

**Ryan White Part B
HIV Care & Treatment Program**

COMPREHENSIVE PLAN
and
Statewide Coordinated Statement of Need

STATE OF OREGON

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The Oregon Health Authority, Public Health Division, HIV/STD/TB Program gratefully thanks and wishes to acknowledge the work of the following Oregon HIV Care Coalition subcommittees in developing this document:

Statewide Coordinated Statement of Need Work Group

Oregon HIV Care Coalition

Oregon HIV Medical Case Management Task Force

Statewide HIV Services Quality Management Task Force

CAREAssist Advisory Committee

Workgroup for the Integration and Improvement of HIV Services.

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INTRODUCTION

Oregon's Comprehensive HIV Planning Process

The HIV Care and Treatment Program convenes the Oregon HIV/VH/STI Integrated Planning Group (IPG) in partnership with the Oregon HIV Prevention Program funded by the CDC, which is a statewide prevention and services planning body composed of 45 members including people living with HIV/AIDS, representatives from state and county government agencies, HIV service providers, and community leaders. This integrated planning group is responsible for supporting the National HIV/AIDS Strategy by identifying strengths, needs, gaps and service priorities resulting in a statewide comprehensive plan that will support people living with, affected by, or at risk for HIV, viral hepatitis and sexually transmitted infections. Additionally, the HIV Care and Treatment Program convenes several program/task specific advisory groups which include the CAREAssist (AIDS Drug Assistance Program) Advisory Committee, the HIV Case Management Task Force, the HIV Medical Care Coordination Task Force, the "Getting to Work Initiative" Advisory Committee and the Statewide Coordinated Statement of Need Work Group. The program further participates as a member of the Oregon HIV Services Quality Management Task Force, a statewide cross-parts workgroup which aims to coordinate quality management initiatives across the state. In addition to the HIV Care & Treatment Program-convened planning committees, an OHA cross-program planning group called the Work Group for the Improvement and Integration of HIV Services (WIISH) meets monthly and brings together state programs such as HIV Community Services, CAREAssist, HIV Prevention Program, STD Program and Viral Hepatitis Program to develop and implement the Ryan White Part B Program EIIHA Plan.

The Oregon HIV Care and Treatment Program incorporates five distinct planning processes, with five written documents, into a statewide HIV care and treatment comprehensive planning process that produces the **Comprehensive Plan** document. These five planning processes were formally developed into one contiguous planning process:

- ❑ **The Statewide Coordinated Statement of Need** developed by the SCSN Work Group,
- ❑ **A Strategic Plan** with Goals and Objectives developed by the Oregon HIV/VH/STI Integrated Planning Group,
- ❑ **Ryan White Part B Program Implementation Plan** that is developed by HIV Care and Treatment staff each year,
- ❑ **The Quality Management Plan** reviewed by the Oregon HIV Services Quality Management Task Force, and
- ❑ **The EIIHA Plan** developed by the Work Group for the Improvement and Integration of HIV Services (WIISH).

Statewide Coordinated Statement of Need

Introduction

► Why Create a Statewide Coordinated Statement of Need (SCSN)?

Language in Section 2617 (b) (6) of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) requires grantees to develop a Statewide Coordinated Statement of Need (SCSN). The SCSN planning process provides a collaborative mechanism to identify and address significant care and treatment issues related to the needs of people living with HIV and AIDS (PLWH/A), and to maximize coordination, integration, and effective linkages across all Ryan White Program Parts.

► What is in the Statewide Coordinated Statement of Need (SCSN)?

Oregon's 2012 Statement of Need is organized into the following sections:

- *Developing Oregon's Statewide Coordinated Statement of Need*—a description of participants and the collaborative process we used;
- *Overview of HIV/AIDS in Oregon*—a description of the latest trends in HIV epidemiology statewide and a discussion of emerging service populations and populations with special needs;
- *Unmet Need in Oregon*—an estimation of the number of PLWH/A in Oregon who are aware of their infection, but not receiving medical care, and information about people who receive their HIV diagnosis late in the course of their disease;
- *Oregon's HIV Continuum of Care*—a description of services currently provided to PLWH/A statewide, as well as a discussion of service needs and gaps identified by PLWH/A and providers through client interviews, regional Listening Sessions and other data collection efforts;
- *Needs of Special Populations*—a description of the needs of special populations, including but not limited to adolescents, people who inject drugs, homeless individuals, and transgender individuals.
- *Cross-Cutting Service Goals and Issues*—important service issues identified by the SCSN Advisory Group and our shared goals related to those issues;
- *Appendices*—the appendices include additional data, such as a full list of SCSN Advisory Group members, SCSN timeline and tasks, a list of data sources used to create this document, and data from regional Listening Sessions (including number and type of participants; identified themes).

Developing Oregon's Statewide Coordinated Statement of Need

► Who Participated and What Planning Process was Used?

The Oregon HIV Care and Treatment Program (the Part B grantee; part of Oregon Health Authority) was responsible for convening partners across the Ryan White continuum of care, facilitating the development/update of the SCSN, and submitting the SCSN to the Health Resources and Services Administration (HRSA). The SCSN Advisory Group included people living with HIV and AIDS (PLWH/A) and representatives from public agencies, federally-recognized Indian tribes, and all Ryan White grantees. A full list of Advisory Group members is available in Appendix A.

The Part B grantee designated Program Design & Evaluation Services (PDES), a public health research and evaluation group affiliated with both the Oregon Health Authority and the Multnomah County Health Department, to facilitate the process.

The planning process took place between May and December of 2011. Stakeholder input was gathered in three key ways:

- In-person feedback at two full-day Oregon HIV Care Coalition (OHCC) meetings, in May and November 2011. OHCC is a statewide body comprised of service providers, consumers, and other stakeholders;
- In-person feedback from HIV+ consumers at Listening Sessions in Eugene and Medford, and through phone interviews with consumers from frontier and rural counties in Eastern Oregon and the Oregon Coast. Data from six community forums conducted with consumers in the Portland metropolitan area during April and May 2011 were also included;
- E-mail feedback, from August – December 2011, from the SCSN Advisory Group, an ad-hoc body that included PLWH/A and representatives from public agencies, federally-recognized Indian tribes, and all Ryan White grantees.

A full timeline showing key deadlines, tasks, and responsible parties is provided in Appendix B.

Overview of HIV/AIDS in Oregon

Understanding the epidemiology of HIV/AIDS in Oregon is a key component of health services planning. Data presented in this “Overview” section are drawn from the 2009 Epidemiological Profile.

HIV/AIDS Prevalence in Oregon

► How Many People are Infected with HIV in Oregon?

From 1981 through 2009, 8,467 Oregonians were diagnosed and reported with HIV infection, and 41 percent (n=3,466) had died. Since 1997, approximately 275 new diagnoses have been reported each year in Oregon, and an average of 85 Oregonians with HIV died each year. The number of Oregon cases living with HIV increased each year, from 2,717 in 1997 to 5,001 in 2009.

The actual number of people living with HIV infection in Oregon is about 21% higher because many people who already have HIV infection have yet to be tested and do not yet know they are infected (MMWR 2008). Furthermore, an additional, unknown number of people with HIV who were diagnosed elsewhere and moved to Oregon after diagnosis may also require HIV-related services in Oregon, but would not be reflected in the official surveillance used in this section.

► What are the Characteristics of People Living with HIV in Oregon?

Of the 5,001 living cases reported at the end of 2009, 87% were men and 49% were aged 35-49 years. Among men living with HIV disease, 71% reported their transmission risk as sex with men (MSM), 9% as MSM with injection drug use (MSM/IDU), and 8% as IDU alone. Among women, high-risk heterosexual contact accounted for 60% of prevalent cases, and 24% of women reported IDU transmission risk.

► How are HIV Cases Distributed in Oregon?

Service delivery in Oregon is divided geographically into the Portland Transitional Grant Area (TGA), which includes five counties in and around the Portland metropolitan area (Clackamas, Columbia, Multnomah, Washington and Yamhill)¹, and the Balance of State, which includes the remaining 31

¹ The TGA includes a sixth county: Clark County in Vancouver, Washington. Information on Clark County cases is not included in the Oregon SCSN.

Oregon counties stretching to the Washington, California, Idaho, and Nevada borders. Key facts about the distribution of PLWH/A in Oregon² include:

- Most PLWH/A (73%) lived in the Portland TGA at time of initial diagnosis.
- Fifty-six percent of cases lived in one county: Multnomah. Multnomah County is over-represented in the epidemic, as only 1 in 5 Oregonians live in Multnomah County compared to almost 3 in 5 PLWH/A who lived there at diagnosis.
- Balance of State counties with 50 or more PLWH/A include the following seven counties: Deschutes, Douglas, Jackson, Josephine, Lane, Linn, and Marion. Clackamas and Washington Counties (in the TGA) also counted more than 50 cases.
- Although Oregon is a large, primarily rural state, approximately 90% of PLWH/A receiving Ryan White CARE Act (RWCA)-funded services lived within 25 miles of Interstate 5 at time of diagnosis.

Recent Diagnoses (2005-2009)

► What are the Characteristics of Recent Infections in Oregon?

Data from cases diagnosed within the most recent five years for which data are available (2005-2009) provide a window into the current state of HIV in Oregon. Key facts about recent diagnoses in Oregon:

- Diagnosis rates were 6 times higher among males than females (13 vs. 2/100,000) during this five-year period.
- Diagnosis rates increased among people aged 20-29 during this period, although the average age at diagnosis was 37 years.
- New diagnosis rates were 3.5 times higher among blacks and African Americans and 1.2 times higher for Hispanics than for non-Hispanic whites.
- 51% of people with newly diagnosed HIV were Multnomah County residents.
- MSM transmission continues to be the leading risk reported in Oregon, accounting for 61% of all new cases diagnosed between 2005 and 2009 and 69% of new cases among men.
- 75% of diagnoses among women during this time period were due to sex with men.

Late Diagnosis

► How Many People are Diagnosed Late and Who are They?

Many Oregonians continue to be diagnosed with HIV infection at a late stage of disease. Approximately 40% of the 1,380 cases diagnosed during 2004-2008 either had AIDS at the time of their initial HIV diagnosis or they progressed to AIDS within 12 months of initial HIV diagnosis. Late diagnosis was more common among some groups, including:

- Hispanics (compared to non-Hispanic whites)
- Men with injection drug use or unknown HIV risk (compared to MSM)
- Rural residents (compared to urban)

² These data reflect county of residence at time of diagnosis. Because people are mobile, and diagnosis may have occurred many years ago, these data should be considered along with other more current data sources when assessing geographic distribution.

- Older patients—people over age 40, with relative risk of late diagnosis highest among those age 60+ (compared to people < age 40)

Co-morbidities

Sexually transmitted diseases (STDs) are indicators of ongoing sexual behavior that could transmit HIV, and having a concurrent STD may increase the likelihood that a PLWH/A could transmit HIV to uninfected partners.

► How Many PLWH/A are Diagnosed with Syphilis, Gonorrhea, and/or Chlamydia?

Rates of early syphilis, gonorrhea, and Chlamydia are much higher among Oregon men with previously reported HIV infection than among the general population of Oregon. For example, average annual rates during 2005-2009 were:

- 116 times higher for **early syphilis** (233/100,000)
- 450 times higher for **gonorrhea** (1,351/100,000)
- 3 times higher for **Chlamydia** (902/100,000)

► How Many PLWH/A are Co-Infected with Hepatitis?

Co-infection with hepatitis B (HBV) and/or hepatitis C (HCV) is of concern for health services planning, but hepatitis C did not become reportable in Oregon until 2005, so data are limited and should be considered a minimum estimate. Some key facts about HIV and hepatitis co-infection:

- From 2005-2009, at least 5% of deaths among PLWH/A in Oregon were liver-related, most from chronic hepatitis C.
- Prevalence estimates of HCV/HIV co-infection vary, depending on the data source; they range from 7% (Epi Profile, 2011) to 11% (CAREAssist 2009) to 21% (MMP, 2011).
- 5% of PLWH/A in Oregon are estimated to have HIV/HBV co-infection.

► How Many PLWH/A are Co-Infected with Tuberculosis?

Oregon has never observed a substantial number of TB/HIV co-infections. Of 888 TB cases in Oregon since 2001, only 44 (5%) were known to also have HIV.

HIV Mortality

The advent of antiretroviral medications in the mid-1990s dramatically improved treatment outcomes among PLWH/A. In Oregon, five-year survival rates increased from about 40% of people diagnosed in 1990 to about 90% of those diagnosed in 2004.

► Do Some People Living with HIV Die Faster than Others?

After adjusting for age, there were no differences in case fatality rates for PLWH/A diagnosed with HIV in Oregon from 1998-2009 by sex, race/ethnicity, region, or transmission category. Average survival time decreased with age at diagnosis. Differences by age at diagnosis probably reflect differences in duration of infection; that is, those who are older are likely to have been infected longer. However, it is possible that differences in survival may be related to a decreasing capacity to combat HIV disease as people age.

Unmet Need for Medical Care in Oregon

HRSA requires Ryan White grantees to estimate annually the number of PLWH/A who are aware of their HIV infection, but not receiving medical care.

People who are receiving regular, high-quality medical care for HIV/AIDS typically visit their doctors at least three times a year and submit blood specimens for testing the quantity of HIV virus circulating in their blood (“viral load test”) and immune function (typically a “CD4 test”). Laboratory results for CD4 and viral loads are used as a proxy for medical care for the purpose of calculating estimates of PLWH/A who are in medical care and who might have an unmet need for primary medical care.

► **How Many PLWH/A Have an Unmet Need for Primary Medical Care?**

During calendar year 2009, 81% of people living with HIV, not AIDS (PLWH) and 72% of people living with AIDS (PLWA) had at least one CD4 or viral load test reported to the Oregon HIV Surveillance Program.

Overall, 25% of PLWH/A did not have any reported CD4 or viral load tests during 2009, suggesting that up to 1 in 4 PLWH/A are not receiving regular medical care (Table 2).

Table 2: Oregon Estimate of Unmet Need, 2009

Population Sizes	Value	Percent	Data Source
A. PLWA aware of infection, 1/1/09-12/31/09	3,280	65%	eHARS (%= A/A+B)
B. PLWH aware of infection, 1/1/09-12/31/09	1,781	35%	eHARS (%= B/A+B)
Care Patterns—Met Need	Value	Percent	Data Source
C. PLWA who received CD4 or VL testing in 2009	2,365	72%	eHARS and Orpheus (%= C/A)
D. PLWH who received CD4 or VL testing in 2009	1,434	81%	eHARS and Orpheus (%= D/A)
Calculated Results—Unmet Need	Value	Percent	Data Source
E. PLWA who did NOT receive CD4 or VL testing in 2009	915	28%	A-C (%=E/A)
F. PLWH who did NOT receive CD4 or VL testing in 2009	347	19%	B-D (%=F/B)
G. PLWH/A who did NOT receive CD4 or VL testing in 2009	1,262	25%	E+F (%=G/(A+B))

► **What are the Characteristics of PLWH/A with Unmet Need for Medical Care?**

Some people were more likely to have an unmet need for primary medical care:

- People with AIDS were 1.6 times more likely to have unmet need compared to people with HIV (28% PLWA vs. 19% PLWH)
- Hispanics (36%), Native Americans (36%) and Blacks or African Americans (33%) were more likely to have unmet need than whites (23%)
- Males with IDU risk (37%) or MSM/IDU risk (38%) had more unmet need than MSM (23%); female IDUs (27%) had more unmet need than females with heterosexual transmission risk (19%)
- Rural cases (33%) had more unmet need than urban cases (24%)
- Foreign-born cases (31%) had more unmet need than US-born cases (24%)

► **Why are PLWH/A in Oregon Out of Care?**

Qualitative data from interviews and group sessions conducted in 2011 indicate that many current Ryan White clients in the Part B area of Oregon were not receiving HIV medical care at some point in their infection, despite knowing their status. Overall, clients reported that their reasons for being out of care were mostly personal, rather than system-related. The main reasons clients cited for being out of care—some for periods of 1 to 15 years post-diagnosis—included denial and depression, side effects of HIV medications or fear of starting medications, and alcohol and drug abuse. A few clients mentioned that issues with their doctor caused them to fall out of care.

The two leading reasons clients gave for entering HIV medical care (or re-entering it after falling out of care for a while) were 1) being forced into care because of illness and 2) being connected through the efforts of a family member, friend, or another individual who reached out.

Based on these data from PLWH/A, we believe some of the needs of people aware of their HIV+ status but not in HIV medical care include mental health services, alcohol and drug treatment services, better education regarding HIV medicines and treatment, and social support/early intervention services that can provide a smoother transition between testing and entry into care.

► **What are the Needs of People Infected But Unaware of their Status?**

It is difficult to identify people who are HIV infected but unaware of their status and comprehensively describe their needs. One assessment that provides insight into the needs of this population in Oregon involved newly reported HIV cases who identified as Hispanic. We focused on this population because Hispanics are often diagnosed late, and may have specific cultural and linguistic needs in addition to those faced by all people who are infected but unaware of their status.

In March and April 2010, a bilingual, bicultural interviewer made follow-up telephone calls to 56 individuals who were reported with HIV between October 1, 2009 and March 31, 2010 and listed on the case report as Hispanic. Three individuals were determined to be ineligible because they told the interviewer they were not Hispanic. Of the remaining 53 potential respondents, the interviewer completed 23 interviews (43%), discovered 12 disconnected telephone numbers, and was unable to reach 18 potential interviewees after multiple attempts. There were no refusals. Most interviews (83%, n=19) were conducted in Spanish.

Most respondents did not report barriers to getting HIV tested or to accessing medical care once infected. At the time of interview, all respondents but one were receiving HIV medical care, and the one who was not had been diagnosed less than one month and was in the process of getting enrolled.

However, many respondents reflected a social norm of not accessing medical care unless one is sick. About 4 in 10 said they did not receive health care prior to HIV diagnosis because they felt there was no need for it. Likewise, 43% of respondents got HIV tested only because they were ill, including seven who were tested at the hospital when their HIV infection was likely very advanced.

Social support around HIV appeared to be lacking among this group of interviewees. About half had disclosed their HIV status to at least one person and about half reported knowing someone else with HIV, but there was no correlation between status disclosure and knowing someone with HIV.

Respondents commonly identified fear of rejection or HIV stigma as a barrier to status disclosure—and

likely to HIV testing and status awareness. In addition, only one respondent reported participation in an HIV support or education group.

Similar to those who reported being out of care after knowing their status, our limited data indicate that the barriers to learning one's HIV status or entering care in Oregon are not classic systemic issues, such as lack of insurance, but rather interpersonal issues such as denial or social norms that discourage medical care unless sick.

Oregon's HIV Continuum of Care

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 directs state and local grantees to spend at least 75% of grant funding on core medical services, defined by HRSA as: outpatient and ambulatory health services; health insurance premium assistance; pharmaceutical assistance; oral health care; substance abuse outpatient services; medical nutritional therapy; home health care, community-based health care, and hospice services; mental health services; early intervention services; and medical case management, including treatment adherence services. The remaining 25% of funding may be spent on a wide range of support services, defined as "services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS." Important supportive services provided in Oregon include non-medical case management, housing, medical transportation, psychosocial support, linguistics, and food and nutritional assistance.

The "HIV Continuum of Care" section details key core medical and supportive services provided across the HIV continuum of care in Oregon, and documents identified needs of PLWH/A related to the specific service area. Data in this section are drawn from a wide range of sources, listed in Appendix C. Two of the main data sources are the HIV Medical Monitoring Project and the 2009 CAREAssist client survey, both described in the text. A third data source is client feedback gathered in the 2011 listening sessions, community forums, and interviews as part of this SCSN process. A summary of those data are provided in Appendix D.

Challenges in the HIV Service Environment

The dire economy has dramatically impacted clients seeking HIV services in Oregon. Like others with limited resources, HIV clients are negatively affected by the rising costs of food, fuel, and housing. HIV service providers report increased anxiety among their patients; clients report difficulty competing for scarce resources within the larger service sector.

► How Great is the Demand for Services among Oregon's General Population?

In 2010, 1 in 4 Oregon adults (n=754,845) received services from the Oregon Health Authority or Oregon Department of Human Services, including cash assistance (n=105,340, 3.6% of Oregon adults), medical assistance/health insurance (n=333,565, 11% of Oregon adults), and nutrition assistance through the Supplemental Nutrition Assistance Program (SNAP) (n=572,375, 19% of Oregon adults). Clearly, the demand for services has increased among all sectors of the population, not just people living with HIV. For example, 11% percent more households received SNAP benefits in July 2010 compared to July 2009.

► Challenges within the Public Health System

The public health infrastructure is also severely challenged by the economic crisis. Local health departments and the State Oregon Health Authority and Department of Human Services are operating with huge deficits. Both have already experienced cuts in services and/or personnel, and more are

expected in the next biennium. Community-based agencies are reporting a decrease in private donations and grant dollars that decrease their ability to provide the same level of services that clients have received in past years. For various reasons, including lack of capacity, many local health departments in Oregon's Balance of State (BOS) have opted out of providing Ryan White Program-funded case management and supportive services over the years, transferring the authority and responsibility for providing these services to the Oregon Health Authority. This has created both challenges and opportunities for delivering high-quality services in a new regional model of HIV care coordination.

SCSN Advisory Group members identified coordination and collaboration among service providers and across HIV care and prevention as key challenges within the HIV service environment. Both clients and providers say that the delivery of HIV care separate from other chronic diseases hinders quality care by creating administrative burdens for staff and confusion for clients, and by introducing unnecessary complexities into the system of care with inefficient and potentially duplicative service delivery. There have already been changes in health insurance for Oregonians dependent on public systems, and this has disrupted continuity of care for many PLWH/A. As Oregon moves forward with health reform, more dramatic changes are anticipated, and will require a high level of coordination and integration across all service systems.

HIV clients in Oregon have always depended on a continuum of services that extend beyond Ryan White Program-funded services, and use the Ryan White Program as a payer of last resort. However, the options available to them beyond Ryan White funds are shrinking—and need for the services has grown dramatically among the general population in Oregon since the last SCSN was developed in 2008. For this reason, descriptions of services available in the HIV continuum of care are generally limited to RWCA or other specifically HIV-related services.

Outpatient Medical Care in Oregon

The full range of primary care services are provided to PLWH/A through a combination of public and private health systems and community-based agencies. Individuals with private or public insurance access primary care through their designated health care providers.

► How Many Medical Providers Manage HIV Medical Care in Oregon?

As of April 2011, there were 70 medical providers working in 36 facilities across Oregon who actively manage HIV medical care for one or more PLWH/A. These providers include 65 MDs, two DOs, two nurse practitioners, and one physician assistant. About 6 in 10 providers (59%) are located in the Portland TGA, 22% are in the Part B service area served by HIV Alliance, and 19% are sited in the remainder of the Part B service area. This distribution is roughly similar to the distribution of PLWH/A in Oregon.

However, there are several geographic areas where PLWH/A might be underserved in regards to HIV care. There are few or no providers located in many rural communities in Eastern Oregon and along the North and South Coast areas, which means the small numbers of patients who live there must travel significant distances to access HIV medical care.

► What are the Characteristics of Medical Facilities Providing HIV Care in Oregon?

According to a 2007/2008 assessment of medical facilities in Oregon, most HIV facilities providing HIV medical care (69%) are private sector practices; the rest are a combination of public and community-based entities. About 1 in 3 facilities—particularly facilities serving higher numbers of PLWH/A—have some type of social support provider (e.g., health educator, social worker, case

manager) co-located with their HIV medical care providers. In addition, about one-third of the facilities offer additional medical support services like treatment adherence help, risk reduction counseling, or an on-site pharmacy. Very few offer important ancillary services like dental health, mental health, or substance abuse care within the facility.

► **The Ryan White Parts C & D Clinic: Multnomah Co. HIV Health Services Center**

The HIV Health Services Center (HHSC) is the largest provider of HIV care in the state of Oregon, serving over 1,000 clients in 2010—an estimated 1 of 4 people living with HIV in the Portland metropolitan area. HHSC has been a Ryan White provider since 1990, and has long participated in HIV/QUAL data collection. The clinic has existing linkages and partnerships with many community-based agencies and is the only Parts C and D provider in Oregon. All clinical providers at HHSC have a minimum of ten years' experience, and support staff members have received specialized training in HIV services. Services provided include: primary medical care; medications adherence support; dental/oral health assessment and referral; nutritional assessments and counseling; substance abuse and mental health assessments and treatment, referral and counseling; case management; high resolution anoscopy and infrared coagulation treatment; peer mentoring; and hepatitis education. In addition, HHSC has been an AIDS Education & Training Center (AETC) clinical training site for a five-state region since 1999, providing preceptorships for physicians, nurses, and pharmacists.

HHSC provides medical care and support services within the context of a health department initiative called Building Better Care (BBC). The BBC model is designed to improve health outcomes through a proactive, patient-centered medical home model that is accessible and cost-effective. The model's foundation is team-based care and rigorous, continuous quality improvement.

HHSC currently has four care teams. Each team includes a medical provider, community health nurse, medical assistant, and a medical case manager. Provider teams are also supported by a pharmacist, a pharmacy tech, a part-time psychiatric nurse practitioner, a part-time mental health consultant, front office staff, peer mentors, and administrative staff. Each team provides care to an assigned panel of patients, in order to promote strong relationships between patients and clinic staff. Everyone on the team maximizes his or her contribution by fully utilizing individual skills and abilities in support of the work, and patients benefit from better continuity of care and increased adherence to medical regimens.

► **What Role Do Part C Clinics in Neighboring States Play?**

Because of the lack of medical providers in the large geographic area east of the Cascade Mountains, some PLWH/A in Eastern Oregon travel across state lines to seek HIV medical care. An estimated 14 PLWH/A in Eastern Oregon receive care from the Part C clinic in Boise, Idaho and 17 receive HIV care at the Part C clinic in Walla Walla, Washington because those facilities are closer and easier to access than medical care facilities in Oregon. Other PLWH/A in Eastern Oregon travel long distances within state for their care, either to Portland or other Oregon cities outside their region.

Overall Needs and Gaps in Medical Care

Data for this section were drawn from two main data sources: 2009-2010 medical records and interview data from the HIV Medical Monitoring Project and data from a 2009 survey of CAREAssist (Oregon's AIDS Drug Assistance Program) clients.

► **What is the HIV Medical Monitoring Project?**

The HIV Medical Monitoring Project (MMP) is a national project funded by the Centers for Disease Control & Prevention, and currently conducted in 17 states and 6 cities. These 23 project areas are estimated to include over 80% of the total HIV/AIDS cases in the United States. MMP assesses clinical outcomes and behaviors of HIV+ adults receiving medical care in the United States. Data include patient interviews and information abstracted from medical records.

In Oregon, data collection will cover the years 2007-2014. The most recent data, cited here, were collected from 539 participants and represent PLWH/A who received medical care in Oregon in 2009-2010. MMP participants include people receiving Ryan White-funded services and people who are not. For example, about 50% of MMP participants were enrolled in CAREAssist, but many others were enrolled in private plans and did not receive health insurance premium assistance from CAREAssist.

MMP participants were demographically similar to reported cases of HIV, giving a rough indication that PLWH/A in Oregon are not disproportionately in or out of medical care based on race, ethnicity, gender, age, or sexual orientation.

► **What Data Do We Have from CAREAssist?**

In 2009, a self-administered survey was mailed to all CAREAssist clients (n=2137 at that time); 1210 clients (58%) returned the survey. The survey was provided in both Spanish and English, and special efforts were made to increase response rate among younger clients. The final sample was representative of the CAREAssist population, except that younger clients, particularly those under age 30 were still under-represented. The survey provides data from a large sample of Ryan White clients on important topics like overall health and well-being; co-morbid conditions; use of medical services, antiretrovirals, and lab testing; housing stability; and met and unmet medical and supportive service needs.

► **How Good is Access to HIV Medical Care in Oregon?**

Among MMP participants (who were selected because they received medical care in the year of sampling), access to care was good. For example:

- **98%** reported having health insurance or coverage, and only 6% reported an insurance gap at some point in the past 12 months.
- **100%** reported having a “usual source of HIV care” in the past 12 months.
- **95%** of those diagnosed in the past 5 years had their first HIV medical visit within 3 months of diagnosis; 5% entered care between 3-12 months post-diagnosis.

► **How Far do PLWH/A Travel and How Difficult is it to Get to HIV Medical Care?**

About 2 in 3 MMP participants (66%) said they travel 30 minutes or less each way to get to HIV medical care. However, distances varied greatly among participants, with one-way trips ranging from 1-300 miles. About 1 in 10 MMP participants (12%) said their travel time to HIV medical care is more than 1 hour each way.

About 1 in 9 MMP participants reported difficulty getting to HIV medical care: 10% said that getting to HIV medical care was “somewhat difficult” and another 4% characterized it as “very difficult.”

► **How Often do PLWH/A Seek Care?**

MMP participants had an average of 4 past-year, face-to-face visits with their medical providers (median: 4, range: 1-18). CAREAssist clients also reported seeing their HIV medical providers frequently; almost two-thirds (61%) reported seeing their HIV clinician four or more times in the past year. Conversely, only 5% reported seeing their clinician less than once every six months; of those, very few (n=5) said

they had zero past-year visits to their HIV clinician. CAREAssist clients in the Portland metropolitan area reported seeing their doctor more frequently than those in the Balance of State, possibly because of greater distances between the doctor's office and home, as well as fewer transportation options in non-metropolitan areas.

