



Meeting Minutes

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



FULL MEMBERSHIP MEETING

Date: June 25, 2014

Number of voting members present: 23

Number of others/non-voting members present: 6

Number of guests present: 5

Agenda Item/Topic	Key Themes in Discussion
Introduction	<ul style="list-style-type: none">• Four new members have joined since the March full meeting. Thank you to everyone for getting the word about about the IPG.• We have a combined listserv that everyone should be on. The purpose of this is to send out information to all partners and stakeholders throughout Oregon. It is encouraged to communicate. Two messages, on average, are sent out each week.• Please be mindful about using technical terms while presenting or talking about a topic.• CDC has notified the Oregon HIV Prevention Program that a Jurisdictional Plan will be due. In previous years, OHA staff developed the plan with opportunities for feedback from IPG. The report aligns closely with the Implementation Plan that was developed. Last year, a two-page document was developed. This will probably be the case this year. The document will be sent out to IPG for feedback. It is due in September. In 2015, the IPG will be involved with requirements from HRSA and CDC. This will probably be the last year for an update. Oregon has an advantage in that the IPG exists and can provide input for both documents.
Announcements	<ul style="list-style-type: none">• The membership committee is continuing even though other committees have gone away. The Executive committee came up some new language for the policies and procedures to enact a new way of getting IPG members involved in the committee. Terms would be for a six-month period. The committee would consist of seven members. Three members were selected.• Hepatitis C is being recognized nationally. More conversations are occurring due to different drug therapies and the lack of access to these treatment options.• CDC had a meeting last week around Viral Hepatitis in the nation. This meeting was also a

	<p>webcast. This is available for viewing.</p> <ul style="list-style-type: none"> • This Friday, June 27, is the National HIV Testing Day. CAP will be providing testing both at their offices and at PIVOT. Tests will be offered from 10:00am – 7:00pm on Friday, June 27 • On Saturday, June 27, a mid-valley AIDS walk is scheduled. It is to support mid-valley services. The AIDS Walk Portland site is up and running. The AIDS Walk will take place on Saturday, September 6. People can register online at aidswalkportland.org. A team can be developed or registrants can join an existing team. • A new director has been selected for Cascade AIDS Project. Tyler Termeer will start July 16th. • CAREAssist has been sending out letters regarding the changes that would impact their subsidy. Posters are being made which will be placed at clinics and offices. A Part B Client training is being piloted online. Topics will include liver health, nutrition, managing stress, and understanding medication. Fliers will be sent out. A phone-based support group is also being piloted which is in response to unmet need for social support. The project will last six weeks and will only be able to have 5 people. Information will be sent out to clients who are under the county model for now.
<p>Membership Update: Who's Here? Who's Not?</p>	<ul style="list-style-type: none"> • An entire year was spent working on the demographic makeup of the committee. • On the membership graph that is posted online, there is a number, then a dash, then another number. • The first number represents the goal to reach. The second number indicates how many people the committee actually has. • The categories come from requirements of either CDC, Ryan White Part B, or both. • A list is available that shows what categories need membership. • A standard letter is also on the website. This document consists of an overview of the committee. • Once new members have been accepted into the committee, mentoring these new members are encouraged. • Anyone on the committee who is a consumer must be willing to state publicly that they are HIV positive. • Consider having the membership committee provide information on the proportion of people coming from those counties. This would include breaking it down by county.
<p>Sexual Health of Gay, Bisexual, and Other MSM</p> <ul style="list-style-type: none"> • Regional MSM Summit Report-back 	<ul style="list-style-type: none"> • There was a meeting held in Seattle which included attendees from Washington, Oregon, and California. The goal of the meeting was to develop a blueprint for sexual health among gay men. • In Oregon, MSM accounts for 71% of HIV diagnoses in recent years. • Nationally, men who have sex with men (MSM) is the only group for which new HIV infections are increasing. In Oregon, more than 1/3 are diagnosed late in the disease. This means that they are diagnosed as having AIDS within 12 months of their diagnosis. • Sex without condoms has increased. Nationally in major US cities, there was an increase of 48%

