

**2015 OREGON HIV PREVENTION PROGRAM**  
**INTERIM PROGRESS REPORT – January 1 – June 30, 2014**  
**Project Narrative**

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Centers for Disease Control and Prevention (CDC)  
Procurement and Grants Office

**Instructions for Preparing an Interim Progress Report**

Catalog of Federal Domestic Assistance (CFDA) Number: **93.940**

Funding Opportunity Announcement (FOA) Number: **CDC-RFA-PS12-120104CONT15**

**PS12-1201, Comprehensive HIV Prevention Programs for Health Departments,  
National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)**

**PROGRESS REPORT (Project Narrative)**

**SECTION I: CATEGORY A: Required Core HIV Prevention Program**

All four required core components should be implemented during this reporting period.

- HIV Testing
- Comprehensive Prevention with Positives
- Condom Distribution
- Policy Initiatives

*Please provide responses to the following questions for the required core components for Category A. Responses to questions should include all four required components.*

1. Have you made any **substantial changes** to your HIV prevention program for the four required core components funded under Category A (HIV Testing; Comprehensive Prevention with Positives; Condom Distribution; and Policy Initiatives) during the reporting period? If yes, please describe the changes made and specify the program component.

**HIV Testing**

During the reporting period, the Oregon Health Authority (OHA) engaged stakeholders and obtained support for a policy change requiring all HIV testing using funds from the OHA HIV Prevention Program to be conducted confidentially. This policy went into effect July 1, 2014. Anonymous HIV testing remains available to any person who purchases a home test or who tests at an agency that offers anonymous testing using other funding sources. This policy change was approved by the Conference of Local Health Officials (CLHO). The decision was informed by findings from an ad hoc Confidential HIV Testing Workgroup, which included representatives from funded agencies and the Oregon HIV/Viral Hepatitis/Sexually Transmitted Infection Integrated Planning Group (IPG). OHA created a confidential HIV testing fact sheet (visit

<http://bit.ly/ConfTest>) to help HIV test counselors discuss the benefits of confidential testing and address fears or myths about how client information is used and protected.

OHA added additional fields to the Statewide HIV Electronic Records (sHIVer) database (Oregon's HIV testing database) to better capture variables related to linkage to care and Partner Services.

From January through June 2014, the number of HIV test sites in Oregon decreased by 21. This decrease was the result of both decreased funding and efforts to better target resources toward sites with higher HIV positivity rates.

### **Comprehensive Prevention with Positives**

In 2014, the OHA STD Program began planning for a transition to a new model for supporting Partner Services for HIV and other STDs. Historically, the role of OHA disease intervention specialists (DIS) focused on providing Partner Services directly and routinely. OHA DIS will help expand the capacity of LHDs (e.g., communicable disease nurses) to implement Partner Services and assist with unique cases as needed. There are a few reasons for these changes. OHA staffing cannot meet the increasing need for Partner Services throughout Oregon using the previous model. STD cases have increased, federal funding requirements have changed and OHA STD Program staffing has changed accordingly. OHA staff must take on duties (e.g., epidemiology, technical assistance) to fulfill newer, more population-based activities. While local public health authorities' responsibility to address STDs is not new, OHA remains committed to supporting LHDs during this transition.

### **Condom Distribution**

Due to funding reductions, OHA decreased the number of budgeted condoms for calendar year 2014 (196,560) compared to 2013 (230,832).

As a result of emerging research and an advisory note from the World Health Organization related to the safety of personal lubricants (see <http://bit.ly/lubeWHO>), OHA discontinued

purchasing water-based lubricant and instead began purchasing and distributing silicone-based lubricant.

### **Policy/Structural Initiatives**

Separate from the policy change described under HIV testing above, there were no substantial changes to policy initiatives during the reporting period.

2. Describe the **successes** experienced with implementing your HIV prevention program for the four required core components funded under Category A (HIV Testing; Comprehensive Prevention with Positives; Condom Distribution; and Policy Initiatives) during the reporting period. Please specify the program component associated with the successes.

### **HIV Testing**

During the reporting period, OHA developed HIV testing policies and procedures (<http://bit.ly/HIVppOR>) to provide contractors with key information about the HIV testing process, including rapid HIV testing algorithms, as well as case reporting and linkage to care and to Partner Services for individuals testing HIV positive.

OHA developed a fact sheet offering tips for delivering test results and supporting clients that test positive for HIV (<http://bit.ly/PosTest>). The fact sheet was developed with input from the IPG and the OHA HIV Community Services (HIV care) Program. The document is intended to help ensure persons testing HIV-positive receive the information and support needed, including linkage to care and to Partner Services. It is posted online as a resource for both funded and non-funded partners (e.g., clinicians considering routine HIV screening).

With decreased funding, Oregon has continued efforts to better target limited resources. While HIV testing at OHA-funded test sites has decreased (3,605 test events from January–June 2014 vs. 6,457 from January–June 2013), the newly diagnosed positivity rate has increased (0.83% from January–June 2014 vs. 0.53% from January–June 2013). We believe the increase in positivity is due to the progress made toward OHA’s goal of targeting at least 70% of HIV tests to priority populations. From January through June 2014, 61% of tests conducted were among

men who have sex with men (41.4%), men who have sex with men and inject drugs (2.6%), persons who inject drugs (15.5%) and heterosexual partners of people living with HIV (2.6%).

Many of our funded agencies have ongoing partnerships with programs offering STD testing, mental health services, Hepatitis testing, family planning services and drug and substance abuse treatment services to refer individuals whose sexual and drug use behaviors put them at risk of contracting or transmitting HIV. These partner agencies refer clients directly to LHDs and community-based organizations (CBOs) that offer HIV testing.

Successes related to the implementation of routine HIV testing are described in the Policy / Structural Initiatives that follows section.

### **Comprehensive Prevention with Positives**

To support re-engagement in HIV care, OHA has continued to partner with LHDs to implement the Out of Care Pilot Project, which seeks to identify and locate people living with HIV (PLWH) who have fallen out of care and offer them assistance accessing medical services. This project involved collaboration between the OHA Data and Analysis, Community Services and HIV Prevention Programs and the Douglas County Health Department. First, OHA staff uses the Oregon Public Health Epidemiologists' User System (Orpheus) to identify HIV cases with a last reported residence in the county of interest and no viral load or CD4 count reported in the last 18 months. OHA explores multiple databases (e.g., CareWare, Social Security Death Index) to find information about clients' current residence and vital status. OHA then notifies the appropriate local health department (LHD) of the cases that are not determined to be living outside Oregon, deceased, or receiving care. LHD staff attempt to contact the clients, their last known providers, their emergency contacts or their next of kin to obtain information about vital status and access to medical care and to offer assistance accessing care. OHA has shared information about the Out of Care Project with LHDs and hopes the project will continue to be replicated by LHDs throughout Oregon. OHA is on track to complete an out of care analysis for each county in Oregon by the end of 2014. Staff members are discussing continuation of the project in future years, as well.

Data from the OHA HIV Data and Analysis Program suggest that most HIV cases (diagnosed in the public and private sectors) in Oregon are linked to care successfully. The OHA HIV Data and Analysis Program reported to CDC that 90% of adults and adolescents newly diagnosed with HIV infection in 2012 had a CD4 count or percent based on a specimen collected within three months following their initial diagnosis, reported by the end of December 2013. Of persons newly diagnosed with HIV in 2014, we expect that the proportion linked to care remains just as high.

