Oregon

Integrated HIV Prevention and Care Plan, 2017 - 2021

September 2016

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Introduction:

Background:

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) require jurisdictions who receive federal funding to engage in a collaborative planning process to develop local strategies to accelerate progress toward reaching the goals of the National HIV/AIDS Strategy. The ultimate goals are to prevent new HIV infections, increase access to care and improve health outcomes, and reduce HIV-related health disparities.

Oregon's Integrated HIV Planning:

The Oregon Health Authority Public Health Division is committed to lifelong health for all people in Oregon. The Public Health Division's (PHD) mission is to promote health and prevent the leading causes of death, disease and injury in Oregon, including HIV, Viral Hepatitis (VH), and other sexually transmitted diseases (STD).

In 2012, the HIV/STD/TB Section of the Oregon Health Authority, the HIV Prevention and Part B grantee, convened a statewide planning group to promote and support a comprehensive and integrated approach to:

1) Prevent HIV infection and co-infections with VH and STI, and
2) Provide quality care for those who are infected with HIV and co-occurring VH and/or STD.

This planning group, called the Integrated HIV/VH/STD Planning Group (IPG) represents a departure from past planning efforts, in which responsibility for planning HIV prevention, HIV care services, STD prevention and care, and VH prevention and care activities was held by separate entities. The IPG aims to identify the knowledge, create tools, and promote networks that people and communities in Oregon need to protect their health from all of these related infections.

IPG Vision

We envision an Oregon where, through prevention, new HIV infections are rare and viral hepatitis and sexually transmitted co-infections are prevented and addressed

effectively. When new HIV infections do occur, every person will have access to high quality care, free from stigma and discrimination.

IPG Mission

The mission of the IPG is to regularly identify strengths, needs, gaps, and service priorities, resulting in a comprehensive plan that will support people in Oregon living with, affected by, or at risk for HIV/VH/STD to live healthy lives.

IPG Values

IPG meetings and decisions seek to be:

1) Inclusive of all Oregonians, including those living with and at risk for HIV from both urban and rural areas
2) High quality, promoting services that are evidence-based and user-friendly
3) Compassionate to the diverse populations we serve
4) Community-focused, so that recommendations are useful and accessible to the communities we serve

IPG Structure

The IPG meets three to four times annually. In addition, each IPG member has opportunities to participate in topic-specific committees each year.

IPG Membership

As of 2016, the IPG includes 36 individuals representing people living with HIV and at risk, HIV prevention, all parts of the Ryan White Care continuum, Coordinated Care Organizations[i], corrections, alcohol and drug prevention and treatment, higher education, and hospice. People living with HIV (PLWH) comprise about 40% of the current IPG membership. About half of the IPG membership are from the Portland metropolitan area and half come from a broad representation of our large and diverse state, including the Willamette Valley, and Eastern, Central, Southern, and Coastal Oregon. A full membership table is included as Appendix A.

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[i] A Coordinated Care Organization (CCO) is a network of all types of health care providers (including physical, behavioral, and dental health) who have agreed to work together in their local communities to serve people receiving health care coverage from the Oregon Health Plan (Medicaid). As of this writing, there are 16 CCOs operating in communities around Oregon.

Planning Process for 2017-2021 Integrated Plan

The IPG has primary responsibility for creating Oregon's Integrated HIV Prevention and Care Plan for 2017-2021. The Integrated HIV Plan is inclusive of information previously published as separate documents: the CDC Jurisdictional and Comprehensive HIV Prevention Plan, the HRSA Statewide Coordinated Statement of Need (SCSN), and the HRSA Comprehensive Plans for both Ryan White Part A and Part B. This living document is intended as a roadmap to guide Oregon's HIV prevention and care planning on an ongoing basis.

Oregon submitted one integrated state HIV prevention and care plan to CDC and HRSA in September 2016.

The IPG's collaborative planning process included 6 meetings in 2015-2016 which convened partners across the Ryan White continuum of care to review data, identify needs and gaps, and develop strategies for addressing Oregon's shared HIV prevention and care goals. The meetings included a geographically representative group of people living with HIV, and key partners representing prevention and the entirety of the Ryan White continuum of care. Stakeholder feedback was collected in six key ways:

- Needs assessment data via the HIV Medical Monitoring Project, surveys of the CAREAssist/AIDS Drug Assistance Program clientele, and additional ad hoc assessments of clients and providers.
- Three in-person meetings with the IPG in 2015 to conduct member checking of the needs assessment data, develop content for the SCSN, and begin to identify gaps, barriers, and strategies for addressing Oregon's goals.
- Three in-person meetings with the IPG in 2016 to develop and refine the prevention, care, and health equity strategies that were identified in 2015.
- On-line feedback from the IPG membership and other community stakeholders to approve a list of activities, synthesized from the many ideas generated at IPG meetings.
- Email review and feedback on all documents from June-Aug 2016 from IPG members, ultimately resulting in a Letter of Concurrence at the end of the process.
- Additional meetings with key stakeholders who are under-represented at IPG.

Of special note: although Part A is represented on the IPG, we invited additional Part A Planning Council members to join regular IPG meetings in 2016, in order to ensure full

collaboration in the Comprehensive Planning Process. These members participated in all discussions, had opportunities to review all documents, and served as liaisons between the Part A Planning Council and the IPG. Several applied for IPG membership and became full IPG members during the course of the year.

Coordination with Oregon's State Health Improvement Plan

Oregon's State Health Improvement Plan (SHIP) identifies seven key priorities for the state, including "protecting the population from communicable disease." The 2017-2021 Integrated HIV Prevention and Care Plan addresses this goal, with the specific aim of reducing forward transmission of HIV, and co-occurring HCV, STD, and TB, through implementation of evidence-based public health interventions, including primary prevention and secondary prevention through provision of medical and supportive services that promote viral load suppression.

How Comprehensive HIV Planning Aligns with Public Health Modernization

Since 2013, Oregon has been working to modernize its public health system so that a common set of core public health capabilities and programs are present in all communities in the state. The goals of Oregon's modern public health system include:

1) Achieving sustainable and measurable improvements in population health;
2) Protecting individuals from injury and disease; and
3) Being fully prepared to respond to any public health threats that may occur.

Communicable disease control, prevention and health promotion, and access to clinical preventive services are three of the four foundational programs in Oregon's modernized public health system—all of which are germane to HIV prevention and care. An assessment of the current implementation of the modernization framework by Oregon's local public health authorities indicates that there are gaps in the current system that will require innovative solutions to breach. This plan identifies some of those innovative ideas for future service delivery and builds on Oregon's history of delivering HIV services through regional models, by sharing resources across local public health authorities, and through public-private partnerships.

Statewide Coordinated Statement of Need

Oregon's Statewide Coordinated Statement of Need (SCSN) is designed to describe the needs of persons at risk for HIV infection and people living with HIV (both those receiving care and those not receiving care), current resources available to meet those needs, and gaps in HIV prevention and care services.

Epidemiologic Overview

Oregon HIV Facts at a Glance

As of Dec. 31, 2014:

- 6,605 people were estimated to be living with HIV/AIDS in Oregon, including people who moved to Oregon after their HIV diagnosis. Fifty percent (3,279/6,605) of those living with HIV/AIDS in Oregon resided in Multnomah County at the end of 2014.
- From 2010 to 2014, approximately 240 people were diagnosed with HIV infection annually in Oregon.
- From 1981 to 2014, 9,692 Oregon residents were diagnosed with HIV infection; 42% (4,070/9,692) died.
- During the past decade, an average of 93 persons with HIV died in Oregon each year, some from other primary causes of death.

Prevalence of HIV/AIDS in Oregon

HIV/AIDS remains an important public health problem in Oregon. From 1981 through 2014, 9,692 HIV infections were diagnosed in Oregon residents; as of the end of 2014, approximately 42% (4,070/9,692) had died (Figure 1). From 1995-2014, an average of 256 new cases were reported each year. This average is declining, with approximately 240 new diagnoses reported each year, on average, in Oregon between 2010 and 2014.

The Oregon Health Authority estimates that 6,605 people with diagnosed HIV infection were living in Oregon at the end of 2014. This total includes approximately 2,026 people who lived outside of Oregon at the time of their diagnosis.

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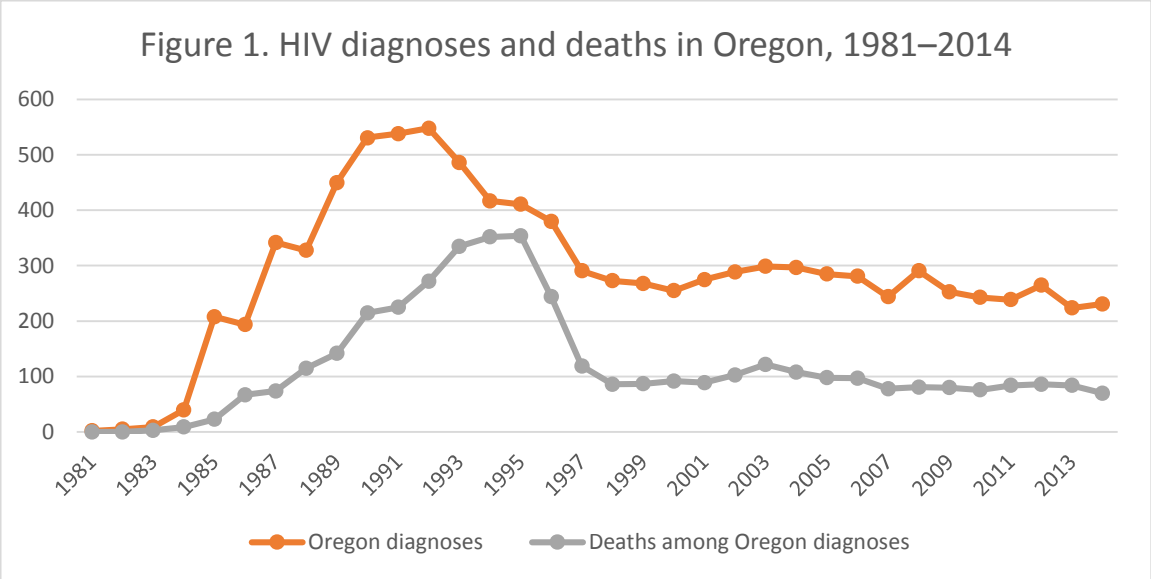


Characteristics of PLWH in Oregon

Eighty-eight percent (5,803/6,605) of Oregon residents living with HIV/AIDS were male, 77% (5,050/6,605) were white, and the average age was 48 years. Men who have sex with men (MSM) and MSM who injected drugs (MSM/IDU) accounted for 84% (4,883/5,803) of male residents living with HIV/AIDS.

Among males, MSM accounted for 70% of cases diagnosed during 2005–2014 (1,580/2,253). Other transmission categories included men who use injection drugs (5%), MSM who also use injection drugs (10%), and men who likely or possibly[ii] acquired their infection from heterosexual transmission (4%). Approximately 10% of recent male diagnoses lacked sufficient information to assign a transmission category.

Among females, IDU accounted for 22% of cases and women who likely or possibly[iii] acquired their infection by heterosexual transmission accounted for 77% of cases. The remainder included cases that lacked sufficient information for classification.

[ii] Includes men who affirmed having sex with women and denied injection drug use, transfusions or transplants during the time the blood supply was not being adequately screened for HIV.

[iii] Includes women who affirmed sex with men and denied injection drug use, sex with men or transfusions or transplants during the time the blood supply was not being adequately screened for HIV.