► **How Often do PLWH/A Receive CD4 and Viral Load Testing?**

Seventy-five percent of MMP participants had 3 or more CD4 counts in the past year, and 80% had at least one undetectable viral load.

► **How do PLWH/A Rate their Overall Physical Health?**

Several different measures on the CAREAssist survey indicate that CAREAssist clients are experiencing poorer physical and mental health and well-being than the general population. Although 71% of CAREAssist clients rated their health as good or better, the average physical health scores on a standardized measure (the SF-12) were lower than average for the general population.

► **How Many PLWH/A Have Other Chronic Medical Conditions?**

Many PLWH/A in Oregon live with multiple chronic conditions, in addition to HIV disease. Some of these chronic diseases are simply part of the aging process, while others may be complications of long-term HIV infection and/or treatment with HIV medicines.

Eighty percent of CAREAssist clients reported having one or more chronic condition, in addition to HIV disease. Two conditions that can have a dramatic impact on functioning and quality of life were the most commonly reported: over half of clients (54%) reported "depression, anxiety or emotional problems" and more than 1 in 3 (38%) reported chronic pain. About 1 in 5 reported conditions like arthritis/rheumatism, hypertension/high blood pressure, or lung/breathing problems, including asthma. Eleven percent reported co-infection with hepatitis C.

Medical record data from MMP also indicate a prevalence of medical co-morbidities. For example, 39% of MMP participants had documentation of hypercholesterolemia or hypertriglyceridemia, 37% had depression diagnoses, and 28% hypertension diagnoses. More than half of MMP patients (52%) reported chronic pain, and 38% are prescribed medicine to manage their pain.

► **What is the Overall Need for HIV Medical Care in Oregon?**

For those engaged in HIV medical care, the care that is available appears to be accessible and frequently used. Furthermore, there did not appear to be disproportionate barriers for specific demographic groups, although CAREAssist clients in the Balance of State reported fewer medical visits than those living in the Portland TGA.

However, PLWH/A in Oregon are heavily dependent on public systems to fund HIV medical care. The CAREAssist Program eliminates financial barriers to HIV medical care and appears to level the playing field for low-income PLWH/A. This service is used by roughly half of PLWH/A in Oregon.

The high prevalence of serious co-morbid medical conditions also reveals significant health burden among PLWH/A in Oregon, and warns of a correspondingly significant, ongoing need for program services, including outpatient medical care, health insurance and pharmaceutical coverage. Given lower physical health scores, more frequent self-reports of poor or fair health, and the higher prevalence of chronic pain among older CAREAssist clients, demand for medical and pharmaceutical services are likely to remain high and even increase further as the PLWH/A population ages.

Barriers to Accessing Medical Care

Ryan White clients participating in the 2011 Listening Sessions and interviews reported that it is easy to gain entry into HIV medical care for most of those who are ready to access it.

Rural and frontier clients are a notable exception since HIV medical care is simply not available in their home communities. Rural clients said they had no trouble entering care, but long distances between home and doctor—up to 3 to 5 hours' drive one-way for many in Eastern Oregon, for example—create ongoing barriers to care. Limited choice of medical providers in other areas of Part B Oregon can also create barriers. Clients gave examples of being “fired” from care for missing appointments or having interpersonal problems with local providers, and then needing to travel out of town to access care through a new provider.

In addition, clients in Part B Oregon reported experiences of stigma and lack of cultural competence while accessing medical care. For example, one client summed it up this way: *“You’re already having trouble being HIV+ in a rural community, and then when you have a physician who treats you like crap, you don’t want to go back. There’s such a limited choice. Why would we want to go back to them?”*

Health Insurance

► How are PLWH/A Insured in Oregon?

The State of Oregon has a unique ability to provide health insurance for virtually every person living with HIV/AIDS in Oregon through the CAREAssist Program (Oregon’s ADAP). The Oregon HIV Care and Treatment Program (Part B Grantee) uses Ryan White ADAP funding to pay health insurance premiums and co-pays for eligible PLWH/A who are not insured through Oregon Health Plan (OHP). By ensuring payment of premiums and providing uninterrupted coverage for these clients, the program leverages the Oregon Medical Insurance Pool (OMIP) to ensure universal coverage for even high-risk clients. Additionally, enrollment into the newly funded federal high risk insurance pool (PCIP) is facilitated by its co-management by OMIP. OMIP/PCIP coverage is available to Oregon residents with qualifying medical conditions that would otherwise restrict their individual health insurance coverage through private insurers. HIV/AIDS is a qualifying medical condition for OMIP/PCIP, and in 2010, OMIP/PCIP covered more CAREAssist clients (41%) than any other single insurer.

► How Many People are Served by CAREAssist?

In 2010, CAREAssist served 2,784 unduplicated clients statewide. There were 435 new CAREAssist clients in 2010, an 8% increase in overall enrollment from 2009. Enrollment has been steadily increasing for years. For example, enrollment has increased 44% since 2007, when the program served 1,928 unduplicated clients.

All CAREAssist clients are low income, with household incomes of less than 300% FPL. About half (46%) are in the lowest income strata, with household income of \leq 100% FPL, and another 39% have income between 101-200% FPL.

► What Do CAREAssist Clients Say about the Program?

The CAREAssist Program last surveyed all clients in 2009 to assess client satisfaction with the program. Overall, 96% of the respondents felt the quality of CAREAssist services was either “excellent” or “good,” with the majority ranking it as excellent (70%).

► **What are the Challenges to Accessing Health Insurance in Oregon?**

Most clients in a 2011 qualitative assessment said that accessing health insurance was “*very, very easy*” and many expressed intense gratitude for CAREAssist services and the medicines that the ADAP program provides. However, it should be noted that many clients require a significant amount of help from their CAREAssist case worker and community-based HIV case managers in order to re-submit the eligibility documentation every six months that keeps them insured.

Upcoming challenges may include the reorganization of public health care systems in Oregon and nationally. Oregon chose to administer federal funds allocated to Oregon for the Pre-existing Conditions Insurance Pool (PCIP) under health care reform legislation (called Federal Medical Insurance Pool [FMIP] in Oregon). As noted, OMIP and FMIP currently insure almost half of all CAREAssist clients for whom CAREAssist pays insurance premiums. As part of health reform efforts, the OMIP and FMIP insurances will be ending on 1/1/14. Local efforts are now focusing on how to transition enrolled ADAP clients to the new system of insurance exchanges that will replace current coverage.

Prescription Drug Assistance

CAREAssist ensures that PLWH/A have access to antiretrovirals by paying for primary health insurance premiums. In addition, CAREAssist has a published drug formulary which provides other prescription drugs that PLWH/A may need, and for which their primary health plans do not pay. These drugs are available to clients when they fill their prescriptions at a CAREAssist contract pharmacy. CAREAssist’s drug formulary includes a wide range of medicines PLWH/A may need to maintain their health and quality of life, including smoking cessation drugs, and other medications that are not covered by Medicare Part D plans or OHP.

► **What is the Demand for Prescription Drug Help among Ryan White Clients?**

Most MMP participants (89%) reported current use of antiretrovirals. Because of the high prevalence of co-morbid health conditions, many PLWH/A take prescription drugs for other conditions, as well. For example, 38% said they took prescription drugs for chronic pain.

In 2010, the CAREAssist Program paid 105,951 prescription co-pays for clients.

► **Challenges Related to Pharmaceuticals and Pharmacy Services**

In 2011, CAREAssist streamlined its pharmacy services, in an effort to control costs. Most pharmacy services are now provided through contracted pharmacy vendors or through a contracted mail-order only. Some exceptions allow other pharmacies to be used, such as for pain medications or short-term acute care needs.

In a qualitative assessment conducted in 2011, some Part B clients reported difficulty accessing HIV medicines through pharmacists in small towns, due to stigma/discrimination issues or simply a lack of privacy.

Medical Case Management

Medical case management consists of assessment, coordination of services and linkages to services inside and outside the Ryan White system of care. All clients have access to medical case management services that include treatment adherence assessment and coordinating timely access to appropriate levels of medical and supportive services, through ongoing client assessment and care plan development.

Statewide, Medical Case Management (and non-medical case management) is performed by teams of nurses, social workers, and other professionals.

► **What is the Need for Medical Case Management in Oregon?**

Sixty percent of MMP participants (which include a mix of Ryan White clients and non-Ryan White clients) reported needing HIV case management services in the past year. Of those, about 55% received case management services, and 5% reported unmet needs for HIV case management. The main barrier to receiving case management services reported by those with unmet needs was confusion about where to go or whom to call for services.

In 2010, 959 clients in the Balance of State received Part B-funded HIV medical case management services. Demand for case management services in the Balance of State has increased steadily, and enrollment has increased 15% since 2007.

In 2010, 1,750 clients in the TGA received Part A-funded medical case management services; enrollment has increased by 17% since 2007.

► **How is Medical Case Management Delivered in the TGA?**

Part A-funded providers deliver services using the Chronic Care Model as the framework for the HIV care provided. The components of this model include community, self-management, delivery system design, decision support, and clinical information systems. Together, these components optimize positive outcomes for chronic conditions by creating an environment in which productive interactions and relationships thrive, resulting in patients and communities that are informed and active, and providers and community partners that are prepared and proactive (Jenkins 2011).

Specialty case management services are also offered in conjunction with primary case management services; this includes nursing case management, intensive case management for high acuity Latino and African and African American clients, and services for clients living in transitional housing units to ensure they are able to maintain housing, thereby impacting their ability to maintain medical care and medication adherence.

► **How are Medical Case Management Delivered in the Balance of State?**

Medical case management services in the Part B areas of Oregon are delivered through a combination of local county health department-based services and a regional service delivery model.

Since the last SCSN in 2008, ten local county health departments in the Balance of State have opted out of providing Ryan White Program funded case management and supportive services, simultaneously transferring the authority and responsibility for providing case management and other supportive services to the Oregon Health Authority. This has created both challenges and opportunities for delivering high-quality services in the Part B-funded areas of Oregon.

Nine local county health departments continue to provide HIV Medical Case Management services to approximately 25% of the Balance of State (the Part B service area) clients in case management. With the exception of one county that has a multi-disciplinary team, all HIV case management delivered by these local health departments is delivered by a Public Health Nurse who does both medical and psychosocial case management.

Seventy five percent of clients in HIV case management in the Balance of State are served under the regionally-based Medical Care Coordination Model of HIV case management. The Oregon Health Authority contracts with an AIDS service organization, HIV Alliance in Eugene, to provide HIV care coordination services and medical and non-medical case management to clients in a nine-county region. The region includes areas on the South Coast, southern I-5 corridor, and along the California border. HIV Alliance also provides non-medical case management in Marion County, which has the second largest number of HIV clients in the Part B area, as well as a large Latino and monolingual Spanish-speaking population; Marion County Health Department provides medical case management services in partnership with HIV Alliance.

HIV Alliance and Marion County Health Department provide medical case management services through AIDS-certified registered nurses located throughout the service region, and provide care coordination/non-medical case management and supportive services primarily by phone, administered through a Care Coordination Center in Eugene. Client surveys in the affected counties, conducted prior to and one year after the changes were implemented, indicate that client satisfaction has remained high in all counties and increased significantly in Marion County. Clients report a high level of access to care coordinators and services, as well as high levels of confidence that their needs will be met by staff at HIV Alliance.

Clients in the large geographic areas in Eastern Oregon are served by another community based organization following the same regional Medical Care Coordination model, Eastern Oregon Center for Independent Living (EOCIL). All Part B clients have access to services delivered by nurses (medical case management) and case managers/care coordinators providing non-medical case management and access to supportive services.

Oral Health Care

Comprehensive dental care is provided by a range of practitioners, some of whom specialize in treating HIV positive patients. Services include diagnostic, preventive and restorative care, oral surgery and emergency care resulting from pain and infection. Crown and bridge procedures are also provided, with some limitations.

► What is the Need for Oral Health Care in Oregon?

For many years, dental care has been consistently cited as the number one unmet need for services among HIV clients. Seventy-nine percent of MMP participants reported needing dental care in the past year.

In 2010, 307 BOS clients received oral health services through Part F-funded services provided by Clock Tower Dental Clinic. In 2010, Clock Tower provided 920 diagnostic, 633 restorative, 461 preventative, and 75 adjunctive services. In addition, the following number of clients received specialized dental services through Clock Tower: periodontics (n=316), prostodontics (n=315), oral surgery (n=245), and endodontics (n=82).

In 2010, 28 additional clients in the Balance of State received oral health care assistance utilizing local Part B funds; 124 received dental services and 44 received initial dental assessment through the State Managed Service Program.

In 2010, 885 clients in the TGA (including 220 new clients) received oral health services through Part A & Part F-funded services at OHSU's Russell Street Dental Clinic. In 2010, Russell Street Dental Clinic

provided 1305 diagnostic, 1454 restorative, 1000 preventive, and 222 adjunctive services. In addition, 673 periodontic, 826 prosthodontic, 283 oral surgery, and 95 endodontic services were provided.

► **How is Oral Health Care Delivered in the TGA?**

In the TGA, Oregon Health and Science University (OHSU) participates in the Part F Dental Reimbursement program at their community-based Russell Street Dental Clinic. This program provides partial payment for unreimbursed costs of HIV care provided by the clinic. OHSU also has a Dental Community Partnership Grant that funds HIV clinical rotations for dental students, expanding access to services for PLWH/A. OHSU coordinates outreach for the grant with the two largest Part A primary care and support services providers, Multnomah County Health Department and Cascade AIDS Project. Part A contributes oral health care funding to help fill the gap in resources for the majority of PLWH/A without dental insurance.

► **How is Oral Health Care Delivered in the Balance of State?**

In the Balance of State, PLWH/A in 17 counties receive Part-F funded services through the Clock Tower Dental Clinic in Eugene and its regional satellite clinics. In addition, clients who are unable to access Clock Tower can receive dental services through local private dental providers funded through Part B funds. Part B funds may also be used for dental services not covered by Part F reimbursement.

► **What Challenges do Clients Face Related to Oral Health Care?**

More than 1 in 4 MMP participants (27%) said they needed dental services in the past year, but could not get them. The two barriers to dental care cited most frequently among MMP participants were cost/lack of insurance and not knowing where to go or whom to call for services. Similarly, 30% reported that they do not have a “usual dentist” and 23% said that their last dental visit was “more than 2 years ago.”

Clients in 4 of 6 Part A community forums reported no gap in dental care. Some clients in the other two groups reported long wait times for appointments and a limited spectrum of services available.

Data from Part B Listening Sessions and interviews indicate that Clock Tower Dental has filled the previously yawning gap in dental care services for many PLWH/A in the Balance of State. Clients reported high levels of satisfaction with services provided through Clock Tower and clients living in Eugene reported no access difficulties whatsoever. Rural clients reported some access difficulties due to distance. Clock Tower provides services through a mobile unit and satellite clinics that bring preventive and other oral health services to local communities beyond the Eugene area. This makes basic oral health care available to many rural clients, but some types of procedures can only be completed in their Eugene clinic. This can create logistical barriers for rural clients, although Clock Tower does try to mitigate transportation-related barriers by providing bus tickets and other assistance.

Substance Abuse Treatment

Ryan White-funded substance abuse treatment services include assessment, individual and group counseling, as well as engagement and coordination in outpatient treatment for clients in alcohol and drug-free housing.

► **What is the Need for Substance Abuse Treatment Services in Oregon?**

There are no definitive data related to the prevalence of substance abuse among PLWH/A in Oregon, but various data sources indicate a substantial need.

In 2009-2010, 15% of MMP participants reported binge drinking on one or more days in the past month. Binge drinking was defined as 4 or more drinks in one day for women and 5 or more for men.

In addition, 29% reported use of other drugs in the past 12 months, including recreational use of marijuana³ (26%), other non-injection drugs (15%), and injection drugs (5%). Almost 1 in 10 participants (9%) reported daily recreational marijuana use. Past-year use of substance abuse treatment services was noted in 10% of MMP participants' medical records in 2007-2008, the most recent MMP data available on this topic, and 2% of MMP participants reported past-year use of inpatient drug and alcohol treatment.

In 2009, 7% of CAREAssist clients self-reported a "problem with drugs or alcohol."

An older study found that 30% of Medicaid-insured PLWH/A had been treated for a substance abuse issue over a two-year period (1999-2000); 20% had been treated for both substance abuse and mental health issues (PDES, 2002).

In 2010, 2 clients in the Balance of State received Part B-funded substance abuse treatment services.

In 2010, 27 clients in the TGA received Part A-funded substance abuse treatment services.

These numbers have always been somewhat low because of challenges discussed below. However, changes in health insurance related to the parity act now allow these services to be billed through insurance plans, which may also decrease the numbers served through Ryan White Program funds.

► **How is Substance Abuse Treatment Delivered in the TGA and Balance of State?**

Substance abuse treatment services are provided by local providers and contracted substance abuse treatment agencies. Recruitment into mental health and substance abuse treatment services by peer mentors is also funded through a joint mental health and substance abuse treatment project in the TGA. The HHSC also offers a harm-reduction based treatment group open to any PLWH/A, regardless of where they receive medical care or whether they live in the TGA.

Nearly all CAREAssist clients are eligible to receive substance abuse treatment services as defined within the primary health insurance coverage purchased by CAREAssist or to which the client has access. CAREAssist pays deductibles and/or copayments on behalf of the client.

► **What Challenges do Clients Face Related to Substance Abuse Treatment?**

Only 1% of MMP participants reported an unmet need for drug and alcohol counseling and treatment in 2009-2010. However, low service utilization levels combined with high levels of self-reported drug and alcohol use would indicate that more PLWH/A may have benefited from services than those who sought them.

Case managers and other service professionals working with PLWH/A report multiple client-level and system-level barriers to getting HIV positive clients enrolled in substance abuse treatment services. These include a client's lack of treatment readiness, lack of providers who will accept a client's insurance, mismatches between treatment modalities and clients' needs, lack of education about HIV in the mainstream behavioral health care system, and limited availability of behavioral health providers with

³ Recreational marijuana use was measured separately from medicinal use of marijuana to treat HIV symptoms or side effects.

an HIV focus or cultural competence dealing with the LGBTQ population, especially within certain geographic areas. In addition, funding in-patient treatment is a challenge because Ryan White funds cannot be used, and most clients lack other options. Clients echoed these themes in the 2011 Listening Sessions and interviews.

Mental Health Services

Ryan White-funded mental health services include assessment and on-site or at-home counseling (individual/couple/family), group counseling, crisis intervention, and medication management for PLWH/A. Mental health services are delivered by mental health professionals (psychiatrists, psychiatric nurse practitioners, licensed social workers, or licensed professional counselors).

► What is the Need for Mental Health Services in Oregon?

About half of CAREAssist clients (54%) reported “depression, anxiety or emotional problems” in 2009, and the average emotional health score on the SF-12 (a standardized measure) was 41 for CAREAssist clients, indicating that they have somewhat poorer emotional health compared to the general adult population (average=50).

About 1 in 3 MMP participants (36%) reported needing mental health services in 2009-2010. In addition, 35% of MMP participants reported being diagnosed or treated for depression and 24% for anxiety in the past year. Just over 1 in 4 MMP participants (28%) showed moderate to severe depression on a standardized measure (the PHQ-9 scale) based on reports of their mood over the past two weeks.

Two percent of MMP participants reported past-year admission to an inpatient mental health facility.

An older study found that 20% of Medicaid-insured PLWH/A had been treated for both substance abuse and mental health issues over a two-year period (1999-2000) (PDES, 2002).

In 2010, 129 clients in the TGA received Part A-funded mental health services, about 23% fewer than in 2007. Providers report this is largely due to implementation of mental health parity laws so clients do not need to access Ryan White funds to complete their treatment.

In 2010, 5 clients in the BOS received Part B-funded mental health services.

Similar to substance abuse services, the numbers accessing Ryan White Program-funded mental health services have always been somewhat low because of challenges discussed below. However, changes in health insurance related to the parity act now allow these services to be billed through insurance plans, which may also decrease the numbers served through Ryan White Program funds.

The state’s Part B ADAP (CAREAssist) purchases insurance—the vehicle by which some clients access mental health services. CAREAssist pays deductibles and copayments behind the primary health insurance (including OHP and Medicare Part B) on behalf of the client. Because Medicare Part B pays at a low percentage on mental health services, the annual allocation to medical service copayments provided by the CAREAssist program may be exhausted prior to the end of the coverage year. In this case the responsibility for paying the copayments may default to other Ryan White funds.

► How are Mental Health Services Delivered in the TGA?

Mental health treatment services are provided by contracted mental health agencies and through a mental health provider stationed at Cascade AIDS Project, supported through Oregon HIV Behavioral Health Initiative (OHBHI) HOPWA grant funds. Recruitment into mental health and substance abuse

treatment services by peer mentors is also funded through a joint mental health and substance abuse treatment project in the TGA. The HHSC provides mental health services by a Psychiatric Nurse Practitioner, as well as limited counseling from a Part D-funded social worker.

► **How are Mental Health Services Delivered in the Balance of State?**

Mental health treatment services are provided by private providers.

► **What Challenges do Clients Face Related to Mental Health Services?**

Eleven percent of MMP participants reported needing but not getting mental health services in 2009-2010. Some participants (14% of those with unmet need) said they were in the process of accessing the service, but had not received it yet. The main barriers to receiving mental health services were psychological (e.g., not feeling ready), not knowing where to go or who to call, and cost/lack of insurance.

As with substance abuse services, case managers and other service professionals working with PLWH/A report multiple client-level and system-level barriers to getting HIV positive clients enrolled in mainstream mental health services. These barriers look similar to those identified by MMP clients, and include a client's lack of treatment readiness, lack of providers who accept a client's insurance, mismatches between treatment modalities and clients' needs, lack of education about HIV in the mainstream behavioral health care system, and limited availability of behavioral health providers with an HIV focus or cultural competence dealing with the LGBTQ population, especially within certain geographic areas. Lack of availability of Spanish speaking counselor has also been mentioned as a barrier. In 2011, clients in Part B Listening Sessions also identified access to "HIV-knowledgeable" mental health providers as an unmet need.

Early Intervention Services

Early intervention services (EIS) focus on newly diagnosed individuals and persons who have fallen out of care. Programs provide counseling and referrals to medical care. Referrals to mental health and substance abuse treatment services are also provided, as appropriate. EIS is currently available in the TGA only.

► **What is the Need for Early Intervention Services in Oregon?**

According to MMP data, clients who are currently in HIV medical care were able to access care quickly after initial diagnosis. Among those diagnosed in the past 5 years, 95% had their first HIV medical visit within 3 months of diagnosis; the other 5% entered care between 3-12 months post-diagnosis.

However, HIV surveillance data indicate that 40% of PLWH/A in Oregon are diagnosed late in their infection, and 25% of PLWH/A were considered "out of medical care" in 2009, based on a lack of reported CD4 or viral load labs.

Qualitative data from Part B Ryan White clients, collected in 2011, indicate that being out of HIV medical care at some point after learning one's diagnosis was a common experience. Most clients reported delaying care, while others said they had fallen out of care at some point after starting. Many clients reported being out of care for significant periods of time, such as 1 - 15 years. The main reason clients gave for being out of care was denial and depression. Others cited side effects of HIV medications or fear of starting HIV medications, alcohol and drug abuse, and problems with doctors as reasons for being out of care.

In 2010, 74 clients in the TGA received Part A-funded early intervention services, a 16% increase from 2007.

EIS is not a funded service in the Balance of State.

► **How are Early Intervention Services Delivered in the TGA?**

The EIS program in the TGA began in July 2007 and has focused on PLWH/A who are out of care and the newly diagnosed, many of whom come into care later in their disease progression with a variety of co-factors including mental health and substance abuse issues.

EIS services are offered through two programs in the TGA: through the Disease Investigation Specialists (DIS), housed at the STD Clinic at Multnomah County Health Department, and through Cascade AIDS Project, the largest AIDS Service Organization in Oregon. The DIS receive information regarding all new HIV diagnoses in the county, follow up with those individuals to ensure they are linked to medical care, and recommend HIV testing for all known partners. Being housed in the STD clinic also provides the opportunity to work with clients who come in for STD treatment and are found to be out of care for their HIV disease. Such patients are assisted with linkage into HIV medical care. DIS also assist with partner notification. CAP staff work with clients who have fallen out of care or need extra assistance to get into care, specifically individuals coming out of corrections or who have mental health/substance abuse issues or may be homeless.

► **How are Early Intervention Services Delivered in the Balance of State?**

There are no Ryan White Part B-funded early intervention services in the BOS. Disease Intervention Specialists, funded through non-Ryan White sources, provide follow-up for newly diagnosed people, linkage to care and treatment services, and partner notification.

The CAREAssist Bridge Program is another way that early intervention service needs are being addressed in both the TGA and BOS. The Bridge program is a medical-provider driven program where clients who are entering care or returning to care can receive a limited number of medical services and prescription drugs.

► **What Challenges do Clients Face Related to Early Intervention Services?**

In 2011, clients involved in Part B Listening Sessions and interviews indicated that they primarily got into care for the first time or re-entered care after falling out of care for two reasons: 1) they were forced into care by serious illness or 2) a friend, family, member or other individual reached out and got them connected (or re-connected) to care. For the most part, these reconnections were incidental rather than systematic. Indeed, Part B clients clearly indicated a need for early intervention services, which they referred to as a “patient advocate” or peer support, particularly after initial diagnosis.

Housing

This service category includes emergency and transitional housing assistance to PLWH/A and their families. Eviction prevention, information and referral, tenant education, housing placement, and housing case management enable clients to access and remain in transitional and permanent housing. Alcohol/drug-free housing is also provided for PLWH/A while enrolled in outpatient substance abuse treatment.

There are also three Housing Opportunities for Persons with AIDS (HOPWA) grantees in Oregon: the State of Oregon (which has both formula and competitive grants), the City of Portland (formula and

competitive), and Our House of Portland (competitive). Between these three sources, housing services are provided throughout the state of Oregon.

► **What is the Need for Housing Services in Oregon?**

Among MMP participants, 71% reported having a stable place to live in the past year, with no past-past year moves. About 1 in 10 MMP participants (11%) reported moving more than once in the past year, 6% reported past-year homelessness, and 4% reported incarceration, which can often lead to homelessness or unstable housing once released.

In 2009, a majority of CAREAssist clients, though by no means all, reported living in safe and stable housing situations. More than three-fourths (78%) characterized their current housing as very safe, 19% said somewhat safe, and 3% said it was not safe at all. Most CAREAssist clients (77%) reported living in their own house or apartment at the time of the survey (either singly or with a partner) and 16% reported living in someone else's house or apartment (e.g., the residence of a parent, other family member, or friend). Four percent reported living in other stable housing, such as a rented room or hospice facility and 2% reported currently living in unstable housing, like transitional housing or a shelter or welfare residence. The unstable housing category also included respondents who reported being currently homeless (n=8). Similar to MMP, 9% reported moving more than once in the past year.

Just over 1 in 10 CAREAssist clients (13%) said they had considered themselves homeless in the past two years.

In 2010, 536 clients in the TGA received Part A-funded housing assistance services, an 11% increase from 2007.

In 2010, 165 clients received Part B-funded emergency and transitional housing services in the Balance of State. Clients with chronic housing assistance needs were referred to Oregon Housing Opportunities in Partnership Program (OHOP), funded primarily by the Department of Housing and Urban Development (HUD). OHOP provided rental assistance to 160 households in 2010, and there were 124 people wait listed.

► **How are Housing Services Delivered in the TGA?**

Housing services in the TGA include permanent and transitional alcohol and drug-free housing; housing with supportive services for clients with mental illness; permanent subsidized housing for homeless and chronically homeless PLWH/A through Shelter Plus Care grants and Supportive Housing Program grants; housing for homeless women through the *Key Not a Card* program; transitional housing for youth; and permanent housing for formerly incarcerated clients. Other housing services include short term financial assistance for move in costs or eviction prevention, mortgage and utility assistance, case management, tenant education, housing placement, referrals to various applicable housing programs, and priority into subsidized or affordable units.

Our House of Portland, a community provider, delivers a continuum of services covered by public and private resources for advanced stage PLWH/A. Services include 24-hour specialized nursing and end of life care, assisted living in adult care homes, and a neighborhood housing and care program that combines stable housing with integrated in-home medical, occupational therapy, and social work services.

The Oregon Health Authority also contracts directly with Cascade AIDS Project (CAP) to deliver HOPWA SPNS OHBHI and HOPWA SPNS OSSCR services in the TGA as they are a project sponsor of those competitive grants. Through this partnership, CAP provided tenant-based rental assistance to an additional 25 households in 2010. Approximately 20 additional households receive rent assistance through a leveraged Shelter Plus Care grant in Multnomah County.

The Portland Housing Bureau contracts directly with Cascade AIDS Project to deliver a range of HOPWA housing services including: tenant based rent assistance, project based rent assistance, short-term rent mortgage utility assistance, Working Choices program, furniture assistance, and case management services. Approximately 250 households receive housing assistance through these HOPWA funds and 60 households receive employment assistance. CAP partners with a variety of housing agencies and property managers for leveraged rent assistance including Shelter Plus Care in Clackamas County and Multnomah County, supportive housing funds from the Multnomah County Continuum of Care, and project based rent assistance through the local housing authority, Home Forward.

Portland Housing Bureau received a HOPWA SPNS grant to serve approximately 60 households with short term rent assistance, extend the working choices program, and integrate HOPWA services into mainstream services. This is effective January 1, 2012.

