



# IPG Meeting Minutes

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



## FULL MEMBERSHIP MEETING

Date: August 21, 2013

Number of voting members present: 27

Number of others/non-voting members present: 8

Agenda Item/Topic	Key Themes in Discussion
<b>Announcements</b>	<ul style="list-style-type: none"><li>• Please feel free to get up and move during the meeting.</li><li>• There have been four resignations since the last meeting.</li><li>• Kim will chair the membership committee and will be part of the Executive committee.</li><li>• IPG members are invited to participate in a workgroup about HIV testing. In the implementation plan, one of the objectives of OHA is to implement a policy that all HIV tests paid for through grant funds are confidential. The majority are confidential. The difference between confidential and anonymous is that names are collected with a confidential test. In the past, providing a name in order to get a test was a barrier for some people. To support the National HIV/AIDS Strategy, we need to start collecting client names. One of the tasks of this workgroup is to develop a list of fears and concerns from clients and develop a plan on how these concerns can be addressed. Let Dano know if interested in participating.</li><li>• Attended a conference in Denver for community planning group leaders across the country. The meeting re-enforced what we are doing. There are still states around the country haven't even thought about planning groups. Since the Ryan White Part B program is not required to have an integrated group, there have been Part A planning councils. Tom and Dano did a presentation on integration in Oregon and how that has worked. There was an emphasis on high impact preventions.</li></ul>

	<ul style="list-style-type: none"> <li>• The state HIV Prevention Program had a site visit from CDC. Great conversations occurred during the visit.</li> <li>• There has been quite a bit of Chlamydia among men who are incarcerated. Need to focus on taking a look at risk behaviors.</li> <li>• There are 36 members of the IPG with a maximum of 45. There have been a couple of resignations. The membership committee has 4 participants at the moment. This committee is the most continuously active among those within the IPG. If anyone would like to join the committee, please let Kim Hutchinson know.</li> <li>• AIDS Walk Portland will be held on September 22. AIDS Walk benefits all of the service organizations who work in HIV/AIDS. The walk is 2.5 miles.</li> <li>• HIV Care &amp; Treatment had a site visit that consisted of a three-day review of the AIDS Drug Assistance Program (ADAP). A full day was spent at HIV Alliance and Linn county. A written report will be provided. Some suggestions may be included in the report.</li> <li>• HIV Alliance will continue to have a Hepatitis B coordinator. It was originally scheduled to be cut at the end of June but has since been extended.</li> </ul>
<p><b>Health Transformation Update</b></p>	<ul style="list-style-type: none"> <li>• “Cover Oregon” will be implemented.</li> <li>• There is a website with some information on how the new healthcare process will work in conjunction with the national Affordable Care Act.</li> <li>• A web-based portal has been set up that allows people to enroll under the Affordable Care Act (ACA).</li> <li>• There is a one-hour training on how to enroll someone in CoverOregon. This must be done in order to attend an additional training on how to enroll someone.</li> <li>• CoverOregon is a public/private relationship. The state has taken on the training aspect. There should be a training in all areas of the state.</li> <li>• Once the training has been completed, an agreement must be signed, someone can be certified as an application assister.</li> <li>• There are three populations that will be affected: People who, by income alone, who will be transferred from private insurers to Medicaid. Medicaid has been expanded to include those that are 138% of median family income.</li> <li>• Anyone over 138% of median family income, people will be able to participate in an insurance exchange program. This will consist of 10 to 12 private insurers who will be</li> </ul>

