End HIV/STI Oregon Statewide Planning Group (OSPG) Meeting Notes

May 15, 2024

Announcements

We are sad to share that Dr. Thomas Cherry, long-time chair of the Part A Ryan White HIV Services Planning Council, recently passed away.

Oregon Viral Hepatitis Elimination Plan

Hepatitis means inflammation of the liver. It is caused by toxins, medications, alcohol, autoimmune disease, bacteria (C. trachomatis) and viruses. Among US states, Oregon ranks third in prevalence and 2nd in mortality related to Viral Hepatitis.

Hepatitis A is caused by fecal-oral transmission and can be prevented by vaccines, handwashing, not sharing injection drug use equipment, and universal precautions. The Centers for Disease Control and Prevention (CDC) estimates that in 2021 there were 11,500 cases of Hepatitis A in the US. While there is no cure for Hepatitis A, it is not chronic.

Hepatitis B can be transmitted via blood, semen, and vaginal secretions and can be prevented by vaccines, condoms, not sharing injection drug use equipment, and universal precautions. The CDC estimates that in 2021 there were 13,300 cases of acute Hepatitis B and 14,229 cases of chronic Hepatitis B in the US. Hepatitis B-related morbidity and mortality is higher among Asian, Native Hawaiian, and Pacific Islander populations compared to other racial/ethnic groups. While there is no cure for Hepatitis B, it is not chronic in most (but not all) cases.

Hepatitis C can be transmitted via blood and can be prevented by not sharing injection drug use equipment, using condoms, and taking universal precautions. Between 2013-2023, 251 cases of acute Hepatitis C Virus (HCV) and 52,205 cases of chronic HCV were reported in Oregon. The CDC estimates that in 2021 there were 60,800 cases of acute Hepatitis C and 107,540 cases of chronic Hepatitis C in the US. Hepatitis C-related morbidity and mortality is higher among Black and African American (US-born) and American Indian and Alaska Native populations compared to other racial/ethnic groups. Access to care for Hepatitis C is lower among people ages 20-39 compared to other age groups. People ages 20-29 have the highest number of acute Hepatitis C cases compared to other age groups; Chronic infections among this age group have increased

from 6% in 2010 to 15% in 2019. While approximately 80% of HCV cases are chronic, HCV is curable with treatment.

Oregon continues to see health disparities and inequities related to viral hepatitis B and C among people who inject drugs and people who are houseless.

- Between 2016 and 2020, 26% of people diagnosed with acute HBV in Oregon reported recent injection drug use, and 62% of those with acute HCV reported acute injection drug use.
- Between 2019-2020, 28% of people in Oregon with acute HBV were houseless, and 40%of people in Oregon with acute HCV were houseless.

The Oregon Health Authority (OHA) is committed to the elimination of viral hepatitis in Oregon by:

- Promoting vaccination and harm reduction,
- Making testing and treatment widely available,
- Reducing stigma and discrimination against persons at risk, and
- Using high-quality data to inform elimination goals.

By partnering across the syndemic, we can ensure the most vulnerable people receive care. Partners can include:

- Advocates, peers, people with lived experience
- Health care systems (community and carceral)
- Substance use and mental health systems of care (community and carceral)
- Community-based organizations
- Harm reduction service providers
- Anyone invested in stopping the spread of, and negative health outcomes associated with, viral hepatitis among people living in Oregon

The proposed National Viral Hepatitis C Elimination Plan has four key components:

- Identify more cases by expanding access to single-visit, rapid results testing.
- Expand access to care by eliminating burdensome requirements for people using Medicaid.
- Lower costs by establishing a subscription model wherein the government negotiates lump some medications.
- Invest in community health programs that are best suited to deliver care while also working to develop a hepatitis C vaccine.

<u>Reflection questions for OSPG members</u>

- Q: When thinking about viral hepatitis elimination, what do you see as key considerations and action items?
    - PATHS: Peer assisted tele-health.
    - Test more and more money for HCV!
- Q: What are next steps in advancing full-spectrum syndemic work?
- Q: How can we best promote and support viral hepatitis across existing partnerships?

OSPG members discussed the following questions in small groups (using Jamboard). Responses are included as appendices.

