Meeting Minutes

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

FULL MEMBERSHIP MEETING

Date: **February 27, 2013**

Number of voting members present: 25

Number of others/non-voting members present: 8

Agenda Item/Topic	Key Themes in Discussion
Announcements	• The White House has sent out communication that is state-specific in regard to the sequestration. It is not known what will happen in Oregon. • It has been recommended by NASTAD and others about the re-authorization of the Ryan White Care Act. A recommendation by HRSA and NASTAD to not be attempted. It does not mean the Care Act will go away. Funding can occur under the current legislation. Going to try for flat funding and no changes in the law. • A meeting was organized for the Transitional Grant Area (TGA) called "Getting to Zero". Want to be sure to integrate with Prevention Projects. Also want to talk about integration of Prevention and Care. The focus will be on the metro area. The next workgroups will be organized soon. • Portland is doing a fundraiser for Grass Roots Soccer. This is a group that teaches kids in Africa through the power of soccer. An event will be held June 9 to raise money. • Addictions & Mental Health are in the process of writing a grant. Contributions are needed from programs on what they are doing. • The Hotline contract was not renewed. The funding ends March 31. Cascade AIDS Project has agreed to support the Hotline through June.
Trends in HIV Prevention and Care at	• The Vision of the National HIV/AIDS Strategy states that "The United States will become a place where new HIV infections are rare and when they do occur, every person,

the Federal Level	regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance will have unfettered access to high quality, life-extending care, free from stigma and discrimination." • The goals of the National HIV/AIDS Strategy are to reduce HIV incidence, increase access to care and optimize health outcomes, and reduce HIV-related health disparities. • In order to reduce HIV incidence, it will be important to focus on communities where HIV is most heavily concentrated, engage in targeted efforts using a combination of effective, evidence-based approaches, and to educate all Americans about the threat of HIV and how to prevent it. • CDC has developed a framework called "High Impact Prevention." This framework is made up of combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas. • The impact of the National HIV/AIDS Strategy (NHAS) will be evident through the process of competitive Funding Opportunity Announcement (FOA's) by CDC • The NHAS will have an impact on local HIV practices which include more of a use of an impactful combination of interventions, the implementation of peer navigator systems, use of linkage to Care coordinators, the expansion of HIV screening and testing through a new algorithm, expanded partner services, and support Post-exposure Prophylaxis (PEP) efforts. • The focus areas for Category C (demonstration projects) funding include structural, biomedical, and behavioral interventions, innovative testing activities, enhanced linkages to and retention in care for people living with HIV, advanced use of technology, and use of CD4, viral load, and other surveillance data. • Several states are collaborating with federal agencies in a Care and Prevention in the United States (CaPUS) project. Required components include increased HIV testing, linkage to, retention in, and re-engagement with care, treatment, prevention, enhanced navigation services, use of surveillance data and data systems to improve care and prevention, and address social and structural factors directly affecting HIV testing, linkage to, retention in, and re-engagement with care, treatment, and prevention. The results of this project will influence funding for future activities. • PrEP was recently approved for use by the FDA. This is being used as a prevention method through the use of antiretroviral medicines. This is a newer, bio-medical technology.