	<p>offering coverage. There will be several plans available.</p> <ul style="list-style-type: none"> <li>• The maximum amount of out-of-pocket expense for anyone is around \$6,480. There will be a separate one for prescription drugs.</li> <li>• Anyone who is 138% - 250% of median family income can qualify for help for co-pays and deductibles.</li> <li>• The Portal will not be accessed by the general public will not happen until mid to late October. An assister is not required.</li> <li>• Open enrollment is October to March 31 for the first year. For every year thereafter, the enrollment period will run from October 1 through December 31.</li> <li>• CAREAssist will review of all available insurance plans to see what the program can support.</li> <li>• A taskforce has been developed to help figure out what can be supported.</li> <li>• A lot of questions have not been answered.</li> <li>• An RFP was released that related to helping people get enrolled in CoverOregon. Not everyone was funded.</li> <li>• Contracts are being developed that will fund agencies to do this.</li> <li>• Another group that CAREAssist is focused on are those who do not qualify for CoverOregon. There will be plans available outside of the Exchange.</li> <li>• If changes need to be made, they need to contact their counselor or case worker.</li> </ul>
<p><b>Local Level CCO Collaboration</b></p>	<ul style="list-style-type: none"> <li>• Open enrollment is not being delayed. The enrollment process will be staged.</li> <li>• The CoverOregon call center is now open.</li> <li>• The shift that needs to occur has to come from people who will participate in the process.</li> <li>• CCOs have to chose three activities that serve community needs.</li> <li>• 90% of people living with HIV/AIDS will be a part of a CCO.</li> <li>• According to information from a recent conference on HIV and the Continuum of Care, President Obama has proposed budgeting a significant increase in funds for services relating to HIV/AIDS as it relates to the National HIV/AIDS Strategy.</li> <li>• HIV/AIDS service delivery has had the coordinated care model for a long time.</li> <li>• Some parts of the state have regional citizen advisory councils while others are specific to a town.</li> <li>• Some CCO's are still working on how they can address the Community Health</li> </ul>

	<p>Implementation Plan.</p> <ul style="list-style-type: none"> <li>• CCO's are required to have their network consist of at least 20% of Essential community providers.</li> </ul>
<p><b>AIDS Education and Training Center (AETC) Overview</b></p>	<ul style="list-style-type: none"> <li>• The training centers across the country provide technical assistance for the Ryan White HIV/AIDS Treatment Modernization Act (formerly known as the Ryan White Care Act).</li> <li>• There are 11 regional centers with over 130 local sites and and four national centers.</li> <li>• The AETC program is administered and funded by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau.</li> <li>• The AETC Network offers training to providers in Tribal health agencies, Community and migrant health centers, Ryan White HIV/AIDS Treatment Modernization Act-funded sites, clinics serving minority or underserved populations, state and local health departments, corrections facilities, private practice settings serving persons with HIV and AIDS, and rural and urban health facilities</li> <li>• Our mission is to improve the quality of life of patients living with HIV/AIDS by providing high quality education and training to health care professionals.</li> <li>• The target audiences include physicians, nurse practitioners, nurses, physician assistants, pharmacists, dental professionals, and other health care professionals.</li> <li>• The AETC National Resource Center is a centralized location for training and clinical materials through a virtual library. This encourages collaboration among regional and local AETC's through national workgroups and resource development.</li> <li>• The National Clinician's Consultation Center provides healthcare professionals with a national resource to obtain timely and appropriate responses to clinical questions related to treatment of persons with HIV infection and/or possible healthcare worker exposure to HIV and other blood-borne pathogens.</li> <li>• The mission of the Northwest AIDS Education and Training Center is to increase providers' capacity to provide high quality HIV/AIDS care within the regions healthcare systems. The service area includes Alaska, Washington, Oregon, Idaho, and Montana.</li> <li>• Training activities are based on assessed local needs. Emphasis is placed on interactive, hands-on training and clinical consultation to assist providers with complex issues related to HIV/AIDS treatment and care.</li> </ul>