- Q: What are some next steps that could be taken in your community for micro elimination that are truly community-driven?
- Q: Who are the key and possibly unusual partners that could support community-driven micro elimination?
- Q: What can OHA's viral hepatitis team do to assist you in community-based micro elimination work?

Resources

- CDC universal screening recommendations for hepatitis B and hepatitis C
- Oregon Viral Hepatitis Elimination Plan
- OHA Viral Hepatitis main page
- Hepatitis Elimination Room
- Save Lives Oregon

The Oregon Viral Hepatitis Collective meets the 2nd Thursday of each month from 5:00 – 6:00 p.m. Contact Ann for the link.

Discussion

- Q: What is micro-elimination?
  - A: Micro-elimination is a community-driven strategy to address Viral Hepatitis locally (not a statewide or national strategy).
- Q: Is drug resistance a problem with HCV antivirals?
  - A: No.
- Q: Have HCV treatments improved? Interferon was very difficult to tolerate.
  - A: Yes, there have been dramatic improvements in HCV treatment. Newer medications are well tolerated.
  - Unfortunately, some patients have been scared to get treated for HCV out of fear that modern day regimens would be as difficult as Interferon.
- Learn more about street medicine from the Street Medicine Institute.

National, State & Local Policy Work Impacting End HIV/STI Oregon

Oregon's Opioid Settlement funding

Over the past 25 years, pharmaceutical manufacturers, distributors, retailers, and marketers contributed to unprecedented increases in opioid prescribing, opioid use disorder, and deaths by overdose. Activities that have contributed to these outcomes include: promoting opioids for chronic pain management while downplaying their risks; influencing medical professionals through financial support, gifts, and sponsorship of

educational events; and funding questionable research and suppressing information in order to downplay the risks and exaggerate the benefits of opioid medications.

Since July 2021, the State of Oregon has reached agreement on national lawsuits against several pharmaceutical manufacturers, distributors, and retailers for their role in fueling the opioid crisis. Funds are divided between local jurisdictions and the State of Oregon. Settlement funds can be spent on a wide variety of opioid prevention, treatment, and recovery strategies.

Oregon will receive a total of approximately $600 million. Approximately $330 million will be paid directly to cities and counties with populations greater than 10,000; Funding allocation decisions are made locally. Approximately $270 million (in multiple payments through 2038) will be allocated by the OSPTR board (staffed by OHA).

To coordinate with local jurisdictions, OHA:

- Has a website with information about the settlement Oregon.gov/opioidsettlement
- Partners with the Department of Justice to releases an annual state/local opioid settlement expenditure report
- Partners with Lines for Life to hold an Annual Oregon Conference on Opioids, Other Drugs, Pain, and Addiction Treatment
- Supports a Local Opioid settlement learning collaborative, which has a virtual learning series on third Thursdays from 12:00 - 1:00 p.m.

The Opioid Settlement Prevention, Treatment, and Recovery (OSPTR) Board holds virtual meetings every first Wednesday from 10:00 a.m. - 1:00 p.m. Meetings are open to the public and include public comment.

The OSPTR Board is allocating 30% of the state portion of opioid settlement funds to the nine federally recognized tribes in Oregon ($27.7 million for the current biennium ending in June 2025). This 30% set-aside will continue as additional settlement payments are deposited, totaling approximately $81 million. The remaining 70% of funds are distributed across the following seven categories:

1. Harm reduction and overdose prevention (22%), including naloxone distribution.
2. Primary prevention (22%), including funding for counties and for culturally and linguistically specific community-based organizations
3. Treatment (21%)
4. Recovery (21%)
5. Leadership, planning, and coordination (6%)
6. Research and evaluation (3%)
7. Emerging issues and administrative costs (2%)

The Alcohol and Drug Policy Commission is collaborating with the OSPTR Board to create a list of overdose prevention funding recommendations, including the following:

- Treatment
    - Increase access to medications for Opioid Use Disorder.