	• A big change comes in the philosophy that treatment is prevention. • 24% of Ryan White clients are uninsured.
HIV Treatment Cascade Presentation	• New infections can be averted through sexual activity that has a lower risk of transmitting HIV or by using a sterile needle. • Infections can also be avoided by suppressing HIV with antiretroviral medication. • A study was conducted in 2011 using couples where one was HIV-positive. With therapy and a lower CD4 count, HIV was less likely to be transmitted. • Approximately two years ago, a paper was published which introduced the concept of state of engagement in HIV care. This is also known as the "care cascade". This assumes that treatment will be effective as prevention. People need to get from not knowing they're infected to viral load suppression, It is estimated that 1.1 million people living in this country with HIV, were aware they were infected with HIV. 60% were linked to care. • At the end of 2011, it was estimated that the total number of people infected with HIV living in Oregon was 7,406. CDC estimates that 82% of people are aware they are infected. • It is believed that overall cases with suppressed or undetectable viral load appears to be over two times higher than the US. • Oregon's opportunities for improving "Treatment as Prevention" have the most room for improvement at one end of the engagement spectrum identifying undiagnosed cases. • Limitations to this analysis include lack of Oregon-specific estimates for undiagnosed persons, linkage and retention use surrogate tests, poor agreements across jurisdictions on definitions, which hampers cross-jurisdictional comparison, missing data, and migration. • Routine testing of everyone would help in the "Treatment is Prevention" model. • House Bill 1507 should help in normalizing HIV testing in healthcare settings. This removes the requirement for an informed consent prior to testing. The law allows that patients can be advised verbally or in writing which would could be included as part of a general consent for treatment.
Review 2012 Accomplishments / Introduce IPG	• Great that there are plans that the committee has worked on. • All of the committees are diverse and worked well. • We have taken the information and are working internally on an implementation plan.

Implementation Plan	• Sub-committee work includes the Coordination committee who is working to ensure that HIV care will be a part of CCO's as they open: Access to Care committee identified gaps and barriers to care in both rural and urban areas: Membership committee is continuing to find and recruit new members and working with those that are new, and the Executive committee has done a great job in keeping the planning going and working on upcoming meeting agendas. • In preparation, HST started a workgroup called WIISH (Workgroup for the Improvement and Integration in Services for HIV. The goal was to determine how a continuum can be built across programs.
IPG Implementation Plan: Prevention	• The Implementation Plan is organized around the Treatment Cascade. • The goal with the Continuum is viral suppression for quality of life and reducing the transmission of the HIV virus to someone else. • Approximately 40% of new diagnoses are happening late in the disease process. We want to find people early so they can be tested and linked into Care. • Sero-sorting and disclosure is about providing accurate information. • Input from the IPG will be requested during the process. • An HIV Essentials training curriculum is available. It will be developed into an online training and will eventually be required for Part B case managers. • The purpose of the pilot project is to offer HIV testing and referral and linkage to partners and their family and friends. The purpose is to fill a gap left by lack of Prevention funding. • The Medication Therapy Management Program (CAREAssist) is contracting with Ramsell mail order pharmacy program for those who would like to receive services but have challenges with adherence. • Goal is for 70% of condoms distributed to go to target prioritized populations.
IPG Implementation Plan: Linkage	• Goals are to link those who are at risk and need to be tested, those who are identified as positive and link them to care, and those who are in care obtain more resources to help pay for their care. • For the first goal, 70% of new positives will be referred to partner service options. This is meant to allow the person to help others get linked to testing. • For the second goal, 93% of those testing positive will have a viral load or medical appointment within the first three months. • For the third goal, ensure that 100% of cases who do not have a CD4 or viral load in an

	18 month period are identified. 10% of those identified cases who can be located will be re-engaged in medical care. • A study was done using Douglas County. • Partners at the local health department level will be needed to reach these goals. • For the fourth goal, provide timely updates to resources in the community.
IPG Implementation Plan: Care & Treatment	• The majority of people diagnosed with HIV are linked to Care within three months. • Once linked into Care, people need supports in order to access treatment. • On-going support is needed for barriers to Care. • CareAssist funds insurance and access to services. This includes local case management, transportation, emergency housing, and other services. • Plan enhances work that is already being done, adds new elements, new partnerships, and allows for things to be done in coordinated ways. • One goal is to expand and promote the self-management program already in place. • Prevention, self-management, and the medication refill project are also outlined. • Activities in the Plan include the promotion and expansion of medical provider capacity to treat HIV, promote and expand essential medical / non-medical services to PLWH/A, and promote the integration of HIV services into the Oregon Healthcare Transformation. • The promotion and expansion of medical provider capacity includes increasing knowledge of training/technical assistance provided by AETC, promote the National Clinician Consultation Center Warmline, coordinate provider contact information with AETC, identify / follow up with providers prescribing inappropriate treatment, improve transportation services in rural Oregon, increase awareness among providers regarding Viral Hepatitis / STI treatment access, and address unmet need for food / nutritional support. • To promote the integration of HIV in health transformation, activities will include convening a health transformation taskforce to share / review information, develop communications, and identify barriers; prepare CAREAssist staff to provide information, referral, and advocacy; respond to changes to address gaps and reduce duplication
IPG Implementation Plan: Social Determinants of Health	• Factors that contribute to determinants of health include social and environmental economics, living and working conditions, community networks, biology, and gender. • Social determinants of health are the conditions and circumstances into which people are born, grow, live, work, socialize, and form relationships and the systems that are in place