To help expand the capacity of LHDs to conduct Partner Services for HIV and other STDs, OHA developed an online training (available at <http://bit.ly/trainHIV>). This introductory training focuses on skills for interviewing persons diagnosed with an STD and partners who may have been exposed. The training is less than 1.5 hours in length and includes five modules that may be completed separately as time allows. The training promotes additional resources, including CDC's Passport to Partner Services training for participants with time to devote to a more in-depth training. Of the staff that have completed both the online training and survey (N=10), most agreed that the training met its objective of providing a basic understanding of how to conduct Partner Services (100%) and felt confident in their ability to conduct an interview with a patient or contact (90%). In May, OHA staff also provided an in-person STD case reporting and interviewing training to LHD staff members (e.g., communicable disease nurses) attending the Oregon Epidemiologists' Meeting Pre-Conference in May. Of the attendees that completed a session evaluation (N=20), most agreed that the training was a valuable use of their time (100%) and provided new information they will use (90%).

OHA and LHDs have continued implementing the Out of Care Project to identify, locate and re-engage persons out of care. For this project, OHA identifies persons without a CD4 or viral load test result reported in the last 12 months, seeks additional data to determine whether they are currently residing in the county in which they resided at the time of the initial case report, alive, and not receiving adequate medical care. LHDs then make efforts to contact the PLWH that were not determined to have moved out of the county, to have deceased, or to have accessed medical care. OHA is on track to complete an out of care analysis for each county in Oregon by the end of 2014. Staff members are discussing continuation of the project in future years, as well. While

this project primarily utilizes HIV surveillance and care staffs, positions funded by the CDC HIV Prevention grant have been involved in the initiative, as well.

OHA has integrated data systems to allow HIV care providers in the Part B service area who agree to follow strict data security and confidentiality protocols to access client viral load data through CAREWare. Regular monitoring of viral load data can help care agencies identify clients who are not virally suppressed. Agencies can use these data to target services to those with the greatest need, to coordinate adherence support interventions with medical providers, and to plan and evaluate programs. OHA will continue to explore how this initiative can be expanded statewide.

### **Condom Distribution**

Oregon agencies have maintained many partnerships with other organizations and businesses that support targeted condom distribution (CD). CD sites continue to display posters promoting condom use that were developed and distributed in 2013.

### **Policy/Structural Initiatives**

OHA has continued supporting the implementation of routine, opt-out HIV screening. During the reporting period, OHA published guidance on methods for implementing opt-out HIV screening (<http://bit.ly/HIVtestOR>) in accordance with Oregon Administrative rules (revised in 2013) and Senate Bill 1507 (passed in 2012). OHA staff continues to conduct outreach to clinicians to discuss and promote routine HIV screening. Following discussions with Legacy Health (which consists of six hospitals and more than 50 clinics in Oregon and southwest Washington), the organization agreed to add HIV screening prompts in its electronic medical records system (EPIC). The OHA HIV Prevention Program also collaborated with the OHA Adolescent Health Program to update its certification standards for school-based health centers (SBHCs), requiring HIV testing to be available in SBHCs in middle and high schools.

During the reporting period, OHA engaged stakeholders and obtained support for a policy change requiring all HIV testing using funds from the OHA HIV Prevention Program to be conducted confidentially. This policy went into effect July 1, 2014. Anonymous HIV testing

remains available to any person who purchases a home test or who tests at an agency that offers anonymous testing using other funding sources. This policy change was approved by the Conference of Local Health Officials (CLHO). The decision was informed by findings from an ad hoc Confidential HIV Testing Workgroup, which included representatives from funded agencies and the Oregon HIV/Viral Hepatitis/Sexually Transmitted Infection Integrated Planning Group (IPG). OHA created a confidential HIV testing fact sheet (visit <http://bit.ly/ConfTest>) to help HIV test counselors discuss the benefits of confidential testing and address fears or myths about how client information is used and protected.

OHA added additional fields to the Statewide HIV Electronic Records (sHIVer) database (Oregon's HIV testing database) to better capture variables related to linkage to care and Partner Services.

3. Describe the **challenges** experienced with implementing your HIV prevention program for the four required core components funded under Category A (HIV Testing; Comprehensive Prevention with Positives; Condom Distribution; and Policy Initiatives) during the reporting period. Please specify the program component associated with the challenges.

### **HIV Testing**

Local health departments and community-based organizations that receive CDC funding to support HIV testing continue to seek new and more effective practices for identifying persons living with HIV who don't know their HIV status.

### **Comprehensive Prevention with Positives**

Many of Oregon's LHDs and CBOs funded to conduct HIV testing have strong systems for facilitating linkage to care, but lack a reliable mechanism to confirm and report these linkages to OHA (e.g., access to client health care information). Thus, the OHA HIV Prevention Program linkage data do not reflect the successful linkage efforts that occur in Oregon. Oregon uses its surveillance system to evaluate linkage to care instead of the current CDC project approach to report this service as testing data. The OHA HIV Data and Analysis Program is able to monitor linkage to care for all reported HIV cases (diagnosed in the public and private sectors) using

CD4 and viral load test results reported to OHA. The OHA HIV Data and Analysis Program reported to CDC that 90% of adults and adolescents newly diagnosed with HIV infection in 2012 had a CD4 count or percent based on a specimen collected within three months following their initial diagnosis, reported by the end of December 2013. Of persons newly diagnosed with HIV in 2014, we expect that the proportion linked to care remains just as high. Work continues to remedy the mis-matched data variables for reporting to CDC.

### **Condom Distribution**

During the reporting period, there were no significant challenges related to condom distribution.

### **Policy/Structural Initiatives**

During the reporting period, there were no significant challenges related to policy/structural initiatives.

4. Describe any **anticipated changes** to your HIV prevention program for the four required core components funded under Category A (HIV Testing; Comprehensive Prevention with Positives; Condom Distribution; and Policy Initiatives) for Year 4 (including proposed changes in venues, contracts, target populations, testing technologies or algorithms, objectives, staffing/personnel, funding resources, etc.). Please specify the program component associated with the anticipated change(s).

### **HIV Testing**

There are no anticipated changes related to HIV testing.

### **Comprehensive Prevention with Positives**

There are no anticipated changes related to Comprehensive Prevention with Positives.

### **Condom Distribution**

There are no anticipated changes related to condom distribution.

### **Policy/Structural Initiatives**

There are no anticipated changes related to policy/structural initiatives.

### **HIV Testing and Comprehensive Prevention with Positives**

*Please review the national performance standards specified in the FOA for Category A.*

1. Provide the following information for HIV testing in both healthcare and non-healthcare settings for the reporting period.