    - Provide flexible funding for sobering centers, withdrawal management and residential facilities .
- Recovery
    - Increase recovery housing.
    - Strengthen the linkage between peers and “overdose reversers” (e.g., emergency responders, public safety, emergency departments).
    - Provide funding to address the gap in recovery community centers.
- Harm reduction
    - Develop a statewide strategy for the purchase and distribution of naloxone
    - Create a statewide drug checking network
    - Expand Syringe Service Programs to ensure access to comprehensive harm reduction wraparound and engagement services in every county
- Youth-Specific Interventions
    - Youth and family treatment services
    - Primary prevention in line with recommendations of the Alcohol and Drug Policy Commission Prevention Committee
    - Funding and staff for the Alcohol and Drug Policy Commission to create a youth substance use disorder strategic plan by 2025

Discussion

- Q: Which agencies are receiving prevention funds?
    - A: Local public health authorities will be receiving prevention funding. Funding decisions will be made with the Conference of Local Health Officials and other partners.

AIDS Watch

AIDSWatch is an annual event in Washington, D.C. It is coordinated by AIDS United in partnership with the Center for Health Law and Policy Innovation and the U.S. People Living with HIV Caucus. It is the largest federal HIV advocacy event of its kind. Participants are trained in practical advocacy skills and how best to share this information with policymakers and their communities. After training, participants meet with members of Congress to share their personal stories about the impact of current policies on their community and to highlight the importance of meaningful involvement of people living with HIV.

AIDS United’s mission is to end the HIV epidemic in the U.S. through strategic grant-making, capacity-building, and policy & advocacy.

The OSPG member who attended AIDSWatch is a Positive Women’s Network (PWN) – USA State Lead and Policy Fellow. PNW-USA is a national membership body of women living with HIV and our allies that exists to strengthen the strategic power of all women living with HIV in the United States. In addition to federal advocacy, PWN-USA supports regional chapters to build leadership at a local and state level. Fifty-one PWN-USA

members attended AIDSWatch 2024 and had approximately 120 meetings on Capitol Hill.

AIDSWatch 2024 participants received policy briefs on health and social issues, syndemics, civil rights, and other topics. The policy briefs include talking points to advocate for access to health care, for more efforts to address social determinants of health (e.g., housing), and for a syndemic approach (e.g., treatment, recovery, and harm reduction services). In her meetings on Capitol Hill, the OSPG member discussed the need to support HIV-negative family members of PLWH.

Discussion

- Q: When is the next AIDSWatch? It would be nice to see more Oregonians participate in the future.
    - A: AIDSWatch takes place each year in March. Registration and scholarships are usually open around November or December.
- The US Conference on HIV/AIDS (USCHA) is in September 2024. Scholarship applications will be accepted through June, and PWN is hosting a series to help support folks with writing scholarships.

Transitioning Out of Carceral Systems

People who have been involved in carceral systems are a priority population. Oregon lacks a coordinated system for transitioning people living with HIV (PLWH) out of carceral systems.

Oregon's Housing Opportunities for People With AIDS (HOPWA) Program is called Oregon Statewide Supportive Community Reentry (OSSCR). Anyone with a history of incarceration that is facing barriers to housing is eligible.

- Oregon Housing Opportunities in Partnership Program (OHOP) serves the balance of state, and Cascade AIDS Project (CAP) serves Part A (the metro area). These programs serve about 40 households per year.
- The process for OSSCR referrals from the Department of Corrections is unstable.
- The majority of people receiving Department of Corrections (DOC) referrals do not obtain long-term housing.

Additional resources include CareLink, Oak, Cultivate, and individual providers.

In Washington, people transitioning out of carceral systems receive housing for 6 months.

If awarded a grant through the Housing Interventions Notice of Funding Opportunity, Oregon could receive a $2.5 million non-renewable grant, with $833,000 in annual funding for 3 years (October 2024 – September 2027). Awards will be announced in June.

Oregon's grant application proposed a program called Oregon Carceral Engagement & Access Network (OCEAN) which would include:

- A transition Coordinator (Behavioral Health Specialist) position at DOC
- CareLink, Oak and Cultivate staff to connect with adults in custody pre-release
- Hotel/motel placement immediately upon release
- Deposit assistance
- Rent assistance in market rate, preferential and set-aside units

If awarded OCEAN DOC staff will ensure PLWH can access care within DOC facilities, including care for STIs and VH among adults in custody, and connect adults in custody to CBO staff at least 6 months pre-release. OCEAN CBO staff will ensure clients have access to housing (hotel/motel to long-term subsidy or other stable housing), Ryan White case management, CAREAssist, and medical care (2 labs post-release).