CAP is also funded by Ryan White to provide short term rent assistance, tenant education, housing placement and planning, and case management to serve 350 people. Leveraged rent assistance includes Home Forwards STRA (short term rent assistance) program and Shelter Plus Care in Washington County.

► **How are Housing Services Delivered in the Balance of State?**

Clients residing in the BOS may receive limited Ryan White Part B-funded emergency and transitional housing services through local case management contractors.

Long term permanent supportive housing is provided through the OHOP Program. OHOP is designed to assist people living with HIV/AIDS in creating a continuum of stable, sustainable housing, in order to improve access to and engagement in HIV care and treatment and to act as a bridge to long-term assistance programs, such as Section 8. Additionally, through 3.6 FTE Housing Case Management staff, the OHOP program assists clients in 31 Oregon counties in locating and/or securing suitable rental housing, identifying other related housing and community based resources that may be available to clients, and providing housing information and referral to those housing resources.

Additional supportive services are provided to clients participating in the HOPWA/SPNS-funded Oregon Housing and Behavioral Health Initiative (OHBHI), Oregon Statewide Supportive Community Re-entry Project (OSSCR) and the Supportive Housing Program for homeless individuals. OHBHI assists clients with HIV and co-occurring behavioral health issues that present barriers to accessing and maintaining stable housing with additional mental health and case management support while OSSCR provides additional case management and service coordination to persons post incarcerated. OSSCR represents a uniquely collaborative client service model that includes the effort of supporting professionals such as local and state corrections. Finally, the Supportive Housing Program provides additional case management, to include frequent home visits to chronically homeless and homeless individuals.

► **What Challenges do Clients Face Related to Housing Services?**

Some CAREAssist clients were significantly more likely to report recent homelessness and unstable housing. Nonwhites (23% vs. 15%, $p = .002$), clients with less education (e.g. 22% with less than high school vs. 9% of college grads, $p = .004$), and younger clients (e.g. 36% under 30 vs. 8% age 60 and older, $p < .001$) were significantly more likely to report homelessness or past-year unstable housing. There were no differences by gender or region. Younger clients and those with less education remained significantly more likely to report homelessness or unstable housing when controlling for the other demographic factors in a logistic regression model; race was no longer significantly associated with unstable housing.

As of October 2011, the OHOP program for the BOS had 123 households awaiting long term housing assistance who were homeless or at risk of becoming homeless. In the TGA, the primary provider of HOPWA-funded services has waitlisted or turned away more than 70 clients in the last year.

Section 8 waiting lists are extremely long or simply closed in most communities, which results in clients remaining on HOPWA programs for longer periods of time than expected. In addition, the recession and high unemployment rates have resulted in more competition for scarce housing resources.

Food and Nutrition

This service category includes emergency food assistance (e.g., food vouchers/grocery gift cards, home delivered meals), nutritional supports, and medical nutritional therapy.

► **What is the Need for Food and Nutrition Services in Oregon?**

Forty percent of MMP participants said they needed meal or food services in the past year; of those, 90% received the needed service.

In 2007, HIV case management clients in the Part B service area were asked about their food needs as part of the annual client satisfaction survey; 57% ($n=220/388$) said they had needed financial help getting food or groceries in the past 12 months. The percentage needing help with food and groceries in 2007 was higher than the 49% identified in the 2005 Needs Assessment survey. The most common source of financial help for food came from food stamps, accessed by 47% of respondents. Other common sources of help were food banks/food pantries (27%), friends and family (25%), and grocery vouchers from case managers (23%).

In 2010, 47 clients in the TGA received Part A-funded food and nutrition services in the form of home-delivered meals, a 23% decrease from 2009.

In 2010, 33 people received Part B-funded medical nutritional therapy by a licensed dietician in the Balance of State, 226 received RN-authorized food vouchers provided in support of the nutritional plan developed by the RN and the client, and 323 received emergency food assistance.

► **How are Food and Nutrition Services Delivered in the TGA?**

Food and nutrition services in the TGA include home-delivered meals. The home-delivered meal program has restructured to adjust to more stringent client requirements around medical necessity for this service, and there have been no cost-of-living increases to the category. As a result, the home delivered meals program now delivers a week's worth of frozen meals to clients once a week; the program is able to ensure that each client in the program has a microwave to heat the meals.

Esther's Pantry, located in the Portland metropolitan area and administered by Our House of Portland, is the only food bank in Oregon specifically serving PLWH/A. It was founded in 1985 "to provide

financially challenged individuals living with HIV/AIDS access to food and personal care items,” and serves approximately 200 PLWH/A each month. The Pantry is unique in that it has always maintained a policy of allowing clients to select the food they want from well-stocked shelves, rather than handing out pre-packaged food boxes, which is a standard procedure at most emergency food programs. However, Esther’s Pantry does not receive any Ryan White funding, only serves the Portland metropolitan area, and has had to limit services over the years due to budget constraints. The Tod’s Corner program provides clothing, household goods, pet food, cleaning and personal care items.

► **How are Food and Nutrition Services Delivered in the Balance of State?**

Emergency food assistance is provided to Part B clients through their HIV care coordinators and case managers. Nutritional counseling and supports is delivered by medical case managers and medical nutritional therapy is delivered by private licensed dieticians.

► **What Challenges do Clients Face Related to Food and Nutrition Services?**

Focus groups conducted in 2007 identified a number of themes surrounding food-related needs and gaps. First, as supported by the scientific literature, PLWH/A have unique nutritional needs that extend beyond health promotion and disease prevention. Nutritional problems caused by ART, including nutritional deficiencies, malabsorption, elevated cholesterol, and lipodystrophy are common, as are digestive problems such as nausea, vomiting, acid reflux, and diarrhea. Identified barriers to eating for optimal health included lack of transportation, lack of appetite, depression, and fatigue, but the most commonly cited barrier was lack of income. Although participants shop at discount stores, buy in bulk and pool resources, in order to stretch limited resources, they are often still short at the end of the month and some buy food on credit cards—a necessary stopgap, but an unsustainable long-term strategy. Although many communities in Oregon are served by food banks, food distribution programs through churches, and congregate meal programs, PLWH/A found these resources only marginally helpful. Most had used these programs, but cited multiple barriers including lack of access, long waits, concerns about food safety and the types of food offered, and feelings of stigma and discomfort related to competing for scarce resources with other individuals and groups in need, particularly women with small children. And, as noted previously, these “mainstream” resources are being stretched thin as record numbers of Oregonians have become dependent on them.

Medical Transportation

This service includes assistance with transportation to and from medical appointments, using the most cost-efficient means available for the client’s locale.

► **What is the Need for Medical Transportation Services in Oregon?**

Just over 1 in 4 MMP participants (28%) said they needed transportation assistance in the past year.

In 2010, 442 PLWH/A received Part B funded medical transportation services.

► **How are Medical Transportation Services Delivered in the TGA?**

Coordination of medical transportation for TGA clients is provided through medical case management. Case managers determine client needs and link them to the most appropriate resources, which are usually transportation resources outside of the RWCA-funded system. Most TGA clients live in Portland or the areas immediately surrounding it, and most Part A-funded services are also located in this area. Tri-Met provides an extensive public transportation system, including buses and light rail in Clackamas, Multnomah and Washington Counties. Case managers can provide gas vouchers or bus/rail

tickets for those who use public transportation and can reimburse other types of transportation (e.g., taxi, gas cards, and other medical transport) for clients unable to use public transportation.

► **How are Medical Transportation Services Delivered in the Balance of State?**

Most Balance of State clients have fewer public transportation options and greater medical transportation needs. Some clients in Eastern Oregon, for example, drive 3-5 hours each way to access HIV medical care. Medical transportation assistance is provided in the Balance of State through gas cards, public transportation (e.g., bus tickets), taxi fare, and, occasionally, special medical transport for clients who need a higher level of assistance due to serious illness and/or mobility limitations.

► **What Challenges do Clients Face Related to Medical Transportation Services?**

Transportation options are limited in the nonmetropolitan areas of the state. As described in other parts of this document, clients living in rural and frontier areas of Oregon must travel long distances for medical care and other supportive services because no local options exist. Even clients in the more populated areas of the state outside of the Portland metropolitan area report having to travel for care sometimes because of few local HIV doctors. For example, clients may choose to see a different provider or be “fired” from care for a variety of reasons, requiring travel to another town. Clients outside of the Portland or Eugene areas may also need to travel to access dental care. Winter weather and mountain passes provide additional challenges.

Clients across Oregon (parts A and B) are challenged by the rise in fuel costs, which make transportation by both private car and public transit far more expensive than in past years.

Psychosocial Support Services

Psychosocial support services offer stability for a marginalized population; this leads to more consistent participation in HIV care and treatment services.

► **What is the Need for Psychosocial Support Services in Oregon?**

Just over 1 in 4 MMP participants reported needing peer group support; of those, about half received the service and half reported an unmet need.

Qualitative data from listening sessions and interviews conducted in 2011 indicated a great unmet need for psychosocial support in the Part B areas of Oregon. Part B clients identified a need for peer support, support groups, and patient advocates.

► **How are Psychosocial Support Services Delivered in the TGA?**

In the TGA, a drop-in day center serves PLWH/A who have difficulty dealing with activities of daily living, many of whom have substance abuse and mental health issues and are homeless or living in temporary housing. The center provides regular supportive activities, meals, peer support, and a place for clients to meet with social service providers. Another center provides services for women and their families, including child care while women participate in support groups and other center activities.

With funding through Ryan White Part D, CAP also provides psychosocial support to children and families affected by HIV through Kids’ Connection. Kids’ Connection provides: 1) developmentally appropriate HIV education and disclosure, 2) a multi-session family group called Families Together that focuses on HIV education, disclosure and family communication, 3) Family Days that provide parenting skills workshops paired with free and fun family activities and social/recreational events for families affected by HIV to help build community and support. Kids’ Connection also partners with the

Pediatric HIV Clinic at OHSU to provide support and education for families when their children are seen for medical care at the clinic. Finally, Kids' Connection and Part D provide support for teens living with HIV through age appropriate education and risk reduction counseling as well as through a twice-monthly group called Always Looking Up.

► **How are Psychosocial Support Services Delivered in the Balance of State?**

Some communities in the Part B areas of Oregon have support groups, but most do not. No communities in the Balance of State currently have peer support programs.

► **What Challenges do Clients Face Related to Psychosocial Support Services?**

Clients outside of the more populated cities of Oregon (e.g., Portland metropolitan area, Eugene) reported feelings of isolation because they have no opportunities for connection to others with HIV. Some said they don't know anyone else with HIV; most say that formal opportunities for social connection and social support are nonexistent.

Part B clients advocated strongly for support groups and other types of 1-1 peer support (such as a "buddy program"), but there is no infrastructure for starting or maintaining these types of services.

Both Part A and B clients suggested that the Oregon AIDS Hotline might also be used as a resource for providing psychosocial support.

Service Needs of Special Populations

Several special populations may have additional service needs or needs that are not currently being addressed by the current HIV continuum of care. We briefly address the service needs of seven special populations below.

PLWH/A Aged 50 Years or Older

In Oregon, 38% of PLWH/A were aged 50 and older, as of 3/31/2010, and an additional 38% of PLWH/A were aged 40-49, representing the next wave of older PLWH/A.

Population increases within this age category are due to both the success of antiretroviral medications in treating HIV/AIDS and increases in the number of persons aged 50 and older being diagnosed with HIV/AIDS for the first time; almost 1 in 5 PLWH/A diagnosed in 2009 (18%) were aged 50 or older.

Many older PLWH/A face serious co-morbid medical conditions, including cardiovascular disease, diabetes, certain cancers, osteoporosis, chronic pain, and depression. These conditions complicate HIV medical care, may require multiple pharmaceuticals, and can compromise quality of life.

Gaps in care that are unique to this patient population include social support groups targeted to their needs; increased outreach, testing, and prevention services to decrease the rates of incidence within this population and bring infected people into care as soon as possible; increased coordination with aging and disabilities services; and increased access to specialists for treatment of conditions associated with aging.

Transitioning clients to Medicare is of major importance. CAREAssist staff, in partnership with HIV case managers, provide coordination and enrollment services for persons enrolling in Medicare Part D. CAREAssist staff monitor age and disability status of 2,224 eligible Medicare clients (as of January

2010), assuring that persons transition smoothly from the Oregon Medical Insurance Pool (OMIP) or the Oregon Health Plan (Medicaid) to Medicare coverage. CAREAssist fully supports Medicare policies to include premiums, prescription co pays and non-prescription co pays. Since 2009, CAREAssist has been covered by Oregon's Statewide Pharmacy Assistance Program (SPAP) so all co-pay assistance made for Medicare Part D client's counts toward the client's out-of-pocket expenses and allows CAREAssist to buy a client through the Medicare Part D "donut hole." Additionally, the program continues to pay for medical service co pays and deductibles which reduces barriers for seniors and older PLWH/A's so that they can receive treatment for the whole spectrum of health care conditions associated with aging, not only HIV.

Women

As of December 31, 2009, women comprised 13% of PLWH/A statewide, including 10% of PLWH/A in the Portland TGA and 19% in the Balance of State. Women with HIV in Oregon are more likely to have HIV than AIDS.

The age-adjusted annual risk of death for female PLWH/A is 11 times higher than for Oregon women overall. Women need accessible primary care providers who have specialized knowledge of HIV and women's health, as well as coordinated access to specialists for treatment of HIV related illnesses and common co-morbidities such as mental disorders and co-infection with hepatitis or STD. The higher proportion of female PLWH/A with current or past history of IDU requires access to substance abuse treatment services, and may indicate greater levels of poverty and/or social isolation. Case management services are particularly important for this population to help coordinate care and keep clients engaged. Women need to receive HIV prevention and early intervention messages in conjunction with their HIV care, and in places where they congregate. All services for female PLWH/A must be gender and culturally appropriate, and childcare should be available to clients while they are receiving other services.

Women participating in 2011 Listening Sessions reported feelings of isolation and indicated a need for social support and peer support. Some women participating in the sessions stated that they had never met another woman with HIV, despite being infected for many years.

Dual Diagnosis of Mental Illness and Substance Abuse

No surveillance data are available on co-occurring HIV disease, substance abuse and mental health disorders, but local needs assessment data show high prevalence of these conditions among PLWH/A and a corresponding high need for services.

Because of Oregon's unique combination of universal health insurance coverage for PLWH/A available through CAREAssist and comprehensive mental health insurance parity, the majority of clients are eligible to receive a full range of behavioral and mental health services through their insurance provider. However, PLWH/A with mental illness and/or substance abuse diagnosis still face multiple challenges to initiating, engaging and remaining in care. These include a lack of treatment readiness; a shortage of culturally competent providers, especially in less populated areas of the state; and mismatches between available providers and client insurance type.

High levels of case management and service coordination are required to reduce the interference of psychiatric disorders, medications, and illegal drugs with HIV medical treatment. These services, particularly mental health services, must be designed and delivered in a manner that is culturally appropriate for ethnic and sexual minority populations. As both mental illness and substance abuse are chronic conditions, access to appropriate services must be assured for extended periods of time, and

treatment must be adjusted to varying levels of acuity over time. Mental health and substance abuse treatment services must be able to be accessed quickly in the case of an emergency, and must be coordinated with primary HIV care. However, mental health and substance abuse providers do not have a systematic way of knowing the HIV status of their clients, so unless clients disclose their own status, treatment in relation to HIV-specific issues is difficult.

People who Inject Drugs

Nineteen percent of all Oregon cases reported injection drug use (IDU) as a risk factor, either solely or in combination with sexual transmission risk (MSM or females with heterosexual transmission risk). In addition, 3% of Oregon cases reported heterosexual contact with an IDU as their transmission risk for HIV, representing an indirect link to IDU as the source of their infection.

Since 1997, there has been a slow, steady decline in the number of diagnosed HIV cases reporting IDU transmission risk in Oregon. However, many people with IDU risk are diagnosed with AIDS within 12 months of their first positive HIV test. In addition, people with IDU risk are less likely to be engaged in HIV-specific medical care, as evidenced by their lower likelihood of having CD4 or viral load tests reported to the surveillance system compared to people with other transmission risks. Finally, people with IDU risk have a significantly shorter survival time compared to others.

People with IDU risk have service needs for medical care that follows a harm reduction model (e.g., not “firing” clients from medical care for drug use), for drug treatment services, and for access to clean syringes through syringe exchange programs and availability of syringes for purchase without prescription through pharmacies.

Homeless/Unstably Housed PLWH/A

Homelessness is a major risk factor for HIV, and HIV is a major risk factor for homelessness. National data show the prevalence of HIV/AIDS to be three to nine times higher among persons who are homeless or unstably housed compared with persons with stable and adequate housing, depending upon the population and geographic area studied. Furthermore, up to 60 percent of all persons living with HIV/AIDS report a lifetime experience of homelessness or housing instability.

Similar to other parts of the nation, housing for PLWH/A continues to be an area with high service needs and gaps in Oregon. Despite comprehensive housing programs, some PLWH/A in Oregon remain homeless, as competition for limited resources is intense. Section 8 waiting lists are extremely long or simply closed in most communities, which results in clients remaining on HOPWA programs for longer periods of time than expected. In addition, the recession and high unemployment rates have resulted in more competition for scarce housing resources.

Housing status has profound implications for persons living with HIV/AIDS. Data from multiple studies (as well as local experience) show that PLWH/A need stable housing in order to negotiate bureaucracies, file entitlement applications, keep appointments, and access social and medical services. Research indicates that homeless PLWH/A are more likely than stably housed PLWH/A to report a wide range of negative health outcomes, including lower CD4 counts, less likelihood of undetectable viral loads, poorer self-reported ART adherence, and less likelihood of current treatment with ART. Stable, adequate housing is an important factor in promoting consistent ART adherence and avoiding consequent drug resistance.

Consequently, HIV case managers spend a high proportion of service time assisting homeless and unstably housed clients to maintain their health insurance, adhere to HIV medicines, and obtain and retain stable housing.

Adolescents

In 2009, 10% of new HIV diagnoses were among individuals aged 13-24 (n=24 cases).

In 2008, the Oregon State Public Health Lab reported 2605 HIV tests conducted in Multnomah County among youth age 13-24 at Multnomah County Health Department sites (n=1745), Cascade AIDS Project (CAP) (n=62), and Outside In (OI) (n=798); 1.1% of tests were positive (n=28). The most commonly reported risk factors among testers age 13-24 were MSM (38%), IDU (12%), and partner at risk (5%); 3.3% reported MSM/IDU risk.

Anecdotal information indicates that homeless youth may be a group of adolescents at high risk of HIV infection. Few local data exist related to HIV risk behavior and seroprevalence among homeless youth in the Portland area and/or in Oregon. The most recent local seroprevalence study, conducted between 1994 and 1997, found the HIV seroprevalence among a group of homeless Portland youth to be 0.3%. More recent national estimates vary, ranging from 1.1% -17%, depending on the city, population, and age cohort.

HIV risk factors among homeless youth include survival sex, MSM sexual activity, IDU and other drug use, sexual assault and coercion, and elevated rates of STD infection. Between 20-40% of all homeless youth identify as lesbian, gay, bisexual, transgender, queer, or questioning.

Transgender Individuals

HIV surveillance data only report two genders: male and female. Consequently, we do not know how many PLWH/A in Oregon identify as transgender, nor do we know how many PLWH/A who currently identify as male or female were assigned a different sex at birth.

In 2009, 843 Portland metropolitan area individuals who identified as lesbian, bisexual, gay, transgender, or queer completed the Speak Out survey, which included a range of health data. Transgender-identified individuals reported significant disadvantages in accessing health care, higher rates of mental health issues, and more days of physical and mental disability. However, no transgender individuals identified as HIV+ compared to 18% of those identifying as male and <1% of those identifying as female.

Cross-Cutting Service Goals and Issues

Members of the SCSN 2011 Advisory Group agreed that the four themes identified in 2008 remained a good way to organize the cross-cutting service goals and issues:

- **Preventing new HIV infections,**
- **Finding HIV+ people who need care and treatment services,**
- **Engaging HIV+ people in care and treatment services,** and
- **Retaining HIV+ people in care and treatment services.**

We acknowledge that there is overlap between these four areas and that actions in one area often affect the others (e.g., engaging and retaining people in care can prevent new infections).

Service Needs Identified by the SCSN 2012 Planning Process

The group identified a need to build stronger links between HIV prevention and care services, in order to prevent new HIV infections and to link newly infected people into care earlier. According to the group, we need to focus on vulnerable populations in order to find HIV+ people who are out of care. We also need to test people in a larger variety of settings and develop effective systems for seamlessly triaging newly diagnosed individuals into care. One important means for developing these stronger links between prevention and care, and achieving our shared goals in the future, will be the new Integrated Planning Group for HIV, a combined statewide HIV care services and prevention planning group in Oregon.

In addition, there is a need to build bridges to “mainstream” social services, in order to engage HIV+ people in care, and to provide a full spectrum of disease management services to HIV+ people as early as possible. Funding shortages coupled with increasing case loads make creation of a parallel HIV service system unfeasible, so there is a need to move clients between the RWCA system and other general social service programs and community services. Referrals outside of the RWCA system can be tricky, however, and provide opportunities for HIV+ clients to “fall through the cracks.” Facilitated referrals work better than simply giving clients a phone number; RWCA providers need to develop better systems for collaborating with a wide range of services for clients and ensuring a smooth transition for clients between programs and services.

Likewise, there is a need for more responsive services for HIV+ people, in order to keep them retained in care. The group said that integrated behavioral health services are needed, since both active substance abuse and untreated mental illness impede medical care. However, there are many barriers to accessing substance abuse and mental health services for HIV+ clients, including limited treatment modalities and insurance difficulties. Services tailored to older PLWH/A are also in ever greater demand, with the aging of the HIV+ population. Each part of the RWCA system is responsible for identifying and working to remove client barriers, wherever possible. Identified needs for system changes included coordinating intake forms, providing client-centered care, track appointments and making follow up phone calls to clients, soliciting provider input, and triaging clients to specialty and/or “mainstream” providers or disease management programs, where appropriate.

Finally, on a broader scale, the group identified a need for ongoing evaluation and assessment, in order to ensure that we are using our limited funds in the most efficient and beneficial manner. The group also advocated for identification of promising evidence-based models for delivering care and treatment services, without imposing a one-size-fits-all approach onto very different populations across the state. The group called for honest assessments of service capacity in different regions; rural areas face additional challenges related to resources and need creative approaches to service delivery. For the long-term, the group advocated for an upstream approach to service delivery, framing our goals broadly to address specific service needs, but to also address structural factors like poverty, racism, and homophobia, in our efforts to prevent and treat HIV disease in Oregon.

Broad Goals Defined by the SCSN 2012 Workgroup

The group identified the following broad goals within each of the four thematic areas:

1. Preventing New HIV Infections:
 - Develop stronger linkages between HIV care and treatment and HIV prevention
 - Develop and disseminate consistent messages around HIV testing and linkage to care & treatment that:

- i. can be used in a variety of sites (e.g. private providers/primary care, hospitals, emergency rooms, correctional settings);
 - ii. are consistent with CDC guidelines for routine screening and risk reduction messaging for high risk groups, and
 - iii. harness the power of social media (e.g., Facebook, twitter, online education, other social media).
 - Shore up “prevention with positives” efforts using DIS and other early intervention service modalities.
2. Finding HIV+ People Who Need Care and Treatment Services:
- Continue to gather data to better understand why people are out of care
 - Develop evidence-based systems to follow up on people who fall out of care
 - When looking for people who may be out of care, go beyond “emerging populations” and consider larger social determinants of disease transmission (e.g. poverty, marginalization, and access to education and health care).
 - Increase access to testing
3. Engaging HIV+ People in Care and Treatment Services:
- Shore up early intervention services, particularly in the Balance of State
 - Identify and reduce system barriers, particularly in the period immediately following diagnosis (possibly via peer advocates/health navigators)
 - Develop flexible models of care that better reflect client needs and do not attempt a “one size fits all” approach. Target disparate populations with culturally relevant approaches to care and prevention.
4. Retaining HIV+ People in Care and Treatment Services:
- Develop client-centered approaches to care and adoption of patient centered medical home models, as health care reform, including adoption of Coordinated Care Organizations, is implemented in Oregon.
 - Implement and promote self-management programs and tools for clients further along disease management continuum.
 - Develop strong linkages between systems so clients don’t fall through the cracks and cross-agency collaborations are maximized.
 - Engage in evaluation/assessment/continuous quality management to ensure that services are accomplishing intended goals.

Appendix A: SCSN 2012 Advisory Group Roster

Name	Agency/Affiliation	Title
Annick Benson-Scott	Oregon Health Authority Part B Grantee	HIV Community Services Manager
Jeff Capizzi	Oregon Health Authority HIV Surveillance/Data & Analysis	Epidemiologist
Tom Cherry	Part A HIV Planning Council	Co-Chair/Community Member
Jodi Davich	HIV Health Services Center Part C Grantee	HIV Clinic Manager
Linda Drach	Oregon Health Authority Program Design & Evaluation Services	Research & Evaluation Manager
Robert Duehmig	Oregon Office of Rural Health	Communication Director
Heidi Eidler	Eastern Oregon Center for Independent Living (EOCIL)	Director of Programs & Services
Victor Fox	Oregon Health Authority Part B Grantee	HIV Care and Treatment Program Manager; Co-Chair, CAREAssist Advisory Committee
Alison Frye	HIV Health Services Center Part D Grantee & Part A Planning Council	Program Manager
Ruth Helsley	Oregon Health Authority HIV Prevention	HIV Prevention Manager
Kelly Jurman	Washington Co Health Dept	<i>Program Manager</i>
Kristin Kane	Cascade AIDS Project	<i>Director of Housing and Supportive Services</i>
Veda Latin	Oregon Health Authority HIV/STD/TB Programs	HIV/STD/TB Programs Section Manager
Jude Leahy	Oregon Health Authority HIV/STD/TB Programs	Adult Viral Hepatitis Prevention Coordinator
Dana Lord	Clackamas County Health Dept	HIV Case Manager
Amanda McClusky	HIV Alliance Part F/SPNS Grant	Dental Program Coordinator
Tom McConnell	Oregon HIV Care Coalition	Member, Community Member
Susan McCreedy	Deschutes County Health Dept	HIV Case Manager
Wayne Miya	Our House of Portland HOPWA Provider	Director
Christy Myers	Oregon Health Authority Part B Grantee	Grants Coordinator
Erin Nortrup	Cascade AIDS Project	Manager, CARELink Program
Karen Pancheau	Oregon HIV Care Coalition	Co-Chair, Community Member
Steven Pierson	AIDS Education & Training Ctr	Program Manager
Thomas Rafalski, MD	Private practice AETC clinician	Physician

Margy Robinson	Multnomah County Health Dept Part A Grantee	HIV Care Services Manager Quality Management Taskforce Co-Chair
Stephanie Craig Rushing	Portland Area Indian Health Board: Red Talon Project	Project Director
Valerie Rux	Oregon Health Authority Division of Medical Assistance Programs	Healthy Kids Program Coordinator
John Scharff	HIV Statewide Planning Group	Community Member
Ann Shindo	Oregon Department of Corrections	HIV & Hepatitis Prevention Coordinator
Robert Skinner	HIV Prevention State Planning Group	Co-Chair, Community Member
Marilee Smith	Kaiser Permanente	Case Manager/LPC
Debbie Spicer	Lincoln County Health & Human Services	Nurse Case Manager
James Strohschein	Oregon Health & Sciences Univ. Russell Street Dental Clinic/Part F	Director
Kim Toevs	Multnomah County Health Dept Part A Grantee	Program Manager, HIV/STD, HCV Programs
Tasha Wheat- Delancey	Cascadia Behavioral Health	Clinical Supervisor
Renee Yandel	HIV Alliance	Program Manager

Appendix B: SCSN 2012 Timeline and Key Tasks*

Date/Deadline	Activity	Staff Responsible
5/3/11	OHCC meeting—introduce proposed SCSN process to key stakeholders; solicit feedback on process and Steering Committee membership	PDES
May 2011	Refine SCSN process. Begin to assemble Steering Committee based on input from OHCC/ stakeholders and HRSA guidance	PDES
June 2011	Set Listening Session dates and logistics; promote participation through Steering Committee, case managers, agencies, etc	PDES
August 2011	1st Contact with SCSN Advisory Group: Review roles & responsibilities, timelines, etc	PDES
August/Sept 2011	2 nd contact with SCSN Advisory Group: Solicit feedback on Listening Session logistics and guide	PDES
Sept & Oct 2011	Conduct in-person “Listening sessions” in Eugene and Medford. Conduct interviews with clients in Eastern Oregon and other rural parts of the state.	PDES
Sept 2011	3 rd contact with SCSN Advisory Group: Discussion of cross-cutting themes	PDES
Oct 2011	Transcribe, compile, and identify themes from Listening Session and interview data.	PDES
	Synthesize Listening Session data with all other data sources (Epi, data from Portland Listening Sessions, etc)	PDES
	4 th contact with SCSN Advisory Group: Share Listening Session data and solicit feedback. Continue discussion of cross-cutting themes.	PDES
Oct 2011	5 th contact with SCSN Advisory Group: Ask for feedback on continuum of care section of document.	PDES
Nov 2011	Complete final draft of SCSN document	PDES
Nov 2011	Present data in SCSN document to OHCC. Use for development of the Comprehensive Plan.	PDES & HST Program
Dec 2011	6 th contact with SCSN Advisory Group: Distribute final draft of SCSN document and solicit feedback during 3 week comment period	PDES
Dec 2011	Integrate feedback. Finalize SCSN document.	PDES
2012	Submit final document to HRSA	HST

***Oregon conducted the SCSN in 2011, despite HRSA pushing the due date back to June 2012, because we are starting a new integrated HIV care and prevention statewide planning body in January 2012. This body replaces the former groups, OHCC (for care services) and SPG (for prevention). We felt it would be unrealistic and unfair to the new body to ask them to complete the**

SCSN planning process & Part B Comprehensive Plan during their first 6 months as a group, so we completed the processes early, through the involvement of the existing care group (OHCC) and a representative, ad hoc SCSN Advisory Group.

