Announcements

- Please welcome Michael as the new IPG community co-chair!

Viral suppression in Oregon

Presentation: The Epidemiology of Viral Suppression in Oregon

We're making progress.
- The proportion of people living with HIV (PLWH) in Oregon who are linked to care within 30 days of diagnosis has increased from 67% in 2016 to 87% in 2019. We are close to our 2022 goal of 90%.
- Of the 7,504 people in Oregon who have been diagnosed with HIV, 83% are virally suppressed. In addition, the proportion of people who are virally suppressed within 3 months and within 12 months of diagnosis have been increasing since 2012.

There's work to do to improve health equity.
- Populations of PLWH with a lower proportion of people linked to care (less than 87%) within 30 days in 2019 include:
  - Black men who have sex with men (69%)
  - Men who inject drugs (73%)
  - Latino/a/x people (74%)
  - Black/African American people (78%)
- Populations of PLWH with lower rates of viral suppression (less than 82%) include:
  - Transgender men (50%)
  - Transgender women (74%)
  - Native Hawaiian/Pacific Islanders (68%)
  - American Indian/Alaska Natives (72%)
  - People who inject drugs (73%)
  - Men who have sex with men and inject drugs (75%)
  - Multi-racial persons (73%)
  - Black/African American people (75%)
  - Latino/a/x people who are U.S. born (80%)
  - PLWH in frontier (77%) and rural (79%) areas
- Oregon’s Medical Monitoring Program found that PLWH less likely to be durably viral suppressed include people experiencing:
Houselessness (63% virally suppressed)
- Food insecurity (67%)
- Gaps in insurance (68%)
- Poverty (74%)

Has COVID impacted HIV care?
The proportion of PLWH without a viral load test increased from 8% in 2019 to 12% in 2020.

Discussion
- Do we have data about viral suppression among people engaging in transactional sex?
  - The following data were researched and included after the meeting:
    - **Orpheus data**: As of 12/31/2020, there were 8,154 PLWH in Oregon. The majority (86%) of cases were missing transactional sex information.
      - 9% (87/990) cases reported sex for drugs or money (among those responding Yes/No and reported being in care).
      - 91% (819/903) of those reporting NOT exchanging sex for drugs or money were known to be suppressed on their last result in 2020.
      - 79% (69/87) of those reporting sex for drugs or money were known to be suppressed on their last result in 2020 (statistically lower than those reporting not exchanging sex for drugs/money, P = .0008)
      - ~86% of cases were missing transactional sex information.
    - **Oregon HIV Medical Monitoring Project (MMP) data (2015-2018)**: Among PLWH in the MMP sample:
      - 4% reported having transactional sex (sex in exchange for things like food, shelter, transportation, money, or drugs.)
      - Among participants NOT engaging in transactional sex, 88% were virally suppressed.
      - Among participants who had transactional sex, 82% were virally suppressed (these were not statistically different, P = 0.5126).
      - Data on transactional sex was missing among 43% of participants because they skipped out of the question due to not having any sexual partners.

- Are any sites offering both HIV and COVID testing?
  - HIV Alliance offers COVID testing at syringe exchange sites in Lane, Marion, Douglas and Josephine and is working on pairing vaccine clinics with those efforts. HIV Alliance offers HIV, Hepatitis C and syphilis rapid testing at each of these sites and offers STI testing in Lane and Douglas Counties. COVID testing is available to all clients and to potential clients. Staff saw limited uptake for COVID testing, but the demand has doubled since incentives have been offered.
Panel presentation

What has helped you be successful with HIV treatment?

- Panelist 1: Choosing to accept treatment and having support. As a heterosexual cisgender woman of color, support can be difficult to find.
- Panelist 2: Understanding how HIV medications work and the consequences of not taking them. I use a weekly pill box to stay on track. I keep appointments with my HIV doctor. I support myself with positive people (both people with HIV and people with a positive attitude).
- Panelist 3: I want to live and to live a good life. I have a supportive family.

What barriers have you faced and how did you handle them?

- Panelist 1: My medical files were breached and shared. I handle challenges by surrounding myself with supportive people and advocates.
- Panelist 2: Health care professionals: When I received a positive result, I was told not to worry. I was told it must be a false positive. I asked for a viral load test immediately and got on treatment quickly. My self-imposed stigma was also a barrier. Part of me wanted to hide.
- Panelist 3: Stigma (including fear of disclosure), dealing with loss, health care providers with limited knowledge of HIV, and needing to travel to Portland for care. The U=U message helped tremendously; it allowed me to open up to others.