OCEAN program goals include:

- Eliminate release to homelessness among adults in custody living with HIV.
- Reduce recidivism among PLWH across Oregon.
- Increase quality data.
- Develop a model to be replicated in other jurisdictions.
- Adapt programming based on client and community input and need.

AETC hosted a Syndemic Health Improvement for Carceral Populations conference. Attendees have continued to meet monthly to discuss services for carceral populations and break down silos.

<u>Discussion</u>

- Some funding secured and some not?
    - A: HOPWA funding is needed to support the full program. If not awarded, OHA will explore other funding sources.
- The RN release person for ODOC is for people who have very high acuity health care.
- Approximately 20% of people in ODOC are HCV+.
- Other activities in communities that are really important and related is a group that is looking at creating a Healing Center / Transition clinic network clinic (maybe.) so there is a culturally specific holistic care clinic to link people to at least in the metro. Hopefully sometime within the next (year?)... LOL https://transitionsclinic.org/

Addressing HIV/STI Co-Infection, Part 2

Findings from a four-year (2018 - 2022) Early Intervention Services and Outreach (EISO) evaluation were shared at the February OSPG meeting. Key findings include:

- 67% of people newly diagnosed with HIV were tested for other STIs (syphilis and gonorrhea). Of those who tested positive for HIV, 17% also tested positive for syphilis, and 16% tested positive for gonorrhea.
- 55% of people newly diagnosed with early syphilis (not known to be HIV+ at the time of diagnosis) were also tested for HIV. Of those tested, 4% had an HIV-positive test result.
- 60% of people newly diagnosed with rectal gonorrhea (not known to be HIV+ at the time of diagnosis) were tested for HIV. Of those tested, 4% had an HIV-positive test result.
- From 2018 - 2022, 1 in 5 people who received EISO services were infected multiple times. People with multiple enrollments for STI were more likely to seroconvert to HIV; 10% of clients with multiple enrollments and not known to be HIV-positive at the time of their STI diagnosis seroconverted.
- Though PrEP referrals for people diagnosed with STI is a high priority, PrEP referrals were low; 36% of people newly diagnosed with early syphilis received a PrEP referral; 32% of people newly diagnosed with rectal GC received a PrEP referral; and 42% of visits with people who had multiple EISO enrollments for rectal gonorrhea or syphilis and who later tested positive for HIV included a PrEP referral.

Discussion

- Q: What counts as a PrEP referral?
    - A: A PrEP referral simply means that PrEP was discussed with the client.
- One member shared that he does not know anyone using injectable PrEP.
- One member shared a bit about his experience using injectable PrEP, which is provided at his home through OHSU. However, working with insurance has been challenging.
- Here's information about the PrEP@Home study.

OSPG members discussed the following questions in small groups (using Jamboard). Responses are included as appendices.

- Q: Where do you see opportunities for more integrated HIV/STI messaging or services?
- Q: How can we increase PrEP referrals and/or PrEP uptake and maintenance?
- Q: What ideas do you have for creating clear but trauma-informed messaging for people with STI about the risk of HIV seroconversion?
- Q: What priority populations in your community should we try and reach with targeted social media advertising?
- Q: What resources/access challenges might prevent priority populations from seeking out PrEP and/or HIV integrated testing?

Viral Hepatitis Elimination

Jamboard Session during OSPG Meeting on May 15, 2024

What are some next steps that could be taken in your community for micro elimination that is truly community-driven?

Campus HEP C screening and vaccinations, increase awareness in younger population.

Portland Metro Area: overlap with syphilis elimination: co-test. use the syphilis elimination infrastructure.

Work with PATHS to help people in more rural/frontier areas get access to HCV treatment via telehealth.

More communication or education about HCV

To address HCV disparities, outreach/education CBOs working with AA/Blk and NA/AI communities.

Work with tribal governments to increase awareness/testing. Facilitate treatment.

test when doing HIV testing

Work with alcohol/drug tx providers to reach those with highest rates of HCV.

working with drug treatment, detox, other SUD providers

Tx people while in prison (stable housing for a bit).