Appendix C: Data Sources Used in Creating the SCSN 2012 Document

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McLaughlin M, Jenkins L, Elman M, Smith C. 2010 STD/HIV/Hepatitis C Program Annual Report. Multnomah County Health Department: Portland, OR; 2011.

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Appendix D: Summary of 2011 Ryan White Client Listening Sessions and Interviews

Objective:

To collect qualitative data from Ryan White Parts A and B clients about service needs and gaps and satisfaction with services. In addition, Part B clients were asked about their entry into HIV medical care and experiences, if any, with being out of medical care.

Methods:

Staff members from Multnomah County Health Department conducted Community Forums with groups of Ryan White Part A clients using a semi-structured interview guide. The goal for consumer participation was to obtain a heterogeneous sample of individuals with a cross-section of experience in the Ryan White system. Community Forums took place in April and May 2011.

Staff members from Program Design & Evaluation Services (PDES) facilitated group Listening Sessions and conducted individual telephone interviews with Ryan White Part B clients using a semi-structured interview guide. Interviews and Listening Sessions took place in October 2011.

Participants:

A total of 63 Part A and 43 Part B Ryan White clients participated in these activities, as follows:

- There were a total of 6 community forums in the Portland metropolitan area conducted with 63 members of the following Ryan White Part A sub-populations:
 - Spanish speaking individuals (n=9)
 - Communities of color (n=11)
 - Women (n=12)
 - Men who have sex with men (n=11)
 - Low-income individuals (n=10)
 - Clark County residents (n=10)
- 2 Listening Sessions were conducted in two different geographic areas of the Part B region:
 - Eugene (n=22)
 - Medford (n=4)
- Individual interviews were conducted with 17 clients living in more rural areas of the state, primarily the Central and South Coast, Central Oregon, and Eastern Oregon.

Brief Summary of Part A Community Forum Findings:

Overall, clients at several forums elaborated upon the need for housing and for dental care. Substance abuse treatment was also mentioned as a necessary service but there was no elaboration on concerns with existing services. While there was an appreciation for the coordination and referrals that case managers offer, clients also expressed frustration with having multiple case managers who specialize in different services (medical, housing, CAREAssist etc.), instead of having one case manager who could meet all of their needs. In addition, clients conveyed that some of their needs may be met through “mainstream” service providers and that there is not always a need for HIV-specific services.

Additional information about the Part A Community Forums is available at: Jenkins L. Ryan White Part A Community Forums Report. Multnomah County Health Department: Portland, OR; 2011.

Brief Summary of Part B Listening Session and Interview Findings:

Several themes emerged across the interview and listening session data. Overall, clients across the Part B region reported that access to HIV medical care, health insurance, and many supportive services is generally easy for those who are ready to engage with those services. The previously yawning gap in dental care was reported to be mostly filled by services provided by Clock Tower Dental. However, rural clients identified ongoing challenges with remaining engaged in HIV medical care because of transportation difficulties and lack of local options. Even clients in more populated areas of Part B said that travel may be necessary to access certain services, like dental care or mental health services, and this can be a barrier. Also, clients in many areas of the Part B region said that HIV stigma is still common (e.g., among doctors or pharmacists).

Many Part B participants reported having been out of HIV medical care at some point after receiving their HIV diagnosis. The reasons given for being out of care were almost exclusively individual-level reasons, rather than system-level reasons. The main reasons given for being out of care were: denial/depression, side effects of HIV medications and/or fear of starting HIV medications, alcohol and drug abuse, and interpersonal issues with the HIV doctor. Part B clients reported two reasons for entering or re-engaging with HIV medical care: 1) they got very sick, so had no choice or 2) a friend, family member, or another person reached out to them and got them connected.

Themes of isolation and “feeling alone” were common and some also reported feeling confused about how to access services after first diagnosis. Many Part B clients identified a need for peer support and/or peer navigation services to help bridge the gap between first diagnosis and entry into HIV medical care and services.

COMPREHENSIVE PLAN

I: Where Are We Now?

A. Description of local HIV/AIDS epidemic

Epidemiologic Profile

HIV/AIDS remains an important public health problem in Oregon. According to data from the Oregon Public Health HIV/AIDS Reporting System (eHARS) collected from 1981 through 2010, the number of newly diagnosed cases per year has not changed appreciably since 1997, but the total number of people living with HIV/AIDS continues to grow, presenting challenges for prevention and clinical services. Furthermore, people living with HIV/AIDS and other illnesses such as mental illness and substance abuse may find it particularly difficult to stay engaged in care. Finally, the complexities of maintaining insurance coverage and managing rigorous treatment regimens present challenges for all.

From 1981 through the end of 2010, a total of 8,753 cases of HIV or AIDS were diagnosed and reported among Oregon residents. Forty percent of those had died by the end of 2010, meaning 5,213 were believed to be living with HIV or AIDS through 2010. Since 1997, the numbers of new diagnoses has held steady at between 250 and 300 while deaths have fallen somewhat, meaning the number of Oregon residents diagnosed with HIV or AIDS, and believed to be living, increased by 150–200 per year. Oregon does not monitor current addresses of people with previously diagnosed cases of HIV and AIDS. Because Oregon only retains the county of residence at diagnosis, to the extent that people move within and out of Oregon after HIV or AIDS diagnosis, these numbers do not accurately reflect the actual number of people living with HIV or AIDS in any given location. In addition, people with HIV or AIDS diagnosed and reported in another state might move to Oregon, but because the case had already been reported in another state, their residence (and use of health care and other services) in Oregon will likewise not be reflected in these estimates.

Although it is home to 53% of the state's population, 27% of reported cases of HIV or AIDS among Oregon residents from 1981–2010, and believed to be living through 2010, were residents of the Balance of State (BOS) at the time of diagnosis. Residents of these counties at time of diagnosis and living through 2010 were more likely to report injection drug use among potential HIV transmission routes than urban dwellers.

As of December 31, 2010, there were 1,882 people living with HIV (but not AIDS) in the state of Oregon (36% of all PLWH/A). Compared with PLWA, PLWH were more likely to be younger (< 40 vs. ≥ 40 years of age), female (vs. males), and heterosexual women who reported sex with males of unknown risk (vs. other female transmission categories). This is consistent with modest recent increases in the proportion of women among those newly infected. Proportionally, men living with HIV (not AIDS) were more likely to acknowledge sex with other men and correspondingly slightly less likely to report injection drug use or both risk factors. Otherwise no notable differences were observed between the numbers of PLWA and PLWH by sex, race/ethnicity or presumed mode of transmission.

Despite gains in long term survival, more Oregonians continue to be diagnosed with HIV infection at an advanced stage. As of December 31, 2010, there were 3,331 people living with AIDS (PLWA) in the state of Oregon (64% of all PLWH/A). Approximately 40% of those diagnosed during 2005–2009 had AIDS at the time of their HIV-infection diagnosis or their infection progressed to AIDS within 12 months. Delayed diagnosis was more common among older patients, males of unknown risk compared to men who have sex with men (MSM), and among rural and mixed urban/rural residents relative to urban residents at time of diagnosis. Cases in the BOS were more likely to experience delayed diagnosed compared to those in the

transitional grant area (TGA) (47% vs. 37%). No trends or changes in prevalence were observed between 2009 and 2010.

The rate of new HIV/AIDS infections by year of earliest reported diagnosis reached a high of 18 cases per 100,000 people, for a total of 529 cases in 1990. The following year, however, saw the beginning of a decline. By 1997 the rate had dropped to nine cases per 100,000 people, a rate that has remained stable through 2010.

Of those first diagnosed in 2009, by December 31st of 2009, 100/248 or 40% had an AIDS diagnosis. Of those first diagnosed in 2010, by December 31st of 2010, 89/237 or 38% of those cases had an AIDS diagnosis. Between 2009 and 2010, 485 cases of HIV infection were diagnosed in Oregon. As of December 31, 2010, 204 (42%) of those cases had been diagnosed with AIDS. Within the last two calendar years (2009 – 2010), 366 new AIDS cases (many of which had been diagnosed with HIV (not AIDS) in previous years) were reported to the HIV/AIDS Surveillance Program.

Living Oregon cases of HIV infection by region, HIV/AIDS status, demographics and exposure category, 2010 (Source: eHARS 7/1/2011)

	Oregon					
	HIV(non AIDS)		AIDS		HIV/AIDS	
	Count	Percent	Count	Percent	Count	Percent
Sex						
Male	1,616	86%	2,944	88%	4,560	87%
Female	266	14%	387	12%	653	13%
Total	1,882	100%	3,331	100%	5,213	100%

Age-group on 12/31/09						
0-12 yrs	8	0%	1	0%	9	0%
13-19 yrs	24	1%	4	0%	28	1%
20-24 yrs	89	5%	27	1%	116	2%
25-29 yrs	168	9%	93	3%	261	5%
30-34 yrs	221	12%	171	5%	392	8%
35-39 yrs	217	12%	294	9%	511	10%
40-44 yrs	298	16%	533	16%	831	16%
45-49 yrs	288	15%	786	24%	1,074	21%
50-54 yrs	230	12%	564	17%	794	15%
55-59 yrs	163	9%	460	14%	623	12%
60-64 yrs	108	6%	229	7%	337	6%
65 yrs over	68	4%	169	5%	237	5%
Total	1,882	100%	3,331	100%	5,213	100%

Race						
Missing	2	0%	1	0%	3	0%
Hispanic	196	11%	371	12%	567	11%
American Indian/Alaskan Native	16	1%	35	1%	51	1%
Asian	21	1%	50	2%	71	1%
Black/African American	124	7%	221	7%	345	7%
Native Hawaiian/Pacific Islander	5	0%	8	0%	13	0%
White	1,397	78%	2,523	78%	3,920	78%
Multiracial	18	1%	12	0%	30	1%
Unknown	1	0%	0	0%	1	0%
Total	1,780	100%	3,221	100%	5,001	100%

Male exposure category						
MSM only	1,261	78%	2,008	68%	3,269	72%
IDU only	86	5%	275	9%	359	8%
MSM & IDU	118	7%	304	10%	422	9%
Heterosexual contact only	37	2%	116	4%	153	3%
High-risk heterosexual contact	0	0%	0	4%	0	3%
Perinatal exposure	11	1%	5	0%	16	0%
Other	8	0%	24	1%	32	1%
No identified risk	23	1%	30	1%	53	1%
No risk reported	72	4%	184	6%	256	6%
Total	1,616	100%	2,944	100%	4,560	100%

Female exposure category	IDU only	57	21%	92	24%	149	23%
	High-risk heterosexual contact only	153	58%	240	62%	393	60%
	Perinatal exposure	14	5%	3	1%	17	3%
	Other	0	0%	5	1%	5	1%
	No identified risk	5	2%	7	2%	12	2%
	No risk reported	37	14%	40	10%	77	12%
	Total	266	100%	387	100%	629	100%
Total	1,882	100%	3,331	100%	5,213	100%	

Unmet Need

An important aspect of planning for HIV treatment and prevention is an estimation of the number PLWH/A in Oregon who are aware of their infection but not receiving medical care. The Health Resources Services Administration (HRSA) requires all states and metropolitan areas that receive federal support for HIV/AIDS health care under the Ryan White CARE Act to estimate annually the size of this medically needy population. For purposes of unmet need estimates, Oregon counted the number of PLWH/A diagnosed in Oregon by the end of 2010, aged 13 years or older, who were aware of their infection. HIV case reporting completeness was estimated to be 98% by a comparison of Medical Monitoring Project respondents and eHARS. No adjustment for case reporting incompleteness was made in the calculation of unmet medical need.

Since August 2006, all CD4 tests and viral load tests have been reportable to the Oregon HIV Program. These lab results are housed in a laboratory database (Orpheus). Prescription and/or adherence to antiretroviral medication are data not collected by the Oregon HIV Program. If an Oregon case in eHARS had a record of a CD4 count or percent or a viral load test in 2010, this was taken as evidence of receipt of primary HIV/AIDS medical care. Adjustments were not made for incompleteness of lab reporting because there was no evidence of labs which had not been submitted to the HIV Program. Additional adjustments were not made to primary medical access in 2010 for cases deceased in 2010 or cases newly diagnosed 2010. Analysis in previous years suggested that the proportion of cases with a CD4 or viral load was not influenced by including cases that died in the same year or excluding the recently diagnosed. Adjustments were not made for migration because there is no comprehensive information of which cases reported in Oregon have since left the state.

Several limitations of these estimates require mention. The actual number of PLWH (aware of their infection) is not known. Some Oregon HIV/AIDS cases might have received out-of-state medical care, which would falsely inflate unmet need estimates. Our approach also did not attempt to account for migration of PLWH and PLWA in and out of Oregon. This may have contributed to the finding that older people were more likely to have an unmet need.

In Oregon people with HIV(not AIDS) were more likely than AIDS cases to have had a CD4 or viral load test in 2010 (81% vs. 72%; OR 1.5; 95% CI 1.32, 1.72). Whites were more likely to have had a CD4 or viral load test than Hispanics, Native American/Alaskan Natives or blacks (76% vs. 64%, 63% or 68%). Whether a case had a CD4 or viral load test did not appear to be associated with age. Men who have had sex with men (MSM) were more likely to have a CD4 or viral load than male injecting drug users (IDU) or MSM/IDU (75% vs. 65% or 68%). Urban cases were more likely than rural cases to have had a CD4 or viral load in 2010 (74% vs.64%). Non-foreign-born cases were more likely to have had a CD4 or viral load

(75% vs. 66%). Females were more likely than males to have a CD4 or viral load in 2010 (78% vs. 73%). Cases which did not progress to AIDS within 12 months of diagnosis were more likely to have a CD4 or viral load in 2010 (76% vs. 69%). In Oregon 26% of HIV/AIDS cases had an unmet medical need in 2010.

Outside the Portland metropolitan area, people with HIV(not AIDS) were more likely than AIDS cases to have had a CD4 or viral load test in 2010 (75% vs. 68%; OR 1.4; 95% CI 1.06, 1.76). Whites were more likely to have had a CD4 or viral load test than Hispanics or blacks (72% vs. 55% or 62%). MSM were more likely to have a CD4 or viral load than male IDU or males with an unknown risk (73% vs. 62% or 62%). Non-foreign-born cases were more likely to have had a CD4 or viral load (73% vs. 53%). There were no differences in unmet need by sex, female risk factors or age at the end of 2010. Cases which did not progress to AIDS within 12 months of diagnosis were more likely to have a CD4 or viral load in 2010 (73% vs. 66%). Outside the Portland metro area, 29% of cases had an unmet medical need in 2010.

Overall, the level of unmet need in both the BOS and all of Oregon has been decreasing over the past 5 years, from 35% in 2005 to 29% in 2010. See table below.

		2005	2006	2007	2008	2009	2010
Balance of State	Number of PLWH/A who did not receive HIV primary care medical services	35%	35%	38%	25%	28%	29%
Oregon	Number of PLWH/A who did not receive the specified HIV primary care medical services	32%	33%	31%	22%	25%	26%

Based on the data, there are five communities with greater levels of unmet need: People of color, Persons who Inject Drugs (PWID), Foreign-Born, People with an AIDS Diagnosis, and Persons living in rural geographical areas. While more evaluation is needed to fully understand the needs and barriers to care within these groups, we can make some assumptions based on existing literature and experience. Persons of color, although a minority in Oregon, continue to be disproportionately affected by HIV. Barriers specific to this community include increased levels of experienced and perceived discrimination, lack of culturally competent medical providers, and increased socio-economic barriers to accessing care. Potentially the largest barrier for Foreign-Born PLWH/A is related to language and health illiteracy. Cultural, transportation and legal barriers are also known challenges for accessing care. While persons with an AIDS diagnosis would seemingly have increased need for care, it may be that these are individuals who have been living with HIV for several years and may be experiencing treatment fatigue. Finally, persons who are geographically franchised face transportation barriers in accessing care. A PDES evaluation conducted in 2008 found that PLWH/A who live in the eastern counties of the state (which are considered rural or frontier) often have to travel great distances to access an HIV specialist. Given the small numbers of persons living in this area, there is also lack of social support within the local communities, another significant psycho-social need for those living in the most rural areas of the state.

Early Identification of Individuals with HIV/AIDS (EIIHA)

P1. All Individuals in Oregon who are Unaware of their HIV Status (HIV Positive & HIV Negative)						
P2. Tested in Past 12 Months		P3. Not Tested in Past 12 Months				
		P4. PWID	P5. MSM	T4. Partners of HIV +	T5. Transgendered Individuals	P6. Persons who identify as Hispanic or Latino
			T2. Young (25 and under) MSM			T6. Migrant or Seasonal workers
		T1. MSM and IDU	T3. MSM with STI Diagnosis			

T1. MSM & IDU - Because of chronic and disabling substance use, Persons who Inject Drugs (PWID) are typically focused on activities of survival. Concerns related to HIV or other health issues are usually secondary to housing, food, and securing drugs. PWID specifically, tend to be a transient population, often battling homelessness and co-morbid mental health issues. It can also be difficult to provide results for those who are moving in and out of correctional facilities. Referral to substance treatment and other services is often a higher priority than HIV treatment. Testing locations such as local health departments, community based organizations and the Part C HIV Clinic in Portland find that a “warm hand-off” (actually introducing the client to the referral) is a more effective method, but one that is resource intensive and not always practical. Late diagnosis is more common among men with injection drug use (compared to MSM). Among MSM infected with HIV, 9% also reported IDU risk.

T2. Young MSM (25 and under) - Although HIV has had a disproportionate impact on MSM, some are fatigued by HIV prevention, assume they already have the virus, or because it has become normalized in some circles, hold a misconception that HIV is easy to live with. MSM may be resistant to referral, especially if they have friends or partners who are also positive. They may prefer to rely on these relationships for information, and consequently, be at risk of receiving misinformation. The primary challenge for MSM in rural areas, however, is a lack of community support; MSM in rural areas face increased discrimination and homophobia. Stigma and isolation for males who have unreported MSM risk is more common in rural areas where homosexuality is not as accepted as urban areas and there are less supports for MSM. Furthermore, anonymity of testing can be compromised in small communities. Finally, not all counties receive adequate funding to provide specific outreach services to MSM, a situation that will worsen through 2016 with cuts in HIV prevention funding. Cultural/community issues, such as feelings of government interference in personal lives, pose a challenge to informing people of their HIV status regardless of location. Diagnosis rates increased among people aged 20-29 during the past five years.

T3. MSM with STI diagnosis MSM with an STI diagnosis face much of the same barriers and challenges as Young MSM. Rates of early syphilis, gonorrhea, and Chlamydia are much higher among Oregon men with previously reported HIV infection than among the general population of Oregon. For example, average annual rates, among 2005-2009 were:

- 116 times higher for early syphilis (233/100,000)
- 450 times higher for gonorrhea (1,351/100,000)
- 3 times higher for Chlamydia (902/100,000)

By focusing efforts on high risk MSM who are identified through an existing STI diagnosis, we are likely to find individuals are also unaware of their HIV infection. Among MSM with an initial syphilis or gonorrhea diagnosis, 4.2% of them had a subsequent positive HIV test within 60 days, an HIV positivity rate much higher than among any populations in Oregon. Cultural challenges of this target group include challenging condom and prevention fatigue, and the culture of sex parties and the adult sex industry prevalent in Oregon.

T4. Partners of HIV positive - Because of HIV related stigma, disclosure of status to a partner can be traumatizing for both the infected and affected person. The most common challenges to identifying Partners of HIV positive individuals are PLWH who are unwilling to notify partners and/or those who have little contact information for their partners. Specific to partners, the shock of learning one's partner is positive can be a traumatic event in itself. Persons who are recently informed of their partner's status may be unable to confront their own risk while they simultaneously accept news of a partner's status. For individuals who are unaware of their partner's risk, being informed of their own HIV status may be a shocking and traumatic experience for which they are unprepared.

T5. Transgendered Individuals – Throughout the spectrum of HIV services, there is a lack of data and information specific to the needs of transgendered individuals in Oregon. This is in part due to the fact that HIV surveillance data only reports two genders: male and female. Consequently, we do not know how many PLWH/A in Oregon identify as transgender, nor do we know how many PLWH/A who currently identify as male or female were assigned a different sex at birth. Transgender-identified individuals report significant disadvantages in accessing health care, higher rates of mental health issues, and increased rates of physical and mental disability. With acknowledgement to national data that finds transgendered individuals (in particular individuals who have transitioned from male to female) are disproportionately infected with HIV, we can only assume a similar situation in Oregon.

T6. Migrant or Seasonal Farmworkers – Migrant and seasonal farmworkers, especially those who are Spanish speaking, are disproportionately unaware of their HIV status due to a variety of cultural challenges. Hispanics face barriers related to language and culture. Many individuals are also suffering economic burdens, and survival issues may rank higher in their priority list than HIV diagnosis and care. Knowledge regarding the availability of HIV specific care and treatment resources is especially limited in rural and frontier areas, especially those individuals living outside of the Interstate 5 corridor.. Many Hispanic identified Individuals have fear about testing and being “outed” (revealing of their HIV status or sexual orientation) within their communities. There is also a significant amount of distrust of government and health institutions, including fear around immigration and documentation. Anecdotally, HIV Prevention staff report that substance abuse is prevalent among migrant farm workers, adding legal aspects to barriers for successful outreach interventions because of fears regarding immigration and risk of deportation. In a recent study with newly diagnosed Hispanics, about four in ten said they did not receive health care prior to HIV diagnosis because they felt there was no need for it. Likewise, 43% of respondents got HIV tested only because they were ill, including seven who were tested at the hospital when their HIV infection was likely

very advanced. Respondents commonly identified fear of rejection or HIV stigma as a barrier to status disclosure—and likely to HIV testing and status awareness. Across the state, late diagnosis is more common among Hispanics (compared to non-Hispanic whites).

B. Description of Current Continuum of Care

Overview

There are five Ryan White Parts providing HIV care and treatment services in Oregon. The Oregon Health Authority, HIV Care and Treatment Program is a joint program of the Public Health Division and the Pharmacy Services Division, and directly administers the Ryan White Part B Program, to include the AIDS Drug Assistance Program statewide and case management and support services in 31 Oregon counties (Balance of State/BOS). Ryan White Part A Program funds HIV care services in the six county Transitional Grant Area, known as the TGA, (Columbia, Washington, Clackamas, Multnomah, Yamhill Counties and Clark County in the state of Washington) and is administered by Multnomah County Health Department. Ryan White Part C and D Program funds the Multnomah County HIV Clinic, located in Portland, and administered by Multnomah County Health Department. Ryan White Part F Programs funds the Russell Street Dental Clinic, Oregon Health Sciences University, in Portland and the Clock Tower Dental Clinic, Lane Community College, in Eugene, Oregon. The Oregon AIDS Education and Training (AETC) Center, also funded by the Ryan White Part F Program, provides training to physicians and nurse case managers throughout the state.

Outside of the TGA, local county public health departments and community based organizations provide services which include HIV Counseling, Testing and Referral (CTR), and HIV case management. This creates an important link between public HIV testing and HIV care and treatment. There are two models of case management in the BOS: (1) Local county health department-based HIV Medical Case Management delivered by licensed public health nurses and (2) Regionally-based HIV Medical Care Coordination delivered by a multi-disciplinary team of AIDS Certified Registered Nurses and Care Coordinators (non-medical case managers). Seventy two percent of persons living with HIV and AIDS (PLWH/A) living in the Part B service area are enrolled in case management services. The HIV Care and Treatment Program also funds supportive services that include medical transportation, medical nutritional therapy, emergency financial assistance, emergency housing, mental health treatment, substance abuse recovery, and oral health care services.

Ryan White funded services in Oregon:

Outpatient Medical Care

The full range of primary care services are provided to PLWH/A through a combination of public and private health systems and community-based agencies. Individuals with private or public insurance access primary care through their designated health care providers.

As of April 2011, there were 70 medical providers working in 36 facilities across Oregon who actively manage HIV medical care for one or more PLWH/A. These providers include 65 MDs, two DOs, two nurse practitioners, and one physician assistant. About 6 in 10 providers (59%) are located in the Portland TGA, 22% are in the Part B service area served by HIV Alliance, and 19% are sited in the remainder of the Part B service area. This distribution is roughly similar to the distribution of PLWH/A in Oregon.

However, there are several geographic areas where PLWH/A might be underserved in regards to HIV care. There are few or no providers located in many rural communities in Eastern Oregon and along the North and South Coast areas, which means the small numbers of patients who live there must travel significant distances to access HIV medical care.

According to a 2007/2008 assessment of medical facilities in Oregon, most HIV facilities providing HIV medical care (69%) are private sector practices; the rest are a combination of public and community-based entities. About 1 in 3 facilities—particularly facilities serving higher numbers of PLWH/A—have some type of social support provider (e.g., health educator, social worker, case manager) co-located with their HIV medical care providers. In addition, about one-third of the facilities offer additional medical support services like treatment adherence help, risk reduction counseling, or an on-site pharmacy. Very few offer important ancillary services like dental health, mental health, or substance abuse care within the facility.

The HIV Health Services Center (HHSC) is the largest provider of HIV care in the state of Oregon, serving over 1,000 clients in 2010—an estimated 1 of 4 people living with HIV in the Portland metropolitan area. HHSC has been a Ryan White provider since 1990, and has long participated in HIV/QUAL data collection. The clinic has existing linkages and partnerships with many community-based agencies and is the only Parts C and D provider in Oregon. All clinical providers at HHSC have a minimum of ten years' experience, and support staff members have received specialized training in HIV services. Services provided include: primary medical care; medications adherence support; dental/oral health assessment and referral; nutritional assessments and counseling; substance abuse and mental health assessments and treatment, referral and counseling; case management; high resolution anoscopy and infrared coagulation treatment; peer mentoring; and hepatitis education. In addition, HHSC has been an AIDS Education & Training Center (AETC) clinical training site for a five-state region since 1999, providing preceptorships for physicians, nurses, and pharmacists.

HHSC provides medical care and support services within the context of a health department initiative called Building Better Care (BBC). The BBC model is designed to improve health outcomes through a proactive, patient-centered medical home model that is accessible and cost-effective. The model's foundation is team-based care and rigorous, continuous quality improvement.

HHSC currently has four care teams. Each team includes a medical provider, community health nurse, medical assistant, and a medical case manager. Provider teams are also supported by a pharmacist, a pharmacy tech, a part-time psychiatric nurse practitioner, a part-time mental health consultant, front office staff, peer mentors, and administrative staff. Each team provides care to an assigned panel of patients, in order to promote strong relationships between patients and clinic staff. Everyone on the team maximizes his or her contribution by fully utilizing individual skills and abilities in support of the work, and patients benefit from better continuity of care and increased adherence to medical regimens.

Because of the lack of medical providers in the large geographic area east of the Cascade Mountains, some PLWH/A in Eastern Oregon travel across state lines to seek HIV medical care. An estimated 14 PLWH/A in Eastern Oregon receive care from the Part C clinic in Boise, Idaho and 17 receive HIV care at the Part C clinic in Walla Walla, Washington because those facilities are closer and easier to access than medical care facilities in Oregon. Other PLWH/A in Eastern Oregon travel long distances within state for their care, either to Portland or other Oregon cities outside their region.

Health Insurance

The State of Oregon has a unique ability to provide health insurance for virtually every person living with HIV/AIDS in Oregon through the CAREAssist Program (Oregon's ADAP). The Oregon HIV Care and Treatment Program (Part B Grantee) uses Ryan White ADAP funding to pay health insurance premiums and co-pays for eligible PLWH/A who are not insured through Oregon Health Plan (OHP). By ensuring payment of premiums and providing uninterrupted coverage for these clients, the program leverages the Oregon Medical Insurance Pool (OMIP) to ensure universal coverage for even high-risk clients. Additionally, enrollment into the newly funded federal high risk insurance pool (PCIP) is facilitated by its co-management by OMIP. OMIP/PCIP coverage is available to Oregon residents with qualifying medical conditions that would otherwise restrict their individual health insurance coverage through private insurers. HIV/AIDS is a qualifying medical condition for OMIP/PCIP, and in 2010, OMIP/PCIP covered more CAREAssist clients (41%) than any other single insurer.

In 2010, CAREAssist served 2,784 unduplicated clients statewide. There were 435 new CAREAssist clients in 2010, an 8% increase in overall enrollment from 2009. Enrollment has been steadily increasing for years. For example, enrollment has increased 44% since 2007, when the program served 1,928 unduplicated clients.

All CAREAssist clients are low income, with household incomes of less than 300% FPL. About half (46%) are in the lowest income strata, with household income of \leq 100% FPL, and another 39% have income between 101-200% FPL.