What’s the most important thing we can do to make viral suppression a reality for everyone?

- Panelist 1: Education: so many people still don’t know about U=U and view HIV as a death sentence. Education is key to combating stigma.
- Panelist 2: Reducing stigma and engaging people involved in alternative economies (e.g., sex workers).
- Panelist 3: The U=U message. We need an aggressive U=U campaign that reaches PLWH and people who are HIV-negative alike.

Social Determinants of Health

The IPG plays a pivotal role in shaping Oregon’s 5-year Integrated Plan for addressing HIV. Our updated plan will be due to federal funding agencies in 2022. Thank you to those of you who participated in the IPG anti-racism training. We recognize that factors such as racism and homophobia create social determinants of health and health disparities. In our breakout groups, we’re going to try using a new racial equity tool recommended by OHA’s Office of Equity and Inclusion. Food insecurity is less complex than some other social determinants of health, so we want to start by discussing this issue. This will also help OHA build upon the work to address food security that has already occurred. Big thank you to our VISTA Volunteer, Savannah New, who spent 2020-21 with us doing a preliminary assessment of food insecurity among PLWH as her VISTA project.
Food security (breakout group discussions)

Each breakout group discussed a different strategy for improving food security.

Group 1: Allocate more money for food cards

Data questions:
- Who is food insecure and what are their needs?
- What amount of assistance is needed to ensure someone isn't food insecure?
- Do persons know how to prepare food? If not, what options are provided?
- What do clients think of food cards?
- What other sources have available and are we using them?

Are we reaching the right people?
- What do people need to eat to stay healthy in their own culture/community?
  - Are food cards purchased at stores that provide culturally appropriate food options?
  - Are we supporting local businesses (probably not, most are purchasing cards at big box stores)?
  - Are we using farmers markets?
- How useful are cards for unhoused folks?
  - They may not have access to traditional ways of cooking.
  - $30 doesn't go very far for prepared foods, even for housed folks.
- What else would be helpful if this resource isn't helpful?
  - Use CARES funding for gift cards to Dollar Tree or Goodwill (Think about where the gaps are).
  - Gift cards for laundry services
  - Don't question how people use the assistance; it results in shame.

If we increased/or enhanced eligibility/services, what would happen? Who is at an advantage? Who is at a disadvantage? Who are we missing?
- Food cards are a good engagement tool for clients who face more barriers.
- Rural clients may have a harder time finding big box stores (except Dollar Tree) and access to healthy foods.
- Persons who need other supports indirectly related to food (stove, cooking supplies, transportation).
- Provided food card amounts need to consider the whole family/size of household, not just the Ryan White client.
- Currently there is low utilization of SNAP assistance – low access, funds of last resort. How can we increase knowledge and use of SNAP?
- Potentially CBOs could buy food in bulk for distribution.
What are other opportunities to provide access in a different way. Messaging or services/food through:

- Not everyone is in a Ryan White program. We can’t provide financial assistance if Ryan White eligibility is not up to date.
- ID/MD providers
- Mental health providers
- Dental program

Unintended Consequences:

- Cards are more of a band aid service, last resort, they are not a sustainable source of food services that lessens a person’s concern or worry about food ongoing.
- Part A and B use of food cards is different. Consider equity in solutions across the State.

Group 2: Partner with food banks to increase/adapt services

How prevalent is the problem and who is most affected? How do we identify people facing people with food insecurity? Could CAREAssist help identify people? Use the data to work in a very targeted way to address gaps through addressing existing services the populations – get as granular as possible with the data. Find out about the related barriers and issues (e.g., transportation= huge, related gap).

How can we engage people most affected by food insecurity & by this potential strategy?

- Reach people individually – community outreach, ask people!
- Peers – like PRIME Plus, other peer programs, CHWs, etc.

What are the implications of race/ethnicity? What other intersectional identities should we consider?

- Again, see data: Are some groups more affected than others? What cultural issues are at play?
- Level of respect—not offering “just any” food, having a wide variety of food available, shopping style food banks.
- Rurality is an issue: Some regions have poor food choices—lots of carbs, sweets, etc. Agencies can focus on augmenting food bank choices to ensure fruits & vegetables, culturally-specific foods.
- Houseless clients can’t cook, may live in motel rooms, and need food that makes sense for their situation.

