

# IPG Meeting Notes

July 10, 2019, 9:00 a.m. – 3:15 p.m.

800 NE Oregon St., Portland, OR 97232, Room 1B

## Announcements

The Part A Ryan White Program will soon be making funding decisions for the coming year. If you have input or ideas, please share with Amanda.

## Public comment

There was no public comment.

## Stigma

Stigma can involve prejudice and discrimination directed at people living with HIV (PLWH).

- It can occur at the structural, community, institutional, interpersonal, and intrapersonal (internalized) levels.
- HIV stigma intersects with stigma that encompasses other identities (e.g., racial/ethnic, sexual orientation, gender).
- HIV stigma can negatively impact:
  - HIV prevention behaviors (e.g., testing, risk taking)
  - Mental health
  - Medication adherence
  - Health
  - Health disparities

Data from the Medical Monitoring Project (MMP) in Oregon were collected from PLWH (2015-2017). Findings include:

- 1/4 to 1/2 of participants reported stigma-related experiences, such as feeling hurt or losing friends due to disclosing their HIV status.
- 3/4 are very careful who they tell they have HIV.
- 1/5 feel they are not as good as others because they have HIV.
- Social determinants of health (e.g., low income, unstable housing) and poor mental health were associated with increased stigma.

Since stigma occurs on various levels, interventions should use multiple approaches. Examples may include:



- Education (e.g., U=U marketing campaigns)
- Counseling/social support
- Coping skills building/promoting resilience
- Contact with stigmatized individuals
- Biomedical and structural interventions (e.g., healthcare access and normalization)

#### Discussion:

- Have new HIV drugs helped reduce HIV stigma? We don't have data to answer that question.
- What does stigma look like in other states, and how does Oregon compare?
  - There are not a lot of studies examining stigma and viral suppression.
  - A study did find that perceptions of discrimination can impact access to care. Dayna can share the study.
  - Oregon has added questions to the MMP study on social support, isolation, and other related topics. Data will continue to be analyzed and shared.
- What is the most common source of stigma in Oregon (e.g., interpersonal, structural)?
  - The analysis did not explore that question, but it would be interesting to do so! The analysis focused on perceptions of stigma.
- The AETC provided training to two clinics with low HIV screening rates. The results suggest stigma training can be impactful.
  - One clinic received training on HIV screening practices. Screening increased, then went back down.
  - One clinic received training on HIV stigma and bias, which included a secondary focus on the End HIV Oregon goals. Screening rates increased and remained high.
- Many people don't realize HIV is still a problem, and more public education campaigns would be helpful.
- Many people in Latinx communities don't know about PrEP and PEP and perceive HIV as only affecting gay people.
- It was encouraging to see Dr. Menza's email highlighting the relationship between methamphetamine use, stigma, and HIV. With methamphetamine, micro-aggressions from providers can feel like macro-aggressions.

## Undetectable = Untransmittable (U=U)

Multiple studies have shown that HIV treatment is prevention. As a result, HIV campaigns have evolved. While messages about deciding not to transmit HIV used to be commonplace, newer campaigns are sharing messages about not being able to transmit HIV with antiretroviral therapy.

#### Background:

- In 2016, a group of researchers and consumers released a consensus statement stating people living with HIV who take daily ART and have an undetectable viral load cannot



transmit HIV. This finding has held true with heterosexuals and gay, bisexual and other men who have sex with men. U=U does not apply to needle sharing. More research is needed.

- Viral “blips” have not been shown to increase HIV transmission.
- An STI can increase the risk of HIV transmission if a partner has a detectable viral load, but it does not pose a significant risk of HIV transmission if the partner is undetectable.
- An activist group came up with a third U: “unequal,” which calls for universal access to health care.
- U=U is a powerful tool to reduce stigma and yields many psychological benefits (e.g., reduced fear of transmission).
- To date, OHA has used language about HIV transmission that mirrors that used by federal partners (e.g., HIV-positive people with an undetectable viral load have effectively no risk of transmitting HIV to sexual partners).
- Thirteen state health departments and 23 city/county health departments have endorsed U=U.
- For Oregon, endorsing U=U would mean:
  - Updating OHA program materials
  - Incorporating U=U messaging into future End HIV Oregon communications
  - Encouraging End HIV Oregon partners to sign on as U=U community partners
- If there is an affirmative IPG vote today, the HIV/STD/TB Section will present the letter of endorsement to OHA’s public health director.

#### Discussion:

- Does U=U apply to breastfeeding? We do not have a definitive answer.
  - It’s difficult to research, and viral blips can be more unpredictable in pregnant women. Often, babies with HIV-positive mothers are on PrEP.
  - The caveats about mother-to-child transmission are important, but only relevant to a small population in Oregon. The U=U message is important for so many people in the state, both HIV-positive and HIV-negative.
- How do you suggest we discuss U=U in regards to injection drug use?
  - Discuss U=U as one prevention tool that can be used in combination with other tools available (e.g., sterile injection equipment).
- Some doctors in Oregon still do not subscribe to U=U.
- U=U is one of the most powerful prevention messages there is and should be known in communities.
- The Oregon AETC has been incorporating U=U messaging.

