Thank you to those that provided feedback. More feedback opportunities will be available before the Plan is due.</li> <li>• The state public health director has taken an interest in what the committee is doing. This means additional reviews may need to occur before the document is made public</li> </ul>
<b>Membership Issues: Elections, Renewals, and Thank You</b>	<ul style="list-style-type: none"> <li>• The current community co-chair will be stepping down after this meeting. A new co-chair will be elected during this meeting.</li> <li>• The eligibility criteria and expected duties of a community co-chair were reviewed.</li> <li>• Three IPG members have been nominated or expressed interest in becoming the community co-chair.</li> <li>• 28 people in IPG will have their memberships expire on September 30, 2016. An e-mail will be sent to</li> </ul>

	<p>persons' whose membership is about to expire asking that if they want to renew to please respond to the e-mail. Renewing in this way will allow for proper documentation of membership. This does not guarantee that the renewal will be approved. Membership will be based on Parity, Inclusion, and Representation (PIR) as a requirement from the Centers for Disease Control and Prevention (CDC) as well as the Health Resources and Services Administration (HRSA).</p>
<p><b>NHAS Goal 3: Reducing HIV-related Disparities</b></p>	<ul style="list-style-type: none"> <li>• If a health outcome is seen to a greater or lesser extent between populations, there is disparity.</li> <li>• Health outcomes are often linked to the social determinants of health.</li> <li>• Health equity means the attainment of the highest level of health for all people.</li> <li>• Addressing HIV-related inequities include Focus on disproportionately affected communities and populations, the implementation of structural approaches to HIV prevention and care that address the conditions of people's lives, address stigma and discrimination associated with HIV, and address stigma and discrimination faced by disproportionately affected communities.</li> <li>• Disparities along the Care Continuum exist in testing, viral suppression, and death rates, race, ethnicity, sexual orientation, and risk factor.</li> <li>• There is not much local data related to transgender individuals.</li> <li>• Men Who Have Sex with Men (MSM) have the most cases of HIV in Oregon.</li> <li>• Rates of new diagnosis are five times higher for Black / African Americans and two times higher for Latinos than for non-Latino whites in Oregon.</li> <li>• People who know their status can begin receiving Anti-Retroviral Therapy (ART) and other needed care, and take steps to protect others from infection.</li> <li>• Late diagnosis creates poor health outcomes for individuals and creates opportunities for transmission that could be avoided.</li> <li>• In Oregon, Latinos and people who inject drugs (PWID) are more likely to progress to AIDS within 12 months of their initial HIV diagnosis (indicating they were likely infected &amp; undiagnosed for years).</li> <li>• Viral suppression is important for optimal health and because viral suppression drastically reduces transmission risk.</li> <li>• In 2016, HIV is no longer "a death sentence" for most people infected.</li> <li>• This quest for social justice is ongoing—these conversations will continue over the next 5+ years, with a goal of greater involvement of affected communities.</li> </ul>

	<ul style="list-style-type: none"> <li>• Examples of activities could include contracts with Oregon’s Regional Health Equity Coalitions to conduct needs assessments in communities of color and advise the Oregon Health Authority (OHA) on addressing HIV-related racial and ethnic disparities, engage more diverse communities in HIV planning through IPG member recruitment promote policy approaches to reduce stigma and promote LGBT civil rights, expand syringe exchange, and ensure patient navigation services are available for specific communities.</li> </ul>
<p><b>Addressing Disparities: LGBTQ</b></p>	<ul style="list-style-type: none"> <li>• MSM disproportionately account for most of the most HIV cases in Oregon.</li> <li>• There is a lack of data for transgender individuals. This group is known to have high risk and experience disproportionate infection.</li> <li>• Men of unknown risk might not disclose MSM risk.</li> <li>• Current activities for MSM include targeted outreach and information for them and their partners.</li> <li>• The National HIV Behavioral Surveillance (NHBS) project will focus on the MSM community in Year 2.</li> <li>• There is a significant lack of knowledge and interventions across Oregon’s HIV Continuum for the transgender population.</li> <li>• Prevention and treatment challenges include high-risk sexual activity, stigma and discrimination, high rates of past trauma, and possible HIV fatigue.</li> <li>• Possible activities include expanding PrEP-related services, expanded access to testing, implement stigma reducing strategies, ensure availability of partner services, and conduct an assessment of service needs across the HIV Continuum for transgender individuals.</li> </ul>
<p><b>Think, Pair, Share</b></p>	<ul style="list-style-type: none"> <li>• Men of unknown risk – MSM being the target population is not necessarily one thing but rather are split into different categories. Examples include those at higher risk, those who may not identify as MSM. Need to reduce stigma to help them come out to identify themselves. Need to find ways in which information can be shared to those in different categories of MSM.</li> <li>• It is very hard to reach out to the transgender community. Consider greater outreach to the trans population statewide and support services.</li> <li>• Consider messaging to trans communities saying that you only have to come out once and be safe.</li> <li>• Increase availability and awareness of at home testing. Also work with AETC on normalizing HIV and Hep C screening. Find out if there are activities that trans populations participate in.</li> <li>• Change / expanding the images of HIV.</li> </ul>