<b>Table A-1. Newly diagnosed positive HIV test events</b>											
	Number of Test Events	Newly Diagnosed Positive Test Events*		Newly Diagnosed Positive Test Events with Client Linked to HIV Medical Care**		Newly Diagnosed Confirmed Positive Test Events		Newly Diagnosed Confirmed Positive Test Events with Client Interviewed for Partner Services		Newly Diagnosed Confirmed Positive Test Events with Client Referred to Prevention Services	
		n	%	n	%	n	%	n	%	n	%
<b>Healthcare Settings</b>	2624	24	0.91	15	62.50	21	0.80	12	57.14	n/a	
<b>Non-healthcare Settings</b>	981	6	0.61	3	50.00	6	0.61	2	33.33	n/a	
<b>Total</b>	3605	30	0.83	18	60.00	27	0.75	14	51.85	n/a	

\*Includes unconfirmed preliminary positive test events plus confirmed positive test events

\*\* Referred for medical care and attended 1<sup>st</sup> medical appointment within 90 days (3 months) of positive test date

<b>Table A-2. Previously diagnosed positive HIV test events</b>											
	Number of Test Events	Previously Diagnosed Positive Test Events*		Previously Diagnosed Positive Test Events with Client Re-engaged in HIV Medical Care**		Previously Diagnosed Confirmed Positive Test Events		Previously Diagnosed Confirmed Positive Test Events with Client Interviewed for Partner Services		Previously Diagnosed Confirmed Positive Test Events with Client Referred to Prevention Services	
		n	%	n	%	n	%	n	%	n	%
<b>Healthcare Settings</b>	2624	1	0.04	1	100	1	0.04	1	100	n/a	
<b>Non-healthcare Settings</b>	981	5	0.51	5	100	5	0.51	0	0	n/a	
<b>Total</b>	3605	6	0.17	6	100	6	0.17	1	16.67	n/a	

\*Includes unconfirmed preliminary positive test events plus confirmed positive test events

\*\* Referred for medical care and attended 1<sup>st</sup> medical appointment within 90 days (3 months) of positive test date

<b>Table A-3. Test events and positive test events in healthcare and non-healthcare settings, by site type</b>			
	Number of HIV Test Events	Newly-Diagnosed Positive Test Events*	Previously-Diagnosed Positive Test Events*
<b>Healthcare Sites</b>			
Emergency Departments	0	0	0
Urgent Care Clinics	0	0	0
Inpatient Units	0	0	0
Community Health Centers	587	3	0

**Table A-3. Test events and positive test events in healthcare and non-healthcare settings, by site type**

	Number of HIV Test Events	Newly-Diagnosed Positive Test Events*	Previously-Diagnosed Positive Test Events*
Other Primary Care Clinics**	0	0	0
Pharmacy-based Clinics	0	0	0
STD Clinics	1694	21	1
TB Clinics	0	0	0
Other Public Health Clinics	0	0	0
Dental Clinics	0	0	0
Correctional Facility Clinics	185	0	0
Substance Abuse Treatment Facilities	158	0	0
Other Healthcare Settings	0	0	0
<b>Non-Healthcare Sites</b>			
CBOs and Other Service Organizations	744	6	5
Other Non-healthcare Settings	237	0	0
<b>Total</b>	3605	30	6

\*Includes unconfirmed preliminary positive rapid tests plus confirmed positive tests.

\*\*Includes hospital-based or free-standing primary care clinics, health maintenance organizations, family planning and reproductive health clinics, college and university student health clinics, and retail-based clinics.

**Table A-4. Test Events and Positive Tests in Healthcare and Non-Healthcare Settings, by Gender, Race/Ethnicity, and HIV Risk Category**

	Healthcare Settings			Non-Healthcare Settings		
	Test Events	Newly-Diagnosed Positive Test Events*	Previously-Diagnosed Positive Test Events*	Test Events	Newly-Diagnosed Positive Test Events*	Previously-Diagnosed Positive Test Events*
<b>Gender</b>						
Male	1980	21	1	737	4	5
Female	619	2	0	221	2	0
Transgender	15	1	0	4	0	0
Unknown Gender	10	0	0	19	0	0
<b>Total</b>	2624	24	1	981	6	5
<b>Race/Ethnicity</b>						
Hispanic	334	6	1	174	0	2
Non-American Indian/Alaskan Native	40	0	0	13	0	1

**Table A-4. Test Events and Positive Tests in Healthcare and Non-Healthcare Settings, by Gender, Race/Ethnicity, and HIV Risk Category**

		Healthcare Settings			Non-Healthcare Settings		
		Test Events	Newly-Diagnosed Positive Test Events*	Previously-Diagnosed Positive Test Events*	Test Events	Newly-Diagnosed Positive Test Events*	Previously-Diagnosed Positive Test Events*
Hispanic	Asian	64	1	0	28	0	0
	Black/African American	194	0	0	42	0	0
	Native Hawaiian/Pacific Islander	10	0	0	4	0	0
	White	1808	17	0	636	5	2
	Multi-race	73	0	0	25	1	0
Unknown Race/Ethnicity		101	0	0	59	0	0
<b>Total</b>		2624	24	1	981	6	5
<b>HIV Risk Category</b>							
MSM			18	1	407	3	2
IDU			1	0	117	2	0
High-risk Heterosexual			0	0	112	1	0
MSM/IDU			3	0	35	0	1
Other Risk Category			1	0	0	0	0
Unknown Risk Category			1	0	310	0	2
<b>Total</b>			24	1	981	6	5

\*Includes unconfirmed preliminary positive rapid tests plus confirmed positive tests.

**Table A-5. Indirect Tests – Healthcare and Non-Healthcare Settings\***

	Total Tests	Newly Identified HIV-positive Tests**
Tests not reported to CDC as test-level data (from Healthcare settings only)	0	0
Tests not reported to CDC as test-level data (from Non-Healthcare settings only)	902	14

\*These are tests that are not paid for by the health department, but for which the health department claims responsibility by virtue of having promoted routine HIV testing to the facility and provided training or technical assistance to the facility

\*\*Includes unconfirmed preliminary positive test events plus confirmed positive test events

**Table A-6. Interventions and services for HIV-positive persons**

Target Population	Total # of HIV-Positive Persons Enrolled in Behavioral Risk	Total # of HIV-Positive Persons Enrolled in Individual- and Group-level	Total # of HIV-Positive Persons Enrolled in Community-level Evidence-based	Total # of HIV-Positive Persons Enrolled in Other Locally Developed

	Screening	Evidence-based Interventions	Interventions	Programs
0	0	8	0	0

In Lane County, HIV Alliance began implementing Healthy Relationships during the latter part of the current reporting cycle. Information about the eight individuals who completed the 5-week course will be added to future CDC reports.

### Condom Distribution

1. Provide the total number of condoms distributed overall (to HIV-positive individuals and high-risk HIV-negative individuals) during this reporting period.

From January through June 2014, a total of 319,077 condoms were distributed, including 27,805 (9%) condoms to HIV-positive individuals and 291,272 (91%) to high-risk negative individuals.

### Policy Initiatives

1. What policy initiatives did you focus on during this reporting period? Please indicate the type/level of intended impact for each policy initiative (e.g., change on a local level, health department level, or statewide/legislative level) as well as the stage of the policy process (e.g., identification, development, implementation, evaluation). If no policy initiative was focused on during this reporting period, please explain.

