

HIV Integrated Planning Group



**STRATEGIC PLANNING FRAMEWORK,
DATA SUMMARY,
AND ROAD MAP FOR TODAY'S MEETING**

**APRIL 18, 2012
SALEM, OREGON**

Strategic Planning Process Review



- **Step 1: Get Organized**
- **Step 2: Take Stock**
 - Review Goals & Strategies, Examine Data, Begin to Identify and Discuss Priority Areas and Potential Action Steps
- **Step 3: Set Direction**
 - Develop the Strategic Plan: Choose Priorities and Flesh out the Action Steps
- **Step 4: Adopt & Refine the Plan**

Step 2: Taking Stock



- **Review Goals of Each Committee**
 - Note relationship to National HIV/AIDS Strategy
- **Analyze Available Data**
 - Review answers to data questions generated by IPG membership
 - Identify data gaps
- **Identify Ways to Address Establish Strategies**
 - Use data to guide discussion around range of action steps

Oregon HIV/AIDS Strategies



- Reduce new HIV infections and co-occurring STI and VH
- Increase access to prevention and care services
- Improve coordination of HIV, STI, and VH care and prevention services
- Reduce HIV-related health disparities

Reducing New Infections



- Intensify prevention efforts in communities where HIV and co-occurring STI and VH is most heavily concentrated.
- Expand targeted efforts to prevent HIV (and co-occurring STI/VH) using a combination of effective, evidence-based approaches.

Reducing New Infections



- Educate all Oregonians about the threat of HIV, VH, and STI and how to prevent them.
- Adopt community-level approaches to reduce HIV and co-occurring STI/VH in high-risk communities.

Increasing Access to Prevention & Care



- Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.
- Take deliberate steps to increase the number and diversity of available providers for clinical care and related services for PLWH and those with co-occurring STI/VH.

Increasing Access to Prevention & Care



- Support HIV+ people living with co-occurring health conditions like VH and STI and those who have challenges meeting their basic needs, such as housing.
- Reduce HIV-related mortality in communities at high risk for HIV infection.

Improve Coordination of Care & Prevention Services



- Increase the coordination of HIV, STI, and VH programs across and between federal, state, territorial, local, and tribal governments, as well as private providers.
- Develop improved mechanisms to monitor and report on progress towards achieving Oregon's goals.
- Reduce stigma and discrimination against PLWH.

Specific Tasks for the Next 3 Meetings



- Meeting 2 (today): Brainstorm wide range of critical issues that need to be addressed to achieve committee strategies.
 - Pie in the sky is OK for today.
 - Identify approaches that exist now as well as those that do not exist.
- Meeting 3 (July): Prioritize areas of focus and action steps to be taken in Oregon.
 - Reality sets in...
- Meeting 4 (October): Finalize action steps, responsibilities, and timelines.
 - Content for IPG Plan should be set at end of Meeting 4.

National/Oregon Benchmarks



- Oregon benchmarks will correspond to NHAS benchmarks: (Examples from NHAS, July 2010)
 - By 2015, lower the annual number of new infections by 25%.
 - By 2015, increase the proportion of newly diagnosed patients linked to clinical care within 3 months of their HIV diagnosis to 85%.
 - By 2015, increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%.

Data Review



**SOME THINGS TO CONSIDER
AS WE DEVELOP OUR ACTION STEPS**

Data Review: Five Key Questions



- Which communities in Oregon are most heavily burdened by HIV, and co-occurring STI and VH?
- What are the strengths and gaps in Oregon's continuum of HIV care and prevention services?
- What interventions and services can be used to meet the needs of the most marginalized and highest risk groups?

Data Review: Five Key Questions



- What are evidence-based approaches to reduce HIV and co-occurring STI and VH?
- What partnerships exist in Oregon to address the identified service and prevention needs and gaps? What partnerships are lacking?



Key Question 1

Some critical issues...

HIV prevalence

*Disproportionate
impact*

Delayed diagnosis

*Engagement with HIV
medical care*

*Co-infection with
STI/VH*

- Which communities in Oregon are most heavily burdened by HIV, and co-occurring STI and VH?

Burden of HIV in Oregon: MSM



- **Men who have sex with men (MSM):**
 - Gay & bi men = 2 – 4% of Oregon's population, but 61% of all new HIV infections in OR.
 - An additional 9% of men report MSM/IDU risk.
 - MSM cases more likely to receive HIV medical care; less likely to have delayed diagnosis.
 - Co-occurring STI is common among HIV+ MSM.
 - ✦ 1 in 5 syphilis cases in Oregon were MSM with HIV.