	<ul style="list-style-type: none"> <li>• LGBT youth want to know the history of the LGBT community in HIV.</li> <li>• Reaching out to doctors who treat trans persons around their general health through the transition.</li> <li>• Highlight medical welcoming environments around the state.</li> <li>• Reach out to staff at public school systems to become involved with IPG.</li> <li>• Have conversations around HIV prevention being more than just getting tested.</li> <li>• Expanding services to STI providers.</li> <li>• Take sexual history checks for everyone and not just those at highest risk.</li> <li>• Create messaging around condom use even with PrEP being available and used.</li> <li>• Make PrEP and PEP free or low-cost.</li> </ul>
<p><b>Addressing Disparities: People Who Inject Drugs</b></p>	<ul style="list-style-type: none"> <li>• Determining the scope of health disparities among persons who inject is difficult to determine.</li> <li>• Four national surveys have been completed with varied amounts of success based on their limitations.</li> <li>• Among people diagnosed for the first time in Oregon, between 2004 and 2013, 15% reported injection drug transmission risk.</li> <li>• Oregon is one of the first states to have legal access to non-prescription syringes.</li> <li>• MSM / IDU are more likely to be diagnosed late and are more likely to have an AIDS diagnosis in the first year.</li> <li>• Persons who inject are more likely to face co-morbidity with Hepatitis C.</li> <li>• People who inject drugs have a higher rate of homelessness.</li> <li>• Harm reduction is anything that can be done to reduce the chances that someone is going to get some type of blood-borne infection.</li> <li>• For access to medication assistance treatment is anything that is taken that takes away cravings or have a person not feel well when they inject.</li> <li>• Free disposal options are limited.</li> <li>• Potential options for syringe access and disposal include doing a syringe take-back program, vending machines, syringe prescriptions, a supervised consumption facility, and drop boxes in more public places.</li> </ul>
<p><b>Think, Pair, Share</b></p>	<ul style="list-style-type: none"> <li>• Have medical providers at syringe exchange sites.</li> </ul>

	<ul style="list-style-type: none"> <li>• Identify interventions that reduce stigma for persons who inject.</li> <li>• Have money available for communities to use as they see fit.</li> <li>• Coverage by insurance carriers for medication assistance treatment.</li> <li>• Make the community (general public) aware of the problem.</li> </ul>
<b>Addressing Disparities: Communities of Color</b>	<ul style="list-style-type: none"> <li>• Racial &amp; ethnic disparities exist all along the HIV care continuum in Oregon.</li> <li>• In Oregon, there is a balancing act between dividing resources among communities most affected and those who are disproportionately affected, but who have small numbers.</li> <li>• On national health care access ratings, Oregon ranks 48<sup>th</sup> on equity measures and 42<sup>nd</sup> on racial &amp; ethnic equity.</li> <li>• Although Medicaid expansion reduced rates of uninsured in Oregon, disparities still exist: 21% of Latinos, 21% of American Indian / Alaskan Native (AI/AN), and 18% of Hawaiian/Pacific Islanders (PI) are still uninsured.</li> <li>• African Americans are more likely to be newly diagnosed with HIV and less likely to achieve viral suppression.</li> <li>• Latinos are more likely to be newly diagnosed with HIV and more likely to have delayed diagnosis.</li> <li>• Newly diagnosed Latinos reported not seeing themselves at risk for HIV and not seeking medical care.</li> <li>• Lower viral suppression rates and higher rates of HIV-related mortality (lower probability of surviving 10 years after diagnosis).</li> <li>• Approaches to eliminate the gap include targeted HIV prevention activities, medical care, social support, health equity, social justice &amp; reduction of overall disparities, and culturally competent medical care.</li> </ul>
<b>Think, Pair, Share</b>	<ul style="list-style-type: none"> <li>• More DIS services throughout the state. This will allow someone to talk to someone who is familiar with the culture and possibly answer more specific questions.</li> <li>• Do community engagement without an agenda. Being a part of the community will allow trust to build and opportunities to offer information.</li> <li>• Develop a checklist that people can use when they visit the doctor to help normalize a conversation about HIV and STD testing.</li> <li>• Culturally specific counseling on more of an holistic level.</li> </ul>

**Wrap-Up**

- Information from this meeting will be incorporated into the Plan which will then be e-mailed back out to everyone for review.
- Other stakeholders have been and will be contacted to get their feedback on the Plan.
- The IPG membership will be contacted as part of the Letter of Concurrence process.
- Membership and Policies & Procedures will be reviewed later this year.