Policy topic	Stage of policy process (identification, development, implementation, evaluation)	Progress made	Level of intended impact (local, OHA, statewide)
Condom availability	Implementation	OHA HIV Prevention Program and the OHA HIV CAREAssist Program (Oregon’s AIDS Drug Assistance Program) continued implementation of a free, mail-order condom distribution program for PLWH enrolled in Oregon’s Medication Therapy Management Program (MTMP). MTMP offers assistance with HIV medication adherence to clients who have had late medication refills or other indicators of non-adherence. MTMP clients receiving medications via a mail-order pharmacy are asked if they would like to receive a large supply of condoms and lubricant with their medications every three	Statewide

		months. Once this option is selected, condom shipments are automatic and sustained.	
Required trainings for HIV case managers	Development	Currently, HIV case managers in Oregon are not required to receive training on risk reduction. OHA developed a training on risk reduction with PLWH, which will be updated and converted to an online training. By the end of 2014, this training will be available online and required for HIV case managers.	Statewide
HIV test consent process and linkage to care	Implementation	In early 2013, Oregon Administrative Rules (OAR) were revised to align with Senate Bill 1507, passed in February 2012. These policy changes allow health care providers to obtain consent for HIV testing in a manner similar to that used for other common tests (i.e., HIV testing may be included in a general medical consent). These changes also allow for more timely linkage to HIV care and treatment; The OHA Public Health Division or local public health authority may disclose the identity of an individual with an HIV-positive test to a health care provider (e.g., physician, nurse, clinic manager) for the purpose of referring or facilitating treatment for HIV infection. In early 2014, OHA published guidance on methods for implementing opt-out HIV screening ( <a href="http://bit.ly/HIVtestOR">http://bit.ly/HIVtestOR</a> ) in accordance with revised Oregon Administrative Rules.	Statewide
Routine HIV screening	Implementation	OHA has continued supporting the implementation of routine HIV screening. OHA staff continues to conduct outreach to clinicians to discuss routine HIV screening and share our fact sheet promoting routine HIV screening ( <a href="http://bit.ly/HIVscreen">http://bit.ly/HIVscreen</a> ). Following discussions with Legacy Health (which consists of six hospitals and more than 50 clinics in Oregon and southwest Washington), the organization agreed to add HIV screening prompts in its electronic medical records system (EPIC). The OHA HIV Prevention Program also collaborated with the OHA Adolescent Health Program to update its certification standards for school-based health centers (SBHCs), requiring HIV testing to be available in SBHCs in middle and high schools.	Statewide
Confidential HIV Testing	Implementation	In late 2013 and early 2014, OHA engaged stakeholders and obtained support for a policy requiring all HIV testing using funds from the OHA HIV Prevention Program to be conducted confidentially. This policy went into effect July 1, 2014. Anonymous HIV testing remains available to	Statewide

		any person who purchases a home test or who tests at an agency that offers anonymous testing using other funding sources. This policy change was approved by the Conference of Local Health Officials (CLHO). The decision was informed by findings from an ad hoc Confidential HIV Testing Workgroup, which included representatives from funded agencies and the Oregon HIV/Viral Hepatitis/Sexually Transmitted Infection Integrated Planning Group (IPG). OHA created a confidential HIV testing fact sheet ( <a href="http://bit.ly/ConfTest">http://bit.ly/ConfTest</a> ) to help HIV test counselors discuss the benefits of confidential testing and address fears or myths about how client information is used and protected.	
HIV laws education	Implementation	OHA revised its HIV laws guide ( <a href="http://bit.ly/HIVlaws">http://bit.ly/HIVlaws</a> ) to better educate service providers and the public about rules and statutes relating to HIV testing, confidentiality, HIV in the workplace, HIV and insurance, and comprehensive sexuality education in schools.	Statewide
Adult video/book stores	Identification	OHA plans to meet with partner agencies to explore possibilities for pursuing policy-structural interventions that would promote the sexual health of persons who engage in risk behaviors at adult video and bookstores.	Statewide
HIV testing data quality	Implementation	In early 2014, OHA staff met with LHD partners to discuss HIV testing data discrepancies and quality improvement efforts (e.g., regarding new vs. previous positive diagnoses and linkage to care). All parties agreed that OHA staff can add and edit client records in the Statewide HIV Electronic Record (sHIVer) database, which contains data entered by LHDs initially. OHA staff is now updating sHIVer data as needed based on laboratory data reported to OHA through the Oregon Public Health Epidemiologist User System (Orpheus). It was determined that these new data management practices could be implemented without revising the current data agreement between OHA and LHDs.	Statewide
Viral suppression monitoring	Implementation	OHA has integrated data systems to allow HIV care providers in the Part B service area who agree to follow strict data security and confidentiality protocols to access client viral load data through	Part B (all Oregon counties other than Clackamas,

		<p>CAREWare. Regular monitoring of viral load data can help care agencies identify clients who are not virally suppressed. Agencies can use these data to target services to those with the greatest need, to coordinate adherence support interventions with medical providers, and to plan and evaluate programs. OHA will continue to explore how this initiative can be expanded statewide.</p>	<p>Columbia, Multnomah, Yamhill, and Washington)</p>
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**CATEGORY A: Recommended Components**

Please indicate which recommended components were implemented during this reporting period. *If none, please indicate none and go to the required activities section.*

- Evidence-based HIV Prevention Interventions for High-Risk Negative Individuals
- Social Marketing, Media and Mobilization
- PrEP and nPEP
- None

*Please provide responses to the following questions for the recommended components for Category A, if implemented. Responses to questions should cover all three recommended components.*

1. Have you made any **substantial changes** to your HIV prevention program for the recommended components funded under Category A (Evidence-based HIV Prevention Interventions for High-Risk Negative Individuals; Social Marketing, Media, and Mobilization; and PrEP and nPEP) during the reporting period? If yes, please describe the changes made and specify the program component.

**Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals**

There were no changes to plans related to evidence-based interventions for high-risk negatives; no interventions were implemented during this period.

**Social Marketing, Media and Mobilization**

During the reporting period, there were no substantial changes to social marketing, media and mobilization activities.

**PrEP and nPEP**

During the reporting period, there were no substantial changes to PrEP and nPEP activities.

2. Describe the **successes** experienced with implementing your HIV prevention program for the recommended components funded under Category A (Evidence-based HIV Prevention Interventions for High-Risk Negative Individuals; Social Marketing, Media, and Mobilization; and PrEP and nPEP) during the reporting period? Please specify the program component associated with the successes.

### **Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals**

There were no successes related to evidence-based interventions for high-risk negatives; no interventions were implemented during this period.

### **Social Marketing, Media and Mobilization**

Mobilization activities in Lane and Marion counties have successfully utilized volunteers, community members and businesses to help distribute materials promoting HIV testing, recruit persons for testing, and promote and attract media coverage for awareness days. Social marketing activities in Clackamas and Washington counties have involved weekly outreach using Grindr and Scruff mobile applications and the distribution of materials promoting HIV testing.

### **PrEP and nPEP**

While PrEP and nPEP information sharing efforts have continued, there were no notable successes related to PrEP or nPEP during this period.

3. Describe the **challenges** experienced with implementing your HIV prevention program for the recommended components funded under Category A (Evidence-based HIV Prevention Interventions for High-Risk Negative Individuals; Social Marketing, Media, and Mobilization; and PrEP and nPEP) during the reporting period? Please specify the program component associated with the challenges.

### **Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals**

There were no challenges related to evidence-based interventions for high-risk negatives; no interventions were implemented during this period.

### **Social Marketing, Media and Mobilization**

During the reporting period, there were no substantial challenges related to social marketing, media and mobilization.

