Oregon's 2022-2026 Integrated Plan and Statewide Coordinated Statement of Need

December 2022

Oregon Health Authority

END HIV

Multnomah County

Contents

Section I: Executive Summary of Integrated Plan and SCSN

Executive Summary

Oregon's 2022-2026 Integrated Plan and Statewide Coordinated Statement of Need (SCSN) represent the synthesis of information gathered from community planning, ongoing needs assessment, public comment, and listening sessions. Since 2012, Oregon has had an integrated statewide planning group, the End HIV/STI Oregon Statewide Planning Group (OSPG), which takes a syndemic approach to address all parts of the status-neutral continuum, and which guided the development of this plan. This Integrated Plan and SCSN is a joint submission of Oregon's HIV Prevention Program, Ryan White Part A Program, and Ryan White Part B Program.

The key strategies from our previous 2017-2021 plan and branded End HIV Oregon Initiative were carried over to the current 2022-2026 Plan, updated, and the plan format slightly reorganized to match the model provided by the National HIV/AIDS Strategy and federal guidance from HRSA and CDC. The goals and objectives outlined here also align with Healthier Together Oregon, Oregon's State Health Improvement Plan. End HIV Oregon's four key pillars are:

Diagnose
Prevent
Treat
Respond to End Inequities

Oregon's goals and objectives are written with our vision of ending inequities in mind. Our priority populations include an expanded list of those prioritized in the National HIV/AIDS Strategy. Oregon is focused on ending new HIV/STI transmission by using a syndemic lens, and by leading with race/ethnicity. Prioritizing community partnerships, shifting resources to communities of color and other communities experiencing inequities, and supporting community-led needs assessment, education, outreach, and ability to respond to clusters and outbreaks are themes woven through all goals and objectives.

Oregon's priority populations are listed alphabetically below, with the recognition that many people have intersectional identities; these are not mutually exclusive groups.

- American Indian/Alaska Natives
- Black/African American people
- Gay, bisexual, and other men who have sex with men (MSM)
- Latino/a/x people
- Native Hawaiian/Pacific Islanders
- People experiencing houselessness/unstable housing
- People who inject drugs (PWID)
- People who live in rural or frontier areas
- People who use methamphetamine
- People with sexually transmitted infections, particularly syphilis and rectal gonorrhea

- Transgender, nonbinary, and gender diverse people, with a focus on transgender women[1]
- Youth

Approach

Oregon used a broad, iterative planning process to update our 2017-2021 Integrated Plan, engaging the community to identify priorities, develop strategies, and approve the final documents. Since 2012, Oregon has had an integrated statewide planning group, which takes a syndemic approach to address all parts of the status-neutral continuum. The key strategies from our previous plan and branded End HIV Oregon Initiative (testing, prevention, treatment, and ending inequities) were carried over to the current 2022-2026 Plan, activities updated, and the plan format slightly reorganized to match the model provided by the National HIV/AIDS Strategy and federal guidance from HRSA and CDC. Oregon is not an EHE jurisdiction.

Documents submitted to meet requirements

The following documents are included in this submission:

- The Statewide Coordinated Statement of Need
- Oregon 2022-2026 Integrated Plan
- Oregon Needs Assessment Inventory (Appendix 1)
- Community Opinions Survey, 2022 (Appendix 2)
- Oregon HIV Continuum of Care Outcomes by Demographics, 2020 (Appendix 3)
- Oregon HIV Prevention, Care & Treatment Resource Inventory (Appendix 4)
- End HIV Oregon Strategy Map, 2022-2026 (Appendix 5)
- Submission Checklist (Appendix 6)

Hyperlinks are included for all references that can be accessed online.

[1] Broad engagement with transgender and nonbinary communities are important to ending HIV efforts; transgender women are called out specifically in the priority populations because of their over-representation in new HIV diagnoses.

Section II: Community Engagement and Planning Process

Jurisdictional Planning Process

Oregon used a broad, iterative planning process to develop our 2022-2026 Integrated Plan, engaging the community to identify priorities, develop strategies, and approve the final documents.