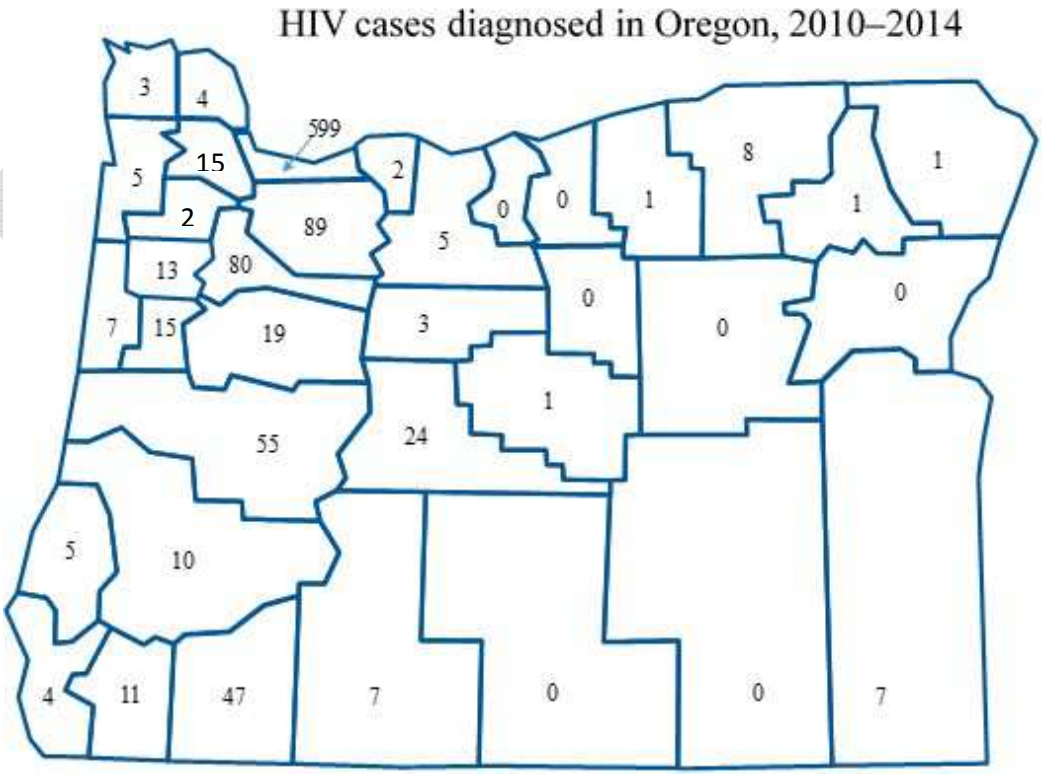
Recent demographic trends, among cases diagnosed from 2005-2014, include the following:

- Statewide, men were approximately seven times more likely than women (12.0 vs. 1.6 per 100,000) to be diagnosed with HIV. The average age at diagnosis was 37.7 years for males and 36.8 years for females.
- New diagnosis rates were nearly five times higher among Blacks and African Americans than whites (27.4 vs. 5.9 per 100,000).
- The rate of new diagnoses for Latinos was 1.8 times higher than for white non-Latinos (10.7 vs. 5.9 per 100,000).
- Other races and ethnicities accounted for roughly 6% of all diagnoses.

Geographic Distribution of HIV Cases

Of the 1,202 recent HIV diagnoses (2010 to 2014), 50% (n=599) were diagnosed in Multnomah County (Figure 2).

Figure 2:



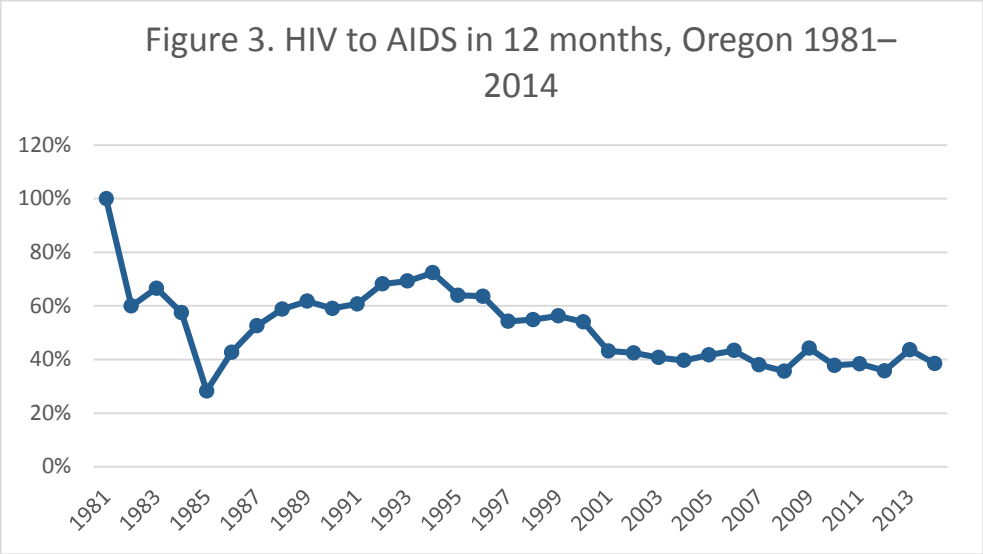
Oregon's HIV service delivery area is divided geographically into Part A, which includes five counties in and around the Portland metropolitan area (Clackamas, Columbia, Multnomah, Washington and Yamhill), and Part B (the Balance of State), which includes the remaining 31 Oregon counties stretching to the Washington, California, Idaho, and Nevada borders. Part A's service area also includes Clark County in Washington State. Although Clark County service needs are not included in this statewide Oregon plan, we are mindful that Clark County clients do receive Part A services on both sides of the Oregon/Washington border.

Although Oregon is a large, primarily rural state, a majority of PLWH were diagnosed in and/or receive Ryan White-funded services in the counties located along the I-5 corridor.

Characteristics of PLWH with Delayed Diagnosis

Many Oregonians continue to be diagnosed with HIV infection at a late stage of disease (Figure 3). Approximately 39% of cases (466/1,202) diagnosed during 2010 to 2014 either had AIDS at the time of their initial HIV diagnosis or progressed to AIDS within 12 months of initial HIV diagnosis. Late diagnosis was more common among some groups, including:

- Latinos (compared to non-Latino whites): 47% of newly diagnosed Latinos had delayed diagnosis compared to 39% of white, non-Latinos
- People who inject drugs (PWID): 43% of PWID had delayed diagnosis compared to 35% of MSM



PLWH with Co-Morbidities

Hepatitis C (HCV) and hepatitis B (HBV) are common infections among people also infected with HIV. HIV infection accelerates progression to cirrhosis, end-stage liver disease and hepatocellular carcinoma caused by viral hepatitis. People who are co-infected with viral hepatitis and HIV can also have fewer HIV treatment options.

Here are some key Oregon HIV and viral hepatitis facts at a glance:

- At least 5% of deaths in people with HIV were liver-related. Most of these were from chronic hepatitis C.
- 19% of Oregonians with HIV reported ever having HCV; 20% reported ever having HBV (based on MMP 2011-2014 data)
- People who inject drugs are more likely to be HIV-HCV co-infected: Among diagnosed HIV/AIDS cases in Oregon during 2004–2013 with history of reported IDU, 33% of men (110/330) and 49% of women (34/70) also had chronic hepatitis C by the end of 2013.
- Viral hepatitis prevalence among Oregonians with HIV may be higher because of underreporting.
- Chronic HCV is a more severe infection in people with HIV than in people who are not HIV-infected.

Sexually transmitted diseases (STDs) are indicators of ongoing high-risk sexual behavior, such as multiple concurrent partners and inconsistent condom use, which could transmit HIV. Having a concurrent STD may also increase the likelihood that PLWH can transmit HIV to uninfected partners.

Here are some key Oregon HIV-STD facts at a glance:

- During 2008–2013, the average annual rate of syphilis was 272 times higher among people with HIV than among the general population (1,196 per 100,000 vs. 4.4 per 100,000).
- During 2008–2013, the average annual rate of gonorrhea was 45 times higher among people with HIV than among the general population (1,792 per 100,000 vs. 40 per 100,000).

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- Some people with HIV are more likely to have acquired another STD in the past 5 years (among people living with HIV as of Dec. 31, 2013): people < age 26, MSM, men who have never progressed to AIDS, and urban dwellers.
- Syphilis and HIV often occur together: During 2014, people with HIV accounted for 42% of Oregon's new early syphilis cases.

HIV Mortality

Of 9,692 cumulative cases of HIV infection diagnosed in Oregon from 1981 to 2014, 4,195 (43%) had died by Dec. 31, 2014. The advent of antiretroviral medications in the mid-1990s dramatically improved treatment outcomes. The probability of surviving five years after diagnosis was approximately 42% among people diagnosed in 1990, whereas for people diagnosed with HIV in Oregon from 2004 to 2013, the probability of surviving 10 years after diagnosis was 88%. The number of deaths among people with HIV declined from 354 deaths during 1995 to 70 cases during 2014.

However, disparities exist. Some people have a lower probability of surviving 10 years after diagnosis compared to others. These include:

- American Indians or Alaska Natives (compared to white non-Latinos)
- People aged >36 years at diagnosis relative to people in younger age groups;
- People with CD4 counts <200 cells/mm^3 at diagnosis (compared to people with higher CD4 counts at diagnosis)
- People who acquired HIV through injection drug use (IDU) (compared to other modes of transmission)
- People co-infected with HCV (compared to people without hepatitis C)

During 2004–2013, HIV disease remained the leading underlying cause of death (43%) among people with HIV. Cancer (15% of deaths) was the second most common underlying cause.

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HIV Risk Behaviors in Oregon

Data show that people who know their HIV status are much less likely to engage in behavior that could transmit HIV than those who do not know their status. According to the 2013 Oregon BRFSS, only 37% of adult Oregonians have ever been tested for HIV. Although testing rates among Oregonians age 25-44 rise to just over 50%, we still have ample room for improvement.

While working to improve testing rates and reduce risk among all Oregonians, diminishing resources require us to identify and target our prevention resources to populations most at risk based on local data. The HIV Prevention Program's 2014-2015 needs assessment identified three priority populations for HIV prevention activities in Oregon:

- PLWH and their sex and needle sharing partners
- Men who have sex with men (MSM) whose HIV status is unknown or was negative at last test
- People who inject drugs (PWID) whose HIV status is unknown or was negative at last test.

PLWH and their sex and needle sharing partners:

Oregon is an HIV Medical Monitoring Project (MMP) site, collecting data annually from PLWH receiving medical care in Oregon. MMP data collected from 2011-2013 (N=776) suggest that one in eight (12%) people receiving HIV care in Oregon have had unprotected vaginal or anal sex with a partner of negative or unknown HIV status in the past 12 months (9% among men, 17% among women). An additional one in five (20%) MMP participants reported unprotected sex only with HIV-positive partners, which warrants concern about STD transmission.

Six percent of MMP participants reported injecting drugs in the preceding 12 months; MMP does not collect data about needle sharing.

In addition, high rates of STI among PLWH indicate high rates of unprotected sex. As noted previously, HIV positive MSM accounted for 41% of the syphilis cases reported in Oregon from 2008-2013. Rates of syphilis among PLWH are 272 times higher than among the general population, and gonorrhea rates are 45 times higher.

During a one-week rapid ethnographic assessment in 2014, trained interviewers conducted semi-structured qualitative interviews with community members, health care providers, and persons representing agencies and businesses serving MSM to discuss

community awareness of syphilis, perceived reasons underlying syphilis increases, and recommendations for improving prevention efforts. Syphilis increases were attributed to lack of awareness and knowledge of syphilis symptoms, sequelae, and transmission routes among both patients and providers.

In addition, the data indicate that many MSM consider syphilis "treatable," and not a major concern, condom use has declined, and serosorting by HIV status is common. Connecting with anonymous sex partners via social media sites and methamphetamine use were also considered contributing factors. A case-control study conducted in Multnomah County in 2014 confirmed that early syphilis was associated with meeting partners on-line, an association explained by significantly higher numbers of sex partners among cases (median: 5, range 1-70) than controls (median 2: range 1-50).

MSM:

Data collected among MSM in 2004 and 2005 through rapid HIV behavioral assessments at Gay Pride indicated that about 1 in 10 MSM in the Portland metropolitan area engaged in high-risk sexual activity that might facilitate transmission of HIV (e.g., unprotected anal intercourse with someone of discordant or unknown HIV status).

In 2006-2007, Portland-area MSM participating in the Community Promise study identified themes related to risky sexual behavior among the small subset of MSM engaged in highest risk behavior for HIV transmission:

- Serosorting (unprotected sex with partners of the same HIV status) was common among people based on assumptions of HIV status rather than fact (e.g., seroguessing: "if he was HIV positive, he would have told me" or "If he was worried about HIV, he would have said so, so he must be positive").
- Seropositioning (an HIV-positive partner takes the receptive role in anal sex with a partner of HIV-negative or unknown status), and engaging in unprotected sex with HIV-negative partners when one's viral load is undetectable were also common, albeit imperfect, risk reduction behaviors reported by MSM.
- Methamphetamine use, anonymous sex in public sex environments, hook-ups via social media sites, and higher numbers of partners (e.g., more than 10/year, and often many more) were also identified as behaviors placing MSM at increased risk for acquiring and transmitting HIV.

People who inject drugs:

During 2004-2013, 15% (400/2,595) of cases diagnosed with HIV in Oregon acknowledged past injection drug use. This includes male and female PWID, as well as MSM/IDU. An additional 1% of male cases and 11% of female cases reported heterosexual contact with a sex partner who used injection drugs.

Oregon has collected information about HCV behavior risk (which often corresponds to HIV behavior risk, as well) among persons tested for HCV through the state's High Risk Adult HCV Screening Project. Between 2007 and 2013, the screening project performed 4,027 HCV tests among persons who reported risk factors for HCV. Twenty local health departments and four syringe exchange programs participated in the screening.