	<ul style="list-style-type: none"> <li>• The NW AETC applied for and was awarded a long term grant to develop an HIV telehealth resource similar to the University of New Mexico’s Project ECHO for hepatitis education.</li> <li>• The NW AETC ECHO aims to build the confidence and skills of rural, low-volume health care providers and clinics in the Northwest region to provide high quality HIV care to patients.</li> </ul>
<b>Public Comment</b>	<ul style="list-style-type: none"> <li>• There were no comments</li> </ul>
<b>Antibiotic-resistant Gonorrhea</b>	<ul style="list-style-type: none"> <li>• During 2012, Multnomah county accounted for 51.6% of Gonorrhea cases statewide. Multnomah county has 19% of Oregon’s total population.</li> <li>• Priority populations include African Americans, those age 15 – 24, men who have sex with men, and others.</li> <li>• In the 1940’s, there was a resistance to Sulfanilamides.</li> <li>• From the 1950’s to the mid-1970’s, there was a decreased susceptibility to PCN.</li> <li>• In 1976, there was resistance to PCN.</li> <li>• In the 1980’s, there was resistance to Tetracyclines.</li> <li>• From 2000 – 2006, there was resistance to Quinolones.</li> <li>• Since 2009, there has been decreased susceptibility to Cephalosporins.</li> <li>• Gonorrhea treatment failure can occur if the GC infection persists after treatment, and sexual exposure after treatment has been ruled out.</li> </ul>
<b>Serosorting, Disclosure, and Testing Frequency: What’s our Message?</b>	<ul style="list-style-type: none"> <li>• The United States Preventive Services Task Force indicates that the evidence is insufficient to determine the optimal time intervals for HIV screening. Repeat screening of persons who are known to be at risk for HIV infection is a reasonable approach”(e.g., retest every 1 to 5 years based on risk)</li> <li>• CDC recommend that persons at high risk for HIV infection should be screened for HIV at least once a year.</li> <li>• State and local agencies recommend testing every three to six months.</li> <li>• Things to consider include the frequency that is needed to diagnose HIV early and break the chain of transmission, when is it easy to remember to test, when is it convenient to get tested, what motivates our priority populations to get tested, what are the program implications, what are the psychological implications for clients, and how can we frame messages so that people feel a sense of choice and empowerment.</li> <li>• Options for recommending testing include monthly, every three months, every three to</li> </ul>

	<p>six months, at least once a year, or another interval.</p> <ul style="list-style-type: none"> <li>• Messages that might help promote regular testing include testing when dating someone new or you have a new sex partner, ask for a test whenever you visit a health care provider, get tested if you have a fever, and other messages.</li> <li>• Nearly 3/4 of sexually active MSM receiving HIV care in Oregon reported discussing their HIV status with all sex partners in the past 12 months before having sex for the first time.</li> <li>• Disclosure can be challenging due to stigma, social norms, fear of rejections, the feeling that it's not ones' responsibility, or indirect communication.</li> <li>• Encouraging disclosure has the potential benefits of encouragement of disclosure from partners, helps inform decisions about risk reduction, and starts a conversation about sexual health.</li> <li>• Serosorting is an attempt to limit unprotected sex to partners with the same HIV status.</li> <li>• Serosorting is occurring through HIV testing, direct communication, indirect communication, and assumptions.</li> <li>• Concerns for PLWH around those who serosort include the risk of STI infection, the risk of a super infection, risk of HIV transmission to partners due to incorrect assumptions about partners' HIV status</li> <li>• Concerns for HIV-negative persons who serosort include risk of HIV infection and/or the risk of STI infection.</li> </ul>
<p><b>Transportation Assistance in Eastern Oregon</b></p>	<ul style="list-style-type: none"> <li>• The goal is to reduce reported transportation barriers among Ryan White clients by 2015 to access medical providers, pharmacies, mental health therapy, substance abuse treatment and oral health services.</li> <li>• Identified barriers include the approval and reimbursement process, lack of appropriate transportation vendors in each community, and increased case management time needed to assist clients.</li> <li>• Additional project goals include improved access to core medical services among clients living in eastern Oregon, increasing the use of non-Ryan White funded transportation services, and reduce the transportation acuity of participating clients.</li> <li>• Project activities include an assessment of transportation service availability and gaps, coordinate with 211, HIV/AIDS Hotline, and other resources to ensure inclusion of transportation services that are identified, develop community-based partnerships to</li> </ul>

	<p>address needs throughout the region, and develop individualized plans for clients needing assistance accessing core medical services.</p> <ul style="list-style-type: none"><li>• Eligibility requirements include enrollment in EOCIL case management services, current barriers in accessing core medical services, and have a transportation acuity assessed at 3 or 4.</li><li>• Evaluation of the project will answer questions such as whether the need for transportation was met, has the proportion of transportation acuity 3 and 4 clients decreased, have options for medical transportation expanded, whether the clients like the service, as well as successes and challenges.</li></ul>
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