Specifically, data were synthesized from more than 40 existing data sources (see Needs Assessment Inventory, Appendix 1) and additional primary data were collected in 2020-2022 from under-represented voices, including Oregonians who are Black/African American, Latina/o/x, tribal-affiliated, youth, trans and/or nonbinary, and people living with HIV (PLWH). Primary means of collecting data included surveys, focus groups, engagement of planning bodies, individual interviews, and community meetings/town halls.

Oregon's planning process kicked off with a 5-hour anti-racism training that introduced the End HIV/STI OSPG members to shared concepts and language, as well as the use of an equity lens. Needs assessment data were shared with OSPG and RWHAP Part A Planning Council members for use in developing goals, objectives, and action steps during online meetings. Data were shared via presentations and members were engaged in small and large group discussions to identify existing activities, priority activities, resources, gaps, equity implications, and potential unintended consequences. Most small group discussions were facilitated using an equity tool to ensure an anti-racism lens; polls and the online tool, Jamboard, were used to ensure optimal participation while using a remote meeting format.

Additional groups and individuals were engaged on specific portions of the plan; for example, the Statewide PrEP/PEP Advisory Group gave input on the portions of the plan related to PrEP and PEP and helped develop those goals and objectives. Input on at-home HIV/STI self-collection and testing strategies was collected through a listening session with health department and community-based organization (CBO) colleagues. Individual and group meetings with key community partners (e.g., grantees, subrecipients, CBOs, partners representing priority populations) to discuss needs and priorities were ongoing throughout 2021-2022.

Community members were recruited through direct invitation, listservs, agency partners, and social media to provide detailed feedback on high-level priorities, goals and objectives, and the entire Integrated Plan through the following opportunities:

- A community listening session that included a broad representation of 35 agency and community partners, facilitated by a set of key questions related to priorities.
- Providing public comment through our Community Opinions survey on key parts of the document, provided in English and Spanish, on endhivoregon.org, as well as answers to key questions related to priorities.

The Community Opinions Survey used to solicit additional community input on priorities can be found in Appendix 2. We sent direct invitations to participate in our Listening Session and/or provide Public Comment through our Community Opinions survey to people representing the interests listed in Table 1a below and asked those individuals to share the survey links within their networks. We also advertised the Community Opinions survey on social media.

All stages of planning included representation from priority populations, including PLWH, people at increased vulnerability to HIV, communities facing HIV inequities, RWHAP partners from Parts A-F, syndemic service providers, and other interested community members. See below for more detail.

Groups involved in the process

NOTE: Representatives of all groups listed below were invited to participate in End HIV/STI Oregon Community Listening Session and/or Community Opinions Survey.

Interests Represented	Represented on Planning Group(s)	Additional Means of Engagement
Health department staff*	X	Gathered input from HIV Early Intervention Services & Outreach program staff Gathered input from local, tribal, and community partners related to HIV/STI at-home and self-collection testing Gathered input and data from disease intervention specialists during cluster response Direct coordination with COVID-19 response units that intersect with HIV care and treatment
Community- based organizations serving populations affected by HIV/HIV services providers*	X	Listening session in July 2022 Participation in Community Opinions survey Program planning sessions with seven Ryan White Part A funded sub-recipients
People living with HIV*	X	Oregon HIV Medical Monitoring Project Part A Client Experience Survey 10 1:1 interviews with PLWH Engaged a minimum of 33% unaligned consumers on the Part A Planning Council Engaged consumers in leadership and membership on OSPG
Populations at risk or with HIV representing priority populations	X	Chime In survey (National HIV Behavioral Health Survey) – survey itself + formative research and data debrief community meetings Statewide PrEP/PEP Advisory Group, Statewide TelePrEP Advisory Group Interviews with HIV/STI partner services clients
Behavioral or social scientists	X	
Epidemiologists	X	Gathered data for cluster response
HIV clinical care providers including (RWHAP Part C and D)*	X	Part C/D Clinic participated in strategic planning meetings and conducts technical assistance for rapid ART program Part F Dental Clinic participated in strategic planning meetings
STD clinics and programs	X	Representatives of STD Clinics during cluster response, strategic planning, and within the End HIV/STI Oregon statewide planning group