Overall, 16% of the persons screened and 21% of persons who reported IDU were positive for HCV. The prevalence of HCV increased with age, ranging from 6% in persons less than 20 years of age to 39% in persons aged 50–54. The prevalence of HCV did not vary by sex or by race in this population. Since the screening program targets persons at highest risk for HCV, the majority tested (72%) reported IDU at some point in their lives. Those with injection drug use risk reported methamphetamine and heroin as the primary drug injected (74% and 21% respectively). HCV prevalence between users of these two drugs did not vary. Of the 2,467 who reported IDU and responded to a question about their most recent drug use, 85% said they had injected within the past three years. This sub-group of recent injectors was young: 52% were under age 30. Half reported sharing needles with someone who had HCV, 54% lived with someone with HCV, and 46% reported having sex with someone with HCV. The prevalence of HCV antibodies in this group of recent injectors under the age of 30 was only 11%. This suggests that intervention in this age group could be effective in preventing further transmission of HCV.

Emerging Populations: High-Risk Heterosexuals

In 2015, Oregon became a new National HIV Behavioral Surveillance (NHBS) site. Chime In, as Oregon calls the NHBS survey project, is surveying high-risk heterosexuals in its first year of data collection. Four percent of new HIV diagnoses among men in Oregon are attributed to heterosexual contact, and another 10% had no identifiable risk; 77% of women diagnosed with HIV are attributed to heterosexual contact.

A 2010 cross-sectional study of 208 young (18–25 years of age) homeless adults in Portland yielded a sample of both heterosexual (64%) and sexual minority participants (36%). The researchers found a high rate of sex without barrier protection in the past 30 days (52% among heterosexual participants), as well as myths about effective HIV prevention methods (e.g., oral contraceptive pills can prevent HIV). Six participants tested positive for HIV, none of whom identified as heterosexual.[iv] As this study found, we expect many sub-populations of heterosexuals in the Portland Metropolitan Statistical Area (MSA) might have high frequency of HIV-related risk behaviors, but low rates of HIV infection. National NHBS findings suggest heterosexual subpopulations more likely to test positive for HIV include those who are black, are unemployed or disabled, have less income, have never previously tested for HIV, have engaged in exchange sex, or have used crack cocaine in the past 12 months.[v]

HIV Care Continuum

The HIV Care Continuum is a model that is used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to PLWH across the entire HIV Continuum of Care. The HIV Care Continuum has five main "steps" or stages including: HIV diagnosis, linkage to care, retention in care, antiretroviral use, and viral suppression.

The HIV Care Continuum provides a framework that depicts the series of stages a person with HIV engages in from initial diagnosis through their successful treatment with HIV medication. It shows the proportion of individuals living with HIV who are engaged at each stage. The HIV Care Continuum allows grantees and planning groups to measure progress and to direct HIV resources most effectively.

Oregon's Care Continuum is based on the following definitions:

- Infected: persons diagnosed with HIV and those unaware of being diagnosed with HIV
- Diagnosed: persons diagnosed and confirmed by the Oregon HIV Surveillance Program as cases

[iv] Logan JL, et al. Correlates of HIV risk behaviors among homeless and unstably housed young adults. Public Health Rep. 2013 May-Jun; 128(3): 153-160. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3610067/

[v] CDC MMWR. HIV Infection among Heterosexuals at Increased Risk – United States, 2010. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6210a2.htm

- Linked to care: persons with a lab result used to monitor HIV collected within 90 days of first diagnosis
- In care: persons with an HIV-related lab result collected in 2014
- On treatment: persons prescribed ART
- Suppressed: persons whose last reported HIV viral load in 2014 was $\leq$ 200 copies/mL

The Oregon HIV Care Continuum gives us a picture of the HIV epidemic in Oregon at the end of 2014 (Figure 4):

- An estimated 6,605 residents of Oregon had diagnosed HIV infection.
- Approximately 987 Oregonians were infected with HIV, but remained undiagnosed (and presumably do not know their status)
- 85% (1,023/1,202) of new diagnoses in Oregon (2010-2014) were linked to care within 90 days, and 94% were linked within 1 year (1 year data not shown in Figure 4).
- Approximately 837 residents diagnosed with HIV were not in medical care in 2014.
- 97% (5,595/5,768) of those in HIV medical care were on ART. (Oregon Medical Monitoring Project, 2009-2013 chart abstraction data)
- Viral load suppression was achieved among more than 68% (4,502/6,605) of those living with diagnosed HIV, and may be as high as 79% if we take into account people who left Oregon and whose viral loads did not get reported to the Oregon HIV Program.

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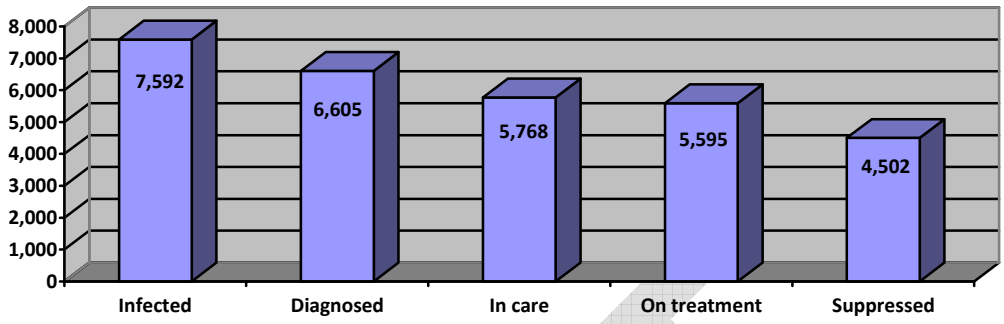
Figure 4. Oregon HIV Care Continuum*



*The difference between "Infected" and "Diagnosed" is an estimate from the CDC (13% of infected are not diagnosed). The "On treatment" estimate is based on Oregon HIV Medical Monitoring Project data, which observed 97% of people "in care" were prescribed ART. All other numbers are from Oregon's HIV surveillance system, Orpheus.

A Note on Viral Suppression:

In 2013, the CDC estimated that 30% of all people infected with HIV in the U.S. were virally suppressed.[vi] This estimate included people with undiagnosed HIV and did not control for migration. If suppression were calculated the same way for Oregon, the estimate of suppression would be 59% (4,502/7,592). The difference between the national and Oregon estimates may be due to Oregon's more complete viral load reporting, more up-to-date residence information, or better access to care.

Some groups in Oregon were less likely to be virally suppressed than others. American Indian/Alaska Natives and Black/African Americans were less likely to be virally suppressed than Whites (25% and 20% non-suppressed, respectively vs. 9%). Men who have sex with men and have injected drugs (MSM/IDU) were less likely to be suppressed than MSM (17% non-suppressed vs. 9%). Other groups took longer after diagnosis to become suppressed: 20-24 year olds, males reporting heterosexual risk (partner's risk unknown) and females with heterosexual risk (partner's risk unknown).

[vi] Linkage to and Retention in HIV Medical Care, Centers for Disease Control and Prevention, www.cdc.gov/hiv/prevention/programs/pwp/linkage.html www.cdc.gov/hiv/pdf/dhap_continuum.pdf

Financial and Human Resources Inventory

Financial Resources

This section describes the CDC-funded high impact prevention services and the HRSA-funded core medical and support services. We also describe other funding sources that are allocated in FY 16 (State Fiscal Year, July-June) to PLWH and people at risk for HIV in Oregon.

Table 3a. Financial Resources Available to Support HIV Prevention & Care in Oregon, 2016

Funding Source	Amount (% of total available FY 16 funds)	Funded Agencies & Services	Point of Care Continuum Impacted
CDC HIV Prevention	$1,501,702	OHA and Clackamas, Deschutes, Jackson, Lane, Marion, Multnomah & Washington Counties (HIV testing & prevention with positives)	Infected, Diagnosed
CDC HIV Prevention	$350,000	Cascade AIDS Project (CAP) (high –impact prevention)	Infected, Diagnosed
CDC HIV Surveillance	$355,744	OHA (for HIV, STD, HCV surveillance activities)	All points of Care Continuum
CDC HIV Medical Monitoring Project	$662,792	OHA (special surveillance project)	In care, On treatment, Suppressed
CDC National HIV Behavioral Surveillance	$756,346	OHA and Portland State University (special surveillance project)	Diagnosed, In care, On treatment, Suppressed
CDC STD Prevention	$891,454	OHA (STD medications, labs, data, condoms, TA, training, consultation)	Infected, Diagnosed, In care
Ryan White Part A	$3,995,794	Multnomah County Health Department (MCHD), CAP, Clark Co (WA) Health Department, Ecumenical Ministries of Oregon, OHSU Partnership Project, Quest Integrative Health Center, OHSU Russell St Dental Clinic, Washington Co. Health Dept. (Full range of case management and supportive services)	Diagnosed, In care, On treatment, Suppressed

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Funding Source	Amount (% of total available FY 16 funds)	Funded Agencies & Services	Point of Care Continuum Impacted
Ryan White Part A	$446,296	MCHD HIV Health Services Center (HHSC)* (Medical Case Management)	Diagnosed, In care, On treatment, Suppressed
Ryan White Part A	$599,873	MCHD HIV Health Services Center (HHSC)* (Ambulatory medical services for adults)	Diagnosed, In care, On treatment, Suppressed
Ryan White Part B	$6,491,091	OHA (insurance, co-pay, deductible payments); HIV Alliance and 6 LPHAs (full range of case management and supportive services); HIV Alliance (pharmacist treatment adherence and engagement advocate services through competitive supplemental funds)	In care, On treatment, Suppressed
Ryan White Part C	$846,805	MCHD HHSC (Ambulatory medical services for adults)	Diagnosed, In care, On treatment, Suppressed
Ryan White Part D	$342,449	MCHD HHSC (Medical, Medical Case Management, and Mental Health Services for Women and young adults (≤24 years))	Diagnosed, In care, On treatment, Suppressed
Ryan White Part F	$12,800	MCHD HHSC (Pass-through dental case management)	Diagnosed, In care, On treatment, Suppressed
Ryan White Part F	TBA	Russell Street Dental Clinic, Lane Community College (Dental care)	Diagnosed, In care, On treatment, Suppressed
Ryan White SPNS	$300,000	MCHD HHSC (Patient navigation services for homeless patient with severe mental illness and/or addiction services)	Diagnosed, In care, On treatment, Suppressed
Ryan White/AETC	$80,500	MCHD HHSC (Preceptorships and consultation; TA in practice transformation)	All parts of continuum: Western States

*The two shaded columns are duplicative of the data provided by Part A—Part A passes the money to the Part C clinic for medical case management and ambulatory medical services at that site.

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Funding Source	Amount (% of total available FY 16 funds)	Funded Agencies & Services	Point of Care Continuum Impacted
Non-Ryan White Program Income	$2,484,075	MCHD HHSC (Clinic administration and operations, medical, medical case management, navigation, mental health services, and direct client support (hotel vouchers, food vouchers, transportation).	Diagnosed, In care, On treatment, Suppressed
HOPWA- Formula	$378,910	OHA Oregon Housing Opportunities in Partnership (OHOP) (rental assistance, Support Services, Housing Information)	In care, On treatment, Suppressed
HOPWA OSSCR	$454,601	OHA OHOP and CAP (rental assistance, support services)	In care, On treatment, Suppressed
HOPWA OHBHI	$405,355	OHA OHOP, CAP (rental assistance, support services); Cascadia Behavioral Healthcare (Support Services)	In care, On treatment, Suppressed
HOPWA funds via City of Portland	$1,016,339	CAP and Central City Concern (rental assistance, support services)	In care, On treatment, Suppressed
Low Income Energy Assistance Program (LIHEAP)	$70,000	OHA OHOP (Utilities)	In care, On treatment, Suppressed
Rural Oregon Continuum of Care	$68,014	OHA OHOP (rental assistance)	In care, On treatment, Suppressed
City of Salem	$79,800	OHA OHOP (rental assistance)	In care, On treatment, Suppressed
Program Income	$13,002,700	OHA (insurance, co-pay, deductible payments, pharmacy payments, dental, adherence services, smoking cessation, health insurance enrollment); CAP (transitional housing)	In care, On treatment, Suppressed
340B Rebates (ADAP)	$4,380,000	OHA and Ramsell (pharmacy benefits manager, pharmacy services, pharmacy payments)	In care, On treatment, Suppressed
Supplemental Rebates (NASTAD)	$119,800	OHA (housing and employment services)	In care, On treatment, Suppressed

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Human Resources and Workforce Capacity

Oregon ensures that PLWH and people at risk of HIV receive services through a combination of public and private sources.

Most PLWH outside of the metropolitan area receive medical care through private providers and/or Coordinated Care Organizations. PLWH in the Portland area have a range of options for HIV care, including Oregon's only Parts C and D clinic, Multnomah County Health Department's HIV Health Services Center (HHSC). HHSC employs 36.7 FTE, including medical providers (3.8 FTE), medical case managers (4.8 FTE), nurses (4 FTE), patient navigators (4 FTE), mental health providers (1.2 FTE), and a range of other medical and administrative professionals. HHSC has been a Ryan White provider since 1990 and an AETC clinical training site for a five-state region since 1999. HHSC serves an estimated 1 in 4 PLWH living in the Portland metropolitan area.