CCC - Mobile clinic - HEP A/B vaccines

education on new treatment to avoid the old stigma with treatment

offer testing and education in syringe exchange

Who are the key and possibly unusual partners that could support community-driven micro elimination?

Community leaders

utilize standing orders to increase nursing support for hep c treatment

Peer-led programs with experience of Hepatitis most appreciated. Would mean building a health worker pathway.

Treatment in CBO settings

co-locate hep c care with safe injection sites?

build partnerships with urgent/emergency care to increase screening/linkage to care

Affordable testing and treatment

Street medicine

CPOP, Insurance Assisters for people who may be eligible but do not have Medicaid/OHP

Culturally specific outreach workers

CCO's that will support health fairs to provide education.

work with substance use treatment centers

working with carceral settings to facilitate screening/treatment'

What can OHA's viral hepatitis team do to assist you in community-based micro elimination work?

Addressing HIV/STI Co-Infection

Jamboard Session during OSPG Meeting on May 15, 2024

What resources/access challenges might prevent priority populations from seeking out PrEP and/or HIV integrated testing?

Providers

Immigration status, and other legal status

Lack of peer navigation. And siloed peers (maybe not whole person). For example, mental health peers, substance use peers.

Lack of information about any of it.

Prioritizing other health care needs first. Competing priorities.

Community might have other priorities or might not want to focus on sexual health. Again, competing priorities with other well-established networks

Health insurance status (underinsured, not insured)

Stigma-trust issues

Geographical access. Transportation, access.

Provider education

Expand PH Modernization. Should be focused on community needs and less about where funding has come from.

Where do you see opportunities for more integrated HIV/STI messaging or services?

Behavioral health - missed opportunity for sensitization re: PrEP / referral to SRH services

Broader advertising focusing on reducing the stigma associated with HIV/STI

Substance use treatment facilities

Behavioral health

Primary care clinics - offer more routine testing / prevention messaging

Medical mistrust: folks may seek care from alternative providers - this is also a missed opportunity: could be an entry point to discuss safety/efficacy of PrEP

Bundling services! (example: harm reduction offerings at queer roller-skating event) - meet people where they are, people will select the services they need

Correctional facilities - integrate HIV/STI/viral hep screening, treatment, prevention

School based health centers - promote PrEP education even if uptake is low

home based test kits (could increase funding, awareness) - take me home, together take me home, indigenous i want the kit, etc.

Target at-home testing to rural communities / others with barriers to testing

Tribal health centers: support more routine testing / education

What ideas do you have for creating clear and trauma-informed messaging for people with STI about the risk of HIV seroconversion?

Create and ensure safety to discuss sex

Routinize sex positivity

Combine messaging on prep with doxypep "did you know we have tools to prevent both bacterial and viral stis?"

Talk to ALL about PrEP.

Explain the correlation between STI and HIV acquisition.

conversations about treatable v curable

Have you thought about the possibility of getting HIV? And how that might impact your partner and your quality-of-life, perhaps you could consider the possibility of Prep

How can we increase PrEP referrals and/or PrEP uptake and maintenance?

School based health centers can play a role in educating and normalizing PrEP. Planting the seed

Promoting injectable PrEP for folks for whom that will work better than a daily pill

PrEP at Home ... other mail order PrEP providers -- can help expand PrEP access

combine messaging about PrEP and doxy PEP -- tools for preventing HIV and other STI

Seeing a provider every 3 months is a barrier. Is there a way to decrease the frequency of appointments?

Improve PrEP messaging: How can we broaden the conversation so that heterosexual people are receiving referrals too?

Incorporate sexual history and PrEP referrals into intake processes?

What priority populations in your community should we try and reach with targeted social media advertising?

monolingual Spanish speakers

Translations needed in Eurasian, Russian, African, and other languages

people who speak/read languages other than English as their primary language

Youth - social media accounts and portals

Transitional Age Youth/ those no longer in school...

Youth - can we collaborate with school-based health clinics and systems?

Flyers with QR codes linking to social media or websites and social media logos linking to social media sites

Social media - youth videos catering to the youth

Social Media catering to young adults

Aging populations

Can we help community colleges to make reputable resources recognizable?