Black/African American Men & Women



- 2% of Oregon's population and 6% of PLWH.
- New diagnosis rates 3.5 times higher than for whites.
- 1 in 3 Black/African American cases is foreign-born.
- Black/African American men less likely to identify as MSM than white men (59% vs. 72%)
 - More likely to identify as high-risk heterosexual (20% vs. 2%)
- Less likely to be in HIV medical care.

Latinos and Latinas



- 12% of Oregon's population and 11% of PLWH.
 - But new infections are increasing: rates of NEW diagnosis are 1.2 times higher than for non-Hispanic whites.
- About 1 in 3 new HIV cases among Hispanic men report no likely transmission category.
 - Lack of identified risk factor more common among male and female Hispanics.
- More likely to be diagnosed with advanced disease and less likely to be engaged in HIV medical care.

People who Inject Drugs



- Unknown how many people in Oregon inject drugs; 19% of Oregon HIV cases have IDU risk.
 - IDU-related HIV cases have declined substantially since 1997.
- HIV+ people who inject drugs:
 - More likely to have delayed diagnosis
 - Less likely to be engaged in HIV medical care
 - Have shorter survival times
 - Have high rates of HCV co-infection—about 1 in 3 HIV+ male IDU and 1 in 2 HIV+ female IDU are HCV co-infected

“Hidden” Populations



- Some populations may not represent large or disproportionate numbers in the local epidemic, but may merit special attention.
- HIV Statewide Planning Group (SPG) identified 2 “hidden populations” of concern in Oregon:
 - Migrant workers
 - Transgender people
- Both of these groups are diverse.

Migrant Workers



- No prevalence data, but issues identified among Latinos are relevant (e.g., delayed diagnosis, less likely to be in medical care).
- Structural and cultural barriers identified:
 - Language
 - HIV-related stigma
 - Beliefs about health, illness, and masculinity
 - Lack of insurance and financial resources
 - Concerns about documentation status
 - Negative experiences/lack of trust with providers

Transgender People



- National literature shows very high prevalence among trans women (12 – 28%)
 - But most of these studies included samples of trans women engaging in survival sex and sex work.
- Trans men have lower rates (2 – 3%) in 2 needs assessments, but most studies don't include them.
 - Trans MSM may be at particularly high risk (programs in Ontario and San Francisco to explore prevention needs).
- Speak Out survey in Portland found 0% trans respondents HIV+ vs. 18% males, 4% GQ, and <1% female respondents.

Overall Data: Co-Occurring HIV/STI/VH



- Rates of STI much higher among PLWH, particularly male PLWH.
 - Syphilis rates: 116x higher
 - Gonorrhea rates: 450x higher
- Prevalence estimates of HIV/HCV co-infection vary, depending on data source:
 - 7% (Epi Profile) to 11% (CAREAssist) to 21% (MMP)
- 5% of PLWH in Oregon estimated to have HIV/HBV co-infection.



Key Question 2

Some critical issues...

*Access to HIV medical
care*

Access to HIV testing

*Access to other
essential services, like
housing*

- What are the strengths and gaps in Oregon's continuum of HIV care and prevention services?

Access to HIV Medical Care



- Local data indicate that HIV medical care in Oregon fairly accessible once people are ready to access it:
 - 95% of MMP participants* began HIV medical care within 3 months of diagnosis; 5% entered within 12 months.
 - Assessment among newly reported HIV+ Hispanics didn't reveal systemic barriers to testing or to HIV care, once +.
 - Part B assessment in 2011: nearly all participants reported being out of care at some point; barriers mainly individual-level, rather than systemic.

Reasons Given for “Out of Care”



- Reasons given by PLWH in Part B Oregon, 2011:
 - Denial and depression
 - Side effects of HIV medicines/fear of starting ART
 - Alcohol and drug abuse
- Findings consistent with national , scientific literature on why PLWH are out of care.
- 2 main reasons for entering or returning to care:
 - Illness
 - Connected via efforts of concerned family, friend, or other

Who is Out of Care in Oregon?