Prescription Drug Assistance

CAREAssist ensures that PLWH/A have access to antiretrovirals by paying for primary health insurance premiums. In addition, CAREAssist has a published drug formulary which provides other prescription drugs that PLWH/A may need, and for which their primary health plans do not pay. These drugs are available to clients when they fill their prescriptions at a CAREAssist contract pharmacy. CAREAssist's drug formulary includes a wide range of medicines PLWH/A may need to maintain their health and quality of life, including smoking cessation drugs, and other medications that are not covered by Medicare Part D plans or OHP.

Medical Case Management

Medical case management consists of assessment, coordination of services and linkages to services inside and outside the Ryan White system of care. All clients have access to medical case management services that include treatment adherence assessment and coordinating timely access to appropriate levels of medical and supportive services, through ongoing client assessment and care plan development. Statewide, Medical Case Management (and non-medical case management) is performed by teams of nurses, social workers, and other professionals.

Part A-funded providers deliver services using the Chronic Care Model as the framework for the HIV care provided. The components of this model include community, self-management, delivery system design, decision support, and clinical information systems. Together, these components optimize positive outcomes for chronic conditions by creating an environment in which productive interactions and relationships thrive, resulting in patients and communities that are informed and active, and providers and community partners that are prepared and proactive (Jenkins 2011).

Specialty case management services are also offered in conjunction with primary case management services; this includes nursing case management, intensive case management for high acuity Latino and

African and African American clients, and services for clients living in transitional housing units to ensure they are able to maintain housing, thereby impacting their ability to maintain medical care and medication adherence.

Medical case management services in the Part B areas of Oregon are delivered through a combination of local county health department-based services and a regional service delivery model. Ten local county health departments in the Balance of State have opted out of providing Ryan White Program funded case management and supportive services, simultaneously transferring the authority and responsibility for providing case management and other supportive services to the Oregon Health Authority. This has created both challenges and opportunities for delivering high-quality services in the Part B-funded areas of Oregon.

Nine local county health departments continue to provide HIV Medical Case Management services to approximately 25% of the Balance of State (the Part B service area) clients in case management. With the exception of one county that has a multi-disciplinary team, all HIV case management delivered by these local health departments is delivered by a Public Health Nurse who does both medical and psychosocial case management.

Seventy five percent of clients in HIV case management in the Balance of State are served under the regionally-based Medical Care Coordination Model of HIV case management. The Oregon Health Authority contracts with an AIDS service organization, HIV Alliance in Eugene, to provide HIV care coordination services and medical and non-medical case management to clients in a nine-county region. The region includes areas on the South Coast, southern I-5 corridor, and along the California border. HIV Alliance also provides non-medical case management in Marion County, which has the second largest number of HIV clients in the Part B area, as well as a large Latino and monolingual Spanish-speaking population; Marion County Health Department provides medical case management services in partnership with HIV Alliance.

HIV Alliance and Marion County Health Department provide medical case management services through AIDS-certified registered nurses located throughout the service region, and provide care coordination/non-medical case management and supportive services primarily by phone, administered through a Care Coordination Center in Eugene. Client surveys in the affected counties, conducted prior to and one year after the changes were implemented, indicate that client satisfaction has remained high in all counties and increased significantly in Marion County. Clients report a high level of access to care coordinators and services, as well as high levels of confidence that their needs will be met by staff at HIV Alliance.

Clients in the large geographic areas in Eastern Oregon are served by another community based organization following the same regional Medical Care Coordination model, Eastern Oregon Center for Independent Living (EOCIL). All Part B clients have access to services delivered by nurses (medical case management) and case managers/care coordinators providing non-medical case management and access to supportive services.

Oral Health Care

Comprehensive dental care is provided by a range of practitioners, some of whom specialize in treating HIV positive patients. Services include diagnostic, preventive and restorative care, oral surgery and emergency care resulting from pain and infection. Crown and bridge procedures are also provided, with some limitations.

In 2010, 307 BOS clients received oral health services through Part F-funded services provided by Clock Tower Dental Clinic. In 2010, Clock Tower provided 920 diagnostic, 633 restorative, 461 preventative, and 75 adjunctive services. In addition, the following number of clients received specialized dental services through Clock Tower: periodontics (n=316), prostodontics (n=315), oral surgery (n=245), and endodontics (n=82).

In 2010, 28 additional clients in the Balance of State received oral health care assistance utilizing local Part B funds; 124 received dental services and 44 received initial dental assessment through the State Managed Service Program.

In 2010, 885 clients in the TGA (including 220 new clients) received oral health services through Part A & Part F-funded services at OHSU's Russell Street Dental Clinic. In 2010, Russell Street Dental Clinic provided 1305 diagnostic, 1454 restorative, 1000 preventive, and 222 adjunctive services. In addition, 673 periodontic, 826 prosthodontic, 283 oral surgery, and 95 endodontic services were provided.

In the TGA, Oregon Health and Science University (OHSU) participates in the Part F Dental Reimbursement program at their community-based Russell Street Dental Clinic. This program provides partial payment for unreimbursed costs of HIV care provided by the clinic. OHSU also has a Dental Community Partnership Grant that funds HIV clinical rotations for dental students, expanding access to services for PLWH/A. OHSU coordinates outreach for the grant with the two largest Part A primary care and support services providers, Multnomah County Health Department and Cascade AIDS Project. Part A contributes oral health care funding to help fill the gap in resources for the majority of PLWH/A without dental insurance.

In the Balance of State, PLWH/A in 17 counties receive Part-F funded services through the Clock Tower Dental Clinic in Eugene and its regional satellite clinics. In addition, clients who are unable to access Clock Tower can receive dental services through local private dental providers funded through Part B funds. Part B funds may also be used for dental services not covered by Part F reimbursement..

Substance Abuse Treatment

Ryan White-funded substance abuse treatment services include assessment, individual and group counseling, as well as engagement and coordination in outpatient treatment for clients in alcohol and drug-free housing. Substance abuse treatment services are provided by local providers and are accessed within the Balance of State through HIV case management.

Recruitment into mental health and substance abuse treatment services by peer mentors is also funded through a joint mental health and substance abuse treatment project in the TGA. The HHSC also offers a harm-reduction based treatment group open to any PLWH/A, regardless of where they receive medical care or whether they live in the TGA.

Nearly all CAREAssist clients are eligible to receive substance abuse treatment services as defined within the primary health insurance coverage purchased by CAREAssist or to which the client has access. CAREAssist pays deductibles and/or copayments on behalf of the client.

Mental Health Services

Ryan White-funded mental health services include assessment and on-site or at-home counseling (individual/couple/family), group counseling, crisis intervention, and medication management for

PLWH/A. Mental health services are delivered by mental health professionals (psychiatrists, psychiatric nurse practitioners, licensed social workers, or licensed professional counselors).

The state's Part B ADAP (CAREAssist) purchases insurance—the vehicle by which some clients access mental health services. CAREAssist pays deductibles and copayments behind the primary health insurance (including OHP and Medicare Part B) on behalf of the client. Because Medicare Part B pays at a low percentage on mental health services, the annual allocation to medical service copayments provided by the CAREAssist program may be exhausted prior to the end of the coverage year. In this case the responsibility for paying the copayments may default to other Ryan White funds. Within the Balance of State, mental health services are provided by private providers and accessed through HIV case management.

Mental health treatment services are provided by contracted mental health agencies and through a mental health provider stationed at Cascade AIDS Project, supported through Oregon HIV Behavioral Health Initiative (OHBHI) HOPWA grant funds. Recruitment into mental health and substance abuse treatment services by peer mentors is also funded through a joint mental health and substance abuse treatment project in the TGA. The HHSC provides mental health services by a Psychiatric Nurse Practitioner, as well as limited counseling from a Part D-funded social worker.

Early Intervention Services

Early intervention services (EIS) focus on newly diagnosed individuals and persons who have fallen out of care. Programs provide counseling and referrals to medical care. Referrals to mental health and substance abuse treatment services are also provided, as appropriate. EIS is currently available in the TGA only. The EIS program in the TGA began in July 2007 and has focused on PLWH/A who are out of care and the newly diagnosed, many of whom come into care later in their disease progression with a variety of co-factors including mental health and substance abuse issues.

EIS services are offered through two programs in the TGA: through the Disease Investigation Specialists (DIS), housed at the STD Clinic at Multnomah County Health Department, and through Cascade AIDS Project, the largest AIDS Service Organization in Oregon. The DIS receive information regarding all new HIV diagnoses in the county, follow up with those individuals to ensure they are linked to medical care, and recommend HIV testing for all known partners. Being housed in the STD clinic also provides the opportunity to work with clients who come in for STD treatment and are found to be out of care for their HIV disease. Such patients are assisted with linkage into HIV medical care. DIS also assist with partner notification. CAP staff work with clients who have fallen out of care or need extra assistance to get into care, specifically individuals coming out of corrections or who have mental health/substance abuse issues or may be homeless.

There are no Ryan White Part B-funded early intervention services in the BOS. Disease Intervention Specialists, funded through non-Ryan White sources, provide follow-up for newly diagnosed people, linkage to care and treatment services, and partner notification.

The CAREAssist Bridge Program is another way that early intervention service needs are being addressed in both the TGA and BOS. The Bridge program is a medical-provider driven program where clients who are entering care or returning to care can receive a limited number of medical services and prescription drugs.

Housing

This service category includes emergency and transitional housing assistance to PLWH/A and their families. Eviction prevention, information and referral, tenant education, housing placement, and housing case management enable clients to access and remain in transitional and permanent housing. Alcohol/drug-free housing is also provided for PLWH/A while enrolled in outpatient substance abuse treatment.

There are also three Housing Opportunities for Persons with AIDS (HOPWA) grantees in Oregon: the State of Oregon (which has both formula and competitive grants), the City of Portland (formula and competitive), and Our House of Portland (competitive). Between these three sources, housing services are provided throughout the state of Oregon.

Housing services in the TGA include permanent and transitional alcohol and drug-free housing; housing with supportive services for clients with mental illness; permanent subsidized housing for homeless and chronically homeless PLWH/A through Shelter Plus Care grants and Supportive Housing Program grants; housing for homeless women through the *Key Not a Card* program; transitional housing for youth; and permanent housing for formerly incarcerated clients. Other housing services include short term financial assistance for move in costs or eviction prevention, mortgage and utility assistance, case management, tenant education, housing placement, referrals to various applicable housing programs, and priority into subsidized or affordable units.

Our House of Portland, a community provider, delivers a continuum of services covered by public and private resources for advanced stage PLWH/A. Services include 24-hour specialized nursing and end of life care, assisted living in adult care homes, and a neighborhood housing and care program that combines stable housing with integrated in-home medical, occupational therapy, and social work services.

The Oregon Health Authority also contracts directly with Cascade AIDS Project (CAP) to deliver HOPWA SPNS OHBHI and HOPWA SPNS OSSCR services in the TGA as they are a project sponsor of those competitive grants. Through this partnership, CAP provided tenant-based rental assistance to an additional 25 households in 2010. Approximately 20 additional households receive rent assistance through a leveraged Shelter Plus Care grant in Multnomah County.

The Portland Housing Bureau contracts directly with Cascade AIDS Project to deliver a range of HOPWA housing services including: tenant based rent assistance, project based rent assistance, short-term rent mortgage utility assistance, Working Choices program, furniture assistance, and case management services. Approximately 250 households receive housing assistance through these HOPWA funds and 60 households receive employment assistance. CAP partners with a variety of housing agencies and property managers for leveraged rent assistance including Shelter Plus Care in Clackamas County and Multnomah County, supportive housing funds from the Multnomah County Continuum of Care, and project based rent assistance through the local housing authority, Home Forward.

Portland Housing Bureau received a HOPWA SPNS grant to serve approximately 60 households with short term rent assistance, extend the working choices program, and integrate HOPWA services into mainstream services. This is effective January 1, 2012.

CAP is also funded by Ryan White to provide short term rent assistance, tenant education, housing placement and planning, and case management to serve 350 people. Leveraged rent assistance includes Home Forwards STRA (short term rent assistance) program and Shelter Plus Care in Washington County.

Clients residing in the BOS may receive limited Ryan White Part B-funded emergency and transitional housing services through local case management contractors.

Long term permanent supportive housing is provided through the OHOP Program. OHOP is designed to assist people living with HIV/AIDS in creating a continuum of stable, sustainable housing, in order to improve access to and engagement in HIV care and treatment and to act as a bridge to long-term assistance programs, such as Section 8. Additionally, through 3.6 FTE Housing Case Management staff, the OHOP program assists clients in 31 Oregon counties in locating and/or securing suitable rental housing, identifying other related housing and community based resources that may be available to clients, and providing housing information and referral to those housing resources.

Additional supportive services are provided to clients participating in the HOPWA/SPNS-funded Oregon Housing and Behavioral Health Initiative (OHBHI), Oregon Statewide Supportive Community Re-entry Project (OSSCR) and the Supportive Housing Program for homeless individuals. OHBHI assists clients with HIV and co-occurring behavioral health issues that present barriers to accessing and maintaining stable housing with additional mental health and case management support while OSSCR provides additional case management and service coordination to persons post incarcerated. OSSCR represents a uniquely collaborative client service model that includes the effort of supporting professionals such as local and state corrections. Finally, the Supportive Housing Program provides additional case management, to include frequent home visits to chronically homeless and homeless individuals.

Food and Nutrition

This service category includes emergency food assistance (e.g., food vouchers/grocery gift cards, home delivered meals), nutritional supports, and medical nutritional therapy.

Food and nutrition services in the TGA include home-delivered meals. The home-delivered meal program has restructured to adjust to more stringent client requirements around medical necessity for this service, and there have been no cost-of-living increases to the category. As a result, the home delivered meals program now delivers a week's worth of frozen meals to clients once a week; the program is able to ensure that each client in the program has a microwave to heat the meals.

Esther's Pantry, located in the Portland metropolitan area and administered by Our House of Portland, is the only food bank in Oregon specifically serving PLWH/A. It was founded in 1985 "to provide financially challenged individuals living with HIV/AIDS access to food and personal care items," and serves approximately 200 PLWH/A each month. The Pantry is unique in that it has always maintained a policy of allowing clients to select the food they want from well-stocked shelves, rather than handing out pre-packaged food boxes, which is a standard procedure at most emergency food programs. However, Esther's Pantry does not receive any Ryan White funding, only serves the Portland metropolitan area, and has had to limit services over the years due to budget constraints. The Tod's Corner program provides clothing, household goods, pet food, cleaning and personal care items.

Emergency food assistance is provided to Part B clients through their HIV care coordinators and case managers. Nutritional counseling and supports is delivered by medical case managers and medical nutritional therapy is delivered by private licensed dieticians.

Medical Transportation

This service includes assistance with transportation to and from medical appointments, using the most cost-efficient means available for the client's locale.

Coordination of medical transportation for TGA clients is provided through medical case management. Case managers determine client needs and link them to the most appropriate resources, which are usually transportation resources outside of the RWCA-funded system. Most TGA clients live in Portland or the areas immediately surrounding it, and most Part A-funded services are also located in this area. Tri-Met provides an extensive public transportation system, including buses and light rail in Clackamas, Multnomah and Washington Counties. Case managers can provide gas vouchers or bus/rail tickets for those who use public transportation and can reimburse other types of transportation (e.g., taxi, gas cards, and other medical transport) for clients unable to use public transportation.

Most Balance of State clients have fewer public transportation options and greater medical transportation needs. Some clients in Eastern Oregon, for example, drive 3-5 hours each way to access HIV medical care. Medical transportation assistance is provided in the Balance of State through gas cards, public transportation (e.g., bus tickets), taxi fare, and, occasionally, special medical transport for clients who need a higher level of assistance due to serious illness and/or mobility limitations.

Psychosocial Support Services

Psychosocial support services offer stability for a marginalized population; this leads to more consistent participation in HIV care and treatment services.

In the TGA, a drop-in day center serves PLWH/A who have difficulty dealing with activities of daily living, many of whom have substance abuse and mental health issues and are homeless or living in temporary housing. The center provides regular supportive activities, meals, peer support, and a place for clients to meet with social service providers. Another center provides services for women and their families, including child care while women participate in support groups and other center activities.

With funding through Ryan White Part D, CAP also provides psychosocial support to children and families affected by HIV through Kids' Connection. Kids' Connection provides: 1) developmentally appropriate HIV education and disclosure, 2) a multi-session family group called Families Together that focuses on HIV education, disclosure and family communication, 3) Family Days that provide parenting skills workshops paired with free and fun family activities and social/recreational events for families affected by HIV to help build community and support. Kids' Connection also partners with the Pediatric HIV Clinic at OHSU to provide support and education for families when their children are seen for medical care at the clinic. Finally, Kids' Connection and Part D provide support for teens living with HIV through age appropriate education and risk reduction counseling as well as through a twice-monthly group called Always Looking Up.

Some communities in the Part B areas of Oregon have support groups, but most do not. No communities in the Balance of State currently have peer support programs.

Non-Ryan White funded services:

HIV Medical Case Management services are provided at the local level through contracts with public health departments and community based organizations and is the primary resource for assisting clients to access non-Ryan White funded services. All case managers will, on the first visit, assess the client's eligibility to participate in any and all systems of medical care and supportive services. Persons at or below 100% of the FPL who also have a disability status verified by SSA are referred to the Oregon Health Plan (OHP - Medicaid). Military veterans are referred to the Veteran's Administration (VA) Health System for care though these clients have the choice of receiving medical care outside of the VA system and may sign up for services through CAREAssist (Oregon's AIDS Drug Assistance Program). Clients eligible for housing assistance must be referred by an HIV case manager to an OHOP Housing Coordinator. OHOP Housing Coordinators will then assist the appropriate clients to access housing services through either HOPWA/OHOP or provided through the local CAP agencies. The public health departments who are contracted to provide HIV Medical Case Management can immediately refer internally to the full spectrum of public health services. The community based organizations work very closely with the local health departments in their services areas, and in some cases, have Medical Case Managers co-located within a local health department, allowing for streamlined referral to public health programs.

Persons ineligible for other medical care programs and with income up to 300% of the FPL are eligible to receive benefits from the state managed AIDS Drug Assistance Program (CAREAssist). CAREAssist pays for HIV specific medications from its formulary to clients who are in a "pre-existing condition" exclusionary phase under insurance programs or are ineligible for prescription drug coverage, supports costs of co-pays and deductibles, and/or purchases insurance that will cover medication and care costs. Those not eligible for the Oregon Health Plan (OHP) or other forms of insurance are directed to the Oregon Medical Insurance Pool (OMIP) and the Federal Medical Insurance Pool (FMIP). Through OMIP or FMIP, CAREAssist is able to purchase insurance with pharmacy benefits. Ninety nine percent (99%) of all PLWH/A enrolled in CAREAssist are fully insured, including clients who are undocumented. Clients must use care systems for which they are eligible. Ryan White is the payer of last resort for services. Additional core and support services which directly facilitate a client's ability to access health care and therapy may be authorized. However, clients must meet the income eligibility requirements of 250% (or less) of the FPL and must only receive supportive services if the client has not been qualified for other coverage or where there is an immediate emergency need to access care and treatment.

How the service system/continuum of care has been affected by state and local budget cuts, as well as how the Ryan White Program has adapted:

Both HIV Community Services and CAREAssist have been heavily impacted by budget cuts and flat funding and have made significant changes to the delivery of their services in response. HIV Community Services developed, piloted and has implemented a new Regional Medical Care Coordination regional service delivery model and CAREAssist has implemented a new pharmacy services delivery model. Both of these models are described below.

Prior to 2007, Part B funded case management and supportive services had been primarily contracted through local county health departments with public health nurses playing the primary role as HIV Medical Case Managers. Beginning in 2007, local county health departments, experiencing severe budget short falls, began to opt-out of providing HIV case management and supportive service access.

Additionally, the HIV service system was experiencing an increase in client case loads, an increase in clients presenting with co-occurring complex medical and psychosocial issues, and flat funding over many years. The HIV Community Services Program determined that the current Oregon Ryan White Program, Part B case management service delivery model must be reviewed and examined in order to improve service quality and service delivery. In 2008, the program began a planning process involving local, state and national experts, stakeholders and consumers, which resulted in the development of a demonstration pilot project. The pilot project goals included:

- Revise and strengthen the current HIV Medical Case Management model so that it complies with federal legislative requirements.
- Align case management activities and goals with acute and chronic HIV disease management needs of PLWH/A.
- Strengthen communication between HIV Medical Case Managers and client health care providers to encourage client access to and successful adherence with medical treatment.
- Reduce the disparities in client access to care coordination and supportive services.
- Provide a short-term client education intervention coordinated by an HIV Medical Case Manager for all newly diagnosed clients.
- Provide greater access to expertise in key areas of client need: (a) assessment and interventions for treatment adherence, nutrition, oral health, liver health/Hep C disease management and HIV exposure risk reduction; (b) targeted assessment and interventions for mental health and substance abuse issues; (c) chronic disease management/self management training; (e) AIDS Drug Assistance Program case management and benefits coordination; (f) housing case management; and (g) supportive services information, referral and access coordination.
- Improve the clinical outcomes of people living with HIV in the Oregon.

The pilot was initiated in 2009 with four counties participating and expanded to seven counties in 2010. Baseline evaluation was completed in 2009 with a 12 month follow-up evaluation for the first four participating counties. There was a second baseline evaluation conducted in 2010 and a 12 month follow-up was completed in 2011. The follow-up client satisfaction evaluations showed significant improvement in client satisfaction with services under the new model in one area and showed no degradation in satisfaction from the old model to the new model in another area. The pilot was successfully completed in June 2011. Effective July 2011, the model is now known as the Regional Medical Care Coordination (MCC) model. Also, effective July 2011, an additional region composed of nine Eastern Oregon counties began offering the Regional Medical Care Coordination model. Currently, the Regional MCC model is implemented under two contracts serving approximately 700 clients from 22 counties receiving services under the Regional MCC model. This represents over 60% of clients in the Ryan White Program Part B service area known as the Balance of State (BOS).

The Oregon Medical Care Coordination model provides HIV case management services under a coordinated program that recognizes the need for three distinct areas of expertise: (1) eligibility determination/administrative; (2) psychosocial services coordination/helping clients access programs that will help pay for medical treatment and (3) medical care and treatment engagement. Under this model, the Intake Coordinator (IC) is responsible for all enrollment and re-enrollment administrative activities; the Care Coordinator (CC) is responsible for all psychosocial services coordination and traditional social work activities that include helping the client find a payer for their medical care and the Medical Case Manager (MCM)/Nurse Case Manager (RN) is responsible for assisting the client to

successfully engage in medical care and treatment. In the Oregon MCC model, the MCM must be an AIDS Certified RN (ACRN).

Two additional components set this model apart from the more traditional HIV case management models of the past: (1) a telephone triage, performed by the IC, for low acuity clients (Acuity 1 and 2) that ascertains the need for more direct interventions from a CC and/or RN and (2) while a Nursing Assessment by a Medical/Nurse Case Manager is required for all newly enrolling clients, ongoing Medical/Nurse Case Management is only available to high need/acuity clients. Within the service region there is an MCC Center where the Intake Coordinators and Care Coordinators are located. Some of the Medical/Nurse Case Managers are also located at the MCC Center but others are located throughout the region, which provides greater face-to-face access to medical case management for high acuity clients. Additionally, the Medical/Nurse Case Managers are expected to case conference with clients' medical providers on a regular basis.

The cost of medication has increased significantly in the past few years and the number of clients served by CAREAssist has increased from 1,700 in December 2007 to 2,667 in December 2011, with Ryan White funding not increasing at a commensurate rate. In order to continue to serve the increasing number of clients eligible for care in Oregon, not have to institute a waiting list and to implement effective cost containment measures, CAREAssist implemented a new pharmacy services delivery model in FY2011 in order to become a 340B Hybrid. The program directly purchases pharmaceuticals while retaining the ability to seek rebates on some copayment activities. CAREAssist has entered into a contractual relationship with 39 "in network" pharmacies, including both a mail order pharmacy service and a network of contracted point of sale pharmacies located throughout the state. The new system is based on a pharmaceutical product replenishment model where pharmacies dispense their own product to an approved CAREAssist client and then the ADAP directly purchases the same pharmaceutical product and replenishes the drug to that pharmacy. At the time of the initial dispensing to the client, the pharmacy bills the client's primary health insurance. The contract pharmacy then remits the full amount of the insurance reimbursement to CAREAssist and is paid a fee-for-service from the ADAP program. The CAREAssist Pharmacy Benefits Administrator (PBA) is Ramsell Public Health Rx. A CAREAssist eligibility file is updated hourly and sent to Ramsell, thereby assuring that only eligible clients receive services. Ramsell acts as the data transfer hub (clearinghouse) for the network of pharmacies. Contracted pharmacies access client eligibility via Ramsell and Ramsell collects data from the participating pharmacies, transmitting that data to the CAREAssist program. The program monitors the dispensing patterns via the transmitted data and then authorizes its wholesalers to replenish the dispensing pharmacy based on dispensing activities reported.

C. Description of need

The following need information is compiled from two primary sources: the HIV Medical Monitoring Project (MMP) and a CAREAssist client survey. The HIV Medical Monitoring Project (MMP) is a national project funded by the Centers for Disease Control & Prevention, and currently conducted in 17 states and 6 cities. These 23 project areas are estimated to include over 80% of the total HIV/AIDS cases in the United States. MMP assesses clinical outcomes and behaviors of HIV+ adults receiving medical care in the United States. Data include patient interviews and information abstracted from medical records.

In Oregon, data collection will cover the years 2007-2014. The most recent data, cited here, were collected from 539 participants and represent PLWH/A who received medical care in Oregon in 2009-

2010. MMP participants include people receiving Ryan White-funded services and people who are not. For example, about 50% of MMP participants were enrolled in CAREAssist, but many others were enrolled in private plans and did not receive health insurance premium assistance from CAREAssist.

MMP participants were demographically similar to reported cases of HIV, giving a rough indication that PLWH/A in Oregon are not disproportionately in or out of medical care based on race, ethnicity, gender, age, or sexual orientation.

Among MMP participants (who were selected because they received medical care in the year of sampling), access to care was good. For example:

- **98%** reported having health insurance or coverage, and only 6% reported an insurance gap at some point in the past 12 months.
- **100%** reported having a “usual source of HIV care” in the past 12 months.
- **95%** of those diagnosed in the past 5 years had their first HIV medical visit within 3 months of diagnosis; 5% entered care between 3-12 months post-diagnosis.

About 2 in 3 MMP participants (66%) said they travel 30 minutes or less each way to get to HIV medical care. However, distances varied greatly among participants, with one-way trips ranging from 1-300 miles. About 1 in 10 MMP participants (12%) said their travel time to HIV medical care is more than 1 hour each way. About 1 in 9 MMP participants reported difficulty getting to HIV medical care: 10% said that getting to HIV medical care was “somewhat difficult” and another 4% characterized it as “very difficult.”

MMP participants had an average of 4 past-year, face-to-face visits with their medical providers (median: 4, range: 1-18). CAREAssist clients also reported seeing their HIV medical providers frequently; almost two-thirds (61%) reported seeing their HIV clinician four or more times in the past year. Conversely, only 5% reported seeing their clinician less than once every six months; of those, very few (n=5) said they had zero past-year visits to their HIV clinician. CAREAssist clients in the Portland metropolitan area reported seeing their doctor more frequently than those in the Balance of State, possibly because of greater distances between the doctor’s office and home, as well as fewer transportation options in non-metropolitan areas. Seventy-five percent of MMP participants had 3 or more CD4 counts in the past year, and 80% had at least one undetectable viral load.

In 2009, a self-administered survey was mailed to all CAREAssist clients (n=2137 at that time); 1210 clients (58%) returned the survey. The survey was provided in both Spanish and English, and special efforts were made to increase response rate among younger clients. The final sample was representative of the CAREAssist population, except that younger clients, particularly those under age 30 were still under-represented. The survey provides data from a large sample of Ryan White clients on important topics like overall health and well-being; co-morbid conditions; use of medical services, antiretrovirals, and lab testing; housing stability; and met and unmet medical and supportive service needs.

Several different measures on the CAREAssist survey indicate that CAREAssist clients are experiencing poorer physical and mental health and well-being than the general population. Although 71% of CAREAssist clients rated their health as good or better, the average physical health scores on a standardized measure (the SF-12) were lower than average for the general population.

Many PLWH/A in Oregon live with multiple chronic conditions, in addition to HIV disease. Some of these chronic diseases are simply part of the aging process, while others may be complications of long-term HIV infection and/or treatment with HIV medicines.

Eighty percent of CAREAssist clients reported having one or more chronic condition, in addition to HIV disease. Two conditions that can have a dramatic impact on functioning and quality of life were the most commonly reported: over half of clients (54%) reported “depression, anxiety or emotional problems” and more than 1 in 3 (38%) reported chronic pain. About 1 in 5 reported conditions like arthritis/rheumatism, hypertension/high blood pressure, or lung/breathing problems, including asthma. Eleven percent reported co-infection with hepatitis C.

Medical record data from MMP also indicate a prevalence of medical co-morbidities. For example, 39% of MMP participants had documentation of hypercholesterolemia or hypertriglyceridemia, 37% had depression diagnoses, and 28% hypertension diagnoses. More than half of MMP patients (52%) reported chronic pain, and 38% are prescribed medicine to manage their pain.

For those engaged in HIV medical care, the care that is available appears to be accessible and frequently used. Furthermore, there did not appear to be disproportionate barriers for specific demographic groups, although CAREAssist clients in the Balance of State reported fewer medical visits than those living in the Portland TGA.