**PrEP and nPEP**

A number of challenges can impact PrEP and nPEP access. Among health care providers, there is a variation in knowledge, patient risk assessments, availability of medication, and willingness to provide nPEP “starter packs” due to cost concerns relating to pills that are dispensed (patients may not be able to afford them) and to pills that are not dispensed (opening medication advances the expiration date of the entire supply). Moreover, addressing these barriers for nPEP clients within 72 hours of exposure can be challenging. However, a number of helpful tools are available to help address some of these barriers, including local fact sheets, OHA publications with clinical recommendations, and NASTAD’s fact sheet with information about PrEP and nPEP patient assistance programs. Stigmatizing perceptions of PrEP and nPEP users (e.g., reckless, promiscuous) and misperceptions about the drugs (e.g., PrEP is a cure, serious side effects of PrEP are common) also impact our ability to promote these tools. We will continue share information that address these misperceptions.

4. Describe any **anticipated changes** to your HIV prevention program for the recommended components funded under Category A (Evidence-based HIV Prevention Interventions for High-Risk Negative Individuals; Social Marketing, Media, and Mobilization; and PrEP and nPEP) for Year 4 (including proposed changes in venues, contracts, target populations, interventions, objectives, staffing/personnel, funding resources, etc.). Please specify the program component associated with the anticipated changes.

**Evidence-based HIV Prevention Interventions for High-Risk Negative Individuals**

**Not applicable**

**Social Marketing, Media and Mobilization**

**Not applicable**

1. Indicate if you are promoting and/or supporting a CDC social marketing campaign. If yes, please indicate the specific CDC social marketing campaign.

CDC campaigns are promoted on the OHA website and social media accounts (e.g., Facebook, Twitter) and also via LHD and CBO social media accounts. CDC campaigns promoted include:

- Testing Makes Us Stronger
- HIV Screening. Standard Care.
- Prevention is Care
- Take Charge. Take the Test.
- Let's Stop HIV Together
- Reasons (This campaign also was promoted at Portland Pride and Portland Latino Pride events)
- Act Against AIDS
- Start Talking. Stop HIV.

**Pre-exposure Prophylaxis (PrEP)**

**Not applicable**

1. Are you currently supporting PrEP? If yes, which populations and what is being supported?

OHA's efforts related to PrEP have focused on information sharing. Recent efforts have focused on the promotion of PrEP via social media accounts. OHA discussed PrEP at an Oregon HIV/STI/Viral Hepatitis Integrated Planning Group meeting and identified educational needs and key talking points on the topic. These talking points will be used to develop future materials and online trainings. OHA has continued to share its publication about PrEP and nPEP (<https://bitly.com/nPEP-PrEP>), which was distributed to health care providers throughout Oregon in 2013.

**Non-occupational Post-exposure Prophylaxis (nPEP) Services**

**Not applicable**

1. Are you currently supporting nPEP for high risk populations? If yes, which populations and what is being supported?

OHA's efforts related to nPEP have focused on information sharing, primarily via social media accounts. OHA has continued to share its publication about PrEP and nPEP (<https://bitly.com/nPEP-PrEP>), which was distributed to health care providers throughout Oregon in 2013.

### **CATEGORY A: Required Activities**

All three required activities should be conducted during this reporting period.

- Jurisdictional HIV Prevention Planning
- Capacity Building and Technical Assistance
- Program Planning, Monitoring and Evaluation, and Quality Assurance

### **Jurisdictional HIV Prevention Planning**

1. Have you made any **changes** to your HIV planning group (HPG) to realign with the FOA, NHAS and the current HIV planning group guidance (e.g., changes in composition or structure, bylaws, frequency of meeting, etc.). If yes, please describe the changes made.

The Executive Committee of the Oregon HIV/STI/Viral Hepatitis Integrated Planning Group (IPG) changed the structure of the Membership Committee to foster greater participation and improve workload distribution. Participation in the Membership Committee is now a shared responsibility among all IPG members. At any given time, the committee consists of seven voting IPG members, including one elected committee chair. With the exception of the committee chair, members complete their committee term after six months, and six new members are then selected.

2. Describe the **engagement process** for your HIV planning group during this reporting period (e.g., communication, engaging stakeholders, data sharing, etc.). *Please ensure the letter of concurrence, letter of concurrence with reservation, or letter of non-concurrence is submitted.*

The IPG has had two meetings, and a third meeting in 2014 is planned. These meetings have offered OHA opportunities to update the group on progress made and to gather additional input on implementing activities described in the [2013-2015 IPG Implementation Plan](#). Input from members also was gathered via ad-hoc workgroups formed to assist with short-term projects related to a variety of topics (e.g., smoking cessation for PLWH, cultural sensitivity, confidential HIV testing).

Email is the primary communication method used to engage IPG members between meetings. IPG members receive regular messages via:

- Emails from co-chairs with OHA updates, meeting evaluation summaries, and Executive Committee decisions (approximately one message per month)
- OHA's HIV/Viral Hepatitis/Sexually Transmitted Infection email listserv, which is used to share a wide variety of information, resources, and learning opportunities (approximately one message per week)
- The OHA HIV Prevention and STD Program newsletter, which highlights key program updates, news, resources and best practices (bimonthly)

To engage the IPG to provide input on Oregon's Jurisdictional HIV Prevention Plan addendum:

- OHA drafted an addendum to Oregon's Jurisdictional HIV Prevention Plan outlining key changes in HIV Prevention in Oregon. The addendum was emailed to the IPG on August 8 with a request for input and for each member to email a vote (concurrence, concurrence with reservations, or non-concurrence) by the end of August.

The majority of members submitted a vote of concurrence. On September 3, 2014, the co-chairs completed a letter of concurrence on behalf of the IPG. On September 9, 2014, Oregon's letter of concurrence and updated jurisdictional HIV prevention plan were emailed to CDC (ps12-1201@cdc.gov and odessa.dubose@cdc.hhs.gov).

Current information about the IPG is available on the OHA website, including the IPG mission, structure, meeting agendas and minutes, orientation materials for members, and an application for interested persons.

3. Describe the **successes** experienced with implementing your HIV prevention planning activities during the reporting period.

IPG member responses to 2014 meeting evaluations suggest that planning efforts to date have been successful. In each evaluation, the majority (83% to 100%) of members reported agreeing that the meeting was a good use of their time and resources. The success of the IPG is largely related to the evaluation and planning efforts of the Executive Committee, which consists of the IPG co-chairs, IPG sub-committee chairs, and OHA staff. The Executive

Committee meets after each IPG meeting to review meeting evaluations; findings are used to help plan the next IPG meeting agenda and to change policies and procedures as needed.

4. Describe the **challenges** experienced with implementing your HIV prevention planning activities during the reporting period.

There were no substantial challenges related to HIV prevention planning during the reporting period.

5. Describe any **anticipated changes** to your HIV prevention planning activities for Year 4.

**Note:** Please submit any *updates* to your Jurisdictional HIV Prevention Plan to CDC at the same time as this IPR, by September 15, 2014. Please submit your updates to the jurisdictional plan to [ps12-1201@cdc.gov](mailto:ps12-1201@cdc.gov) by the due date. Please ensure that the letter of concurrence, letter of concurrence with reservation, or letter of non-concurrence is submitted to the mailbox and your assigned project officer.

The updated Jurisdictional HIV Prevention Plan and Letter of Concurrence were submitted to CDC and assigned project officer on September 12, 2014.

### **Capacity Building and Technical Assistance (CBA/TA)**

1. Did you **access** CBA/TA services during the reporting period? If yes, please provide the type of CBA/TA received and the name(s) of CBA/TA provider(s). Please explain (be specific) if the CBA/TA provided did not meet your needs/expectations.