Medical case management services are provided by multiple agencies in the Portland Metro Area, depending on where the client lives and/or receives medical care. These include Cascade AIDS Project, Kaiser Permanente's Immune Deficiency Clinic, HHSC, and through the HIV Partnership Project at OHSU, Legacy Emanuel, Good Samaritan, Providence St. Vincent, Providence Portland and Veteran's Affairs.

Outside of the Portland metropolitan area, case management is provided to PLWH residing in 31 Oregon counties by seven local public health departments and two contracted agencies, HIV Alliance and/or Eastern Oregon Center for Independent Living, depending where an individual lives.

Interaction of Funding Sources

CDC, HRSA, and HUD-funded entities in Oregon work with each other and with community partners to ensure that PLWH and those at risk of HIV receive high-quality, accessible HIV prevention and care services. The Oregon Health Authority (Part B grantee) and Multnomah County Health Department (Part A grantee) directly administer HIV care and treatment services, as well as pass funds through to contracted community-based agencies. CDC prevention funds are distributed by OHA's HIV Prevention Program to seven Oregon counties. Cascade AIDS project also is a CDC Prevention grantee. HOPWA funds are administered by OHA and the City of Portland, and are distributed to contracted agencies throughout the state.

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The Oregon HIV Program is modernizing the way it delivers HIV services in Oregon, aiming to work across funding streams, to the extent allowable by funders, in order to enhance its coordinated approach to prevention and care services. The Oregon Program is developing a matrix management model that builds cross-departmental work teams, in order to implement the integrated approaches to HIV care and prevention that were identified in this five-year plan.

Resource Gaps and Oregon's Plan to Fill Them

A 2016 assessment of Oregon's governmental public health system found meaningful gaps across all local public health agencies. These gaps were not uniform, but no foundational programs or capabilities had yet been fully implemented in any of the 34 local public health authorities (LPHA).

For a few examples specific to this plan:

- 1 in 5 LPHAs report limited capacity to assure the availability of partner notification services for newly diagnosed cases of syphilis, gonorrhea, and HIV, This represents a potential service gap for about 15% of Oregon's population.
- 1 in 4 LPHAs report limited capacity to assure access to treatment for STD, either as a component of primary care or as specialty care. This represents a potential service gap for about 37% of the population.
- 1 in 3 LPHAs report limited capacity to provide appropriate screening and treatment for HIV, STD, and TB cases, including pre- and post-exposure prophylaxis for HIV. This represents a potential service gap for about 33% of Oregon's population.

Only seven Oregon counties currently receive HIV prevention funding. Although HIV case management is available in all counties—delivered via LPHA or community-based organization, depending on one's county of residence—some PLWH live several hours from their medical providers and case managers and must communicate primarily by phone.

There are about 70 "HIV medical providers" around the state (based on MMP data): the Portland metro areas and central Oregon are well-represented, but some other parts of the state (notably, the Coast and Eastern Oregon) have a shortage of HIV specialists. The AETC is working to fill these gaps through training, provision of clinical preceptorships, and telemedicine projects.

In general, Oregon's approach to modernizing public health services, including HIV prevention and care, is to promote the most effective, evidence-based service delivery model and to support and promote resource-sharing relationships, where appropriate.

Assessing Oregon's Needs, Gaps, and Barriers Related to HIV Care and Prevention Services

Needs Assessment Process

Oregon's HIV Prevention and Care Programs identify HIV care and prevention service priorities through multiple means, including needs assessments and gap analyses. These are conducted both formally and informally, using existing data and by conducting special studies. Specifically, we use ongoing surveillance data, epidemiologic investigations, surveys, special studies, program assessments, community meetings and input, contract monitoring, and feedback from service providers and consumers.

The Integrated Planning Group (IPG) plays a central role in identifying HIV prevention and care service needs of PLWH and people at higher risk for HIV. As of June 2016, the IPG includes 36 individuals representing people living with HIV and at risk, HIV prevention, all parts of the Ryan White Care continuum, Coordinated Care Organizations[vii], corrections, alcohol and drug prevention and treatment, higher education, and hospice. PLWH comprise about 40% of the current IPG membership. About half of the IPG membership are from the Portland metropolitan area and half come from a broad representation of our large and diverse state, including the Willamette Valley, and Eastern, Central, Southern, and Coastal Oregon.

The IPG continues to seek representation from a broader base of constituents. Identified gaps include demographic groups (especially transgender and Latino stakeholders), geographic areas (particularly Region 2, which are lower-incidence counties with 50-70 PLWH), and service provider groups (specifically, Veterans, education, and faith-based). The Membership Committee continues to work on recruitment, and the Oregon HST Program has begun discussions with community stakeholders to address these gaps and to conduct assessments in communities of color that face HIV-related disparities.

[vii] A Coordinated Care Organization (CCO) is a network of all types of health care providers (including physical, behavioral, and dental health) who have agreed to work together in their local communities to serve people receiving health care coverage from the Oregon Health Plan (Medicaid). As of this writing, there are 16 CCOs operating in communities around Oregon.

A full table of data sources used for needs assessment activities can be found on page 35 in the data sources section.

Prevention and Care Service Needs, Gaps, and Barriers for PLWH and Persons at High Risk for HIV Infection

The Oregon HIV program, under guidance from the IPG and based on the needs assessment data listed above, identified the following high-level service needs and gaps facing PLWH and persons at risk in Oregon, presented in alphabetical order:

Accessible, Culturally-Competent Medical Care:

Most data related to medical care for PLWH in Oregon come from the HIV Medical Monitoring Project (MMP). MMP data from 2011-2014 indicate that nearly all PLWH in care (99%) have health insurance, but 1 in 10 reported some kind of insurance gap in the past 12 months. All participants reported having a "usual place for HIV medical care in the past 12 months," and yet, 12% also reported using an emergency room, urgent care, or hospital for HIV care in the past 12 months, which may indicate gaps in service or some difficulty accessing usual sources of care.

Most participants (63%) report one-way travel times to HIV medical care of 30 minutes or less; about 5% report one-way travel times of 90 minutes or more.

Data from the 2013 CAREAssist survey indicate that PLWH have many comorbid conditions that need ongoing medical management, and may require coordination between HIV specialists, primary care providers, and other medical specialists: 81% of CAREAssist clients have one or more chronic medical conditions in addition to HIV; 38% have three or more co-morbid conditions.

Inclusion of HIV medications on formularies for Medicaid-funded CCOs has proved challenging in some areas of Oregon. The HIV Pharmacist at HIV Alliance has worked directly with the Formulary Managers and the Clinical Pharmacists within Coordinated Care Organizations to improve prior authorization processes and medication access. As an example, one CCO in Southern Oregon sought consultation from the HIV Pharmacist regarding changes to their 2015 formulary, discussing health and cost benefit of including certain drug therapies. As a result of this interaction, the CCO modified its formulary to be more inclusive of the therapies clients were reporting difficulty accessing.

Although Medicaid expansion reduced the rates of uninsured people in Oregon, disparities still exist: 21% of Latinos, 21% of AI/AN, and 18% of Hawaiian/Pacific Islanders are still uninsured. Undocumented people in Oregon, most of whom are Latino, still face perceived and actual barriers to accessing medical care. Although CAREAssist, Oregon's AIDS Drug Assistance Program, does not request information on citizenship, many undocumented individuals may be unaware of their eligibility for CAREAssist. CAREAssist has used social networking strategies among Latinos to share program information to those who may need it, but further need exists to promote program services.

In addition, the care that is available may create barriers to access for some clients. A recent study from Oregon State University indicated that about 1 in 4 young Latinos in rural Oregon are dissatisfied with medical care; mistrust and perceived discrimination were identified as reasons.[viii] Clients of Cascade AIDS Project's MAI-funded Latino patient navigation program report similar concerns about lack of access to culturally- competent services. PLWH and service providers on Oregon's planning group report that culturally competent care for lesbian, gay, bisexual, and transgender (LGBT) individuals may also be lacking, particularly in more rural parts of the state.

Adherence Support to Achieve and Maintain Viral Load Suppression:

Adherence to HIV medications is critical for obtaining viral load suppression. Most MMP participants report taking antiretroviral therapies (ARTs) (96%) and 86% say they always follow their regular schedule. Still, 12% report taking a drug holiday in the past year and about 4 in 10 (43%) report missing doses in the past 3 months. The leading reasons given for missing doses were having a change in routine or simply forgetting.

From lab-based surveillance data, we know that some PLWH in Oregon are less likely to achieve viral load suppression than others: American Indian/Alaska Natives, Black/African Americans, and MSM/IDU. Other groups took longer after diagnosis to become suppressed: 20-24 year olds, males reporting heterosexual risk (partner's risk unknown) and females with heterosexual risk (partner's risk unknown). These individuals may need additional support after diagnosis to maintain medical care and stay adherent.

[viii] Lopez-Cevallos DF, Harvey SM, & Warren JT. (2014). Medical mistrust, perceived discrimination, and satisfaction with health care among young-adult rural Latinos. *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association*. *30*(4), 344-51.

Mental health issues and substance abuse may also adversely affect adherence. For example, among the 15% of Part B clients who have yet to achieve viral load suppression, mental illness and addictions are common. Of Part B clients with a high acuity in mental health or addictions, 27% and 20%, respectively, had an unsuppressed viral load.

Oregon Reminders is a mobile health service that offers text, email and voice messages to support the health of people at risk for or living with HIV, including medication adherence reminders for PLWH. Oregon Reminders had 1,812 active users through July 2015. Periodic surveys are conducted with active users of the system to assess the efficacy of Oregon Reminders and user satisfaction. As of August 2015, of the respondents receiving HIV medication or prescription refill reminders, nearly three-fourths reported that Oregon Reminders helps them remember to take their medication (72%) and that they miss dose of their medication less frequently since signing up (70%).

Alcohol & Drug Treatment Services:

MMP participants reported substantial rates of alcohol and drug use: 28% reported past-year non-injection drug use and 6% past-year injection drug use. Among current users of alcohol (61%), 30% reported binge drinking at least once in the past month. In addition, 39% reported current tobacco use, a rate more than twice that of Oregon adults overall.

The 2013 National Survey on Drug Use and Health reported that among all states in the country, Oregon had the highest rates of nonmedical use of prescription pain relievers (6% compared to 3% nationally), and the rate of illicit drug use (other than marijuana) in the past 30 days (among Oregon adults aged 26 and older) increased by 20% between 2002 and 2009, compared to a decrease of 3% nationally.

A very high proportion of PLWH report chronic pain: 58% of MMP participants and 41% of CAREAssist clients responding to the 2013 survey. About 1 in 3 MMP respondents (36%) reported taking prescription medication for chronic pain, and chronic pain was associated with 'poor overall health' among CAREAssist clients. This may put them at risk of chronic opioid use and/or misuse.

There are 141 substance abuse treatment centers within 30 miles of Portland, which is notably higher than most, but not all cities with a similar population size (Las Vegas: 47; Nashville: 72; Oklahoma City: 74; Baltimore: 349).[ix] Per the Affordable Care Act, all health insurance sold on Health Insurance Exchanges or provided by Medicaid to certain newly

[ix] SAMHSA. Behavioral Health Treatment Services Locator. Available at https://findtreatment.samhsa.gov/

eligible adults must include services for substance use disorders.[x] However, most of the country is experiencing a shortage of behavioral health specialists that can treat substance abuse disorders. Nationally, the average is 32 behavioral health specialists for every 1,000 people afflicted with substance abuse disorder. Oregon falls slightly below the national average, with 28 provider/1,000 potential clients.[xi]

PLWH consistently identify a gap in substance abuse treatment services. About 3% of MMP clients between 2011 and 2013 (2014 data not available on this item) used inpatient alcohol and drug treatment in the past 12 months. Rates of unmet need for drug and alcohol counseling or treatment among MMP participants ranged from 15% - 47% across the four years (2011-2014), although the numbers of individuals reporting needing the service were low (about 30 per year). Barriers likely include lack of available treatment facilities, lack of readiness, stigma, transportation challenges, and lack of culturally competent treatment services.

Dental Care:

Sixty-two percent of MMP participants reported a dental visit in the past 12 months, and 28% reported needing, but not receiving dental care. The most common reason for not receiving care, reported by more than half of those with a service gap, was cost or lack of insurance that covered dental care.

Health Disparities:

HIV-related health disparities exist all along the HIV care continuum. Disparities related to testing, viral suppression, and death rates might reflect differences in access to and use of health care and treatment. In Oregon, we see differences in HIV-related health outcome by race, ethnicity, sexual orientation, and risk factor (injection drug use), which have been described in more detail elsewhere. Stigma, discrimination, poverty, and other structural factors contribute to these disparities.

