

Meeting Minutes

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



FULL MEMBERSHIP MEETING

Date: **January 25, 2012**

Number of voting members present: **36**

Number of others/non-voting members present: **1**

Agenda Item/Topic	Key Themes in Discussion	Outcomes (Decisions or Next Steps)
Welcome / Introductions / Announcements / Meeting Logistics	<ul style="list-style-type: none"> • Vision and Mission Statements were reviewed. • Reminder that every voice is important to the process. • Meetings are open to the public. • Ground Rules were reviewed. 	
OHA Welcome	<ul style="list-style-type: none"> • There has been a lot of work taking place with respect to the HIV/AIDS Strategy. • Planning meetings will help support the National HIV/AIDS Strategy. 	
National HIV/AIDS Strategy	<ul style="list-style-type: none"> • Everyone can be proud of the work that has been accomplished thus far. • 40% of tested persons have a late diagnosis. • Oregon's new infection rate has stayed relatively the same at 275 cases per year for the last 15 years. • Persons of color and those living in rural areas are less likely to receive care and other services. • Work is being done at the state and local level to target resources and improve coordination, build capacity, 	

	<p>ensure access and retention to quality care, identify and reduce barriers and disparities.</p> <ul style="list-style-type: none"> • Additional information is available in the member binder and online. • The IPG will play a big role in developing Oregon's overall plan to reduce new infections, increase access to care, improve health outcomes, reduce disparities, and address health inequities. • The IPG will also help refine and enhance the current HIV continuum from unaware through care and engagement services. The committee will also look at new ways to do work and be developing a product that can be used as a statewide tool for program planning at all levels. 	
Federal Overview	<ul style="list-style-type: none"> • The Vision of the National HIV/AIDS Strategy is to create a place where new infections are rare and when they do occur, every person, regardless of age, gender identity, or socio-economic circumstance, will have unfettered access to high quality life-extending care, free from stigma and discrimination. • Goals of the Strategy include the reduction of HIV incidence, increasing access to care and optimize health outcomes, and reduce HIV-related health disparities. • Reducing new HIV infections includes intensifying HIV prevention where HIV is most heavily concentrated, expand prevention to include a combination of approaches, and educate everyone about HIV/AIDS. • Increasing access to care and optimize health outcomes will include the immediate link patients will receive to care, increase the number and diversity of available providers, and provide comprehensive support. 	

	<ul style="list-style-type: none">• Reducing HIV-related health disparities will require the reduction of HIV-related mortality in communities at high risk for infection, adopt community level approaches to reduce infection in high risk communities, and reduce stigma and discrimination against people living with HIV.• A more coordinated national response will include the coordination of program administration, the promotion of equitable resource allocation, streamline and standardize data collection, provide rigorous evaluation of current programs and redirect resources to the most effective programs, provide regular public reporting, and encourage States to provide regular progress reports.• The role that community planning efforts have and will continue to play are reducing stigma and discrimination, promote public leadership of people living with HIV, increase coordination across programs, and increase the focus on coordinated planning for HIV programs and services across agencies• When CDC's new approach is fully implemented, HIV prevention resources will closely match the geographic burden of HIV.• The CDC Health Department Funding Opportunity Announcement entails broadening the group of partners and stakeholders engaged in prevention planning, improving the scientific basis of program decisions, targeting resources to communities at highest risk for HIV transmission, and collaboration plus coordination of HIV prevention, care, and treatment.• The Ryan White Part B Program will align with the National HIV/AIDS Strategy with strategic and necessary changes and strengthen partnerships in programs.	
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	<ul style="list-style-type: none"> • The Department of Education at the national level is not involved with the Strategy. 	
Epi Profile	<ul style="list-style-type: none"> • As of August, 2011, there were roughly 7,400 people living with HIV infections in Oregon: 5,900 of whom have been diagnosed which are cases; approximately 1,500 of whom don't know they are carrying HIV. • Diagnoses and deaths have been steady since 1997. An increasing number of living cases has not resulted in an increase in diagnoses. • Decreases in death and diagnoses are likely due to advances in medical care and adherence to antiretroviral medication, financial and support services that allow sustained access to medical care, and early diagnosis and reducing the risk of infecting others. • Early diagnosis lowers the risk of infecting others. • 20% of infected Oregon residents are unaware they are carrying HIV. • 40% of people newly diagnosed with HIV infections have AIDS within 12 months. • People most likely to be diagnosed late include males with unreported risk and people living in more rural areas of Oregon. • 73% of patients at time of diagnosis had high viral loads. • 13% of reported HIV cases living in Oregon have had no CD4 or viral load test in the last 12 months. • Persons most likely to be out of care include Hispanics, American Indians, those age 35 – 39, male injection drug users (IDU) and men who have sex with men (MSM)/IDU, rural county residents, and foreign-born. • From 2007 – 2010, viral load suppression increased from 67% to 80%. In that same time period, high viral 	