Thus far in 2014, the Oregon Health Authority (OHA-HPP) has made one CBA request to CDC's Capacity Building Branch Division of HIV/AIDS Prevention to have Dr. Ted Duncan lead a webinar on Social Networks Strategy. During the webinar, Dr. Duncan provided an overview of Social Networks Strategy and fielded questions from webinar participants who currently implement SNS at several sites in Oregon as part of their comprehensive HIV prevention counseling, testing, and referral services.

The combination of reduced HIV prevention funding coupled with the lack of adaptable and cost effective EBIs and DEBIs has deterred OHA HPP from making additional on-site CBA training requests.

OHA HPP did ask Balm in Gilead to extend their HIV trainings as part of a 2013 CBA request for our African American/Black faith leadership during this reporting period. Discussions continue on that front and Balm in Gilead officials and the leadership of the Albina Ministerial Alliance remain hopeful that the much needed trainings will occur prior to the end of this year.

OHA-HPP staff did participate in the following CBA/TA web-based or in-person trainings which were offered:

**CDN Center of Excellence for Primary Care Practice-Based Research and Learning Series**

<b>Training (<u>Webinar</u>)</b>	<b>Date</b>	<b>Met Expectations</b>
Upstreamists & Community Health Detailing: How re-imagined workforce and community engagement models can improve healthcare and the social determinants of health	1/21/14	Yes

**Ted Duncan Overview on Social Networks Strategy**

<b>Training (<u>Webinar</u>)</b>	<b>Date</b>	<b>Met Expectations</b>
The Use of a Social Network Strategy for HIV Testing Programs	2/28/14	Yes

**Tribal BEAR Project/NW-AETC)**

<b>Training (<u>Webinar</u>)</b>	<b>Date</b>	<b>Met Expectations</b>
Oregon Regional HIV/STI/HEP C Training – Tribal BEAR Project/NW-AETC)	4/2/14	Yes

**GoTo Webinar**

<b>Training (<u>Webinar</u>)</b>	<b>Date</b>	<b>Met Expectations</b>
Moving Black MSM along the	6/25/2014	Yes

HIV Care Continuum: Challenges, Opportunities and Emerging Practices		
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**HIV Continuum of Care Conference**

<b><u>Training</u> (Webinar)</b>	<b>Date</b>	<b>Met Expectations</b>
Trauma Informed Care, Mandy Davis, LCSW, Clinical Director, Trauma Informed Care Project	April 23-24, 2014	Yes

**NCS D State Policy Training Academy**

<b>Training</b>	<b>Date</b>	<b>Met Expectations</b>
Multiple conference calls and webinars	<b>December, 2013 – July, 2014</b>	<b>Yes</b>

**NCS D “It’s Your Call: Performance Measures: A Work in Progress and Process**

<b>Training (Webinar)</b>	<b>Date</b>	<b>Met Expectations</b>
<b>Webinar</b>	<b>January 30, 2014</b>	<b>Yes</b>

**Oregon Public Health Division “Health System Transformation, What’s in it for Public Health?”**

<b>Training (Webinar)</b>	<b>Date</b>	<b>Met Expectations</b>
<b>Seminar</b>	<b>January 30, 2014</b>	<b>Yes</b>

**CDC**

<b>Training (Webinar)</b>	<b>Date</b>	<b>Met</b>
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		<b>Expectations</b>
<b>HIV Prevention Projects Community Partner Engagement Discussion</b>	<b>February 18, 2014</b>	<b>Yes</b>

**NASTAD**

<b>Training (Webinar)</b>	<b>Date</b>	<b>Met Expectations</b>
“Update HIV Testing Technologies and Testing Strategies” - Webinar	<b>February 19, 2014</b>	<b>Yes</b>

2. Describe any **anticipated changes** to CBA activities for Year 4. Please include CBA/TA needs for Year 4.

Additional CBA/TA needs may arise due to staff turnover within our contracted local agencies that continue to adjust to diminishing funds which support HIV prevention activities in their service areas.

Formal CBA requests for trainings to enhance HIV Prevention Counseling, Testing and Referral Services and Comprehensive Prevention for Positives services in Oregon may occur as our OHA HPP staff and local providers continue to search for methods that allow us to meet and exceed our program goals for finding HIV positivity in our state.

**Program Planning, Monitoring and Evaluation, and Quality Assurance**

1. Have you made any **substantial changes** to your program planning, monitoring and evaluation, and quality assurance activities during the reporting period? If yes, please describe the changes made.

As mentioned above in the Policy Initiatives, there have been many changes related to HIV testing. A large amount of work to align our program for changing to confidential testing was completed for implementation on July 1, 2014. Additionally, the Oregon HIV/STD./TB program is now able to update records in sHIVer with electronic laboratory data from the Oregon State Public Health Lab. These changes have helped resolve many data discrepancies and have

improved our ability to monitor quality improvement efforts for linkage to care and partner services. We also hired a new epidemiologist for HIV Prevention who started in mid-June and began training on the two databases used in Oregon for HIV data collection (ORPHEUS and sHIVer).

2. How are you **using the most current epidemiologic and surveillance data** for program planning, implementation (e.g., data to care), and evaluation purposes during the reporting period? Include the types of data used. How are you disseminating this data and providing feedback to your healthcare and non-healthcare providers and other community partners?

The Oregon HIV/STD/TB Program (HST) manages several HIV-related data sources, which are used to assist in program planning, monitoring and evaluation. Each of these systems provide data that informs the Epidemiologic Profile of HIV/AIDS in Oregon, as well as a variety of other reports. Types of data include demographic information, risk behavior, opportunistic infections and laboratory data related to HIV/AIDS status, CD4 and viral load results, newly identified cases of HIV/AIDS, test results, sexually transmitted diseases, HIV counseling/testing/referral/linkage to care services, health care utilization, quality of care, severity of needs, effectiveness of prevention messages and NHAS/CDC required variables.

The Epidemiologic Profile is published annually and is a comprehensive review of HIV/AIDS in Oregon. More recent and preliminary data is prepared quarterly. Updated reports are posted or disseminated via the Oregon HIV/AIDS Reports and Data webpage, which is accessible by partners, contractors, funders, and the general public. Additionally, some data management systems allow authorized users to access specialized reports as needed. Information that is gathered will be used to make evidence-based policy and funding decisions and to guide treatment services for people living with HIV/AIDS in Oregon.

3. Describe any **anticipated changes** to your program planning, monitoring and evaluation, and quality assurance activities for Year 4?

Oregon will continue to use a local database system, called the HIV Prevention Plan and Report Workbook to track data. In the remainder of 2014, we will continue developing reports in our two database systems: Orpheus and sHIVer. These reports will allow LHD to check in on their sites to see where HIV positivity is being found and monitor linkage to care for new positives. We also are planning to program quality assurance checks when sites are entering data to make sure key fields are entered and that the data are in a usable format.

**SECTION II: CATEGORY B: Expanded HIV Testing Program**  
**X Not applicable**

**SECTION III: CATEGORY C: Demonstration Projects**

1. Have you made any **substantial changes** to your demonstration project during the reporting period? If yes, please describe the changes made.

During the reporting period, there were no substantial changes to Category C activities.

2. Describe any **cost analysis work and outcomes** you plan to conduct during the reporting period.

During the reporting period, OHA conducted a cost analysis focusing on Oregon Reminders, the largest component of Oregon's Category C-funded demonstration project.