<ul style="list-style-type: none"> • Findings from Interviews about Syphilis 	<p>in 2005 to 57% in 2011. It is believed this is related to serosorint. This means that people are choosing their partners based on whether they are positive or not.</p> <ul style="list-style-type: none"> • One of the presentations dealt with positive messaging around gay men and sex. • Another presentation was about Pre-Exposure Prophylaxis (PrEP). • The investigations of early syphilis included a Rapid Ethnographic Assessments, case-control studies, and chart reviews of provider practices. • The Rapid Ethnographic Assessment took place between January 27 – 31, 2014. The assessment was done using teams of two who conducted semi-structured interviews. Those interviewed came from the Multnomah County STD program and Cascade AIDS Project (CAP). • 54 interviews were conducted. Of those 19 were men who have sex with men (MSM), 13 were providers, and 22 were key informants. • The key findings included a high prevalence of unprotected sex, Methamphetamine use, anonymous partners through social media, knowledge gaps, and a lack of concern about STD's other than HIV. • The Case-Controlled Studies occurred between February and May, 2014. The objective was to use specific websites or apps to meet sexual partners. The questions took 15 – 20 minutes and were done using an I-Pad. • Participants in the case studies included residents of Multnomah county, those over the age of 18, MSM, and they had syphilis for all of 2013. • Participants in the control studies included residents of Multnomah county, MSM who have been sexually active in the previous three months, over the age of 18, have not had early syphilis in the last two years, and and were matched 2 – 1 by HIV status and age group. • Participants were recruited from the Medical Monitoring Project, Multnomah county, Fanno Creek Clinic, and Legacy Health. • For methamphetamine use and early syphilis, case studies were 26.3% and control cases were 15.7%. • In online media associated with early syphilis, case studies were at 70.2% while control studies were at 42%. • In addition to looking at overall online behavior as a risk factor for early syphilis, we also asked participants about use of 14 specific social media sites for meeting sexual partners. Of the 14 asked about, only four were significantly associated with early syphilis when adjusted for HIV status and age group. • Currently 188 interviews have been completed of 64 cases and 124 controls. Four cases and 4 controls were excluded because they did not report sexual activity in the time period asked about in the survey. It was also discovered that one control had a recent diagnosis of syphilis. Finally, in
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<p>Brainstorming Next Steps</p>	<p>May recruitment began for monolingual Spanish-speakers. There were 5 cases noted to be monolingual Spanish-speakers. Thus far, three monolingual Spanish-speaking cases have been interviewed, one refused to be interviewed, and one will be interviewed next week. Their data have not yet been included in the analysis. Study enrollment will end once interviews are completed for the last monolingual Spanish-speaking case and an appropriate number of controls.</p> <ul style="list-style-type: none"> • There was no significant difference between cases and controls with regards to age, HIV status, ethnicity, race, education level achieved, or employment status. • There was no significant difference between cases and controls with respect to participating in unprotected oral or anal sex. • In addition to looking at overall online behavior as a risk factor for early syphilis, participants were asked about use of 14 specific social media sites for meeting sexual partners. Of the 14 asked about, only four were significantly associated with early syphilis when adjusted for HIV status and age group. They are Adam4Adam, BBRT, Scruff, and Grindr. The association between the use of any online website or app to meet sexual partners and early syphilis infection remained significant when controlling for education level, income, and race in addition to HIV status and age group. However, only two of the four specific websites, Adam4Adam and BBRT, continued to have a significant association with early syphilis infection in the multivariate analysis. When adding number of sexual partners to the multivariate model, the use of any online website or app to meet sexual partners was no longer significant. • Many survey participants used online websites/apps to meet sexual partners – 70% of cases and 42% of controls • Social media was not statistically significant for early syphilis risk, after controlling for number of sexual partners. This suggests that online activities mediate or facilitate meeting sexual partners; further analyses are needed to better characterize this relationship. • These results are preliminary, monolingual Spanish speakers are still being enrolled. The goal is to have final results by the end of the summer. • Need to think about the kind of messaging that needs to be developed. It should be based on epidemiology. • Other messaging needs to address those with recurring infections. • Consider what has been done in the past. Epidemics come and go in cycles. • The subject of testing in medical settings do not come up unless there is a major medical event. Consider reaching out to the Health Transformation Center. • Some people do not trust their provider. Educating the community may be needed to encourage testing. • Consider developing a palm card that includes where people can get tested.
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<p>Pre-Exposure Prophylaxis (PrEP)</p>	<ul style="list-style-type: none"> • Resources need to be located that are long-term or permanent. • In HIV PrEP, an uninfected person takes HIV antiretroviral medication(s) before potential exposure. • Providing a medication as prophylaxis against an infectious disease is well established. • Biomedical interventions include the prevention of perinatal HIV transmission with the use of HIV medication, occupational and non-occupational post exposure prophylaxis for HIV (PEP / nPEP), and pre-exposure prophylaxis for HIV (PrEP). • Tools to help prevent HIV include condoms and safer sex supplies, behavioral interventions, testing for HIV and STDs, education, mental health and substance abuse counseling, structural interventions, addressing social determinants of health, and biomedical interventions (PrEP and nPEP). • For every infection averted, an estimated \$335,000 is saved in HIV lifetime care. • Six phase three prevention trials involving PrEP have been done over the last several years. Four of the trials were successful while two were not due to futility. • Results of the clinical trials found that drugs are well tolerated and are highly effective when taken on a regular basis, there are minimal drug resistance concerns, and differences occur in drug concentrations in mucosal tissue. • Truvada is a combination of two drugs used to treat HIV infection. The Federal Drug Administration (FDA) approved the use of Truvada for PrEP in 2012. This can only be used by persons who are confirmed to be HIV negative prior to prescribing and at least every three months during use. • New federal guidelines recommend PrEP be considered for people who are HIV-negative and at substantial risk for acquiring HIV. • While not approved by the FDA for I.V. Drug Users (IDU's), The Centers for Disease Control & Prevention (CDC) recommends that providers use these same guidelines as many IDU's engage in high-risk sexual behavior. • In paying for PrEP, some insurance companies are covering Truvada for PrEP while others will only cover treatment for one year. Patient assistance & co-pay cards may be available through Gilead. • During an Infectious Disease Conference in 2013, the majority of HIV specialists were willing to prescribe PrEP - particularly to those in serodiscordant relationships. There are concerns about drug toxicity and risk compensation. Providers with a negative view of PrEP tend to prefer behavioral interventions for high-risk individuals. • Providers were surveyed on their comfort levels of PrEP. While there was a majority of support for PrEP, very few have actually prescribed it. Primary concerns included adherence and resistance, cost and reimbursement, unease on the use of medications in otherwise healthy people, and
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	<p>questions on what constitutes ongoing high risk for HIV infection.</p> <ul style="list-style-type: none"> • The infectious disease HIV clinic is not the ideal setting for PrEP. Primary care providers need training and education. • Obstacles to community interest in PrEP include finding a provider who is open to prescribing and encountering stigma / shaming from providers opposed to PrEP. • The long-term strategy includes the use of PrEP for seasons of risk. It is not sustainable to keep people on PrEP for a lifetime. Behavioral change needs to be initiated over time. • What is next include injectable PrEP and studies on intermittent / on-demand PrEP.
<p>CareAssist Update</p>	<ul style="list-style-type: none"> • Funding comes from the Ryan White – Part B grant. • The first Annual Data Report was submitted. This is the first time this has been done. All information except the names is submitted. CDC will generate a report for Congress in order to justify funding Oregon through the Ryan White program. • Served 3,400 people during calendar year 2013. • 50% of clients are in the Oregon Health Plan because of the Affordable Care Act. 1,200 people are enrolled in Medicaid. 3,400 clients are in Medicare. 15% are covered by other insurance. • Most of the transition occurred in 2 ½ months. This was a collective effort between CAREAssist and community-based organizations. • Open enrollment is closed. 200 undocumented persons received funding for private policies. The next open enrollment will occur in Fall, 2014. • A new program called the Uninsured Persons Program (UPP) has been developed. A rate of pay has been established with doctors plus 25% so they will take these clients. The program is still evolving. May need to make some modifications. • Procedure codes will also be reviewed. • Putting more drugs in the formulary and additional CPT codes is not a case management process. Physicians need to contact CAREAssist. • A smoking cessation program has been started. In 2005, the program looked into smoking and clients. At the time, 47% were current smokers compared to 25% of the total population of Oregon. Last year, the question was asked again. 42% of clients reported that they smoked compared to 17% of the total population of Oregon. An initiative is being started that clients would receive help to quit smoking through the availability of gum and patches. Oregon Health Plan clients are also eligible. • Anyone who has a change with income will need to report it right away instead of at the time of renewal. • A public service campaign has been developed. • The process has begun with filings of Oregon Administrative Rules. A Rules Advisory Committee