Local data related to transgender individuals are sparse. However, national data indicate that transgender individuals may be at high risk of HIV. In Oregon, we know transgender people have barriers to accessing health care.[xii] Cascade AIDS Project is opening a LGBTQ

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[x] Office of National Drug Control Policy. Substance Abuse and the Affordable Care Act. Available at https://www.whitehouse.gov/ondcp/healthcare

[xi] http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists

[xii] Speak Out Survey, 2009. Access at: https://multco.us/file/27403/download

Care Clinic in 2017, which will help fill a gap in the Portland metropolitan area, and large private institutions, like Kaiser Permanente and Oregon Health & Science University (OHSU), have established transgender health programs for their members.

HIV Testing Resources:

The Oregon Health Authority funds public testing sites in 7 higher-incidence counties in Oregon (Multnomah, Washington, Clackamas, Marion, Lane, Jackson, and Deschutes). AIDS Service Organizations provide additional testing venues: HIV Alliance provides testing in Eugene, Roseburg, and Grants Pass; Cascade AIDS Project in Portland provides rapid testing for all at their main office, testing services tailored towards gay and bi men and trans individuals at their Pivot site (a community space dedicated to the health and wellness of all gay/bisexual/queer men and trans-identified people with a focus on sexual health and HIV), and rapid testing in Beaverton, Oregon City, and at community outreach events and public sex environments.

In addition, Oregon Administrative Rules (OAR's) were revised to align with Senate Bill 1507, passed in February, 2012, making HIV testing in private providers' offices and other health care settings easier. These policy changes allow health care providers to obtain consent for HIV testing in a manner similar to that used for other common tests, eliminating the need for written consent.

Still, according to the 2013 Oregon BRFSS, only 37% of adult Oregonians have ever been tested for HIV. Although testing rates among Oregonians age 25-44 rise to just over 50%, we still have ample room for improvement.

As noted previously, Latinos continue to be diagnosed late with HIV. Oregon would benefit from both targeted prevention education and testing for Latinos, and integration of HIV prevention education and testing into usual medical services provided at community health centers and other venues that serve a high number of Latino clients.

HIV testing is available at 10 syringe exchange sites in Oregon (Eugene, Roseburg, Grants Pass, Corvallis, Bend, Redmond, Oregon City, Portland x3 locations). Using state general funds, the HIV Program has worked to increase the number of syringes made available for local county health department partners.

Homelessness and Lack of Affordable Housing:

Just under 1 in 3 MMP participants (31%) reported a need for shelter or housing services in the past 12 months; of those, 22% reported an unmet need. Even worse, 15% of

respondents to the 2013 CAREAssist survey considered themselves homeless at some point in the past 2 years. These clients were more likely to be younger, current smokers, to have more chronic medical conditions, and to have an unsuppressed viral load. In addition, 6% of CAREAssist clients spent time in jail, prison, or a detox center in the past year, which often created a break in housing or difficulty finding housing upon reentry to the community.

Among those in Part B Case Management in 2014, 143 (13%) received a Part B funded housing service, and 201 were served through the HUD-funded, Oregon Housing Opportunities in Partnership (OHOP) program. Despite these systems of support, an additional 86 OHOP eligible persons were on the waitlist for tenant based rental assistance.

The population growth in Portland has been accompanied by significant increases in housing costs statewide. Portland's average rent is now more than $1,200 per month (a 41% increase since 2010), and its vacancy rate is approximately 3%.[xiii] One analysis found that 58% of Portland's formerly lower-priced neighborhoods had gentrified during 2000 to 2013, the highest proportion among America's 50 largest cities.[xiv] Gentrified neighborhoods are concentrated in north and southeast Portland. As a result, many people of color have moved from north and northeast Portland to neighborhoods in east Portland and Gresham, areas that have higher-than-average rates of poverty, unemployment, and low educational attainment.[xv] In the five Oregon counties within the Portland MSA, an estimated 5,698 people experienced homelessness in 2015. Approximately two-thirds (66.7%) are in Multnomah County and half (54.6%) are unsheltered.[xvi] The rising costs and lack of available housing stock seen in Portland are mirrored in the Part B areas of the state, as well.

Incarceration:

Not surprisingly, people with a history of incarceration, and in particular those living with HIV, face many barriers upon release. The inter-related risk factors that are commonly found among offenders translate into high service needs – and gaps in receiving services –

[xiii] Working class priced out, kicked out in new Portland housing boom. The Oregonian. 2015, September 22. Available at http://www.oregonlive.com/watchdog/index.ssf/2015/09/post_19.html.

[xiv] Portland is the most gentrified city of the century. Fusion. 2015, February 4. Available at http://fusion.net/story/44321/portland-is-the-most-gentrified-city-of-the-century/.

[xv] Multnomah County. Multnomah County Comprehensive Gang Assessment. Available at https://multco.us/lpscc/multnomah-county-comprehensive-gang-assessment

[xvi] Oregon Housing and Community Services. Oregon Point-In-Time Homeless Counts, 2015. Available at http://www.oregon.gov/ohcs/Pages/research-point-in-time-homeless-count-in-oregon.aspx.

when prisoners return to the community. Attention to these needs is especially important given Oregon has one of the lowest recidivism rates in the nation.[xvii] While low rates of recidivism indicate success on the part of the Oregon Department of Corrections (ODOC) and other social service systems, it also means more offenders are added to the pool of individuals experiencing needs related to housing, employment, and health care for mental illness, addiction and HIV. From 2011 - 2014, 62 known PLWH were released from the Oregon Department of Corrections. This does not include those who did not disclose their HIV status while incarcerated, those who did not present a housing need upon release, or those who were being released from a Federal or county institution.

PLWH who cycle in and out of county jails also have high needs for shelter and other basic needs, and episodic incarceration puts them at risk of falling out of care, lack of adherence, and ultimately, lack of viral suppression.

Lack of Awareness of HIV Infection:

If diagnosed and treated early, people living with HIV are able to take advantage of life-extending medications and reduce HIV transmission up to 96%. About 4 in 10 PLWH diagnosed with HIV in Oregon are diagnosed late in their HIV infection.

To understand factors contributing to delayed diagnosis in Oregon, the Oregon Public Health Division conducted interviews with 17 people who met criteria for AIDS within 12 months of their HIV diagnosis during 2008–2010. Three themes emerged from the interviews: (1) Failure to identify risk for HIV; (2) Need for routine HIV screening; (3) Missed opportunities for diagnosis.

Many of individuals with delayed diagnosis are Latino or people who inject drugs. An epidemiologic assessment of Latino clients with delayed diagnosis indicated that a personal belief/cultural norm of not seeking medical care until one is sick was prevalent among clients. About 4 in 10 said they did not receive health care prior to HIV diagnosis because they felt there was no need for it; 43% said they only tested for HIV because they were very ill, including a group who were tested during inpatient hospitalization with advanced disease.

Stigma, addiction, and lack of access to health care and basic needs, like housing, transportation, and food, often prevents PWID from seeking medical care.

[xvii] OPB (2011). *Pew study finds low recidivism rate in Oregon prisons.* http://news.opb.org/article/pew-study-finds-low-recidivism-rate-oregon-prisons/

Linkage to Care:
Oregon has been very successful linking clients to medical care once they are diagnosed, with 85% linked within 90 days. However, a series of focus groups conducted in 2011 with PLWH in Oregon found that many current Ryan White clients were "out of care" at previous times in their lives. They said that during these periods, which lasted 1-15 years post-diagnosis, their main reasons for delaying HIV care were depression and denial, and drug and alcohol use. Expansion of patient navigation services, with a focus on addressing substance abuse and mental health issues, may help all newly diagnosed people get linked to care quickly, ideally within one month of diagnosis.

Mental Health Services:
Almost 1 in 4 MMP participants (24%) have major depression, and 35% had received either a depression diagnosis or treatment for depression in the previous year. Twenty nine percent had past-year diagnosis or treatment for anxiety. Fifty-eight percent of CAREAssist clients self-reported "depression, anxiety, or an emotional problem" on the 2013 survey.

Thirty percent of MMP participants received mental health services in the past year; another 24% reported needing, but not receiving mental health services.

Peer Support/Other Sources of Social Support:
Peer support (and social support more generally) are consistently identified by PLWH in Oregon as an urgent unmet need. About 1 in 10 MMP participants (11%) said they had received peer group support in the past year, but 53% of those who needed peer support, reported not being able to access it.

IPG members identified peer support for both newly diagnosed individuals and long-term survivors as a priority need.

Culturally-specific support services are also lacking. About half of Latino PLWH who were interviewed as part of epidemiological investigations of delayed diagnosis had not disclosed their status to anyone. Respondents commonly identified fear of rejection or HIV stigma as a barrier to status disclosure—and likely to HIV testing and status awareness, as well. In addition, only one respondent in that study reported participation in an HIV support or education group. Cascade AIDS Project offers a Gilead-sponsored monthly event called *Reencuentro* for Latinos with HIV to get together, learn about medication and other HIV-related issues, and share a meal. In addition, CAP's Latino

patient navigator hosts a dinner featuring Mexican food at the HIV Day Center once per month, in order to draw more Latino clients to that service. These events are well-attended and attendees have expressed the need for additional opportunities to gather.

Stigma:

Recent surveys have shown that the Portland MSA has the second largest concentration of people who identify as gay, lesbian, bisexual, or transgender (5.4%) in the nation.[xviii] Still, the Speak Out survey, conducted with more than 800 individuals identifying as LGBTQ in the Portland metropolitan area, showed that 57% of respondents sometimes modified their daily activities because of fear of stigma and discrimination. Eighty-two percent reported experiences of verbal harassment, 55% reported threats of violence or intimidation, and 23% had experienced violence based on sexual orientation or gender identity at some point in their lifetimes.

Data from Oregon's Medical Monitoring Project suggest stigma and discrimination toward people with HIV remains a problem. In 2013, nearly one in three (32%) people receiving HIV care in Oregon reported experiencing discrimination in the health care system and one in four (23%) reported feeling ashamed about being HIV-positive.[xix]

Transportation:

About 1 in 5 MMP participants (22%) reported needing and receiving transportation services in the past year, but 34% of MMP participants who reported needing help with transportation did not receive it. Transportation can be especially difficult for PLWH who live in the Part B area of Oregon, which has many rural and frontier areas. Although only 5% of MMP participants report one-way travel times of 90 minutes or longer, that small proportion has substantial difficulty seeing their medical providers as often as recommended, particularly in the winter months when travel over mountain passes further complicates access. In 2015, the Oregon HIV Program provided a contract to EOCIL to conduct a transportation assessment in rural Eastern Oregon. The agency was able to build key partnerships with Medicaid and other rural agencies to build new transportation options and better leverage existing resources for PLWH living rurally.

[xviii] Gallup 2015. San Francisco Metro Area Ranks Highest in LGBT Percentage

[xix] Oregon Health Authority. IPG Implementation Plan, 2013-2015. Available at http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/IPG/Documents/IPGImplementationPlan.pdf

Data: Access, Sources, and Systems

Identifying and using relevant data sources and data systems is vital to ensuring the Integrated HIV Prevention and Care Plan is as complete and accurate as possible. Collaboration among state/local health department colleagues from HIV Surveillance, HIV Prevention, Ryan White HIV/AIDS Programs, and other public health stakeholders, including private entities, helped the Oregon IPG identify the main data sources and data systems that were most appropriate for developing this plan.

Main Sources of Data Used for Oregon Needs Assessment & Care Continuum

Category	Data source/activity	Details
Surveillance & Epidemiology	HIV surveillance data	Collection, analysis, and dissemination of HIV case data
	HCV, STD, TB surveillance data	Collection, analysis, and dissemination of co-morbid disease data
	Special case investigations/ surveillance studies	Detailed case investigations, as needed—for example: 2014 ethnographic investigation of syphilis outbreak among MSM
	Data-to-Care initiative	Investigations of HIV cases with no viral load testing reports to reconnect people to care and improve HIV out-of-care estimates
	HIV Medical Monitoring Project	Population-based survey of people living with HIV who are receiving medical care in Oregon; as of 2016, MMP includes case-based sampling (e.g., some PLWH who may not be in care) as well as medical facility-based sampling
	National HIV Behavioral Surveillance Project	Known locally as "Chime In," Oregon became a NHBS site in 2016.
Other evaluations and assessments	CAREAssist client survey	Periodic survey of CAREAssist/Oregon ADAP clients (n=approx. 3,000, statewide) to assess client needs, health outcomes, and experiences with the program. Last conducted in 2013.
	Needs of PLWH around smoking cessation	Oregon had a R21 grant from National Institutes of Health and conducted additional client and

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		medical provider assessments.
	Epidemiology of recently diagnosed Latinos with HIV	Examined epidemiology of recently diagnosed Latinos to gain insight on risk perception, risk behaviors, testing patterns, and medical care usage.
	Qualitative analysis of delayed diagnosis	Qualitative interviews with 17 PLWH with delayed diagnosis.
Community meetings and forums	Statewide HIV/HCV/STD Integrated Planning Group (IPG)	HIV consumers, providers, and community stakeholders meet for all-day meetings, 3 times per year, to provide input to the Oregon HIVSTD, and VH Programs.
	Part A Planning Council	30-person citizen involvement group. Meets 7 times per year, 3 hour meetings, to set priorities for HIV service delivery and resource allocation.
Feedback from grantee programs and consumers	Part A and Part B case management client surveys	Consumer input about needs and program services
	Oregon Housing Opportunities in Partnership client survey	Consumer input about needs and program services
	HIV case managers	Regular meetings and communications
	CAREAssist Advisory Group	Consumer & stakeholder input about needs and program services—meets 4 times/year
Program Databases	CAREWare	Client utilization and other program data
	HIV testing data	sHIVer--HIV testing data from public test sites/CDC-funded tests

Local Data Policies

Most HIV-related policies in Oregon support HIV prevention and care goals. In 2012, Oregon Administrative Rules were revised to allow health care providers to obtain consent for HIV testing in a manner similar to that used for other common tests. In addition, Oregon Administrative Rules allow the state Public Health Division or a local public health authority to inform an individual who has had a substantial exposure to HIV of that exposure if there is clear and convincing evidence that disclosure is necessary to

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avoid an immediate danger to the individual or to the public. This Rule has been broadly interpreted by the Attorney General to allow data sharing for public health purposes, such as sharing viral load data with HIV case managers.