Background

[Oregon Reminders](#) is a mobile health service that offers text, email and voice messages to support the health of people at risk for or living with HIV. Message options include:

- Daily medication reminders
- Monthly prescription refill reminders
- Reminders to test for HIV/STDs every 3-6 months
- Weekly health tips

The analysis sought to:

- 1) Describe costs for supporting Oregon Reminders during the implementation phase of the project (January–December 2013)

- 2) Assess the cost per message
- 3) Assess the cost per enrollee

### Methods

A cost analysis tool was developed in Microsoft Excel by the California STD/HIV Prevention Training Center. Cost data were entered by staff from the Oregon Health Authority (OHA) and YTH (youth+tech+health, formerly known as ISIS). Cost data were obtained from contracts, expenditure reports, and staff estimates of Category C funds spent on Oregon Reminders (Oregon's Category C funding also supports Social Networks Strategy HIV testing programs and structural changes in online settings).

### Results

From January through December 2013, Oregon expended \$334,620.87 (72%) of its Category C award (\$466,000) to support Oregon Reminders. During this period, 1,197 people enrolled in the service, and a total of 69,501 messages were delivered via text, email or voice. Of the 69,501 messages sent, 62,470 (90%) were medication reminders, 4,726 (7%) were health tips, 929 (1%) were health tips for people living with HIV, 693 (1%) were HIV/STD test reminders, and 683 (1%) were prescription refill reminders.

The cost per message sent to Oregon Reminders users in 2013 was \$4.81. The cost per enrollee was \$279.55. We estimated that 45% of costs were allocated to management, 40% to marketing and promotion, and 15% to indirect costs. Management activities include oversight related to grants, contracts and technical operations, and monitoring and evaluation. Marketing costs include paid media (e.g., online advertising), as well as staff time developing marketing materials, presenting to stakeholders (gaining organizational "buy-in"), and encouraging enrollment (outreach to community members and "inreach" to existing clients).

The analysis includes some limitations. While all people who enrolled in Oregon Reminders during 2013 (N=1,197) were included in this analysis, it is notable that 86 (7%) of these enrollees opted out at some point during the year. The reasons for their discontinuation are

unknown. We expect that, for some users, the reminders selected became unnecessary over time (e.g., after a routine was established or after a change in lifestyle or HIV status).

We expect that the cost per message and cost per user will decline with each year of continued implementation. This assumption is supported by data showing that the vast majority of users (93% during year one of implementation) remain enrolled in the service. With diminished maintenance costs and ongoing growth in the number of users, the cost per message and cost per user should decline on a continuous basis.

3. Describe any **technical assistance** needs and resources needed for your demonstration project.

Currently, there are no new technical assistance needs related to Category C activities. We value the previous technical assistance provided by CDC (for Social Networks Strategy implementation) and by the California STD/HIV Prevention Training Center (for cost analysis planning).

4. Describe any **successes** experienced with implementing your demonstration project during this reporting period.

### **Oregon Reminders**

Oregon Reminders has generated significant interest. Through June 2014, Oregon Reminders had 1,384 active users, including 867 users receiving HIV/STD test reminders every three to six months, 257 users receiving medication reminders daily, 117 users receiving prescription refill reminders monthly, 136 users receiving health tips weekly, and 41 users receiving health tips for PLWH weekly. Interest in the service is not limited to Oregon; approximately one-third (34%) of Oregon Reminders users have a non-Oregon ZIP code. OHA staff presented information about Oregon Reminders at the YTH (youth+tech+health) Live conference in April.

Survey data collected to date (N=60) suggest that Oregon Reminders is helping people maintain or improve healthy behaviors. Of respondents receiving medication or refill reminders (N=31), the majority reported that Oregon Reminders helps them remember to take their medication (81%) and that they have missed doses of their medication less frequently since signing up for

the service (69%). Of survey respondents receiving test reminders (N=29), the majority (65%) indicated that Oregon Reminders helps them remember to test for HIV/STDs, and more than a quarter (27%) reported testing for HIV more frequently since signing up for the service. More than three-fourths (76%) of these respondents reported testing for HIV at least once in the past six months (once, 36%; twice, 36%; three times, 4%). Survey data also suggest that Oregon Reminders is reaching high-risk populations for whom knowledge of HIV status and viral suppression may be particularly important; 65% of respondents receiving medication adherence or prescription refill reminders and 64% of respondents receiving test reminders reported sex without a condom in the past 30 days. While these data are limited to 60 users, the number of responses will continue to increase over time; each month, the survey is sent to a group of users who enrolled six months ago.

The OHA HIV Prevention Program has promoted Oregon Reminders through collaboration with a variety of partners, including YTH, CAREAssist (Oregon's AIDS Drug Assistance Program), the HIV Community Services Program (Part B), the Northwest AIDS Education and Training Center, and a number of local health departments (e.g., the Multnomah County Health Department) and community-based organizations (e.g., Cascade AIDS Project, HIV Alliance). Other efforts contributing to the project's success include online marketing (e.g., Grindr, Facebook mobile) and technical assistance provided by OHA and by local agencies (peer to peer).

### **Social Networks Strategy (SNS)**

HIV Alliance, the Multnomah County Health Department (MCHD) and Cascade AIDS Project (CAP, an MCHD subcontractor) are implementing Social Networks Strategy HIV testing programs that target MSM and utilize technology for recruitment and training. MCHD has developed SNS promotional and training videos, which are available online, and used texting to communicate with and support recruiters on an ongoing basis. Of the 30 network associates tested from January through June 2014, 30% were recruited online or via text message, suggesting technology has been a helpful tool for SNS recruiters.

### **Website changes**

Cascade AIDS Project and HIV Alliance have continued to promote HIV prevention web badges, which other agencies and businesses may embed on their web pages. OHA staff contacted adult dating and sex-seeking apps that are used by MSM to encourage them to share the HIV services locator widget developed by AIDS.gov. Promoting online HIV prevention content fosters structural changes in online settings and helps mobilize businesses and organizations to support HIV prevention, particularly those whose missions do not focus on HIV prevention. When badges are embedded on such agencies' websites, online consumers who are not actively seeking HIV prevention content are more likely to be exposed to sexual health messages. Through June 2014, 24 (15%) of the 158 agencies approached have added an HIV prevention badge or widget to their website or app.

5. Describe any **challenges** experienced with implementing your demonstration project during this reporting period.

### **Oregon Reminders**

During the reporting period, there were no significant challenges related to Oregon Reminders.

### Social Network Strategy (SNS)

SNS recruitment efforts have targeted high-risk persons (e.g., MSM) and venues (e.g., Grindr, STD clinics). Though the projects have not yielded the expected positivity rate, the rate has improved over time. OHA has continued to provide and coordinate peer-to-peer technical assistance on strategies for reaching networks with undiagnosed infection. The CDC capacity building branch provided technical assistance in early 2014; SNS sites were encouraged to continue using existing strategies that result in testing among network associates from the target population.

### **Website changes**

Contractors have reported that many businesses and organizations approached are not interested in adding HIV prevention content to their website. However, we did not expect this initiative to be easy, given that it is designed to build partnerships with agencies whose work does not focus on HIV prevention. We are pleased with the current success rate.

6. Provide the following information below for HIV testing, linkage to care, partner services, and/or use of surveillance data for your demonstration project, if conducted during the reporting period. For HIV testing, please also see Appendix C.