However, PLWH/A in Oregon are heavily dependent on public systems to fund HIV medical care. The CAREAssist Program eliminates financial barriers to HIV medical care and appears to level the playing field for low-income PLWH/A. This service is used by roughly half of PLWH/A in Oregon.

The high prevalence of serious co-morbid medical conditions also reveals significant health burden among PLWH/A in Oregon, and warns of a correspondingly significant, ongoing need for program services, including outpatient medical care, health insurance and pharmaceutical coverage. Given lower physical health scores, more frequent self-reports of poor or fair health, and the higher prevalence of chronic pain among older CAREAssist clients, demand for medical and pharmaceutical services are likely to remain high and even increase further as the PLWH/A population ages.

For many years, dental care has been consistently cited as the number one unmet need for services among HIV clients. Seventy-nine percent of MMP participants reported needing dental care in the past year. In 2010, 307 BOS clients received oral health services through Part F-funded services provided by Clock Tower Dental Clinic. In 2010, Clock Tower provided 920 diagnostic, 633 restorative, 461 preventative, and 75 adjunctive services. In addition, the following number of clients received specialized dental services through Clock Tower: periodontics (n=316), prostodontics (n=315), oral surgery (n=245), and endodontics (n=82). In 2010, 28 additional clients in the Balance of State received oral health care assistance utilizing local Part B funds; 124 received dental services and 44 received initial dental assessment through the State Managed Service Program.

There are no definitive data related to the prevalence of substance abuse among PLWH/A in Oregon, but various data sources indicate a substantial need. In 2009-2010, 15% of MMP participants reported binge drinking on one or more days in the past month. Binge drinking was defined as 4 or more drinks in one day for women and 5 or more for men. In addition, 29% reported use of other drugs in the past

12 months, including recreational use of marijuana⁴ (26%), other non-injection drugs (15%), and injection drugs (5%). Almost 1 in 10 participants (9%) reported daily recreational marijuana use. Past-year use of substance abuse treatment services was noted in 10% of MMP participants' medical records in 2007-2008, the most recent MMP data available on this topic, and 2% of MMP participants reported past-year use of inpatient drug and alcohol treatment. In 2009, 7% of CAREAssist clients self-reported a "problem with drugs or alcohol."

An older study found that 30% of Medicaid-insured PLWH/A had been treated for a substance abuse issue over a two-year period (1999-2000); 20% had been treated for both substance abuse and mental health issues (PDES, 2002). In 2010, 2 clients in the Balance of State received Part B-funded substance abuse treatment services. In 2010, 27 clients in the TGA received Part A-funded substance abuse treatment services. These numbers have always been somewhat low because of challenges discussed below. However, changes in health insurance related to the parity act now allow these services to be billed through insurance plans, which may also decrease the numbers served through Ryan White Program funds.

About half of CAREAssist clients (54%) reported "depression, anxiety or emotional problems" in 2009, and the average emotional health score on the SF-12 (a standardized measure) was 41 for CAREAssist clients, indicating that they have somewhat poorer emotional health compared to the general adult population (average=50). About 1 in 3 MMP participants (36%) reported needing mental health services in 2009-2010. In addition, 35% of MMP participants reported being diagnosed or treated for depression and 24% for anxiety in the past year. Just over 1 in 4 MMP participants (28%) showed moderate to severe depression on a standardized measure (the PHQ-9 scale) based on reports of their mood over the past two weeks.

Two percent of MMP participants reported past-year admission to an inpatient mental health facility. An older study found that 20% of Medicaid-insured PLWH/A had been treated for both substance abuse and mental health issues over a two-year period (1999-2000) (PDES, 2002). In 2010, 129 clients in the TGA received Part A-funded mental health services, about 23% fewer than in 2007. Providers report this is largely due to implementation of mental health parity laws so clients do not need to access Ryan White funds to complete their treatment. In 2010, 5 clients in the BOS received Part B-funded mental health services. Similar to substance abuse services, the numbers accessing Ryan White Program-funded mental health services have always been somewhat low because of challenges discussed below. However, changes in health insurance related to the parity act now allow these services to be billed through insurance plans, which may also decrease the numbers served through Ryan White Program funds.

The state's Part B ADAP (CAREAssist) purchases insurance—the vehicle by which some clients access mental health services. CAREAssist pays deductibles and copayments behind the primary health insurance (including OHP and Medicare Part B) on behalf of the client. Because Medicare Part B pays at a low percentage on mental health services, the annual allocation to medical service copayments provided by the CAREAssist program may be exhausted prior to the end of the coverage year. In this case the responsibility for paying the copayments may default to other Ryan White funds.

Among MMP participants, 71% reported having a stable place to live in the past year, with no past-past year moves. About 1 in 10 MMP participants (11%) reported moving more than once in the past year,

⁴ Recreational marijuana use was measured separately from medicinal use of marijuana to treat HIV symptoms or side effects.

6% reported past-year homelessness, and 4% reported incarceration, which can often lead to homelessness or unstable housing once released. In 2009, a majority of CAREAssist clients, though by no means all, reported living in safe and stable housing situations. More than three-fourths (78%) characterized their current housing as very safe, 19% said somewhat safe, and 3% said it was not safe at all. Most CAREAssist clients (77%) reported living in their own house or apartment at the time of the survey (either singly or with a partner) and 16% reported living in someone else's house or apartment (e.g., the residence of a parent, other family member, or friend). Four percent reported living in other stable housing, such as a rented room or hospice facility and 2% reported currently living in unstable housing, like transitional housing or a shelter or welfare residence. The unstable housing category also included respondents who reported being currently homeless (n=8). Similar to MMP, 9% reported moving more than once in the past year.

Just over 1 in 10 CAREAssist clients (13%) said they had considered themselves homeless in the past two years. In 2010, 536 clients in the TGA received Part A-funded housing assistance services, an 11% increase from 2007. In 2010, 165 clients received Part B-funded emergency and transitional housing services in the Balance of State. Clients with chronic housing assistance needs were referred to Oregon Housing Opportunities in Partnership Program (OHOP), funded primarily by the Department of Housing and Urban Development (HUD). OHOP provided rental assistance to 160 households in 2010, and there were 124 people wait listed.

Forty percent of MMP participants said they needed meal or food services in the past year; of those, 90% received the needed service. In 2007, HIV case management clients in the Part B service area were asked about their food needs as part of the annual client satisfaction survey; 57% (n=220/388) said they had needed financial help getting food or groceries in the past 12 months. The percentage needing help with food and groceries in 2007 was higher than the 49% identified in the 2005 Needs Assessment survey. The most common source of financial help for food came from food stamps, accessed by 47% of respondents. Other common sources of help were food banks/food pantries (27%), friends and family (25%), and grocery vouchers from case managers (23%). In 2010, 47 clients in the TGA received Part A-funded food and nutrition services in the form of home-delivered meals, a 23% decrease from 2009. In 2010, 33 people received Part B-funded medical nutritional therapy by a licensed dietician in the Balance of State, 226 received RN-authorized food vouchers provided in support of the nutritional plan developed by the RN and the client, and 323 received emergency food assistance.

Just over 1 in 4 MMP participants (28%) said they needed transportation assistance in the past year. In 2010, 442 PLWH/A received Part B funded medical transportation services.

Just over 1 in 4 MMP participants reported needing peer group support; of those, about half received the service and half reported an unmet need. Qualitative data from listening sessions and interviews conducted in 2011 indicated a great unmet need for psychosocial support in the Part B areas of Oregon. Part B clients identified a need for peer support, support groups, and patient advocates.

D. Description of priorities for allocation of funds

Funds are allocated based upon a formula that takes into account prevalence and services delivered. The Oregon Coalition of Local Health Officials (CLHO), HIV Committee approves the Ryan White Part B funding award to counties. For case management services, the formula provides \$1,500 base funding per service area (county) [to provide a foundation for the smaller counties] and the remaining funds are allocated based upon a formula with three data sets: 30% - all case management units reported in the

previous calendar year; 40% - unduplicated clients served in the previous calendar year and 30% - HIV/AIDS living in the service area (2 year average), as reported by HIV Surveillance. For supportive services, 75% is based upon unduplicated clients served in the previous calendar year and 25% is based upon HIV/AIDS living in the service area (2 year average), as reported by HIV Surveillance.

Additionally, service caps have been established for core and supportive services based upon historical needs assessment data that shows the level of need, trended client utilization costs, and access to other payers for the services. Finally, at the recommendation of the Oregon HIV Care Coalition to increase equitable access to key services for all clients in the BOS, the state administers payment for some services centrally. The program provides access to core services such as Mental Health Services, Substance Abuse Treatment, Home Health, Oral Health and Medical Nutritional Therapy after a client has been assessed as eligible for the service by their case manager or care coordinator. This allows clients equal access to expensive and needed services that the budgets of smaller contractors could not sustain.

E. Description of gaps in care

Equitable access to HIV specialty care statewide in Oregon represents a gap in care. PLWH/A in the Eastern, South Coast and North Coast regions do not have access to any HIV specialty care and must leave their regions to receive care. Most of the clients in Eastern Oregon receive HIV specialty care at the Ryan White Part C clinic in either Walla Walla or Yakima, Washington; in Boise, Idaho or in Portland. All three clinics require traveling long distances to access HIV specialty care. Additionally, PLWH/A in these regions also frequently report that their primary care givers do not stay current on the changing treatment standards for HIV and that they (the client) often must bring information about new therapies/treatment to their medical provider for review. An evaluation of HIV medical care in Oregon showed that of the 305 medical facilities/practices statewide (including the Portland TGA) that participate in HIV reporting activities, a small proportion (n=44, 15%) actually treat or manage adult patients' HIV disease. Of those facilities, only 28 statewide offer the care and treatment of HIV disease of all severities without need for additional consultation and might be considered HIV specialists, eight co-manage the care of HIV positive patients in conjunction with a HIV specialist, and eight only provide HIV care up to a practice-specific threshold (“until it gets too bad”) and then refer the patient to a specialist. Facility size varies greatly in terms of number of clinicians and patients, and is related to level of HIV care provided. All of the large practices (> 50 patients) provide HIV specialty care, while small practices (<10 patients) provide care across the full range of care levels. All facilities providing care up to a practice-specific threshold before referring to a specialist are small practices with 10 or fewer HIV patients. About half of all HIV medical facilities in Oregon served 15 or fewer PLWH/A. Most of the 44 facilities providing HIV medical care in Oregon are located along the North/South I-5 corridor west of the Cascades, which is also where the vast majority of PLWH/A reside. Eighty-one percent of the facilities are located within three regions: the Portland TGA (n=19, 43%), Central-East (n=9, 20%), and Southern Oregon (n=8, 18%). Of the 44 HIV medical care facilities, most (69%) are private sector practices; the remaining 31 percent are a combination of public and community-based entities. Only one facility in Oregon, in Portland, is Ryan White Part C funded.

Oral health care also remains a gap for rural PLWH/A. For many years, dental care has been consistently cited as the number one unmet need for services among HIV clients. While Part B clients have access to Clock Tower in Eugene or Russell Street in Portland, both require traveling long distances for many clients. Often Part B clients have received very little consistent dental care over many years and the, coupled with poor hygiene and compromised immune systems, the amount of dental work required when they begin to access the service is expensive and requires many visits over long

periods of time. Additionally, with the number of clients who have been, or are, methamphetamine users, the incidence of "meth mouth" is very high and these clients require complicated, expensive and lengthy dental treatment. Coupled with having to travel long distances, the average client faced with these complicated oral health restorative treatment plans often will go to one or two appointments and then the probability of missed appointments increases. Clock Tower has offered satellite clinics in some areas of the Ryan White Part B service region and have committed to attempt to increase the number offered. Part B funds are also available through the subcontracts and are available through a state administered program for procedures not covered by Clock Tower or Russell Street or for clients who cannot travel to receive the services. But, overall, the need for oral health care and the barriers encountered to receiving it often exceeds the system's capacity to delivery effective oral health service.

Housing-related help continued to be a priority need for PLWH/A in the last statewide needs assessment completed, with roughly two in five clients identifying a need for ongoing housing help and two in five reporting a need for Emergency Assistance with Rent or Utilities. A significant proportion of clients (26%) reported having been in unstable housing situations in the past year, and one in seven (15%) had been homeless at some point in the past 2 years. Four percent (4%) reported being currently homeless. One in four (26%) had experienced one or more of the following 'unstable housing situations' as defined by HOPWA in the past 12 months: About one in six (18%) reported staying with friends or family temporarily, 6% had lived in places not meant for housing (like a car, abandoned building or outside), 6% had spent time in jail or prison, 5% had lived in transitional housing or a treatment facility, and 3% had stayed in an emergency shelter sometime during the past 12 months. Both region and age were significantly associated with housing instability. Those who were younger and those who lived in the Portland metro area were more likely to have had an unstable housing situation in the past year. Because of the economic downturn, more PLWH/A are unemployed, the cost of housing exceeds financial assistance available, such as SSDI, and the resulting need for stable housing is increasing. Even with the multiple HUD grants that have been obtained by the grantee, there are inadequate resources to meet the growing need. There are 124 people on the OHOP (Oregon's HOPWA program) waiting list and Section 8 housing has lengthy waiting lists all over the state.

F. Description of prevention and service needs

The dire economy has dramatically impacted clients seeking HIV services in Oregon. Like others with limited resources, HIV clients are negatively affected by the rising costs of food, fuel, and housing. HIV service providers report increased anxiety among their patients and clients report difficulty competing for scarce resources within the larger service sector. HIV clients in Oregon have always depended on a continuum of services that extend beyond Ryan White Program-funded services, however, the options available to them beyond Ryan White funds are shrinking—and need for the services has grown dramatically among the general population in Oregon.

In 2010, 1 in 4 Oregon adults (n=754,845) received services from the Oregon Health Authority or Oregon Department of Human Services, including cash assistance (n=105,340, 3.6% of Oregon adults), medical assistance/health insurance (n=333,565, 11% of Oregon adults), and nutrition assistance through the Supplemental Nutrition Assistance Program (SNAP) (n=572,375, 19% of Oregon adults). Clearly, the demand for services has increased among all sectors of the population, not just people living with HIV. For example, 11% percent more households received SNAP benefits in July 2010 compared to July 2009.

The public health infrastructure is also severely challenged by the economic crisis. Local health departments, the Oregon Health Authority and the Department of Human Services are operating with huge deficits. Many agencies have already experienced cuts in services and/or personnel, and more are expected in the next biennium. Community-based agencies are reporting a decrease in private donations and grant dollars that decrease their ability to provide the same level of services that clients have received in past years. In order to meet the needs in the environment of cutbacks, Oregon is moving forward with health reform in the way that Medicaid services are delivered. This will require a high level of coordination and integration across all service systems.

There is a need to build stronger links between HIV prevention and care services in order to prevent new HIV infections and to link newly infected people into care. Coordinated outreach needs to focus on vulnerable populations in order to find HIV+ people who are out of care. We also need to test people in a variety of settings and develop effective systems for seamlessly triaging newly diagnosed individuals into care. One important means for developing these stronger links between prevention and care, and achieving our shared goals in the future, is the new Integrated Planning Group for HIV, a combined statewide HIV care services and prevention planning group in Oregon.

In addition, there is a need for more responsive services for HIV+ people, in order to keep them retained in care to include integrated behavioral health services, since both active substance abuse and untreated mental illness impede medical care. However, there are many barriers to accessing substance abuse and mental health services for HIV+ clients in Oregon, including limited treatment modalities and insurance difficulties. Services tailored to older PLWH/A are also in ever greater demand with the aging of the HIV+ population. Each part of the RWCA system is responsible for identifying and working to remove client barriers wherever possible. Identified needs for system changes include coordinating intake forms, providing client-centered care, tracking appointments and making follow up phone calls to clients, soliciting provider input, and triaging clients to specialty and/or “mainstream” providers or disease management programs where appropriate.

Finally, on a broader scale, there is a need for ongoing evaluation and assessment, in order to ensure that we are using our limited funds in the most efficient and beneficial manner and we need to identify promising evidence-based models for delivering care and treatment services, without imposing a one-size-fits-all approach onto very different populations across the state. Resources need to be found to provide assessments of service capacity in different regions; rural areas face additional challenges related to resources and need creative approaches to service delivery.

G. Description of barriers to care

Routine testing is likely to result in earlier diagnoses of HIV and increase the proportion of Oregonians who have tested for HIV. Only 42% of Oregonians have ever tested for HIV (excludes blood donation testing). Of the 1,380 HIV cases diagnosed during 2004-2008, approximately 40% had AIDS at the time of or within 12 months of their initial HIV diagnosis. While the proportion of persons diagnosed late exceeded 30% in each transmission category and racial/ethnic group, late diagnoses were more common among the following groups:

- Hispanics (compared to non-Hispanic whites)
- Men with injection drug use or unknown HIV risk (compared to MSM)
- Rural residents (compared to urban residents)
- Older persons — people over age 40, with relative risk of late diagnosis highest among those age 60+ (compared to people < age 40)

Research suggests that low perceived risk for HIV infection and fear of testing positive are the primary reasons for delayed HIV testing. Interview data (2010) from Hispanics in Oregon recently diagnosed with HIV (N=23) suggest that HIV stigma and a social norm of not accessing medical care unless one is sick may also contribute to delayed HIV testing and diagnosis for this population.

Previously, Oregon statute required health care providers to conduct a special informed consent before voluntary HIV testing of patients. Senate Bill 1507, passed in February 2012, removed this requirement and substituted a requirement that patients be notified that HIV testing is intended and given an opportunity to decline. SB 1507 permits verbal or written notification, including a notification that HIV testing might be performed on a general consent for treatment at the time of presentation for health care.

A workgroup is currently reviewing all Oregon Administrative Rules related to consent for HIV testing. These rules are expected to be finalized to reflect the new law in 2012. At that time, OHA will provide guidance and take further action to help promote and implement these changes.

Streamlining the HIV test consent process and normalizing it as a routine practice for all Oregonians is expected to help address a number of barriers to testing (e.g., time, perceived low risk, stigma), ultimately increasing the proportion of Oregonians tested and decreasing the proportion of late diagnoses. These efforts will help align Oregon's HIV test consent process more closely with CDC's 2006 revised recommendations for HIV testing in healthcare settings.

Ryan White clients participating in the 2011 Listening Sessions and interviews reported that it is easy to gain entry into HIV medical care for most of those who are ready to access it. Rural and frontier clients are a notable exception since HIV medical care is simply not available in their home communities. Rural clients said they had no trouble entering care, but long distances between home and doctor—up to 3 to 5 hours' drive one-way for many in Eastern Oregon, for example—create ongoing barriers to care. Limited choice of medical providers in other areas of Part B Oregon can also create barriers. Clients gave examples of being “fired” from care for missing appointments or having interpersonal problems with local providers, and then needing to travel out of town to access care through a new provider. In addition, clients in Part B Oregon reported experiences of stigma and lack of cultural competence while accessing medical care.

Most clients in a 2011 qualitative assessment said that accessing health insurance was “*very, very easy*” and many expressed intense gratitude for CAREAssist services and the medicines that the ADAP program provides. However, it should be noted that many clients require a significant amount of help from their CAREAssist case worker and community-based HIV case managers in order to re-submit the eligibility documentation every six months that keeps them insured. Upcoming challenges may include the reorganization of public health care systems in Oregon and nationally. Oregon chose to administer federal funds allocated to Oregon for the Pre-existing Conditions Insurance Pool (PCIP) under health care reform legislation. As noted, OMIP and PCIP currently insure almost half of all CAREAssist clients for whom CAREAssist pays insurance premiums. As part of health reform efforts, the OMIP and PCIP insurances will be ending on 1/1/14. Local efforts are now focusing on how to transition enrolled ADAP clients to the new system of insurance exchanges that will replace current coverage.

More than 1 in 4 MMP participants (27%) said they needed dental services in the past year, but could not get them. The two barriers to dental care cited most frequently among MMP participants were cost/lack of insurance and not knowing where to go or whom to call for services. Similarly, 30% reported that they do not have a “usual dentist” and 23% said that their last dental visit was “more than 2 years ago.”

Data from Part B Listening Sessions and interviews indicate that Clock Tower Dental has filled the previously yawning gap in dental care services for many PLWH/A in the Balance of State. Clients reported high levels of satisfaction with services provided through Clock Tower and clients living in Eugene reported no access difficulties whatsoever. Rural clients reported some access difficulties due to distance. Clock Tower provides services through a mobile unit and satellite clinics that bring preventive and other oral health services to local communities beyond the Eugene area. This makes basic oral health care available to many rural clients, but some types of procedures can only be completed in their Eugene clinic. This can create logistical barriers for rural clients, although Clock Tower does try to mitigate transportation-related barriers by providing bus tickets and other assistance.

Only 1% of MMP participants reported an unmet need for drug and alcohol counseling and treatment in 2009-2010. However, low service utilization levels combined with high levels of self-reported drug and alcohol use would indicate that more PLWH/A may have benefited from services than those who sought them. Case managers and other service professionals working with PLWH/A report multiple client-level and system-level barriers to getting HIV positive clients enrolled in substance abuse treatment services. These include a client’s lack of treatment readiness, lack of providers who will accept a client’s insurance, mismatches between treatment modalities and clients’ needs, lack of education about HIV in the mainstream behavioral health care system, and limited availability of behavioral health providers with an HIV focus or cultural competence dealing with the LGBTQ population, especially within certain geographic areas. In addition, funding in-patient treatment is a challenge because Ryan White funds cannot be used, and most clients lack other options. Clients echoed these themes in the 2011 Listening Sessions and interviews.

Eleven percent of MMP participants reported needing but not getting mental health services in 2009-2010. Some participants (14% of those with unmet need) said they were in the process of accessing the service, but had not received it yet. The main barriers to receiving mental health services were psychological (e.g., not feeling ready), not knowing where to go or who to call, and cost/lack of insurance.

As with substance abuse services, case managers and other service professionals working with PLWH/A report multiple client-level and system-level barriers to getting HIV positive clients enrolled in mainstream mental health services. These barriers look similar to those identified by MMP clients, and include a client’s lack of treatment readiness, lack of providers who accept a client’s insurance, mismatches between treatment modalities and clients’ needs, lack of education about HIV in the mainstream behavioral health care system, and limited availability of behavioral health providers with an HIV focus or cultural competence dealing with the LGBTQ population, especially within certain geographic areas. Lack of availability of Spanish speaking counselor has also been mentioned as a barrier. In 2011, clients in Part B Listening Sessions also identified access to “HIV-knowledgeable” mental health providers as an unmet need.

Some CAREAssist clients were significantly more likely to report recent homelessness and unstable housing. Nonwhites (23% vs. 15%, $p = .002$), clients with less education (e.g. 22% with less than high school vs. 9% of college grads, $p = .004$), and younger clients (e.g. 36% under 30 vs. 8% age 60 and older, $p < .001$) were significantly more likely to report homelessness or past-year unstable housing. There were no differences by gender or region. Younger clients and those with less education remained significantly more likely to report homelessness or unstable housing when controlling for the other demographic factors in a logistic regression model; race was no longer significantly associated with unstable housing.

As of October 2011, the OHOP program for the BOS had 123 households awaiting long term housing assistance who were homeless or at risk of becoming homeless. In the TGA, the primary provider of HOPWA-funded services has waitlisted or turned away more than 70 clients in the last year. Section 8 waiting lists are extremely long or simply closed in most communities, which results in clients remaining on HOPWA programs for longer periods of time than expected. In addition, the recession and high unemployment rates have resulted in more competition for scarce housing resources.

Focus groups conducted in 2007 identified a number of themes surrounding food-related needs and gaps. First, as supported by the scientific literature, PLWH/A have unique nutritional needs that extend beyond health promotion and disease prevention. Nutritional problems caused by ART, including nutritional deficiencies, malabsorption, elevated cholesterol, and lipodystrophy are common, as are digestive problems such as nausea, vomiting, acid reflux, and diarrhea. Identified barriers to eating for optimal health included lack of transportation, lack of appetite, depression, and fatigue, but the most commonly cited barrier was lack of income. Although participants shop at discount stores, buy in bulk and pool resources, in order to stretch limited resources, they are often still short at the end of the month and some buy food on credit cards—a necessary stopgap, but an unsustainable long-term strategy. Although many communities in Oregon are served by food banks, food distribution programs through churches, and congregate meal programs, PLWH/A found these resources only marginally helpful. Most had used these programs, but cited multiple barriers including lack of access, long waits, concerns about food safety and the types of food offered, and feelings of stigma and discomfort related to competing for scarce resources with other individuals and groups in need, particularly women with small children. And, as noted previously, these “mainstream” resources are being stretched thin as record numbers of Oregonians have become dependent on them.

Transportation options are limited in the nonmetropolitan areas of the state. As described in other parts of this document, clients living in rural and frontier areas of Oregon must travel long distances for medical care and other supportive services because no local options exist. Even clients in the more populated areas of the state outside of the Portland metropolitan area report having to travel for care sometimes because of few local HIV doctors. For example, clients may choose to see a different provider or be “fired” from care for a variety of reasons, requiring travel to another town. Clients outside of the Portland or Eugene areas may also need to travel to access dental care. Winter weather and mountain passes provide additional challenges.

Clients across Oregon are challenged by the rise in fuel costs, which make transportation by both private car and public transit far more expensive than in past years.

Clients outside of the more populated cities of Oregon reported feelings of isolation because they have no opportunities for connection to others with HIV. Some said they don’t know anyone else with HIV; most say that formal opportunities for social connection and social support are nonexistent.

Part B clients advocated strongly for support groups and other types of 1-1 peer support (such as a “buddy program”), but there is no infrastructure for starting or maintaining these types of services. Both Part A and B clients suggested that the Oregon AIDS Hotline might also be used as a resource for providing psychosocial support.

H. Evaluation of 2009-2011 Comprehensive Plan: How'd We Do?

Successes:

The goals in the Oregon 2011 HIV/AIDS Services Comprehensive Plan are organized into four major categories: (1) Preventing New HIV Infections; (2) Finding HIV+ People Who Need Care and Treatment Services; (3) Engaging HIV+ People in Care and Treatment Services; and (4) Retaining HIV+ People in Care and Treatment Services.

(1) Preventing New HIV Infections: The goals in this category include working with partners of current consumers of HIV Care and Treatment services, including “Prevention for Positives” counseling and education in medical case management training and standards, collaborating with HIV prevention programs and developing outreach strategies. The program has successfully implemented a number of objectives including: (a) presenting a half day module by the Oregon HIV Prevention program and HIV Alliance on HIV Risk Reduction Education at the statewide HIV Continuum of Care conference in 2011 for HIV Case Managers, on how to provide education to clients on risk reduction behavior skills building; and (c) initiating a planning process to integrate the Oregon Care Coalition and the HIV Prevention Statewide Planning Group.

(2) Finding HIV+ People: Goals identified in this section include developing an evaluation strategy to find out why PLWH/A are not in care, working with the statewide prevention planning group to develop strategies, and connecting with the CDC funded MMP project. (1) HIV Care & Treatment has facilitated a year-long planning process with HIV Prevention and DIS and has developed a plan to find HIV positive and unaware people as part of the EIIHA planning process. (2) The program also receives regular updates on MMP and the information they are finding in the medical chart reviews. This information is being used for program planning around program retention projects. (3) Oregon’s Medicaid (the Oregon Health Plan - OHP) released data to the program in 2011 that allows the program to determine how many clients are receiving medical care through OHP, further expanding the program’s ability to identify how many PLWH/A are receiving medical care.

(3) Engaging PLWH/A in Care: Goals within this section include reducing barriers to entering care, educating PLWH/A about the importance of being in care and focusing on newly diagnosed and newly identified PLWH/A. CAREAssist continues to undergo comprehensive program improvements that will improve the profitability of the program, thereby insuring that (1) there is not a waiting list and (2) clients who need assistance with accessing HIV treatment will have that need met. Additionally, the program has just completed a two-year pilot and has now fully implemented a Medical Care Coordination Regional model in 22 counties (out of thirty-one counties in Balance of State), representing approximately 700 clients (out of 1,100 clients), that incorporates a multidisciplinary team approach (medical providers, RN/medical case managers and care coordinators) with all services centrally located and medical case managers housed throughout the service region in close collaboration with the key medical providers in the area. A baseline survey of clients was completed that included not only satisfaction questions but questions about client access to care. The survey was then sent again at the 12 month mark for the pilot. The results show a continued high level of satisfaction and access. Low

acuity/need clients were very happy with the reduced “paperwork” and “red tape” that the new model represents for them and high acuity/needs clients were pleased with the enhanced services and increased interventions.

(4) Retaining PLWH/A in Care: Goals within this category include developing an outreach program that targets PLWH/A in medical care who are experiencing a change in care status (such as change in insurance) and implementing a formal retention program. Two adherence programs have now been implemented: (a) CAREAssist Medication Therapy Management program and (b) Pharmacist-led Treatment Adherence Program. These programs are focused on helping clients successfully adhere to their treatment plans. Two best practices have also been established and solidified in the Standards of Care for Medical Care Coordination that further enhance client engagement in care: (1) Medical Case Managers prepare a Summary of Findings Letter for all clients upon completion of the RN Assessment that is sent to the client’s HIV medical provider (providing an opportunity for collaboration, coordination and support of the client’s Medical Treatment Plan by the RN) and (2) the Medical Case Managers are required to case conference with the HIV medical practice for all clients in Medical Case Management at least annually, with quarterly case conferences recommended. One of the key HIV medical providers, who has successfully held quarterly case conferences with the Medical Case Managers in his region for over 10 years worked with the program to communicate with other private providers in the BOS to educate them about the importance and value in collaborating with Ryan White funded case Medical Case Managers. As part of this medical provider communication initiative, a flyer was developed to inform medical providers how medical case managers can assist them with managing their clients. This flyer was sent to all the key medical providers in the Ryan White Part B program service area.