Other local data policies that support HIV care and prevention goals include Oregon's comprehensive human sexuality education laws, which require students to receive medically accurate HIV and STD prevention education at least five times during grades 6-12, unless a parent has requested that their child be excused.

Oregon was the first state to exempt syringes from the drug paraphernalia laws, which allows them to be sold in pharmacies and distributed legally through needle exchange.

Finally, in late 2013 and early 2014, the HIV Prevention Program convened a workgroup to develop messages supporting confidential HIV testing, in conjunction with plans to discontinue funding anonymous testing with federal grant funds. These decisions were made to support improved linkage to care, optimize opportunities for partner services, reduce stigma, and improve data collection and reporting.

Data We Dream About

Oregon's planning group regularly uses surveillance data from case reports and studies like the HIV Medical Monitoring Project as a foundation for planning activities. Some data that would be helpful are unavailable, and other data sources contain inherent limitations. As of 2015, Oregon became a National HIV Behavioral Surveillance site. Our first iteration of data collection (in 2016) will focus on high-risk heterosexuals, followed by MSM (2017), and PWID (2018). These survey data will be a rich source of data on risk and protective behavior, and findings will help inform ongoing updates to this Integrated Plan.

Some data questions/areas of interest and the ways we may be able to address these unanswered or partially answered questions are as follows:

- **Descriptive data about public sex venues:** The HIV Surveillance Program plans to collect data on ever-changing venues in 2016/2017, in preparation for their 2017 NHBS data collection cycle, which targets MSM and is venue-based. These data may also guide prevention activities.
- **Medical visits and viral load/CD4 testing:** Oregon, like other states, estimates medical care visits based on viral load data. In the past, these data have been well-correlated (e.g., among MMP patients, where we had both data points). However,

standards of care are changing, with some providers recommending longer intervals for long-term survivors who are medically stable. Therefore, we need a better measure for estimating who is out of care (e.g., <2 tests/visits may not indicate a medical danger) and/or a better understanding of provider practices so that we can appropriately interpret the data we have.

- **Meth use:** A qualitative study conducted in 2006, Community PROMISE, identified meth use as a strong risk factor for HIV transmission among MSM, but no data related to meth and HIV have been collected since then. NHBS may provide data on current meth use among people at risk for HIV.
- **Number of adults tested for HIV:** We think the BRFSS likely underestimates the number of Oregonians who have ever been tested for HIV because of the methodology used and population reached. NHBS data may help us develop testing estimates for populations with specific risk behaviors, which would be helpful for planning.
- **Out of care and undiagnosed:** We could develop better out of care estimates if we had better data on HIV testing intervals. Through HIV case reports, we collect last negative test from people who test positive.
- **PrEP and nPEP data:** The Oregon program plans to collect data related to PrEP and nPEP, in order to better understand how many providers are providing it, how many patients might need it, and where the gaps are. We would also like to evaluate the efficacy of PrEP and nPEP distribution once they are more widespread.
- **Service needs and barriers among communities of color:** HIV-related disparities by race and ethnicity remain. The Oregon HIV Program plans to conduct needs assessments to better understand service needs and resource gaps.
- **Syphilis screening among MSM:** MMP data begins to address this question, but real-time data with larger samples would be helpful in addressing our current epidemic.
- **Transgender risk, needs, and barriers to services:** The HIV Surveillance Program conducted key informant interviews in 2015 to better understand the needs of transgender people in Oregon. This formative work provided background for future development of a larger assessment that would, ideally, use HIV testing and surveys to assess the male-to-female (MTF) transgender population's size, HIV positivity rate, and HIV risk behaviors, since little local data currently exist.

Oregon's Integrated HIV Prevention and Care Plan

Development of Oregon's 2017-2021 Integrated HIV Prevention and Care Plan was a joint effort that engaged persons at higher risk for HIV infection, PLWH, service delivery providers, and other community stakeholders. The plan sets forth Oregon's commitment to collaboration, efficiency, and innovation to achieve a more coordinated response to addressing HIV. The Integrated HIV Prevention and Care Plan establishes the blueprint for achieving HIV prevention, care, and treatment goals.

Oregon's Goals, Objectives, Strategies, and Activities

Oregon's Integrated HIV Prevention & Care Plan uses the National HIV/AIDS Strategy (NHAS) as the organizing framework. The three NHAS goals are:

(1) Reducing new HIV infections

(2) Increasing access to care and improving health outcomes for PLWH

(3) Reducing HIV-related disparities and health inequities

These goals, strategies, and activities were developed by Oregon's statewide HIV planning group, the IPG. This is a high-level summary of how Oregon intends to do its work towards reaching the National HIV/AIDS Strategy Goals. Between Oct 1 and Dec 31, 2016, Oregon's HIV Prevention and Care Program staff, in collaboration with community partners, will be developing specific work plans for implementing these strategies and activities. Our implementation plan will include timelines, accountabilities, evaluation measures and metrics. One of our first tasks is to prioritize strategies that we believe will have the greatest impact on incidence, quality of life, and/or disparities. As noted throughout this document, this is a statewide plan. Therefore, all partners will work together and some state-funded activities will be contracted out to agencies who are better positioned to do the work.

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Objective 1.1: Increase the percentage of people living with HIV in Oregon who know their serostatus to at least 90%

Strategy 1: Targeted HIV testing

- Create new partnerships, venues, and methods for providing locally-tailored, culturally competent education and testing to targeted populations (in Oregon, these populations include MSM, PWID, and partners of PLWH), and populations facing HIV-related disparities, including communities of color (specifically, Latinos, Black/African Americans, and American Indian/Alaska Natives) and transgender individuals.
- Develop and implement culturally-responsive testing strategies. These may include supporting promising practices for which little data currently exist or retooled approaches where previous efforts have not worked as implemented (e.g., pharmacist-delivered interventions, peer approaches, corrections testing, etc.). Approaches will be based on available data related to best practices, as well as local experiences.
- Ongoing analysis of surveillance and testing data to focus activities on populations, venues, & geographic areas with the highest risk and/or positivity rates.

Strategy 2: Promote universal HIV testing in clinical and non-clinical settings

- Promote policy initiatives focused on universal screening in clinical settings; support incentives and metrics around HIV testing.
- Create a HIV/STD/HCV Best Resources Practice Guide for Coordinated Care Organizations (CCOs) that includes routine HIV screening and best practices for taking a sexual health history.
- Support Home Testing, especially in rural areas and among populations known to have delayed diagnosis.
- Partner with non-traditional partners to offer HIV testing. This may include community-based clinics, like Federally Qualified Health Centers (FQHCs) (e.g., La Clinica, Wallace Medical Concern, Virginia Garcia) and population-specific and/or culturally-specific service organizations to expand HIV/STD/VH testing and health education beyond AIDS Service Organizations.
- Provide technical assistance to support screening in various health care settings that are interested in and able to expand their services to include HIV/STD/VH work (e.g., dental, school-based health centers, recovery programs, methadone maintenance, and correctional settings). Providing trained testers may be a better

strategy in some geographic locations and where integrating HIV testing through a reimbursable model is not feasible.

Strategy 3: Support partner services

- Expand the capacity to integrate HIV services work and other STD casework and follow-up services, to include: HIV testing, HIV/STD prevention and health promotion activities, explaining lab results to clients, linkage and retention in care for clients and others identified as sex and needle sharing partners, encouraging PrEP for HIV-negative people who test positive for syphilis and/or gonorrhea.
- Improve data collection and analysis regarding sexually transmitted diseases (particularly syphilis and gonorrhea), in order to better target services for populations at high risk for HIV transmission—for example, to provide PrEP to HIV-negative individuals who test positive for syphilis and/or gonorrhea.
- Increased outreach and education about Partner Services for non-LHD partners who provide HIV testing, including AETC efforts to educate health care providers.
- Ensure that culturally-specific partner services are widely available across the state; assess how to operationalize this activity.

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Objective 1.2: Reduce the number of new diagnoses from 5.5 cases per 100,000 (about 220/year) to 4.5 cases per 100,000 (about 180/year).

Strategy 1: **Intensify HIV prevention efforts among MSM and PLWH**

- Provide and support partner services, testing, and prevention focused on PLWH and MSM (culturally-competent; using high-intensity prevention approaches, such as Testing Together; develop more targeted messaging for sub-groups within these communities).
- Provide social support through activities such as The Link, Positive Force NW, and Real Talk (Part A) and activities like Guys Like Us and Poz Dinners (Part B).
- Support continued and expanded implementation of High-Intensity Prevention Behavioral Interventions (e.g., CLEAR); assess need for expansion and adaption of interventions to specific populations (e.g., people of color, transgender individuals, MSM/PWID).
- Use social networking apps to link high-risk people to care and prevention services (can include on-line outreach, peer networks, and navigators).

Strategy 2: Intensify HIV prevention efforts among people who inject drugs (PWID)

- Increase syringe exchange at venues statewide, focusing on areas with highest prevalence of IDU and/or HIV/HCV.
- Assess local syringe access policies and practices and develop a policy agenda to address the most essential and attainable changes.
- Increase trainings to health care providers and law enforcement on syringe exchange to promote understanding, and appropriate information and referral services.
- Promote locations where patients can buy clean needles or exchange syringes (see also Objective 3.1, Strategy 4)
- Promote stronger linkages and partnerships between HIV prevention, HIV care, syringe exchange, and substance use treatment programs.

Strategy 3: Support structural interventions to prevent HIV

- Increase condom distribution in high-prevalence counties around Oregon, and in a wider variety of settings (e.g., schools, bars, barber shops, etc).

- Increase evidence-based social marketing efforts, using multiple modes: radio, TV, online, social media, billboards, and popular opinion leaders from various communities.
- Develop new partnerships to inform structural interventions, ensuring they are culturally competent and effective (e.g., Oregon Youth Sexual Health Partnerships (OYSHP) can inform IPG discussions around school-based HIV prevention/care efforts; mental health and substance abuse providers).
- Leverage digital tools and new technologies (e.g., Oregon Reminders) to promote harm reduction and behavioral change.
- Promote a variety of policy changes, as identified in other sections throughout this plan, and which address the social determinants of health.

Strategy 4: Support and expand Pre-Exposure Prophylaxis (PrEP) and nPEP

- Assess PrEP access (e.g., coverage by CCOs and others, need for nontraditional access points), provider knowledge, and unmet client need associated with PrEP/nPEP.
- Educate providers through various means, such as a HIV/STI/HCV Best Resources Practice Guide for CCOs that includes PrEP/nPEP, Grand Rounds, and CD Summary. Explore possibilities for expanding HHSC role in providing one-to-one clinical support/mentoring for primary care providers.
- Expand PrEP/nPEP availability by recruiting/identifying at least one provider per county to deliver PrEP/nPEP. Encourage STI providers, in particular, to become PrEP providers.
- Educate consumers through community forums and innovative messaging.
- Promote PrEP/nPEP access through multiple means, like Oregon Reminders and patient PrEP coordinators/patient navigators, such as CAP's "Get PrEP," which assists with insurance coverage for medication, health insurance exchange registration, and Drug Assistance Programs (DAP).
- Ensure targeted PrEP and nPEP services are available for high priority and potentially underserved communities, including MSM, transgender people, Latinos, Black/African Americans, and other people of color.

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Objective 2.1: Increase the percentage of newly diagnosed people linked to HIV medical care within one month of HIV diagnosis to at least 85%.

Strategy 1: Expand patient navigation and early intervention services

- Increase EIS, linkage to care and patient navigation for newly diagnosed. Seek opportunities to further enhance local health department capacity for STD services and EIS services to link the newly diagnosed, in areas not already doing so.
- Develop and implement tailored patient navigation services for PLWH with co-morbid mental health and substance abuse issues. Provide specialized training, as needed, for staff via state DIS consultation and technical assistance.
- Assess feasibility/desirability of providing Anti-Retroviral Treatment & Access to Services (ARTAS) training for patient navigators and a pilot groups of case managers who will target services to high-acuity/high-risk clients who are newly diagnosed.
- Use innovative forms of technology to link people to care (e.g., Grindr, Scruff, BBRT, and other on-line profiles for MSM).