### **HIV Testing**

Total number of newly-diagnosed HIV positive test events\*: 1

Total number of previously-diagnosed HIV positive test events\*: 0

Total number of HIV test events: 30

\*Includes unconfirmed preliminary positive test events plus confirmed positive test events

### **Linkage to Care**

Total number of newly-diagnosed HIV-positive persons\*: 1

Number of newly-diagnosed HIV positive persons linked to HIV medical care: 1

Total number of previously-diagnosed HIV positive persons that are out of medical care\*\*: 0 (NA)

Number of previously-diagnosed HIV positive persons out of medical care who were re-engaged in HIV medical care: 0 (NA)

\*Includes unconfirmed preliminary HIV positive persons plus confirmed HIV positive persons

\*\*Only includes confirmed previously-diagnosed HIV positive persons

### **Partner Services**

Total number of HIV positive persons\* that were interviewed for Partner Services: 1

Number of partners elicited from these HIV-positive persons: 1

Number of partners elicited that were tested for HIV: 1

Number of newly-diagnosed confirmed HIV positive test events from these elicited partners: 1

\*Includes confirmed newly-diagnosed and previously-diagnosed HIV positive persons

### **Use of Surveillance Data**

Briefly describe how surveillance data were used for your demonstration project:

OHA's demonstration project has used surveillance data as described below:

- To help understand testing behaviors, identify community needs, and inform the development of a demonstration project concept, OHA examined data on the proportion of HIV cases diagnosed late in the course of infection.
- OHA used HIV case rate data by county as part of the scoring criteria for LHDs and CBOs applying for Category C funding.
- HIV case data by county were used to identify priority areas for Oregon Reminders and placements.
- Partner Services interview data were used to identify venues where newly diagnosed persons met partners; many of these venues were then approached about adding HIV prevention content to their websites or mobile applications.

- Contractors implementing SNS used data on late diagnosis in their area to help identify sub-populations of MSM with an increased need for testing and target recruitment accordingly.

7. Provide any **additional project outcomes** not mentioned above.

Additional outcomes include:

- The enrollment of 1,384 active Oregon Reminders users, including:
  - 867 receiving HIV/STD test reminders every 3-6 months
  - 257 users receiving medication reminders daily
  - 257 users receiving prescription refill reminders monthly
  - 136 users receiving health tips weekly
  - 41 users receiving health tips for PLWH weekly.
- The collection of Oregon Reminders survey data that suggests the service is achieving the desired outcomes.
  - The majority (81%) of respondents receiving medication reminders indicated that the service helps them remember to take their medication.
  - The majority (65%) of respondents receiving test reminders indicated that the service helps them remember to test for HIV/STDs.
- The addition of HIV prevention content (HIV web badges or widgets) to 24 websites or applications whose primary focus is not HIV prevention (e.g., student organizations, churches, bathhouses).

These outcomes are described in more detail in the response to question 4 above.

#### **SECTION IV: STAFFING AND MANAGEMENT**

1. Please indicate any organizational and/or key staffing changes (i.e., health department staff responsible for implementing interventions and services for PS12-1201) that occurred during the reporting period. Please indicate any vacant staff positions and provide a detailed plan with timeline for hiring/filling vacancies. Were there any delays in executing contracts during the reporting period? If so, please explain and include any program implications?

## HIV Prevention Program Staff

Program Manager	Ruth Helsley	Current
Program Development Analyst	Larry Hill	Current
Technology Intervention Specialist	Dano Beck	Current
Support Office Specialist	Warren Scott	Current
Epidemiologist 1- HIV/STD Data Analyst	Irina Kasarskis	Current (as of June 16, 2014)
Program Analyst 3 - HIV/STD Technical Consultant	Josh Ferrer	Scheduled to begin work September 16, 2014

The Oregon Health Authority hired an Epidemiologist to meet data collection, data analysis, data reporting and program evaluation needs for the HIV Prevention and STD Program. The bulk of orientation for this new staff member will be completed within 6 months of hire date and will include NHM&E and EvaluationWeb trainings.

The Program Analyst 3 vacancy has been filled with start date in September 2014. The new staff member in this position will have the bulk of orientation completed within 6 months of hire date and training will include CDC data collection and reporting requirements and familiarity with the goals of the current project period.

The delay in hiring these two positions was caused by higher system level reevaluation of vacancy filling and temporary hiring freezes secondary to state budget considerations.

There were no delays in executing contracts during this reporting period (January 1 – June 30, 2014).

## **SECTION V: RESOURCES ALLOCATION**

### **Category A:**

1. Include the percentage of Category A funding resources allocated to the required and recommended program components for Year 3 (2014) and what is being proposed for Year 4 (2015)? *Note: Percentage should be inclusive of both internal health department expenses (e.g., personnel and administrative cost) as well as funding resources being allocated external to the health department for the required and recommended components. This information should be reflected within the budget. Please utilize the information provided in Appendix D: Overall - Budget Allocation with CDC Funding*

Sources for Budget Year 2014 to assist with this section. **Percentages for required and recommended components should total 100%.**

**Year 3 (2014):**

Required components: 100%

Recommended components: 0%

**Proposed for Year 4 (2015):**

Required components: 100%

Recommended components: 0%

2. Please identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease.

<b>Reporting of MSAs/Cities/Areas with <math>\geq 30\%</math> of the HIV Epidemic within the Jurisdiction</b>			
<b>MSA/CITY/AREA</b>	<b>Percentage of HIV Epidemic within the Jurisdiction</b>	<b>Percentage of PS12-1201 Funds Allocated</b>	<b>Components and Activities Funded</b>
<b>Multnomah County / Portland Metro Area</b>	<b>52% - PLWH</b>	<b>34.73% of total Category A award was distributed to Multnomah County. This represents 59.62% of the total funds distributed to local health departments.</b>	<b>HIV Testing, Prevention with Positives, Condom Distribution</b>

**All Categories:**

1. Please provide information for the budget allocation tables for 2014.

The budget allocation tables were completed through EvaluationWeb on September 10, 2014.

**SECTION VI: BUDGET**

1. Did you submit a 424A form and separate budgets for Categories, A, B and C?

Yes, for Categories A and C

2. Are you requesting new Direct Assistance (DA) in lieu of Financial Assistance (FA) for Year 4?

No

3. In states that have directly funded cities, both funded entities must have a Letter of Agreement (LOA) in place detailing the understanding that has been reached regarding the delivery of service, including any funding implications, within the directly funded city. If there have been any changes to the LOA, please submit the updated LOA with this IPR submission. If there are no changes to the current LOA, then please confirm that the current LOA will remain in place for the new budget period (Year 4: January 1, 2015 – December 31, 2015).

Not applicable

## **SECTION VII: ASSURANCES OF COMPLIANCE**

**Instructions:** Submit the completed forms for all materials used or proposed for use during the reporting period of **January 1, 2015 – December 31, 2015**. Attach the following Assurance of Compliance Forms to the application through the “Mandatory Documents” section of the “Submit Application Page” on Grants.gov. Select “Other Documents Form” and attach as a PDF file.

- “Assurance of Compliance with the Requirements for Contents of AIDS Related Written Materials” (CDC 0.1113). Please see <http://www.cdc.gov/od/pgo/forms/hiv.htm> for instructions on completing the Assurance of Compliance Form.

Attached as an appendix.