Challenges:

- Create a common intake process across all programs
- Develop peer advocacy/health navigator programs
- Expand outreach programs for PLWH not in care
- Provide cultural competency education for private medical providers specific to HIV
- Develop consumer-provider relationship building materials

Section Two: Where Do We Need To Go?

A. Plan to meet 2009 Challenges

Create Common Intake Process:

The Part B grantee, working in collaboration with the Part A grantee, has created a common 6 month eligibility determination process requiring the same documentation from clients and using a standardized form. Additionally, Ryan White Part B funded providers now have a data sharing agreement in place with CAREAssist which promotes the sharing of common information and demographics and reduces the burden on clients to have to submit duplicative documents and complete duplicative recertification/application processes every 6 months. The next step will be to continue discussions about creating a common intake process that will be recognized across the system so client eligibility will be centrally determined and accepted by all the other Ryan White funded entities.

Develop peer advocacy/health navigator programs:

Through the EIIHA planning process (the Work Group for the Improvement and Integration of Services for HIV – WIISH), and in collaboration with the community based organization that provides HIV Medical Care Coordination and supportive services to the largest number of PLWH/A in the Part B service area, a discussion about introducing peer advocates has begun. This program component will be integrated into the outreach planning currently being undertaken and is discussed further in the next section.

Expand outreach programs for PLWH not in care:

The Oregon HIV Prevention Program will not be able to continue providing the majority of outreach activities for PLWH not in care. Over the next four years, the HIV Prevention Program will be experiencing a 25% decrease in funding allocation from the CDC in 2012, with additional cuts through 2016. Because CDC provides over 80% of the funds for HIV prevention, prevention activities funded by the HIV Prevention Program will experience significant cuts, affecting the ability of the public sector to identify the HIV unaware. Given that about half of HIV tests are conducted in the public sector, strong coordination with the private sector for the purposes of making persons aware of their HIV status is an ongoing challenge. Despite CDC recommendations that all persons between the ages of 13 and 64 be tested for HIV, the private sector has been slow to adopt these guidelines. There are several reasons why the private sector has been slow in adoption of CDC recommendations including uncertainty on how to bill for HIV testing, and confusion related to the distinction between need for specific informed consent versus standardized pre-test and post-test counseling.

That being said, however, there are some essential activities currently in place in Oregon that help to identify individuals who are unaware of their HIV status. Current activities include several evidence based interventions to reach high-risk groups.

- The Social Network Strategy, a CDC outreach strategy, is currently being implemented in Lane, Yamhill and Marion counties. This strategy provides financial incentives to persons who bring in individuals to test.
- The Prevention program is also collaborating with the Oregon Department of Corrections HIV Prevention Coordinator to implement peer education services within state prisons. Within local

correctional facilities and work release programs, some local health departments provide outreach for testing services.

- The Oregon Harm Reduction and Outreach to Care Services (OHROCS) program, an Oregon specific syringe exchange program, is implemented by 7 counties employing state funds. Some counties distribute and exchange syringes via mobile van, while other counties provide exchange at the health department or a contracted community based organization. Local health departments, through existing substance abuse treatment facilities, also provide outreach to encourage HIV testing and services.
- Community Promise, a CDC evidence based intervention, is currently being implemented in Lane County via community based organization and Part B Grantee, HIV Alliance. Community Promise uses a peer education model to normalize testing and healthy sexual behaviors among MSM.
- Partner Services (PS) serves partners of newly diagnosed and reported HIV. The goal of PS is to assist HIV-positive clients with informing their sex and/or needle-sharing partners of their exposure to HIV and to encourage those partners to seek HIV counseling, testing and related services to reduce their own risk of transmitting or contracting HIV. Partner services are provided statewide by DIS, two of whom speak Spanish. DIS provides patients with accurate information regarding HIV and establishes a contract with the patient to locate and contact potentially exposed partners. In instances where the patient decides to notify and refer his or her own sexual partners, the DIS provides coaching on how to do this successfully. In other cases, patients prefer that the DIS take responsibility to contact and notify partners. When a DIS notifies exposed partners, identifying information about the original patient is never disclosed. Patients and the partners they name are notified within 48 hours when possible.
- Training in risk reduction counseling is provided for all HIV case managers who provide support for PLWH around issues of disclosure. HIV Case Managers may offer a referral to PS for any existing client who reveals sex or needle-sharing partners they wish to notify.
- Many counties are providing specific outreach activities to young and MSM identifying Latino's. For example, local health departments will host speakers or social activities with bicultural/bilingual staff. Local health departments are also learning that mainstreaming HIV within other health services, such as vaccination, has been instrumental at reaching Latino migrant workers and their families.
- The largest provider of Ryan White Part B is currently providing anonymous and confidential testing for eligible individuals. Identified high risk populations (including MSM, PWID, partners of HIV positive individuals, and transgendered individuals) are eligible for rapid testing. HIV Alliance provides testing on site as well as in conjunction with a community based needle exchange program, and in other high risk settings.
- Both CAREAssist case workers and Ryan White Part B funded case managers offer referral to HIV counseling and testing services throughout the state. Because this staff is most often in contact with PLWH, many have direct access to partners of HIV positive individuals, a priority population locally and nationally.

Building on and strengthening the outreach activities currently in place is key to any outreach planning being developed by Part B. The outreach planning will continue through WIISH.

Provide cultural competency education for private medical providers specific to HIV:

The Ryan White Part B program began developing communication and outreach to medical providers. Two important activities have "opened communication" between the Part B funded providers and the

medical providers: (a) an outreach flier was developed and distributed to medical providers that promoted the HIV Medical Case Management/RN services and described the full complement of services available through the Medical Case Management program to assist medical providers in the care and treatment of clients with HIV; and (b) increased expectations about Medical Case Manager (MCM) interaction/case conferencing/communication with their clients' medical providers, including a requirement that MCM's must document all interactions with medical providers. Further, the Oregon AETC collaborates with the Ryan White Part B program in the delivery of an RN Clinical Training for all of the MCM/RN Case Managers. The relationship-building between the Medical Case Management program and medical providers, couple with the strong relationship with the Oregon AETC are the foundation that will provide the impetus for beginning development of a plan to provide cultural competency education for private medical provides. Additionally, the Ryan White Part B program is currently developing on-line training modules for case manager/care coordinators and is considering developing on-line training modules for medical providers.

Develop consumer-provider relationship building materials:

The New York AIDS Institute has an excellent training module for peers to deliver a training called "Getting the Most Out of Your Medical Care" that is under consideration for development in Oregon. This particular module could be very easily modified for inclusion in the catalog of trainings available from the PSMP trainers (the Oregon Part B Master Trainers are an AIDS Certified RN who was a former HIV Medical Case Manager in Oregon for 18 years and a PLWH/A who is a Peer Trainer), who provide short trainings on Liver Health and Managing Stress in addition to PSMP.

B. 2012 Proposed Care Goals

The HIV Care & Treatment Goals for 2012-13 are organized under four focus areas that link to the planning efforts with EIIHA, NHAS, Unmet Need, and the Oregon Integrated Planning Group (IPG) and Work Group for the Improvement and Integration of Services for HIV (WIISH).

Focus Area I: Prevent HIV Infection

- Develop initiatives that target partners of current consumers of Ryan White Part B services.
- Develop risk reduction messages/education for key providers to ensure consistent messaging to clients.
- Collaborate with HIV/VH/STI Prevention Programs to develop targeted outreach strategies.

Focus Area II: Finding PLWH/A Not in Care

- Increase medical provider knowledge and information about PLWH/A not in care.
- Educate front-line staff about finding PLWH/A not in care.
- Improve collaboration/communication between HIV case managers and DIS.
- Increase HIV testing in healthcare and correctional settings.

Focus Area III: Engaging PLWH/A In Care

- Reduce barriers to entering care.
- Educate PLWH/A not in care about the importance of being in care.
- Develop strategies that target newly diagnosed and newly identified PLWH/A.
- Educate front-line staff on engaging clients in care.

Focus Area IV: Retaining PLWH/A In Care

- Educate PLWH/A currently in HIV case management about the importance of staying in care.
- Provide targeted support to clients at risk of falling out of care.

C. Unmet Need Goals

One goal of the Ryan White Part B program is to ensure newly diagnosed HIV infected individuals are linked into medical care as soon as initial referral is made. Furthermore, Part B case managers assure that clients receive health education about their HIV disease, personalized risk reduction counseling, and encouragement to work with HIV Disease Intervention Specialists (DIS) funded by the Prevention Program. As part of an integrated effort of the HIV Care and Treatment Program and DIS, staff are currently strengthening and improving collaboration at the local level; joint conference calls and in-person meetings will be held soon. Both the Care and Treatment and Prevention programs will continue to assess the effectiveness of partner services to assure that appropriate referrals are made for both those known to be HIV positive and those who are at risk.

Furthermore, CAREAssist continues to address unmet need for newly diagnosed PLWH/A and individuals out of care through its Bridge Program. The Bridge Program is designed to remove barriers in accessing HIV treatments by covering office visits, lab tests and HIV medications prior to full enrollment in ADAP. This program allows medical providers to secure ADAP assistance within 24 hours, thereby allowing for immediate care necessary to engage the client in ongoing treatment. Once fully enrolled in ADAP (enrolled in insurance coverage), the program addresses unmet need and barriers to care by covering pre-existing exclusionary outpatient expenses to assure client access to HIV medical care. Exclusionary periods usually last between six months and one year. During this time, ADAP will cover all outpatient costs excluded by the insurance agency as a result of HIV status.

Finally, in response to a recent survey where 56% of participating county jails identified a desire for support and training around the development of an STI screening program, a joint planning committee of the HIV Care and Treatment Program, the HIV Prevention Program and the Tuberculosis Program was formed in 2010. The aim of this planning committee is to meet the needs identified by medical staff in Oregon's county jail system, including the identification of individuals who either test HIV positive while in jail, or referral for those who self-identify as HIV positive and are seeking care. The planning committee has started a quarterly newsletter that covers topics such as Hepatitis infection and HIV treatment recommendations for incarcerated individuals that is distributed to jail medical staff.

D. EIIHA Goals

Increase the number of individuals who are aware of their HIV Status & Increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative. At least half of new HIV infections are transmitted from someone who is unaware of his/her own infection. Reducing new infections is tantamount to timely testing and diagnosing of all new infections. A minority of Oregonians have been tested for HIV even once. Approximately 40% of new infections have advanced to AIDS at the time of diagnosis or shortly after, signifying prolonged delays from infection to diagnosis. The development of a coordinated strategy across HIV Prevention, HIV Care & Treatment and STD Prevention programs in Oregon will increase the resources available for outreach and testing, improve the follow-up and linkage to HIV medical care for previously unaware HIV+ Oregonians, and

reduce duplication of efforts and gaps in the HIV continuum of services. We also propose to expand testing to non-traditional venues and work to eliminate structural barriers that make universal testing inconvenient in Oregon. This in turn will normalize and universalize HIV testing, reducing stigma and fear around testing. Combined, these outcomes will reduce the rate of new infections in the state by decreasing the number of people who are HIV unaware and are involved in behaviors that increase HIV transmission rates, as well as helping those are HIV negative to stay negative.

Increase the number of HIV positive individuals who are in medical care. By increasing access to care and treatment and improving health outcomes, people who are infected but unaware might be more likely to view HIV as a chronic illness instead of a fatal disease. This attitudinal change might then decrease hesitancy to test due to fear of a positive HIV test. Case managers can also work with patients in care to help them encourage their partners to be tested. Additionally, increasing awareness of HIV will also increase the number of HIV knowledgeable PLWH/A who are educated about HIV transmission risks and who practice safer behavior.

E. Closing gaps in care

All of the gaps in care that were previously identified are systemic issues that are multi-faceted, in both the causes and the solutions. The gaps represent elements in the health care delivery system that impact not only PWLH/A, but all Oregonians. While many of the gaps cannot be "closed" by the HIV Care and Treatment program alone, they can be addressed on an ongoing basis through a number of programmatic improvements and "workarounds". The Ryan White Part B program has worked very hard to close these gaps and has made some headway; however, there is still much to do. The introduction of required AIDS Certified RNs providing HIV Medical Case Management was in direct response to the lack of HIV specialty medical care in many regions of Oregon. These RNs provide a critical service in assisting primary medical providers and clients with information, knowledge about current HIV therapies and assistance with adhering to HIV treatment regimens. Additionally, the Pharmacist-Led Treatment Adherence Program and the Medication Therapy Management Program also provide clients with access to pharmacists who have HIV medication therapy expertise. Plans for increasing HIV medical expertise in rural Oregon include developing relationships with community health centers in order to find opportunities to increase HIV medical expertise. Additionally, program staff have been aggressively seeking information about the Oregon Health Care Transformation and the transition to the Coordinated Care Organizational model (CCO) in order to understand how HIV services will be delivered to PLWH/A and ensure continued access to HIV specialists throughout Oregon.

- Because the Ryan White Part B grantee is also the HOPWA sub-grantee, there are a number of coordinating activities that occur to link the two programs and allow for joint planning to address the gaps in housing for PLWH/A in Oregon. At a minimum, PLWH/A must be actively engaged in Ryan White Part B funded HIV case management in order to be referred into the housing program, known as Oregon Housing Opportunities in Partnership (OHOP) and must maintain active status in HIV case management in order to remain in the OHOP program. This requirement ensures that the client has access to important services necessary to maintain housing stability. In addition, case managers and housing coordinators frequently case conference regarding shared clients and are required to share and coordinate housing/care plans. Additionally, the HIV Care and Treatment program receives funding from and participates in the statewide Oregon Housing Consolidated Planning process and is a member of various local Continuum of Care Committees throughout the state, to include the Rural Oregon Continuum of Care Committee convened by Oregon Housing and Community Services. As a result of these partnerships, the HIV Care and Treatment Program is

an important partner in ending homelessness in Oregon and works to develop a continuum of care system in each rural county that includes adequate resources for all. To include: outreach and assessment, prevention, emergency shelter, supportive services, transitional housing, and permanent, affordable housing.

F. Overlaps in care

The opportunity for services available to PLWH/A in Oregon to "overlap" is minimal. Ryan White Part B funded case management and supportive services are only available in the 31 counties outside of the Portland TGA. While Part B may pay for gaps in services (such as an emergency oral health service not offered by either of the Part F funded dental clinics), Part B funded providers are required to access (and document) all other payers before accessing Ryan White funds. The HIV continuum of care and treatment services is so inadequately funded in Oregon (only 1 Part C clinic in the state – located in Portland; essentially flat funding for both Part A and Part B core and supportive services with increasing case loads) that there is very little room for either duplication of services or overlap. The system of care delivery has evolved, by necessity, into a cost effective and efficient system with specific geographic areas funded for specific services. Part A has a very specific geographic region that is different than Part B. Outside of CAREAssist, the most expensive Part B services (mental health, substance abuse, oral health) are all coordinated through a state administered, centralized system and clients are screened for eligibility for all other programs before Ryan White Part B funds are utilized, which further reduces the opportunity for overlap in care.

Part B funded service providers are also required to determine a payer for medical services and prescription drug coverage within 30 days of client intake/enrollment into HIV case management services and annually thereafter. This includes an eligibility assessment for Medicaid, Medicare, private insurance, Oregon's State Children's Health Insurance Program (SCHIP) and CAREAssist. Program guidance specifically requires that any emergency medical service authorized by a case manager must coincide with an application to CAREAssist, and thus Oregon's Medical Insurance Pool (OMIP) or other qualifying insurance provider. Additionally, CAREAssist case-workers review all clients for eligibility in Medicaid, Medicare, the VA, or utilization of their own employee-provided health insurance.

G. Coordinating efforts

The program has continued to coordinate with the Part A, Part C, Part D, Part F, HIV Prevention program, private providers, the STI program, the Viral Hepatitis Program, Medicare and the Oregon Health Plan (Medicaid) through the statewide Quality Management Task Force, the CAREAssist Advisory Group, the former Oregon HIV Care Coalition, the former HIV Prevention Statewide Planning Group, and through the newly convened Oregon HIV/VH/STI Integrated Planning Group. In 2012, most coordination will occur within the IPG as committee work focuses on the National HIV/AIDS Strategy, including increasing access to care to improve health outcomes. The Oregon IPGs work will result in a statewide HIV/VH/STI Comprehensive Plan for 2013 that incorporates coordination activities between all the member programs into one plan that will be used by all the programs.

Section Three: How Will We Get There?

A. Gaps in Care

Strategy #1: Continue to expand/enhance Pharmacist-Led Treatment Adherence/Medication Management Program

Plan	Activities	Lead	Timeline
Expand the program's service area/client knowledge of services available.	Increase funding/ pharmacist FTE/promote services.	HIV Care & Treatment (Community Services & CAREAssist)	2013
Expand MCM consultation (pharmacist available to consult via telephone with MCM)	Develop phone consultation protocol and begin testing the service.	HIV Care & Treatment	By end of 2012
Document current pharmacist's practices so the program can be expanded	Create a Program Protocol that includes documentation of the standards & P/P	HIV Community Services	By end of 2012

Strategy #2: Assist HIV service providers to develop partnerships with CCOs/Health Homes

Plan	Activities	Lead	Timeline
Increase knowledge of and share health transformation information	Share information on Ryan White list serv; set up webinars with experts (such as the Oregon Rural Health Agency) and continue to research the changes.	HIV Care & Treatment	Ongoing
Develop health transformation plan integration plan.	Meet with HIV service providers to develop a more formal plan for integrating HIV services into the health transformation activities.	HIV Care & Treatment	By end of 2012

Strategy #3: Develop/promote HIV-specific cultural competency educational opportunities for medical providers

Plan	Activities	Lead	Timeline
Research what is currently available	Investigate with HRSA, the AIDS Institute, Office of Minority Health, AETC or the Oregon Medical Association about cultural	HIV Care & Treatment	2012-2013

	competency materials available.		
Develop training/module/app (something that MD could bring up as needed, i.e. "How to talk about HIV with an Hispanic client", etc.)	Develop appropriate training and modality for presenting HIV-specific cultural competency to medical providers.	HIV Care & Treatment	2013

B. Individuals Aware of HIV Status but Not in Care

Strategy #1: Develop foundation of knowledge and information about PLWH/A not in care.

Plan	Activities	Lead	Timeline
Gather data.	Continue to gather data from primary and secondary resources.	PDES	ongoing
Use evidence-based strategies to follow-up on PLWH/A who fall out of care.	Research evidence-based strategies.	PDES	2013
Develop a plan	Based on strategies identified, develop a plan to re-engage PLWH/A who fall out of care.	HIV Care & Treatment	By end of 2013

Strategy 2: Reduce barriers to entering care.

Plan	Activities	Lead	Timeline
Improve access to CAREAssist through the use of technology.	Create an online CAREAssist application.	CAREAssist	By mid 2013
Increase referrals to care	Develop formal relationships with FQHC's, Critical Access Hospitals, ERs and HIV Case Management agencies to promote simple, one-step referral and follow-up.	HIV Care & Treatment	2012-2013
Develop a plan to address barriers	Provide information about the assessment of barriers to IPG and integrate goals/objectives related to removing institutional barriers into the 2013 Comprehensive Plan.	PDES/IPG	By end of 2013

Strategy 3: Educate PLWH/A not in care about the importance of being in care.

Plan	Activities	Lead	Timeline
Find PLWH/A who are not in care.	Collaborate with the Prevention for Positive program.	HIV Care & Treatment & HIV Prevention	By end of 2013
Add care messages to prevention campaigns.	Market common messages about HIV care services and the importance of being in care in HIV prevention campaigns.	HIV Community Services & HIV Prevention	2012-2013
Address the myths about HIV treatment	Develop a plan to market/educate around the message "It's important to get into HIV care" and the realities of HIV treatment today (fewer pills, fewer side effects, etc.)	HIV Community Services & HIV Prevention	2012-13
Educate family members	Develop a plan to provide family education about HIV and the importance of being in care.	HIV Community Services & HIV Prevention	2012-13

Strategy 4: Develop a program that targets newly diagnosed and newly identified PLWH/A to ensure access to care.

Plan	Activities	Lead	Timeline
Training for Medical Case Managers	Continue to expand on education and counseling available to newly diagnosed clients by Medical Case Managers, including ongoing training for MCMs on how to work with newly diagnosed clients around engagement in care issues.	HIV Community Services	By end of 2013
Explore the use of peer advocates/health navigators	Investigate the needs and feasibility of developing a peer advocacy/health navigator initiative.	HIV Community Services	2012-2013
Follow up with clients who have not had a lab within an identified period of time.	Develop a plan to identify and follow-up with clients who have not had a lab reported within an identified period of time.	HIV Community Services, HIV Surveillance and HIV Prevention	2012-13
Track medical referrals for newly diagnosed clients.	Develop a process for tracking medical care referrals for newly diagnosed clients and tracking linkage to two medical visits.	HIV Community Services & HIV Prevention	2012-13

Strategy 5: Educate front-line staff on engaging clients in care.

Plan	Activities	Lead	Timeline
Increase provider knowledge and access to referral resources	Improve case manager and provider knowledge of resources available to newly diagnosed clients offering a webinar about the HIV hotline to case managers and DIS, including information on how to provide updates	HIV Community Services	By end of 2013
Promote the HIV Prevention Essentials training developed by HIV Prevention.	Thread the key messages developed during the 2012 Continuum of Care Conference into the HIV Prevention Essentials training, new HIV case manager training and RN clinical training.	HIV Community Services & HIV Prevention	2012-2013

C. Individuals Unaware of HIV Status

Strategy #1: Develop initiatives that target partners of current clients of HIV Care & Treatment Services.

Plan	Activities	Lead	Timeline
Improve linkage between HIV case managers and DIS	Develop list of current staff providing DIS services at the local level and set up teleconference calls between case managers and DIS for each region.	HIV Community Services	2012-2013
Include partners of clients in educational opportunities	Include partners in self-management classes and risk reduction education and counseling provided by MCM.	HIV Community Services	2012-2013
Educate case managers on providing outreach to partners of current clients	Add training and information about engaging partners of current clients.	HIV Community Services & HIV Prevention	By end of 2012

Strategy #2: Collaborate with HIV/VH/STI Prevention Programs.

Plan	Activities	Lead	Timeline
Actively support the Oregon IPG work plan.	Continue to support (providing staff support) and participate in IPG.	HIV Community Services	Ongoing
Include all programs in HIV Care & Treatment planning	Include HIV/VH/STI Prevention program staff in SCSN & HIV Care & Treatment strategic planning processes.	HIV Care and Treatment	2013
Actively support the WIISH work	Continue to support (staffing the group) the	HIV Community Services	Ongoing

plan.	Work Group for the Improvement and Integration of Services for HIV (WIISH).		
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Strategy #3: Develop targeted Outreach strategies.

Plan	Activities	Lead	Timeline
Targeted outreach to current clients	Send a letter to CAREAssist clients encouraging clients to talk to friends and partners about getting tested.	CAREAssist	By end of 2012
Include HIV Care & Treatment resource information in HIV Prevention outreach activities	Develop package of HIV Care & Treatment information/updated brochure that can be included at HIV Prevention outreach activities (such as testing at Health Fairs, etc.)	HIV Care & Treatment	By end of 2012

D. Special Populations

Strategy #1: Adolescents

Plan	Activities	Lead	Timeline
Involve youth in planning	Actively recruit youth to IPG	IPG Membership Committee	2012-2013
Resource information about youth services	Work with local providers statewide to add youth specific organizations to the Oregon HIV Hotline.	HIV Community Services and HIV Prevention	2012-2013

Strategy #2: Injection drug users

Plan	Activities	Lead	Timeline
Involve PWID in planning	Actively recruit PWID to IPG	IPG Membership Committee	2012-2013
Targeted education/training for MCM and Care Coordinators	Develop and present webinar about working with PWID	HIV Community Services	2012-2013

Strategy #3: Homeless

Plan	Activities	Lead	Timeline
Expand awareness in statewide housing planning about PLWH/A needs	Continue to participate in Oregon Consolidated Plan process.	HIV Community Services	2013
Participate in local housing	OHOP Coordinators to continue to	HIV Community Services	2013

planning	participate in local housing planning.		
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Strategy #4: Transgender

Plan	Activities	Lead	Timeline
Involve transgender clients in planning	Actively recruit transgender members to IPG	IPG Membership Committee	2012-2013
Targeted training/education for MCM and Care Coordinators	Develop and present webinar about working with transgender clients	HIV Community Services	2012-2013

E. Coordinating Efforts

The program has continued to coordinate with the Part A, Part C, Part D, Part F, HIV Prevention program, private providers, the STI program, the Viral Hepatitis Program, Medicare and the Oregon Health Plan (Medicaid) through the statewide Quality Management Task Force, the CAREAssist Advisory Group, the former Oregon HIV Care Coalition, the former HIV Prevention Statewide Planning Group, and through the newly convened Oregon HIV/VH/STI Integrated Planning Group. In 2012, most coordination will occur within the IPG as committee work centers around the National HIV/AIDS Strategy, including increasing access to care to improve health outcomes. The Oregon IPG will create a statewide HIV/VH/STI Comprehensive Plan for 2013 that incorporates coordination activities between all the member programs into one plan that will be used by all the programs.

F. Healthy People 2020

HIV-10: *(Developmental) Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.* By providing HIV medical case management (Oregon Part B uses a Nurse Case Management Model), more clients have access to high quality medical care and support services. Case management helps clients navigate a complex health and human service system, access benefits programs to pay for medical care and treatment and provide support services to help clients access and successfully be maintained in HIV specialty medical care. The AIDS Drug Assistance Program (CAREAssist) directly pays for insurance, prescriptions, co-pays and deductibles, increasing the number of PLWH/A who have access to treatment. Oregon also provides bilingual benefits specialty assistance services to increase minority participation in the AIDS Drug Assistance Program, primary care and HIV-related support services.

HIV-11 *Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS (Target: 90.2%).* When clients have early access to HIV care and treatment and they successfully adhere to treatment regimens, the interval of time from HIV to AIDS diagnosis and from AIDS diagnosis to death will increase. Case management helps client’s access high quality medical care and Medical Case Managers provide adherence assessments annually for all clients and, when appropriate, adherence interventions (counseling, education, adherence aides, and home visits). CAREAssist (ADAP) pays for medications and medical care (through insurance) and through case management, assists with oral health care, mental health and substance abuse treatment further assisting clients to gain health and control over their

treatment regimens. Of those first diagnosed with AIDS between 2003 – and 2007, 90% of reported Oregon PLWA were still alive 3 years after their AIDS diagnosis, meeting the target identified by HP2020.

HIV-12 *Reduce deaths from HIV infection* (Target: 3.3 deaths per 100,000 population). HIV Medical Case Management provides medical support to help reduce deaths and assist clients to access necessary treatment and support services to help them successfully stay in treatment. The AIDS Drug Assistance Program (ADAP) helps clients statewide access treatment, thereby reducing deaths from HIV infection. Increasing minority participation in ADAP, primary care and HIV-related support services and reducing the number of deaths from HIV infection. The death rate among known persons living with HIV in Oregon was 2.4 (among 100,000) in 2010, meeting the target identified by HP2020.

G. SCSN

The key issues identified in the SCSN 2012 process have been addressed and are integrated throughout all of the goals identified in this Comprehensive Plan. The SCSN identified a need to build stronger links between HIV prevention and care services, in order to prevent new HIV infections and to link newly infected people into care earlier. The goals addressed the HIV prevention and HIV care collaboration address this issue and HIV Care & Treatment's participation on both the Oregon Integrated Planning Group and the Work Group for the Improvement and Integration of Services for HIV will continue to enhance this coordination of prevention and care services along the HIV continuum in Oregon. In addition, the SCSN identified a need to build bridges to “mainstream” social services, in order to engage HIV+ people in care, and to provide a full spectrum of disease management services to HIV+ people as early as possible. Funding shortages coupled with increasing case loads make creation of a parallel HIV service system unfeasible, so there is a need to move clients between the RWCA system and other general social service programs and community services. Referrals outside of the RWCA system can be tricky, however, and provide opportunities for HIV+ clients to “fall through the cracks.” Facilitated referrals work better than simply giving clients a phone number; RWCA providers need to develop better systems for collaborating with a wide range of services for clients and ensuring a smooth transition for clients between programs and services.

Likewise, there is a need for more responsive services for HIV+ people, in order to keep them retained in care. The SCSN talks about integrated behavioral health services that are needed, since both active substance abuse and untreated mental illness impede medical care. However, there are many barriers to accessing substance abuse and mental health services for HIV+ clients, including limited treatment modalities and insurance difficulties. Services tailored to older PLWH/A are also in ever greater demand, with the aging of the HIV+ population. Each part of the RWCA system is responsible for identifying and working to remove client barriers, wherever possible. Identified needs for system changes included coordinating intake forms, providing client-centered care, track appointments and making follow up phone calls to clients, soliciting provider input, and triaging clients to specialty and/or “mainstream” providers or disease management programs, where appropriate.

Finally, on a broader scale, the SCSN identified a need for ongoing evaluation and assessment, in order to ensure that we are using our limited funds in the most efficient and beneficial manner. The SCSN discussed the need for identification of promising evidence-based

models for delivering care and treatment services, without imposing a one-size-fits-all approach onto very different populations across the state. The SCSN talks about developing an assessments of service capacity in different regions; rural areas face additional challenges related to resources and need creative approaches to service delivery.