- About 25% of PLWH/A may be out of care.
- People more likely to have no CD4/VL testing:
 - People with AIDS (vs. HIV)
 - Hispanics, Native Americans, and Black/African Americans (vs. white, non-Hispanics)
 - MSM/IDU or IDU males (vs. MSM only) and IDU females (vs. females w/ heterosexual transmission risk)
 - Rural (vs. urban)
 - Foreign-born (vs. native born)

Housing



- Even among PLWH in medical care, ~1 in 10 report unstable housing.
 - 11% of MMP participants moved more than once in past year.
 - 6% reported past-year homelessness (MMP)
 - 4% reported past-year incarceration (MMP)
 - 13% of CAREAssist clients homeless in past 2 years (2009 data)

Transportation



- About 2 in 3 MMP participants travel 30 minutes or less each way to get to HIV medical care.
 - Distances vary greatly, from 1 – 300 miles each way
 - About 1 in 9 said travel to HIV medical care is difficult: 10% said “somewhat difficult” and 4% said “very difficult”.
- Rural clients report ongoing barriers to staying in HIV medical care because of long distances between home and doctor, dentist, and other providers.
 - Also report stigma and lack of culturally competent providers in local communities.



Key Question 3

Some critical issues...

*People who are HIV+
but don't know status*

Delayed diagnosis

Perceptions of risk

Incarceration

- What interventions and services can be used to meet the needs of the most marginalized and highest risk groups?

Delayed Diagnosis



- About 20% of HIV+ people don't know their HIV status.
 - Knowledge of HIV status correlated with safer behaviors.
- In Oregon, 40% of recent diagnoses were delayed; may provide clues:
 - Hispanics (vs. non-Hispanic whites)
 - Men with IDU or unknown transmission risk (vs. MSM)
 - Rural residence (vs. urban)
 - Older people—age 40+, with relative risk highest among age 60+ (vs. people < age 40)

Why Don't People Test?



- Five recent studies on reasons for delayed diagnosis found people didn't test for HIV because they didn't think they were at risk:
 - Samples included people with delayed diagnoses from NYC, San Francisco, the Southeastern U.S., the UK, and MSM in Seattle.
 - Other barriers were fear of illness and dying, stigma, and beliefs that their behaviors kept them safe.
 - Two studies also looked at access—access to care was not the main cause of delayed diagnosis.

MSM in Portland Area



- 1 in 10 MSM surveyed reported unprotected anal sex with man of opposite or unknown HIV status.
 - High number of casual & anonymous partners
 - Mixing of social and sexual networks
- Lack of communication fueled confusion about HIV status and indecision about condom use.
 - Both HIV+ and HIV- men often believed they were serosorting in the absence of any evidence that they were doing so.
- Highest risk men held personal narratives that let them believe: 1) their behavior was safe or 2) safer sex responsibility of other person

Incarceration, Briefly



- Prevalence among incarcerated about 3x higher than general U.S. population.
 - In 2008, 1.5% of male inmates and 1.9% of female inmates in state or federal prisons were HIV+.
 - Estimated that nationally, about 25% of PLWH cycle in and out of jail or prison each year.
- About 4% of MMP participants reported past-year incarceration.
- Incarceration is disruptive: HIV treatment, insurance, housing, employment, social relationships...
 - Re-entry can be dangerous and stressful time.



Key Question 4

Some critical issues...

Syringe exchange

Outreach models

*Interventions
addressing stigma*

- What are evidence-based approaches to reduce HIV and co-occurring STI and VH?

Syringe Exchange



- Many studies show that access to clean needles is key:
 - Includes policies that promote wider distribution, secondary exchange, peer outreach models
- Clean syringes available through Oregon pharmacies:
 - Barriers exist, including pharmacist refusal to sell without prescription, cost/packaging, stigma/fear
- Syringe exchange programs may serve different populations of PWID:
 - Studies indicate that PWID who don't use SEP may have riskier behaviors.

Outreach Models



- Shown to increase engagement and retention in HIV medical care.
 - Labor-intensive, many are costly.
- Peer-based programs show promise for improving access to care, as well as for promoting HIV prevention among PWID.
 - Can be administratively complex, costly, may require shift in thinking/political acceptance.

HIV and Stigma



- 1,368 articles came up in recent Medline search; wide variation in how stigma defined.
- High levels of HIV stigma correlated with:
 - Low social support
 - Poor physical health
 - Poor mental health
 - Younger age
 - Lower income
 - Lower likelihood to disclose HIV status

HIV and Stigma: What to Do?



- Only 2 studies out of hundreds described quality, evidence-based interventions that were effective in reducing HIV/AIDS stigma.
- Strategies to reduce stigma include:
 - Informational approaches
 - Skill-building
 - Counseling/support
 - PLWH/A testimonials



Key Question 5

Who is at the table?

What other voices need to be included?

Who can help accomplish our goals?

- What partnerships exist in Oregon to address the identified service and prevention needs and gaps?
- What partnerships are lacking?

Key Partners Identified in NHAS



- Department of Health & Human Services
- Department of Housing & Urban Development
- Department of Justice
- Department of Labor
- Veteran's Administration
- Social Security Administration