Strategy 2: Ensure that medical providers, HIV testers, clinics, and social service agencies have the knowledge and capacity to make appropriate referrals to HIV medical services

- Promote better integration with statewide information & referral resources (211) (Participate on OHA 211 committee, Street Roots guide).
- More cross-training on care resources for people doing testing and more training on testing resources for those providing care services.
- Promote stronger linkages and partnerships between HIV and substance use and mental health treatment programs.

Strategy 3: Support sustainable sources of peer support for newly diagnosed individuals

- Support local ASO/NGOs to host lists of trained peers and/or develop peer support programs and disseminate information about on-line sources of information and support networks.
- Provide funding for peers to attend State Mental Health and Addictions peer support training.

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- Develop social marketing materials for newly diagnosed (e.g., post video clips on HIV services Websites that target newly diagnosed by featuring PLWH telling their stories).
- Promote Positive Self-Management Program. Assess client needs and barriers in attending/participating in the program.

Strategy 4: Create streamlined and client-centered processes for PLWH in Ryan White Care Continuum services in Oregon

- Implement a database solution for the CAREAssist program (Oregon's AIDS Drug Assistance Program) to allow for online enrollment and improved coordination of care.
- Pilot community-based/out-stationed CAREAssist enrollment staff to increase access for new enrollees and members with questions and concerns.
- Increase the use of HIV surveillance data to streamline entry and engagement in HIV services.
- Add an "Other" category for gender and a write-in space on the CAREAssist application, in order to ensure that the application form is more inclusive.

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Objective 2.2: Increase the percentage of people with diagnosed HIV infection who are retained in HIV medical care to 90%.

Strategy 1: Ensure access to core medical services through case management and care coordination services

- Continue paying for medical care expenses, including insurance premiums and prescription/medical services co-pays, through the CAREAssist Program.
- Monitor expansion of CAREAssist services through initiation of an open formulary and expanded coverage of preventive health services that support core medical services, such as tobacco cessation, and substance abuse treatment services like naltrexone, suboxone/buprenorphine, and methadone.
- Ensure HIV case management/care coordination services are available to PLWH statewide to promote engagement in care.
- Assess Oregon providers' practices related to evolving standards for "retention in care." (e.g., what do Oregon providers consider appropriate intervals for patients who are virally suppressed and healthy? Take into account telemedicine, phone visits).

Strategy 2: Ensure access to supportive services to support retention in medical care and adherence to ART

- Continue to provide and, where possible, expand housing and support services for marginally housed and homeless clients, and those at-risk for losing housing.
- Provide mental health and substance abuse treatment; promote integration of these services with HIV medical care, in alignment with health care transformation in Oregon.
- Provide other supportive services, like transportation, utility assistance, and food/nutrition services, to PLWH whose basic needs are not being met, in order to support retention in medical care.

Strategy 3: Promote and expand trauma-informed approaches to services

- Assess all program materials and systems for trauma-sensitivity.
- Ensure that case management staff and other providers in Ryan White Care Continuum receive training in trauma-informed care (TIC) and have opportunities to obtain TIC excellence certification.

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- Examine Medical Monitoring Project data related to trauma and post-traumatic stress disorder (PTSD). Share data with Ryan White providers, in order to facilitate discussion about ways to address findings within our programs.
- Assess the needs of long-term survivors to better understand how to prevent/reduce treatment fatigue.

Strategy 4: Take deliberate steps to increase the capacity of Oregon medical systems and providers to serve people living with HIV

- Expand the use of telemedicine to better serve PLWH living in medically underserved areas in Oregon with HIV specialty care and other medical specialist services.
- Assess feasibility of partnering with traditional health workers and other community-based programs to support testing and linkage to care.
- Promote better coordination with Federally Qualified Health Centers (FQHCs); support FQHC capacity to provide testing and linkage to HIV medical care.
- Provide PEP/NPEP/PrEP training for emergency department and trauma doctors (AETC).
- Expand participation in AETC provider trainings to include mental health providers, substance abuse providers, case managers, and additional Ryan White Care Continuum staff. Address importance of health literacy and trauma-focused care for populations that historically have had challenges navigating systems.

Strategy 5: Continue Data-to-Care work, identifying and linking individuals not in care

- Continue Data-to-Care work statewide, using Surveillance data to identify PLWH who have fallen out of care.
- Ensure coordination with Ryan White providers, to ensure that individuals identified through the Data-to-Care process as out of care are re-engaged and linked to services.
- Develop monitoring and assessment plan that integrates data from all available data sources, including surveillance data, administrative databases, and medical clinic records, in order to enhance monitoring of initial entry into and retention in HIV care.

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Objective 2.3: Increase the percentage of people with diagnosed HIV infection who are virally suppressed to at least 80%.

Strategy 1: Monitor adherence through multiple methods, and use data for ongoing needs assessment and targeting/triaging of services to those not suppressed

- Establish policies and procedures for reviewing viral load data for Ryan White clients on an ongoing basis, in order to ensure clients who may need additional support receive targeted intervention. Analyze data by race/ethnicity, behavioral risk factors (e.g., substance abuse), and other factors to ensure ongoing monitoring of populations facing disparities.
- Establish policies and procedures for routinely obtaining self-reported adherence from all Ryan White patients and case management clients, and develop procedures for systematically assisting and following up with clients who are having adherence difficulties.
- Conduct assessment with PLWH who are not suppressed to better understand their unmet needs and barriers to HIV medical care/adherence.
- Monitor pharmacy refill data for adherence monitoring when medication refills are not automatically sent to CAREAssist clients.

Strategy 2: Use innovative approaches to support adherence, including use of technology and non-traditional partnerships

- Promote and expand use of Oregon Reminders.
- Expand the use of telemedicine to better serve PLWH living in medically underserved areas in Oregon with HIV specialty care and other medical specialist services.
- Develop workgroup that includes key stakeholders across the continuum (PLWH, pharmacists, CAREAssist staff, and case managers) to assess the feasibility and desirability of using pharmacist-supported approaches for supporting adherence and conducting viral load testing—especially in rural counties. This may include collaborative practice agreements and other partnerships.
- Add local questions to the Medical Monitoring Project to better understand adherence problems faced by unstably housed and homeless PLWH.
- Assess the feasibility of integrating Directly Administered ART adherence support (DAART) for clients with substance abuse disorders, possibly in conjunction with patient navigation services.

Strategy 3: Ensure the highest level of HIV care is provided to patients in Oregon, including through Coordinated Care Organizations (CCOs)

- Promote the inclusion of HIV-related metrics and measures, where appropriate: such as universal HIV screening, documentation of sexual histories, or an HIV treatment adherence metric for CCOs and/or an optional CMS measure of viral suppression as a State measure.
- Create a HIV/STI/HCV Best Resources Practice Guide for CCOs.
- Assess CCO formularies for concurrence with DHHS guidelines. Share results with AETC for targeted education, as needed.
- Develop stronger partnerships across Oregon's transformed health care system to achieve a more coordinated response to HIV services—recruit representatives from Medicaid, FQHC, OPCA, dental care, and other key care delivery sectors for IPG membership.
- Assess HIV provider needs around providing screening, management, and treatment for depression and other mental illnesses in combination with adherence counselling for patients.
- Participate in the HIV affinity groups that are being formed by Centers for Disease Control & Prevention, Center for Medicaid Services, and HIV/AIDS Bureau.

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Objective 3.1: Eliminate disparities in new HIV diagnoses rates (e.g., address higher diagnosis rates among MSM, Black/African Americans, PWID, and Latinos).

Strategy 1: Promote/support culturally appropriate HIV prevention programs

- Assess how CLEAR Program and/or other high impact prevention programs could be adopted/expanded in Oregon to include culturally-specific services for groups with disparities (e.g., Latinos, Black/African Americans, MSM/PWID). Support broader intersectional sexual health advocacy, including reproductive justice. Include HIV-related efforts within a more holistic wellness framework.
- Develop, support, and promote targeted prevention messaging and programming for transgender individuals (e.g., develop a positive and inclusive campaign focusing on trans health; LGBTQ-specific medical, support, and behavioral health services; build relationships and share messaging through events like Orange is the New Black Night).
- Work with and within already-trusted community-based agencies (e.g., Urban League, FQHCs) to provide sexual health and HIV prevention activities in a more "mainstream" environment.
- Expand online resources that can be accessed by non-gay-identified men. Offer free condoms, home test kits, and prevention education materials that can be accessed anonymously.
- Identify additional opportunities to incorporate sexual health education as part of multicultural events, such as street fairs, community events and celebrations which are geared towards communities of color.
- Target internet hook-ups/public sex environments with prevention messaging, targeting a wide range of MSM, including non-gay-identified MSM, as well as with condom and home test kit distribution.
- Create plan to analyze surveillance data on an ongoing basis to identify where new diagnoses among communities facing disparities are occurring and target interventions, as needed.

Strategy 2: Support anti-stigma policies and systems changes by embedding anti-stigmatizing and equity-focused procedures throughout Oregon's HIV care and prevention system

- Analyze all HIV prevention and care services systems (policies, procedures, language, and environment) in public health and in grantee organizations for

cultural competence, using an equity lens and make changes, as needed to ensure our programs are welcoming and do not create or reinforce stigma.

- Assess current and future public health interventions to ensure that they first and foremost honor cultural experiences, beliefs and values around health.
- Provide data and education around evidence-based prevention practices in support of policy approaches that reduce barriers to accessing and carrying injection drug works (Oregon's exclusion laws).
- Assess what other state and local policy approaches may be needed to support the full range of HIV prevention activities in Oregon.

Strategy 3: Promote messages that help reduce stigma, are empowering, and sex positive

- Research and then disseminate evidence-based anti-stigma campaigns.
- Diversify prevention messaging to include images of LGBTQ youth, transgender people, women, families, and people with addictions (including messages that normalize/destigmatize addictions).
- Continue to support MSM-focused prevention messaging that is sex positive and sexy.
- Empower LGBTQ youth by promoting strength-based prevention messaging that makes connections to LGBTQ history—an approach supported by local focus group testing.
- Address HIV fatigue through messaging that (a) tailors messages to risk (e.g., doesn't assume all MSM are engaged in the same behaviors/honors diversity within MSM communities) and (b) includes strength-based messaging (e.g., personal stories from partners in mixed status relationships).
- Continue work in schools to promote comprehensive human sexuality and healthy relationships education, as well as support of anti-bullying/safe school policies, to support full inclusion of LGBTQ communities.

Strategy 4. Expand syringe access and disposal options

- Document need for syringe access and disposal by doing counts (like cigarette butt counts to evaluate smoke-free policies). Promote those data and solutions, using techniques shown to be effective in tobacco prevention.
- Include illegal drugs/works in "drug take back" programs—e.g., no questions asked disposal.

- Provide data and education around evidence-based prevention practices in support of safe injection facilities in areas where we know overdose, HIV, and HCV is most prevalent.
- Consider policy approaches to making non-prescription syringe sales more prevalent and to promote pharmacy-based syringe access and disposal (e.g., if stores sell syringes, they need to provide disposal options; prohibitions against selective syringe sales/refusal to sell to certain customers).
- Coordinate with other public health endeavors to align overdose prevention/ prescription drug monitoring, viral hepatitis, and HIV work. Ensure alignment of Oregon's HCV and HIV plans.
- Partner with nontraditional groups like environmental groups and Parks & Recreation on increasing options for syringe access and disposal.

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Objective 3.2: Eliminate disparities in delayed diagnosis rates among groups in Oregon currently experiencing disparities (Latinos, PWID).

Strategy 1: Focus on HIV testing and linkage to care among PWID

- Support PWID-focused services in a one-stop shopping clinical environment; this may include harm reduction centers that focus on wound care, abscess prevention, and issues of high importance to PWID, as entry to primary care (including assistance with health insurance enrollment), HIV prevention and services, and HCV services for PWID.
- Expand services provided at syringe exchange to include distribution of home test kits, on-site HIV/STD/HCV testing, and referral to medical services.
- Expand access to Medication Assisted Therapies (MATs), naloxone, and IM naltrexone by including them on the CAREAssist formulary and other formularies, as appropriate.
- Provide data and education around evidence-based prevention practices in support of expanded HCV treatment access.
- Explore the use of pharmacy-based interventions to expand access to services for rural and/or underserved areas (e.g., syringe access and disposal, testing, information and referral).
- Develop new partnerships with substance abuse treatment services to ensure better coordination.
- Create plan to analyze surveillance data on an ongoing basis to identify where new diagnoses among PWID (especially those with delayed diagnosis) are occurring and target/modify interventions, as needed.