#### Decisions:

- All 22 voting IPG members present voted to endorse U=U.



## New HIV cases in Multnomah County

In the last 18 months, there has been an increase in the number of cases of HIV infection among people who use methamphetamine and inject drugs in Multnomah County. Some notable features of the cases diagnosed with HIV include:

- Almost 90% reported using methamphetamine alone or in combination with opioids; non-injection use of methamphetamine was very common.
- Many cases had been diagnosed with syphilis or hepatitis C infection prior to their HIV diagnosis.
- Many of the women diagnosed with HIV reported that they had had a sex partner who they knew to be living with HIV; only one reported ever taking pre-exposure prophylaxis, PrEP, a daily medication proven to prevent HIV infection.
- Almost 70% of the men who inject drugs newly diagnosed with HIV also reported sex with men.
- Over 60% reported unstable housing.
- Forty percent of new diagnoses among people who inject drugs were made at one of several different hospitals in the county.

Multnomah County is working with OHA and regional partners to raise awareness of the need for testing, needle exchange, PrEP, and partner notification. Staff are encouraging peer-to-peer education among people who use methamphetamine, people who inject drugs, men who have sex with men, and partners of these populations.

## Viral Suppression Support

Part A's viral suppression support plan is now being implemented in the TGA (transitional grant area), which covers 6 counties surrounding Multnomah.

- The plan is a systematic approach to conducting outreach with people who are out of care or not virally suppressed. It involves a number of community partners and has the goal of helping PLWH achieve viral suppression.
- The plan uses CAREWare data, imported from ORPHEUS and involves data sharing among service providers (only when they have a shared client).
- In 2018, 95% of the people receiving Ryan White Part A services have received a viral lab in the past year. The viral suppression rate is now 90%! The focus is now on the remaining 10% and addressing disparities in race, gender, age, HIV risk factor, housing status, and income.



- In the Part A service area, the time from diagnosis to viral suppression has been reduced from approximately 90 days to 30 days.
- The plan involves client follow up by many different people, including medical providers, medical case managers, housing case managers, and disease Intervention specialists.
- Part A is now evaluating year 1 of plan's implementation, which will inform efforts to further improve.
- How does the plan deal with clients who cannot prove income or are uninsurable?
  - Clients can self-certify their income if not formally employed.
  - CAREAssist has programs to support uninsured clients. If there are barriers, OHA would like to learn more.

## Food security

### Food insecurity among Oregonians:

- About 6% Oregonians report hunger, defined as skipping meals or eating too little because of an inability to obtain enough affordable food.
- Oregon was the only state in the nation with a statistically significant increase in food insecurity between 2010-2012 and 2013-2015.
- Rates are now decreasing, but more slowly than in other parts of the nation.

### Food insecurity among low-income Oregonians:

- Among low-income households in Oregon, approximately 1 in 3 (32%) were food insecure in 2016, compared to the national average of 1 in 8 (12%).

### Food insecurity among Oregonians living with HIV:

- Oregon MMP data (2017) show that 16% of people living with HIV (PLWH) in Oregon reported being hungry, but didn't eat because there wasn't enough money for food.
- Local MMP questions from 2015-2016 found that 1/3 (36%) of participants reported food didn't last and they couldn't afford to eat balanced meals.
- PLWH who reported food insecurity were significantly less likely to be durably virally suppressed (48% vs. 63%).
- Food insecurity was higher among heterosexuals and those with less than a college degree.
- Food insecurity was associated with not taking antiretroviral therapy, smoking and drug use, anxiety and depression, and other social determinants of health.

### Discussion:

- Resources for folks include:
  - CAREAssist
  - Case managers
  - HIV day center meal delivery



- EBT shoppers. Fred Meyer has been known to accommodate volunteer groups after hours.
- Oregon State University [Student Health Services](#).
- Meal delivery services, such [Store to Door](#) (Portland area).
- [Aging and Disability Resource Center resource list](#)
- Ideas for potential solutions include:
  - Education on how to eat well with limited money (e.g., recipes)
  - Education about resources available
  - Enhanced training and capacity building at food banks on how to be welcoming to PLWHA and how to understand their nutritional needs
  - Training case managers on how to shop at food banks
  - Sending mail-order food with mail-order medications through CAREAssist
  - Linking directly observed therapy with points for purchasing food
  - Food and meal delivery for people who are unable to cook
  - Partnerships with farmers' markets
  - Nutrition and cooking classes
  - Using Oregon Reminders to find the closest food bank
  - Co-locating food banks and farmers markets with pharmacies or clinics serving PLWH
  - Leveraging potential opportunities for donated day-old or “imperfect” food items from grocery stores and restaurants
  - Culturally relevant (e.g., Asian, Latin American) food options. Ask PLWH what kind of food or resources they need.
- People interested in collaborating to further address food insecurity:
  - Toni, James, Tony, Amanda, Jorge, and Joanne