Strategies & impact vs. intent:
• Distribute food in multiple ways to improve access: through case managers, food at agencies (grab & go model), homeless outreach. Take food to clients at outreach events.
• HIV Alliance has a community kitchen.
• Have resources & information, know the resources, have everyone who has client contact know them.
• CBOs create community: have gardens/garden boxes, food banks, meals to eat together
• Engaging people who are lower-income and don’t have cars is a challenge. Rural areas have more access issues.
• One food bank has a rule that they aren’t giving food unless the person has a car.
• Many PWID have good days and bad days. Some might miss out if they can’t keep appointments or a schedule to follow through with pick-ups.
• We need to work with existing systems to make sure people are using resources that are available (e.g., Oregon Food Bank Food Finder).

**Group 3: Screening and services in clinics and/or case management sites**

Many PLWH are receiving services in clinics and case management sites, so screening or offering services in care settings could help reach PLWH in Oregon.

**What kind of data would we want?**
- The scope of the need for food services
- Context and causes of their food security
- Housing needs among people with food insecurity
- What type of foods are needed and helpful (e.g., can clients prepare the foods?)
- What types of food services are available - and when?
- Do clients need transportation to access food services?
- How frequently are clients with food insecurity seeking in-person HIV care services?

**How can we reach people most impacted by food insecurity?**
- There is stigma around asking for help. We should approach the topic with sensitivity.
- Some people are so accustomed to food insecurity that they may not even view it as a problem.
- Make food available to everyone, without screening. Having food can free up funds to pay for other important items.
- Integrate food services with efforts to re-engage clients in care.

**If we are going to scale up screening and offer more food services, what would be needed?**
- Funding to purchase food and gift cards and staff time to deliver them to clients.
Group 4: Meals: congregate, home-delivered, and/or medically-tailored

What do the data tell us?
- What kind of data do we need to make this decision?
  - Science, nutritional and medical statistics.
  - Medical Providers.
  - We know that nutrition plays an important role in PLWH. Many medications are required to be taken with food. Science is fact.

Community engagement:
- How can we engage people most affected by food insecurity & by this potential strategy?
  - Many do not want to admit food insecurity due to embarrassment. Many say they are eating and have food, but it is not nutritional food.
  - Expand congregate meal delivery.
- What are the implications of race/ethnicity? What other intersectional identities should we consider?
  - Enlisting community support, such as doctors and churches.
  - Offer more cultural food options.
  - Use a rotating culturally competent menu.

Analysis & Strategies:
- Who will benefit (or benefit most) from this strategy?
  - PLWH
  - Lower income
  - Houseless
  - Single people
- Who will be burdened or might miss out because of access problems, etc.?
  - Rural folks
  - People for whom English is not their first language
  - People experiencing houselessness
  - People that may not be engaged in their community
- What unintended consequences should we consider? (think about impact vs. intent)
  - Not being able to reach everyone.
- How can we mitigate the consequences?
  - Food cards, which can be helpful for people in rural areas and people experiencing houselessness.
- How can we advance racial equity and/or eliminate racial, ethnic, and other disparities?
  - Have conversations with the community, not just IPG.
  - Talk with people that are facing food insecurity.
COVID-19 Discussion

What have organizations in Oregon been doing to address COVID-19?

- Partnership Project: Our work to get folks vaccinated has been a challenge. The Johnson & Johnson vaccine news created a lot of fear, especially among folks who were already hesitant, which includes members of communities of color. We have a vaccine clinic for the transgender population in connection with National Transgender HIV Testing Day.

- HIV Alliance: We moved our PrEP/STI clinic to a telehealth model. There has been increased stress among staff and clients. We initiated COVID testing at our syringe exchange sites and have offered vaccine clinics that include HIV testing.

- Eastern Oregon Center for Independent Living (EOCIL): We have been holding COVID-19 clinics and are in the process of creating a food pantry for folks impacted by COVID-19.

- OHA: The state is funding more than 170 organizations to provide contact tracing and other services. OHA's Vaccine Operations Team - Equity (VOTE) is responsible for coordinating vaccine clinics around the state in partnership with local organizations. The state is hosting community engagement sessions and providing information to help increase vaccine confidence.

Please use and share the flyers and information on this OHA page!

Public comment

One guest who provided public comment. The guest voiced concerns about: the state’s collection of CD4 data and its use to assess clinical outcomes; people being misdiagnosed with HIV; pharmaceutical companies profiting from efforts to improve viral suppression rates; side effects of antiretroviral medication; and U=U messaging. The guest urged Oregon to stop focusing on viral suppression as a strategy to address HIV.