	<p>load has decreased from 19% to 9%.</p> <ul style="list-style-type: none"> • Those least likely to have viral load suppression include persons 20 – 39 years of age, American Indians, African Americans, Asians, HIV status, and male / female IDU MSM/IDU. 	
<p>Program Design & Evaluation Services (PDES) Presentation: Planning Process for IPG & Role of PDES</p>	<ul style="list-style-type: none"> • PDES is an evaluation and research group that is affiliated with both the State of Oregon and Multnomah County Health Department, involved with various public health projects, and is funded through a wide variety of grants and contracts. • Recent HIV-related projects include the HIV Medical Monitoring Project, needs assessment for CAREAssist and case management, grants to support HIV prevention for people who inject drugs, and barriers to smoking cessation among people with HIV. • The roles PDES will play in the IPG process include direct and coordinate the work of committee staff, serve as data and evaluation resource to IPG membership, and ensure that IPG has a strategic plan at the end of the one-year planning process that makes sense and has clear action steps. • Steps in the initial planning process include getting organized (January), review data and identify critical issues (April), Analyze critical issues / develop the Strategic Plan (July), and adopt & refine the Plan (October). • In getting organized, much of the work was done by the IPG Transition Planning Group throughout 2011 and some steps are happening during today's meeting. • Objectives for the April meeting include the review of goals of each committee and how they relate to the National HIV/AIDS Strategy, analyze available data, and generate a list of critical issues. 	

	<ul style="list-style-type: none">• Setting the direction of the committee will include the analysis of critical issues that will be identified, establish strategic goals to match critical issues, establish strategies to accomplish each goal, recommend responsibilities, and create timelines with milestones.• Work around adopting and refining a Plan will include building an agreement around the Plan, action planning plus integration with the Strategic Plan, prepare and review the actual document, internal & external marketing plan, and debrief & evaluate.• At some point, the IPG may help create documents required by the funders of HIV care & treatment services (HRSA) and prevention services (CDC).• In 2012, the IPG will not be producing HRSA or CDC-required documents.• The IPG will produce a strategic plan addressing HIV care and prevention services to be used locally.• There are four IPG committees: Membership, Preventing New Infections, Access to Services, and Coordination of Prevention and Care Services.• The committees are the foundation of the IPG. Each meeting will involve committee work. There may be committee work between meetings.• All IPG members will be asked to serve on one committee for the entire year. Each committee will elect a chair who will represent them on the Executive Committee. Each committee will produce content for the Strategic Plan.• Committee chairs will represent the committee on the Executive Committee and facilitate committee meetings which include the development of meeting agendas with staff.• State committee staff will take minutes, develop	
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	<p>committee meeting agendas with the committee chair, take care of logistics, prepare committee reports and handouts, and provide technical assistance.</p> <ul style="list-style-type: none"> • PDES will provide support and guidance to committee staff and serve as a data guide. 	
Committee Reports	<ul style="list-style-type: none"> • Membership Committee only has four people. Need to make sure there is enough representation to get their work done. • MEMBERSHIP COMMITTEE: Came up with six areas to research. One of which is to figure out what the current IPG group consists of and look at recruitment efforts in those areas that need membership. Need to figure out how people have been recruited in the past and what has worked well. Need to determine the best IPG member structure and look at barriers that face those wanting to join the IPG. • COORDINATION OF PREVENTION & CARE SERVICES: Wealth of knowledge and experience within the group. Need to get more information on topics such as the Affordable Care Act. • PREVENTING NEW INFECTIONS: Need to find answers to the following questions: A better understanding of who is at risk, qualitative data information detailing why and what happened that lead to the infection, late testers, understanding the policy climate, and data developed for drug use / syringe access. • ACCESS TO SERVICES: Want to know more about what happens when a person seroconverts and they are brought into care, what hurdles have to be overcome, and how can hurdles be reduced or eliminated. • Committees need to look at representation and think 	

	about who should be participating who currently are not.	
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