	<p>will meet in two weeks. Once the input process is done, there will be a public hearing. The hearing will be done at the same time as the HIV Community Services Rules Process.</p> <ul style="list-style-type: none"> • One rule relates to the Ryan White Part B case management and the other is related to CAREAssist. The Ryan White rule hearing will be on July 15. A few people from the IPG have been invited. There will be additional opportunities for input before the rule goes into effect. Nothing is changing. • Next year, through the Affordable Care Act, clients will be able to sign up for a dental policy along with their medical policy. Open enrollment is November 15 through February 15, 2015. • Want to strengthen our partnership with the AIDS Education and Training Center (AETC). Will be talking about what we do and what can be done. • CAREAssist will have support for Hepatitis C. Clients would be eligible if they have a co-infection of HIV. 25 people will start with the program. • Current standard is that eligibility for services is determined every six months. There is a possibility that CAREAssist would be a centralized eligibility center. This will allow clients to not duplicate eligibility for different programs. • Thank you to CAREAssist staff for their hard work on transitioning clients to different plans.
<p>Rural Medical Access Project Update</p>	<ul style="list-style-type: none"> • The need has been discussed within IPG for quite a while. It was a challenge for people to get to their doctor and other medical appointments because of transportation challenges. • There is a proposal in process for telehealth. This will be a great way for clients to communicate with their providers. • Twelve counties are involved in this project. • It was good to do in-person interviews because it allows relationship building. • In research transportation, there are a number of different options. Sherman, Wheeler, and Gilliam counties have a system to where if a person needs it, transportation is provided. There is lots of flexibility. In the Baker, Union, Wallowa region, there is a larger transportation network available. Umatilla and Morrow counties have services that are funded from the State of Washington. The Gorge Link services Wasco and Hood River counties. They will be the medical transport for 12 counties including Lake and Hood River. The timeline is scheduled for July 1. Indian tribes in the region have transportation available as well. Transportation from a hospital is available. • CCO's and transportation providers will need to work together. • Cost is a big issue. • Through surveys, all transportation that are available are Americans with Disability Act (ADA) compliant. • All operators have gone through state required training.