Strategy 2: Focus on HIV testing and linkage to care among Latinos

- Develop/support inclusive and holistic Latino health services—HIV prevention must also include HIV care and, ideally, some primary care or general wellness (e.g., community-based, full service).
- Bring targeted services, testing, and prevention activities to underserved Latino people where they are: for example, day workers, farm workers, monolingual Spanish speaking communities, undocumented persons, and the NE work center in Portland.

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- Support Latinos in enrolling in health insurance programs. Provide education and messaging around options for undocumented people to access care and testing services.
- Increase the availability of bilingual, bicultural peer navigators and peers/mentors—explore ways to expand these Minority AIDS Initiative-type services within and beyond Part A. Provide disclosure support for Latino PLWH.
- Create plan to analyze surveillance data on an ongoing basis to identify where new diagnoses among Latinos (especially those with delayed diagnosis) are occurring and target/modify interventions, as needed.
- Develop partnerships with Latino-specific community-based organizations to develop implementation plan for Latino-focused strategies and activities.

Strategy 3: Promote messages that help reduce HIV stigma and promote universal HIV/STD testing

- Diversify prevention messaging to include images of more people of color, LGBT youth, transgender people, women, families, and people with addictions (including messages that normalize/destigmatize addictions). Use a "targeted universalism" approach to messaging that "addresses the overlaps" and helps get messaging to those who don't see themselves at risk.
- Use data collected through NHBS, MMP, and other local data systems to assess prevention needs of high-risk heterosexuals/"men of unknown risk" and promote positive messaging that could support their early testing and disclosure.
- Normalize HIV by increasing awareness of status, through messages about universal testing and availability of in-home rapid tests; promote home testing among those most fearful of testing/disclosing (e.g., Latinos, PWID, non-gay-identified MSM).
- Explore the potential of providing prevention education and testing in nontraditional venues: for example, Wallace Medical Concern, testing van, needle exchange van, and agencies that serve low-income individuals,

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Objective 3.3: Eliminate disparities in viral suppression rates among groups in Oregon currently experiencing disparities (American Indians, Black/African Americans, MSM/PWID).

Strategy 1: Commit to authentic and long-term community engagement and partnership building with communities facing disparities (specifically: communities of color, transgender, and substance abuse/PWID communities)

- Build partnerships with Regional Health Equity Coalitions and other organizations serving communities facing disparities (e.g., Indian Health Services, Portland Area Indian Health Board, Urban League, Q Center, Oregon Latino Health Coalition, Causa, NARA, NAYA, refugee organizations, Apano). Support broad-based equity work that address the social determinant of health and root causes of health inequities.
- Conduct needs assessments (e.g., community listening sessions, focus groups, etc.) within communities facing disparities.
- Diversify IPG membership and leadership, including recruiting and retaining representatives from transgender, PWID, and communities of color on IPG.
    - Consider offering participation grants (e.g., paying individuals who are not part of the RWCA continuum or prevention-funded agencies, in order to support attendance).
    - Identify influential people in communities of color, PWID, and transgender communities and ask for their help.
- Develop new partnerships with sex worker community.

Strategy 2: Expand access to culturally competent and culturally-specific medical and behavioral health services

- Create and promote welcoming environments for PLWH and people at risk across the state. For example: get medical providers to be listed on GLMA resource page as either out LGBTQ providers or Straight for Equity providers. Distribute maps.
- Support better and more widespread behavioral health services for LGBTQ and PWID that include sexual health promotion and risk reduction assessment and counseling.
- Increase the availability and use of community health workers (CHWs) within the RWCA system, including HIV+ people (which also promotes PLWH leadership).

Ensure that CHWs are trained in LGBTQ health. Expand role to include linkage and retention in care. Expand role, as appropriate, to include safe injecting.

- Expand cultural competence (racial and ethnic, LGBTQ, PWID) for medical providers, as well as competence related to sexual health (e.g., understanding sexual diversity, taking a sexual health history). Explore mandating cultural competency training as requirement for medical licensure in Oregon
- Enroll LGBTQI, communities of color, and PWID in health insurance.
- Increase the availability of culturally-specific peer navigators and peers/mentors—explore ways to expand these MAI-type services within and beyond Part A.
- Incentivize/support providers who already serve communities of color to expand their knowledge and skills in HIV prevention and care.
- Create plan to analyze surveillance data on an ongoing basis to identify patterns related to viral suppression and identify areas (at the population, geographic and organizational levels) that may need additional support.

Strategy 3: Promote PLWH leadership and leadership within the HIV community among people of color, transgender, PWID and other communities facing disparities

- More use of community health workers, including HIV+ people (which also promotes PLWH leadership). Provide support to get PLWH, especially PLWH from groups with disparities, trained and certified as community health workers, so they can seek paid employment within the field.
- Recruit people of color onto leadership bodies, and then work to retain them.
- Train PWID to provide prevention education and secondary exchange services.
- Increase the valuation of lived experience in hiring. Increase efforts to hire within the communities.
- Create and distribute local PLWH success stories. These should include diverse images and experiences, including serodiscordant couples, transgender people, women, families, people of various races and ethnicities, and PWID

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Resources Needed

Oregon is working to develop a data-driven prioritization and resources allocations process for getting the work started quickly, monitoring its progress, and achieving objectives over the course of this five-year plan.

Challenges and/or Barriers to Consider and Overcome

- Like all jurisdictions, we are still trying to improve our methods for creating a reliable and valid estimate of people infected with HIV, but not yet diagnosed.
- As we increase testing in high-risk communities and the concurrent percent of Oregonians who know their HIV status, we may increase the number of new diagnoses, as well—at least in the short-term.
- Like many jurisdictions, Oregon operated under some constraints related to being a governmental entity. For example, although we have money to allocate to these activities, we often lack the position authority to hire staff. We address these barriers through partnerships and strategic contracts and grants, but these challenges can cause delays.
- Oregon's public health system is currently described as a "patchwork" because jurisdictions have varying capacity to deliver the full range of foundational public health services. Meaningful gaps were found in all local public health authorities (LPHAs) and as of this writing, no foundational programs or capabilities had yet been fully implemented in any of the 34 LPHAs. This five-year plan is being issued at the start of Oregon's public health modernization process.
- Oregon's population is growing and changing rapidly, creating a dynamic HIV care and prevention services environment. We aim to stay abreast of these changes through ongoing surveillance and assessment.

Collaborations, Partnerships, and Stakeholder Involvement

Stakeholder & Partner Contributions

As described in previous sections, this plan was created in full collaboration with Oregon's statewide HIV planning group, the IPG. IPG partners participated in six in-person meetings to review local data, identify strategies, and propose activities to help Oregon reach its goals. Examples of the tools we used in facilitated discussions are provided in Appendix B.

Additional in-person meetings between OHA staff and the leadership teams at key partner agencies (e.g., Multnomah County Health Department, Cascade AIDS Project, HIV Alliance) to review the community planning process and draft documents also took place in July and August of 2016.

New Stakeholders & Partners to Engage in 2017-2021

The IPG identified several stakeholder groups and partners who were not involved or were under-represented in the planning process. Identified gaps include demographic groups (especially transgender, Latino, and American Indian/Alaska Native stakeholders), geographic areas (particularly Region 2, which are lower-incidence counties with 50-70 PLWH), and service provider groups (specifically, Veterans, education, and faith-based). We also seek broader input and engagement with injection drug users and people from the substance abuse treatment community.

OHA is aware of these gaps and has committed to addressing them. The IPG Membership Committee continues to work on recruitment, and OHA is reviewing our membership policies to assess them for ways to promote more flexibility and inclusion. The Oregon HIV Program has also begun discussions with community stakeholders to address these gaps. We are aware that these gaps need to be addressed through a long-term commitment to community engagement and authentic partnership. Therefore, we are exploring future use of participation grants, sponsorships, and partnerships on projects like community needs assessments in communities facing HIV-related disparities.

Letter of Concurrence

A letter of concurrence from the IPG, signed by the IPG Co-Chairs, the Oregon AIDS Director (Part B grantee) and Multnomah County's Adolescent Health and HIV/STD/HCV Program Manager (Part A grantee) is provided in Appendix C.

People Living With HIV (PLWH) and Community Engagement

As described elsewhere, this plan was developed in partnership with Oregon's statewide community planning group, the IPG, which includes PLWH, representatives from all the Ryan White Parts and HIV prevention, and other key stakeholders in the prevention and care arenas. This plan is a living document, and Oregon has plans to continue community engagement on developing an implementation plan and a brief, outward-facing "visioning" document (similar to other states' "End HIV" documents) that will encapsulate the spirit of this document for an external audience.

Representation of PLWH and People at Risk

Forty percent of IPG membership are PLWH. We need to expand representation of people who are not infected with HIV, but may be at risk. OHA has been successful in recruiting PLWH from different geographic areas of Oregon, MSM, and women. However, we aim to include more people of color, more PWID, transgender individuals, and more consumers who are not employed.

How PLWH Contributed to Plan Development

PLWH were involved in all phases of plan development, and will be involved in its monitoring and implementation. Primary needs data were collected from PLWH, including data from the Medical Monitoring Project, CAREAssist, HIV surveillance systems, and other CDC and HRSA-funded programs. Additional data were collected through special studies with PLWH. These data were then shared with the IPG for "member checking" and as a basis for developing data-driven local strategies for addressing the Oregon HIV/AIDS Strategy goals. Finally, PLWH and other IPG members reviewed the plan and provided a letter of concurrence.

Community Engagement Strategies

This plan was developed primarily in collaboration with and under the guidance of the IPG, 40% of whom are PLWH. The IPG spent two years reviewing data and engaging in facilitated discussions about local data, in order to develop the strategies and activities delineated in the plan.

Although Oregon considers this a successful integrated planning process, we are also aware of areas in which we need to improve. As noted previously, we need to work harder to develop and maintain ongoing, collaborative partnerships with communities of color, transgender communities, and communities that include people who inject drugs and those who serve them. We have committed to activities in the plan that will help us build and sustain these relationships over the next five years and beyond. We have also listed activities to help promote PLWH leadership in our community. All of these strategies will strengthen our planning processes in the future.

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Monitoring and Improvement

Ongoing monitoring of the Integrated HIV Prevention and Care Plan will help the IPG and our community stakeholders continuously measure progress towards our goals and objectives, select strategies for collecting information, and analyze information to inform decision-making and improve HIV prevention, care, and treatment efforts.

Oregon's Monitoring and Improvement Plan

Process for Updating the IPG, Other Planning Bodies, and Community Stakeholders

OHA staff and others responsible for implementing activities listed in the plan will provide updates on progress, accomplishments, and challenges at thrice-yearly IPG meetings throughout the five-year period, and will solicit structured feedback for ongoing quality improvement. Written updates will also be posted on the IPG website and distributed to a wide network of stakeholders via the HIV/VH/STD listserve.

The Integrated Plan will be reviewed by the IPG planning body at least annually, and initiatives may be revised, as needed, in order to be responsive to changing conditions. Annual revisions will be published on the IPG website.

Plan to Monitor & Evaluate Implementation of Oregon's Goals and Objectives

OHA staff will meet at least monthly to review progress on plan objectives. Staff will report back to Oregon's HIV community planning group, the IPG, at each of the three meetings held annually with the full membership. We will develop, as needed, ad-hoc IPG sub-committees to provide input on the activities associated with specific initiatives and to help monitor plan activities in those areas. OHA staff and IPG members will also report back to the Part A Planning Council on a regular basis, to be determined by the Planning Council.

Strategy for Assessing and Improving Health Outcomes along the HIV Care Continuum

Oregon plans to continue its Data to Care initiative, using HIV surveillance data to identify HIV-diagnosed individuals not in care, link them to care, and support the HIV Care

Continuum. Oregon successfully used a health department model to implement Data-to-Care, re-engaging people who had fallen out of care and updating our estimates of those not-in-care to account for individuals who no longer live in Oregon. Current estimates indicate that only about 5% of PLWH in Oregon who know their status are truly not in care.

Furthermore, Oregon currently conduct regular matches with its Part B client lists to examine viral load data for clients. This allows case managers to follow up directly with clients who do not achieve and maintain suppressed viral loads, and also allows the program to better understand the factors related to viral load suppression and non-suppression on a population level. This allows us to better target our care and prevention resources. Internal discussions related to data privacy and security are ongoing related to whether and under what circumstances the Part A grantee could share viral load data from surveillance with contractors. However, Part A currently collects viral load data from clients and used those data to target resources to those clients who are not virally suppressed.

Oregon is committed to conducting special qualitative studies with virally nonsuppressed individuals, as needed, to collect additional data related to barriers and facilitators to care. Individuals who are not virally suppressed will be priority candidates for some of the new patient navigation services proposed in this comprehensive plan.

Also, as noted earlier in the plan, Oregon hopes to improve its estimate of individuals who have ever been tested for HIV and estimates of average testing intervals among priority populations participating in the NHBS. These data will help us develop more precise estimates of people who do not know their status, and will help us better target our prevention activities and messaging.

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