Based on these issues, the SCSN specifically recommended the following broad goals that are integrated into the Comprehensive Plan goals:

Preventing New HIV Infections:

- Develop stronger linkages between HIV care and treatment and HIV prevention
- Develop and disseminate consistent messages around HIV testing and linkage to care & treatment that:
 - i. can be used in a variety of sites (e.g. private providers/primary care, hospitals, emergency rooms, correctional settings);
 - ii. are consistent with CDC guidelines for routine screening and risk reduction messaging for high risk groups, and
 - iii. harness the power of social media (e.g., Facebook, twitter, online education, other social media).
- Shore up “prevention with positives” efforts using DIS and other early intervention service modalities.

Finding HIV+ People Who Need Care and Treatment Services:

- Continue to gather data to better understand why people are out of care
- Develop evidence-based systems to follow up on people who fall out of care
- When looking for people who may be out of care, go beyond “emerging populations” and consider larger social determinants of disease transmission (e.g. poverty, marginalization, and access to education and health care).
- Increase access to testing

Engaging HIV+ People in Care and Treatment Services:

- Shore up early intervention services, particularly in the Balance of State
- Identify and reduce system barriers, particularly in the period immediately following diagnosis (possibly via peer advocates/health navigators)
- Develop flexible models of care that better reflect client needs and do not attempt a “one size fits all” approach. Target disparate populations with culturally relevant approaches to care and prevention.

Retaining HIV+ People in Care and Treatment Services:

- Develop client-centered approaches to care and adoption of patient centered medical home models, as health care reform, including adoption of Coordinated Care Organizations, is implemented in Oregon.
- Implement and promote self-management programs and tools for clients further along disease management continuum.
- Develop strong linkages between systems so clients don’t fall through the cracks and cross-agency collaborations are maximized.
- Engage in evaluation/assessment/continuous quality management to ensure that services are accomplishing intended goals.

H. ACA

Oregon has already been working on health reform and the following information is available at: <http://health.oregon.gov/> In 2009, the legislature created the Oregon Health Policy Board (OHPB) and Oregon Health Authority (OHA) to address the issues of cost, quality and access to health care. The Oregon Health Policy Board has created an Action Plan for Health that involves actions by all stakeholders — the legislature, consumers, businesses, health care providers and others — in a staged plan. Coupled with the dollars federal reform will bring into Oregon, this plan meets the legislative mandate to "provide and fund access to affordable, quality care for all Oregonians by 2015." It also meets the spirit of innovation to seek Oregon solutions to address the problems before us. The plan includes many items that do not require legislative action, but may require changes in how we set budget priorities. For instance, a focus on prevention and treatment of addiction saves lives and dollars as does an early focus on prevention and chronic disease. Finally, the plan emphasizes how we deliver and pay for health care to ensure health equity, promote health and contain costs, beginning with the 850,000 lives for whom the Oregon Health Authority buys health care services.

House Bill 2009, which created the Oregon Health Authority, means that Oregon has been laying the groundwork since last July to implement federal reforms as soon as possible and make additional improvements. The federal legislation will help support the reforms already under way. While details of the bill are still being analyzed, here are some of the ways the federal health reform legislation accelerates and complements the reforms of the Oregon Health Authority and Oregon Health Policy Board. Like House Bill 2009, the federal legislation creates an exchange that allows people and small businesses who don't have group care to shop and compare prices and policies. Just like Oregon's Healthy Kids Plan, an affordable option will be available to adults. Additionally, the federal legislation helps us fulfill the promise of the Oregon Health Plan to expand coverage to low-income working families and make it more feasible to achieve our goal of affordable health care for all by 2015. The legislation will bring \$5 billion in new Medicaid funds to Oregon over the next 10 years.

Today health insurance companies can keep people out who have pre-existing conditions. Oregon's high-risk health insurance pools (OMIP and state administered PCIP) provide coverage for people who have been blocked from other health care plans and is already up and running. These pools provide a bridge to 2014 when the legislation prohibits private insurance carriers from denying coverage to people with pre-existing conditions.

Thanks to the work already started on everything from electronic health records to establishing quality standards for health care providers and hospitals, the Oregon Health Authority is well-positioned to be a national leader in these elements contained in the federal legislation.

In Oregon, as in all states, consumers will benefit from insurance reforms that will take effect within the next six months to eliminate lifetime limits on benefits, prohibit insurers from rescinding coverage for those already enrolled in a plan and allow unmarried children to remain on their parents' plans until age 26. And in Oregon, the Insurance Division now requires health insurance companies to report administrative costs, executive salaries and other information so Oregonians know how their dollars are being spent.

As Oregon improves care, expands coverage and reforms the insurance system, the state will make progress in reducing the health care "cost curve" over time. States will compete to adopt better and more affordable ways to deliver care. Investments in public health and wellness will be encouraged.

Under House Bill 2009, a fast deadline was created. OHA and the Board must deliver a comprehensive blueprint that will ensure coverage for all Oregonians by 2015. With the Senate's support and the President's signature, this legislation will accelerate and expand the reforms now being advanced in communities throughout the country. States like Oregon can look forward to an exciting period of innovation in our health care system and a healthier future for our people.

One of the most important transformative activities currently being undertaken by Oregon is the creation of Affordable Care Organizations known as Coordinated Care Organizations (CCO) in Oregon, which is a network of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid). Under CCOs, the Oregon Health Plan's medical benefits will not change. CCOs will have the flexibility to support new models of care that are patient-centered and team-focused, and reduce health disparities. CCOs will be able to better coordinate services and also focus on prevention, chronic illness management and person-centered care. They will have flexibility within their budget to provide services alongside today's OHP medical benefits with the goal of meeting the Triple Aim of better health, better care and lower costs for the population they serve. CCOs will be local and will have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs will be accountable for health outcomes of the population they serve. They will be governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk. Across the state, care providers, hospitals and health care plans are coming together to apply to become Coordinated Care Organizations. The first CCOs should be launched by August 1, 2012. There will be four open application periods for CCOs in 2012. More information is available at: <http://health.oregon.gov/OHA/OHPB/health-reform/ccos.shtml>

There are very specific goals in this Comprehensive Plan that address the communication, linkage and collaboration of HIV service providers and the HIV service delivery system with the Oregon Health Transformation process. At a minimum, the HIV Care and Treatment staff are becoming well informed about the process, attend regular OHA debriefings, receive regular updates that are forwarded to all of the HIV contractors and attend trainings about the Health Transformation process. They will continue to promote the inclusion of HIV outcomes in the outcome measures currently being developed by OHA and the role of HIV service providers as partners in CCOs.

I. NHAS

The National HIV/AIDS Strategy identifies four goals that align with the goals in this Comprehensive Plan and the goals of the EIIHA initiative. All of the planning being done within the program and with its planning groups is organized under the goals of the NHAS, making all of the goals that have been discussed in this document relevant to the national strategic planning process. However, very specific activities can be related to specific goals:

NHAS Goal #1: Reduce new HIV infections

Comprehensive Plan/EIHA Goal: *Increase the number of individuals who are aware of their HIV Status & Increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative.* At least half of new HIV infections are transmitted from someone who is unaware of his/her own infection. Reducing new infections is tantamount to timely testing and diagnosing of all new infections. A minority of Oregonians have been tested for HIV even once. Approximately 40% of new infections have advanced to AIDS at the time of diagnosis or shortly after, signifying prolonged delays from infection to diagnosis. The development of a coordinated strategy across HIV Prevention, HIV Care & Treatment and STD Prevention programs in Oregon will increase the resources available for outreach and testing, improve the follow-up and linkage to HIV medical care for previously unaware HIV+ Oregonians, and reduce duplication of efforts and gaps in the HIV continuum of services. We also propose to expand testing to non-traditional venues and work to eliminate structural barriers that make universal testing inconvenient in Oregon. This in turn will normalize and universalize HIV testing, reducing stigma and fear around testing. Combined, these outcomes will reduce the rate of new infections in the state by decreasing the number of people who are HIV unaware and are involved in behaviors that increase HIV transmission rates, as well as helping those are HIV negative to stay negative.

NHAS Goal #2: Increase access to care and improve health outcomes

Comprehensive Plan/EIHA Goal: *Increase the number of HIV positive individuals who are in medical care.* By increasing access to care and treatment and improving health outcomes, people who are infected but unaware might be more likely to view HIV as a chronic illness instead of a fatal disease. This attitudinal change might then decrease hesitancy to test due to fear of a positive HIV test. Case managers can also work with patients in care to help them encourage their partners to be tested. Additionally, increasing awareness of HIV will also increase the number of HIV knowledgeable PLWH/A who are educated about HIV transmission risks and who practice safer behavior.

NHAS Goal #3: Reduce HIV related disparities and health inequities

Comprehensive Plan/EIHA Goal: While a goal of EIHA does not specifically align with this NHAS goal, in order to successfully achieve the NHAS, it is mandatory that the interventions of EIHA address those populations that have high levels of unmet need, and those who are late to test, including persons of color, and persons with co-morbidity. By targeting communities disproportionately affected by HIV with culturally specific services, individuals more likely at risk will be made aware of their status. Additionally, many of the goals in the Comprehensive Plan address reducing disparities and health inequalities by expanding programs so they are accessible to more clients in underserved regions, promoting more collaborative efforts that will address access to medical care statewide and by continuing to enhance the AIDS-Certified Nurse Medical Case Manager's role to providing access to this high level of expertise to all clients in the state which is especially important to PLWH/A who live in regions of the state with limited or no access to HIV specialty medical care.

NHAS Goal #4: Achieve a more coordinated national response to the HIV epidemic

Comprehensive Plan/EIHA Goal: While a goal of EIHA does not specifically align with the issue of program coordination, in order to successfully achieve the NHAS, EIHA interventions will need to be coordinated across the state. By coordinating efforts with HIV Prevention, STD Prevention, Viral Hepatitis, other Ryan White grantees within the state, and private providers, we will be able to deliver a more comprehensive and unified continuum of care, improving delivery of services for persons at all stages of risk and infection. There are numerous goals in the Comprehensive Plan that address cross-program collaboration and coordination.

J. Unanticipated Changes

The Oregon HIV Care & Treatment Program has developed expertise (and has much experience) dealing with changes in the Ryan White legislation, the State of Oregon Health Authority (and how the State administration is organized), changes in health care, changes in local service delivery and local county health departments, changes in funding, changes in reporting requirements by federal agencies and changes in the role of a comprehensive plan in local planning. At the center of the program's ability to adapt and even thrive is a commitment to transparency and developing partnerships with all stakeholders in order to work in collaboration around making necessary changes and improvements. The Oregon Integrated Planning Group, the Work Group for the Improvement and Integration of Services for HIV, the two HIV Medical Case Management Task Forces, the statewide Oregon HIV Services QM Task Force and the CAREAssist Advisory Committee all reflect this commitment to partnership and transparency. Not only does having all of the stakeholders in the state at the same table help provide foresight and information about changes coming (so we don't deal with "unanticipated" changes), the program, system of service delivery and the continuum of care improvements and changes that happen have complete community and client support from the beginning. These groups are ready and able to tackle the coming changes.

Additionally, this program has never hesitated to assertively and regularly go after additional funding from many funding sources. Whether it is creating an entirely new model for ADAP that is increasing program income and containing costs or it is successfully securing twelve different grants from more than one federal agency on the HIV Community Services side of the program, HIV Care & Treatment is innovative and forward-thinking and learned many years ago to not rely on just one funding source to successfully meet the needs of Oregonians with HIV. This commitment to innovation and "thinking outside the box" continues and will serve the program well with the coming Health Transformation and Ryan White legislative reauthorization.

Section Four: HOW WILL WE MONITOR OUR PROGRESS?

Quality Management Plan

Quality Statement

The Oregon HIV Care and Treatment Program is committed to developing and continually improving a quality continuum of HIV treatment and supportive services that meets the identified needs of people living with HIV/AIDS (PLWH/A) and their families. The Quality Management (QM) Program supports this mission by gathering and reporting on the data and information needed to measure both program and service quality and then implementing improvement activities based upon the data analysis. The following domains for improvement guide the QM program implementation: (1) improving access to and retention in care, (2) integrating data and information systems, (3) optimizing the management of resources and (4) aligning jurisdictions and services across the entire continuum of care.

Quality Infrastructure

The HIV Care & Treatment program is a joint partnership between the Public Health Division and the Office of Pharmacy Services. The ongoing development and implementation of the QM Program is coordinated and directed by a contracted consultant. The QM Team within HIV Care & Treatment includes the following staff:

- HIV Community Services Manager
- CAREAssist Program Manager
- CAREWare Technical Advisor
- HIV Care & Treatment Program Consultant
- CAREAssist (Oregon's ADAP) program staff
- CAREAssist data specialist from Data & Analysis
- eHARS data specialist from Data & Analysis
- Dedicated program staff in the Information Technology department
- Program liaison from Program Design and Evaluation Services

This team is responsible for implementing the QM Plan, gathering and reporting the data from various databases, evaluating program elements and reporting on the findings, developing and implementing the PDSA/improvement change activities and providing input and feedback to the overall QM Program.

Oregon HIV Services Quality Management Task Force

The Oregon HIV Services Quality Management Task Force was formed to centralize and coordinate quality management efforts across Ryan White grantees statewide. The Task Force is made up of representatives from Ryan White Program Part A, Part B and Part C administration, the AIDS Education and Training Center (AETC) and the Dental SPNS program; contractors with the Part A and Part B programs; Planning Council representatives; Oregon Integrated HIV/VH/STI representatives; and consumer representation from urban and rural areas. The Task Force meets quarterly and is responsible for reviewing the Quality

Management plans for all three Ryan White Program Parts, for promoting collaboration, and for establishing shared measures and standards whenever possible.

Participation of & Communication with Stakeholders

Stakeholder	Type of Involvement	Communication
Persons Living With HIV	<ul style="list-style-type: none"> • Participate in IPG and on QM Task Force; • Participate in surveys; • Give feedback to providers; • Review reports on-line. 	<ul style="list-style-type: none"> • Participates on IPG and QM Task Force; • Reports & survey results posted on web site.
Contractors	<ul style="list-style-type: none"> • Provide data on services provided; • Participate in QI processes such as Case Management Task Force; • Participate in IPG; • Meet Standards of Service; • Implement their own QI programs. 	<ul style="list-style-type: none"> • Statewide meetings and trainings; • Technical assistance; • Summary report on the Local CM Chart Review distributed; • Participates on IPG; • Reports & survey results posted on web site.
Oregon Integrated Planning Group (IPG) Members	<ul style="list-style-type: none"> • Participate in discussions about data and information; • Make recommendations; • Develops a statewide integrated HIV/STI/VH plan 	<ul style="list-style-type: none"> • Written & verbal reports to IPG meetings; • Statewide plan posted on web site.
Oregon HIV Services QM Task Force	<ul style="list-style-type: none"> • Provide input; • Shared knowledge and education about QM methodology & issues; • Networking and collaboration toward standardization statewide. 	<ul style="list-style-type: none"> • Reports at meetings. • Reports & survey results posted on each program's web sites.
HIV Care & Treatment staff	<ul style="list-style-type: none"> • Provide data. • Provide analysis of data. • Provide suggestions on improvement. • Implement improvement activities. • Review program reports. • Assist in writing grant 	<ul style="list-style-type: none"> • Staff meetings. • Reports. • Participation at IPG and the QM Task Force.

	applications – the QM components.	
Program Design & Evaluation Services	<ul style="list-style-type: none"> • Provide evaluation skills. • Evaluate program components. • Develop reports on findings. • Report to IPG & QM Task Force. 	<ul style="list-style-type: none"> • Staff meetings. • Reports. • Participation at IPG and the QM Task Force.

QM Program Goals for 2012

Domain #1: Improving access to and retention in care

Goal 1.1: Continue to measure the retention rate in CAREAssist (pending status, re-certification, and termination); develop and test program QI initiatives to improve retention.

Goal 1.2: Continue to measure the transition rate from CAREAssist Bridge program to full CAREAssist membership; develop and test QI initiatives to improve transition.

Goal 1.3: Continue to measure the outcomes for the regional Medical Care Coordination model; continue to develop and test ongoing QI changes to improve quality and effectiveness of model.

Goal 1.4: Continue to measure Medical Case Management focus of interventions on newly HIV diagnosed clients and test QI changes to improve intervention.

Goal 1.5: Measure and monitor health and process outcomes for the Hispanic retention project in CAREAssist.

Goal 1.6: Survey CAREAssist clients for customer satisfaction.

Goal 1.7: Develop and implement a Plan across HIV Prevention, HIV Care & Treatment, DIS and STI to identify activities related to Identification, Informing, Referring and Linking clients to medical care in collaboration with EIIHA requirements.

Domain #2: Integrating data and information systems

Goal 2.1: At least annually, have HARS run the number of labs clients received and the values of the labs for both the CAREAssist active client list and the CAREWare active client list.

Goal 2.2: Begin regularly reviewing health outcomes measures triangulated between the CAREAssist database, County-Led CAREWare contractors, Regional Medical Care Coordination contractors and statewide surveillance database.

Domain #3: Optimizing the management of resources

Goal 3.1: Continue to measure and analyze the outcomes for the HAB required Care Plan indicator for Medical Case Management. Develop QI opportunities and implement.

Goal 3.2: Continue to measure and analyze the outcomes for referral process in the HIV Medical case management program. Develop QI opportunities and implement.

Goal 3.3: Continue to measure and analyze the cost effectiveness and efficacy of the new Medical Care Coordination model compared to the Balance of State (old HIV case management model.)

Domain #4: Aligning jurisdictions and services across the entire continuum of care

Goal 4.1: Develop a plan to collect data for the new HAB required-clinical measures.

Goal 4.2: Continue to participate on the Oregon HIV Services Quality Management Task Force, sharing QM plans and assessment system-wide outcome measures evaluating client engagement in medical care.

Goal 4.3: Develop statewide, cross-parts goals, measurements and a statewide, cross-parts Quality Management Plan.

Goal 4.4: Continue to collect and report statewide aggregate client information from HARS (lab information, HIV or AIDS status at diagnosis, progression from HIV to AIDS and number of people who die within 12 months of HIV diagnosis.)

Implementation Plan: Data Collection Activities

1. CAREWare is installed in all Part-B funded provider locations and is generating real-time, unduplicated data reported via a secure central server.
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<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Case Management services utilization	Reported & reviewed in March of each year.	Program Manager
Support Services utilization data		
Health outcomes data		
Quality Assurance data		

2. CAREAssist data base

<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Health outcomes data	Quarterly reports	D&A
Quality assurance data		
Quality Improvement data		

3. HIV/AIDS Reporting Systems (HARS) data base (surveillance data)

<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
HIV & AIDS status of CAREAssist clients	Quarterly reports	D&A
HIV & AIDS status of		

CAREWare clients		
Number of labs / year for all PLWH/A in state		
Number of labs / year for CAREAssist clients		
Number of labs / year for CAREWare clients		
Lab values for all PLWH/A in state		
Lab values for CAREAssist clients		
Lab values for CAREWare clients		

4. Provider site visit & client file review		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Compliance with HIV Case Management Standards	5 sites/year (final report in June of each year)	Program Manager
CAREWare data quality		
Evaluate accuracy of locally managed client file review		

5. Contractors (providers) perform an internal chart review and CARE Ware data audit, following a proscribed protocol.		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Compliance with HIV Case Management Standards	Annually – report is due at end of October each year. (Summary Report for state in December.)	Contractors
CAREWare data quality		

6. Contractors (providers) submit: (1) annual plans which report on compliance with program requirements, (2) quarterly service utilization and financial reports, and (3) quarterly program narrative reports.		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Annual plans	Annually	Contractors
Service utilization and financial report	Quarterly	
Program narrative report		

7. Client Satisfaction Surveys		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Case Management Program Client Satisfaction	Bi-Annually	Program Design & Evaluation Services (PDES)
CAREAssist Client Satisfaction	Annually	

Medical Care Coordination Pilot Baseline and 12 month Follow-up Client and Case Management Satisfaction Surveys	August 2009 and September 2010	
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8. Special evaluation projects		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Medical Care Coordination Pilot “2010 HIV Case Management QM Survey: Results from the Baseline Assessment of the Pilot Service Region”	Completed August 2009	Program Design & Evaluation Services (PDES)
Medical Care Coordination Pilot “2010 HIV Case Management QM Survey: Results from the Follow-up Assessment of the Pilot Service Region”	Completed September 2010	
HIV Case Management: A Case Study of a Public-Private, Regional Collaboration (evaluation of best practice of MD and Medical Case Management quarterly case conferencing)	Completed June 2010	
2009 CAREAssist Client Survey: A Report on Clients’ Health and Well-Being and their Experiences with the Program.	Completed January 2010	
Time to Quit: CAREAssist Clients’ Smoking Cessation Experiences	Completed July 2009	
An Evaluation of Access and Care Delivery Barriers for Latino PLWH/A in the Part B Region of Oregon	Completed April 2009	
Oregon Medical Practices that Provide HIV Care: 2008 Snapshot	Completed April 2008	
Client Satisfaction with Case Management Services: Ryan White Part B Service Area	Completed December 2007	
Eating Right When Money’s Tight: Evaluating the Need	Completed December 2007	

for Food & Nutritional Assistance Among RW Part B Case Management Clients		
Out of Care Study (CAREAssist clients)	Completed May 2007	
HIV Case Management acuity scale evaluation	Completed in April 2007	
HIV Case Management key informant survey	Completed in April 2007	
“Alive and Healthy”, CAREAssist Client Satisfaction Survey	Completed April 2007	

Implementation Plan: Performance Measures

CLIENT-LEVEL HEALTH OUTCOMES

Outcomes	Indicators	Data Elements	Data Sources & Methods
Disease progression among Ryan White Program clients is slowed or prevented over time.	<p>Improved or maintained CD4 counts and viral loads as measured over a six month period of time.</p> <p>Increased percentage of aggregate clients in overall Acuity Levels #1 and 2, over a twelve-month period of time.</p>	<p>Test results needed to calculate changes in CD4 counts & viral loads for individual clients annually.</p> <p>Case manager reported acuity level results for individual clients every twelve months.</p>	<p>Sources: <i>CARE Ware & HARS</i> Reported by case Managers</p> <p>Sources: <i>CM Chart Review & CARE Ware</i>. Reported by case managers.</p>
Proportion of clients accessing primary health care services increases over time.	Change in the number of clients with reported “primary source of medical care” and primary care provider.	Number and percent of clients with “no primary source of medical care” and no primary care provider in record and the number and percent of HIV-positive clients with record of “primary source of medical care” and primary care provider.	Source: <i>CARE Ware & CM Chart Review</i> . Reported by case managers.
Proportion of clients who have health insurance increases over time.	Change in the number of clients with reported “primary source of insurance” and health insurance.	Number and percent of clients with “no primary source of insurance” and no health insurance in record and the number and percent of HIV-positive clients with record of “primary source of insurance” and health insurance.	Source: <i>CARE Ware & CM Chart Review</i> . Reported by case managers.

<p>Quality of life of Ryan White Program clients is improved or maintained over time.</p>	<p>Increased percentage of aggregate clients in Acuity Levels #1 and 2, over a twelve month period of time</p>	<p>Case manager reported acuity level results for individual clients every twelve months.</p>	<p>Sources: <i>CM Chart Review & CARE Ware.</i> Reported by case managers.</p>
<p>Number of clients adhering to HIV medications regime increases over time.</p>	<p>Increased percentage of aggregate clients who are assessed in the Adherence Life Stage at Acuity Level #1 and #2, over a twelve month period of time.</p>	<p>Case manager reported Adherence acuity level results for individual clients every twelve months.</p>	<p>Source: <i>CM Chart Review & CAREWare.</i> Reported by case managers.</p>
<p>Number of clients receiving HIV-related treatment that adheres to PHS standards increases over time.</p>	<p>Increased percentage of aggregate clients who have current (within past 12 months) labs in their case management files.</p> <p>Increased percentage of aggregate clients who have a CD4 or VL test result reported in the database within the past 12 months.</p> <p>Increased percentage of clients in CAREAssist who report having a CD4 or VL within the past 6 months on their re-certification application.</p> <p>Increased percentage of statewide aggregate clients in HARS with a CD4 or VL test in the first 6 months of</p>	<p>Current labs appear in the client file.</p> <p>Case manager reported CD4 and VL for individual clients every twelve months.</p> <p>Client reported CD4 and VL test dates on CAREAssist re-certification application every 6 months.</p> <p>CD4 and VL tests reported to surveillance by laboratories.</p>	<p>Source: <i>CM Chart Review.</i></p> <p><i>CAREWare.</i> Reported by case managers.</p> <p><i>CAREAssist database.</i></p> <p><i>HARS database.</i></p>

	the reporting period and the second 6 months of the reporting period.		
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Number of clients receiving HIV-related treatment that adheres to PHS standards increases over time.	Increased percentage of statewide aggregate clients in HARS with a CD4 test in the first 6 months of the reporting period and the second 6 months of the reporting period or a VL test in the first 6 months of the reporting period and the second 6 months of the reporting period.	CD4 and VL tests reported to surveillance office by laboratories.	Source: <i>HARS database.</i>
Persons with HIV are identified early in their disease progression and are able to access services earlier with better health outcomes.	Decreased number of individuals newly reported with HIV infection who also have an AIDS diagnosis.	Number of individuals newly reported with HIV infection who also have an AIDS diagnosis vs. total number of individuals who were reported.	Source: <i>HARS database.</i>
Persons with HIV are accessing HIV treatment to slow the progression of HIV to AIDS.	Decreased number of individuals who progress from HIV to AIDS within a 12 month period.	Number of individuals newly reported with HIV (not AIDS) who progress to an AIDS diagnosis within 12 months of HIV diagnosis vs. total number of individuals newly reported with HIV.	Source: <i>HARS database.</i>
Persons with HIV are successfully accessing HIV treatment.	Decreased number of individuals with HIV who die within 12 months of their diagnosis.	Number of individuals who die within 12 months of their HIV diagnosis vs. total number of individuals who were newly reported with HIV.	Source: <i>HARS database.</i>

Quality Assurance/Process Evaluation

Criteria	Indicators	Data Elements	Data Sources & Methods
Ryan White funds are used as payer of last resort.	<p>Standard income verification form completed with allowable documents attached in client file. referrals and follow-up in client file.</p> <p>Case management progress notes and CARE Assist event records document all referrals and follow-up to referrals.</p>	<p>Number and percent of client files with appropriate documentation for income verification.</p> <p>Number and percent of client files with documentation in progress notes or event records of all referrals and follow-up activities.</p>	Source: <i>CM Chart Review & CAREWare</i> . Case Manager Reported.
Every client accessing Ryan White Part B services will have a case manager.	Every client record contains the name of their case manager.	Number and percent of Ryan White Part B clients with a case manager listed in their record.	Source: <i>CARE Ware & CARE Assist</i> . Collected annually through data reports.
All clients in case management will receive at least one Nurse Assessment per year.	Clients receiving at least one RN Assessment or Re-assessment and documented in CAREWare.	Number and percent of clients with documentation of an RN Assessment or Re-assessment.	Source: <i>CAREWare</i> . Case Manager Reported.

Quality Improvement Capacity Building

The HIV Care & Treatment Program continues to build QI capacity through the Ryan White Program funded system of service delivery by regularly implementing the following activities:

- All County-led contractors are contractually required to perform a client chart review annually, utilizing a standard protocol provided to them by the program. These results are reported in October of each year. The program then compiles the results in a report that is distributed to each provider, is included in the annual Quality Management Report presented to the Oregon HIV Care Coalition, and is posted on the program's web site.
- The results of all evaluation activities (such as the Case Management Client Satisfaction Survey, the Case Manager Satisfaction Key Informant interviews, the CAREAssist Client Satisfaction Survey, the Out of Care Study, etc.) are published in a printed report that is presented to the Oregon HIV Care Coalition, are sent to all the contracted providers and are posted on the program's web site.
- The Medical Case Management Task Force is open to all HIV Case Managers funded by the program and meets every two years to review and improve the HIV Medical Case Management Standards of Service and the statewide standardized forms. This QI process offers a direct opportunity to provide QI training and technical assistance to all of the front-line providers.
- CAREAssist (ADAP) staff meet regularly to review the CAREAssist QI data and work as a team to develop strategies for improvement. They also convene a bi-annual all-day Policy Retreat where they review the CAREAssist policies and procedures and make improvements.

Quality Management Program Evaluation

The Quality Management Team regularly assesses the effectiveness of the QM Program by:

- Reviewing the data and analysis for applicability to planning needs and effectiveness in answering key questions required in monitoring the quality of the service system, as well as the program itself;
- Reviewing and revising the indicators/performance measures (including revising the definitions of the numerator and the denominator used to collect the data) to assure that the most accurate measures are being trended to help determine the quality of all services delivered;
- Reviewing and improving the site visit protocol and the local, contractually required chart review protocol;
- Reviewing and improving the contract language and requirements;
- And meets regularly to review all evaluation projects regularly undertaken by Program Design & Evaluation Services. The results of these evaluation projects are used to make system improvements.

Finally, the regular reporting of the Quality Management Plan implementation outcomes to both the statewide Quality Management Task Force results in a feedback mechanism that, not only holds the program accountable for implementing the plan, but provides good input and advice from an entire community of experts.