	<ul style="list-style-type: none"> • For those who speak Spanish, the service is inconsistent and dependant on whether someone is available that speaks the language. There are other methods in which communication can occur. • Transportation providers are obligated to let people know that they are available. This can be done through the building of relationships between transportation providers. • Community health workers could assist those who would normally go to the emergency room for services and towards urgent care. They can also accompany the client through the appointment and pharmacy process to make sure everything is understood. • A transportation task force has been proposed to address issues.
<p>Equitable Syringe Access</p>	<ul style="list-style-type: none"> • This is something that needs to be included when talking about available services. • The conflict of how people feel about syringe access needs to be addressed. • Half of the cases of Hepatitis C are under the age of 30. • Oregon was the first state to approach sterile syringe access as a public health issue. In 1987, Oregon passed a paraphernalia law that excluded syringes from the list of items that can be classified as such if a person is arrested. • It is legal in Oregon to sell syringes without a prescription and distribute syringes free through exchanges and other mechanisms. • Pharmacies are not required to sell syringes. • Washington reformed their laws between 1999 and 2002. Pharmacies could sell and they would not be held responsible if something happened to the person they sold the syringes to. • Less than 15% of pharmacies surveyed state they have policies in place to sell syringes. Business and safety were the concerns of why these were not being sold. • California has a number of requirements before syringes can be sold. 50% of HIV/IDU cases live in counties where syringe access is legal. • Crime rates did not go up in areas of California where syringe access occurred. • Outreach to pharmacies could be done. Also will need to talk about whether they would provide prescription and/or non-prescription sales. • Will need to find someone who will take on this topic and bring it forward to legislators and policy makers.