	to deal with health and wellness. • Stigma and discrimination are components of the outermost layer of social determinants of health framework. • The traditional concept of stigma is a social process which can reinforce relations of power and control. It also leads to status loss and discrimination for the stigmatized. • The functions of stigma include enforcement of social norms, avoidance of disease, and exploitation and dominance. • Forms of stigma include those from individuals, institutional, and internalized self-stigma. • HIV-related stigma constitutes one of the largest barriers in effectively addressing the HIV/AIDS epidemic. • High HIV-related stigma levels found across research studies to be consistently and significantly associated with low social support, poor physical health, poor mental health, age, and income. • The first goal is to decrease experiences of discrimination among PLWH/A in Oregon. • The smart objective consists of reducing the proportion of Medical Monitoring Program (MMP) respondents who report experiencing discrimination and the healthcare system since testing positive for HIV from 38% to 25% by 2014. • Actions will include incorporating the issue of stigma into existing OHA HIV training curricula and review MMP respondent data regarding experiences of discrimination and partnering with the Office of Equity and Inclusion to address identified issues as needed. • The second goal is to decrease self-stigma among PLWH/A in Oregon. • The smart objective is to reduce the proportion of MMP respondents who agree with the statement “I am ashamed that I am HIV positive” from 31% to 25% by 2015 and to reduce the mean overall score of the AIDS-related stigma score among MMP participants from 2.16 to $\leq$ 1.56. • Actions include the creation of or link for PLWH/A to online social networks to foster social support, work with IPG and existing OHA programs to integrate anti-stigma activities into existing and future programs, and using social marketing materials at community venues to increase awareness and normalize discussions about HIV, Viral Hepatitis, and STI’s. • The third goal is to decrease institutional discrimination experienced by PLWH/A. • Smart objectives include the development of an MMP question to measure PLWH/A’s experience of institutional stigma for inclusion in a MMP survey instrument, and to access existing HIV Prevention and HIV Care service program eligibility rules and operational

	requirements for low threshold eligibility and reasonable accessibility. • Actions include assessing the knowledge of case managers statewide regarding service program rules and eligibility issues that make accessing services stressful or difficult through focus groups at case manager trainings, analyze data and distribute reports to case managers and determine next steps to address identified institutional barriers to prevention and care services.
Public Comment	• There were no comments
Membership Committee Update	• Several people have left the committee recently. • Looking for people who can fulfill areas where the committee is lacking in membership. • Need membership from the Department of Education, faith-based organizations, anyone who is trans-gender, persons age 19 – 25, previously incarcerated, African American, Native American, Asian, Hispanic • The membership application is on the web. • Three spots are available.
Future IPG Work	• OHA has been working on the Implementation Plan. • A question has come up on the structure of meetings. • The IPG will be asked for input on specific topics. • CDC requires the IPG to concur with the HIV Prevention Jurisdictional Plan as well as input on the Statewide Coordinated Statement of Need. • The IPG met quarterly in 2012. The goal is to maintain a cohesive group. • During the Executive Committee meeting, there were mixed feedback and ideas. • Consider having fewer face-to-face meetings and instead, have monthly e-mails from the IPG co-chairs on updates to activities. • Other topics that IPG would provide input on include expanding the website, expanded use of technology (conference call, webinar, etc.), and the use of ad-hoc committees within IPG. • One proposal is to have 3 face to face meetings in 2013. • A second proposal is to have two meetings (one in August). • The final proposal is to keep the schedule the way it is.