Non-elected community leaders including faith community members and business/labor representatives*		Focus group with Allen Temple conducted by African American AIDS Awareness & Action Alliance (A6)
Community health care center representatives including FQHCs*	X	Representatives participated in Community Opinions survey
Substance use treatment providers*	X	Representatives participated in planning bodies and in Community Opinions survey Participation of Part A funded SUD providers, benefits coordinators, and peers within advisory boards and strategic planning sessions Expanded testing in partnership with MH/SUD treatment providers
Hospital planning agencies and health care planning agencies*	X	
Intervention specialists	X	Workforce training needs assessment conducted by National Coalition of STD Directors
Academic institutions		1:1 meetings with representatives from OHSU and OSU Engaged with CFAR at UW for potential future collaborations and technical assistance
Mental health providers*	X	Expanded testing in partnership with MH/SUD treatment providers
Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility*	X	Consumer participation within the Part A Planning Council (position currently vacant, but recruiting for it)
Law enforcement, correctional facilities, juvenile justice		Partnerships formed with local law enforcement for street outreach/harm reduction mobile units
Social services providers including housing and homeless services representatives*	X	Coordination with Part A and Balance of State HOPWA programs Part A participation on local housing care continuum advisory boards Formal funded partnerships with Portland Street Medicine; representatives from Central City Concern and other social services on planning groups
Local, regional, and school-based clinics; healthcare facilities; clinicians; and other medical providers	X	
Medicaid/Medicare partners	X	Ongoing and ad hoc discussions with Medicaid and Medicare partners about issues relevant to End HIV Oregon priorities
Latina/o/x people	X	Familias en Acción leading statewide needs assessment via Regional Learning Collaboratives and interviews with key informants

		Data collected at the 2021 Latino Health Equity Conference
African Americans	X	Five community focus groups conducted by the African American AIDS Awareness Action Alliance (A6) 3 Community Listening Sessions/Chime In data debrief sessions conducted in 2019
Pacific Islanders	X	
American Indian/Alaska Natives	X	Northwest Portland Area Indian Health Board conducting needs assessment with all federally-recognized tribes in Oregon.
Gay, bisexual, and other men who have sex with men (MSM)	X	Chime In survey (2017) Chime In survey (2020, trans-identified MSM)
People who inject drugs (PWID)		Chime In survey (2018, 2021)
Long-term survivors	X	1:1 interviews Oregon HIV Medical Monitoring Project (MMP)
Youth	X	Oregon Student Health Survey
Community members unaligned or unaffiliated with agencies currently funded through HRSA and/or CDC	X	Community Opinions survey Participation on Part A Planning Council, Part A BIPOC Data Review Committee, and OSPG
Community- and faith-based organizations, including civic and social groups		2022 focus group with African American faith community at Allen Temple conducted by A6.
Professional associations		Asked key associations to solicit member participation in Community Opinions survey
Local businesses		Participate in formative research for MSM cycle of Chime In (gay bars, bookstores, bathhouse)
Existing community advisory boards	X	MMP, Chime In, CAREAssist Advisory Boards
Community members resulting from new outreach efforts	X	Asked list of 40 agencies that applied for HIV funds to solicit constituent participation in Community Opinions survey

Role of RWHAP Part A Planning Council

This Integrated Plan was developed jointly by partners and service providers from Parts A and B. Specifically, the RWHAP Part A Planning Council participated in plan development in the following ways:

- Presentations at RWHAP Part A Planning Council meetings (12/7/21 and 10/4/22)
- At-least bimonthly meetings of Part A Planning Council and (Part B) End HIV/STI Oregon Statewide Planning Group key staff liaisons throughout 2022
- Participation by RWHAP Part A Planning Council members on the Statewide Planning Group –the Statewide Planning Group Community Co-Chair was the Part A Planning Council Community Co-Chair for much of 2021-2022, ensuring tight coordination during the planning process
- Specific invitations issued to Part A Planning Council members, including members of the BIPOC Data Review Committee, to review and comment on the planning document via *google docs*

- Signed Letter of Concurrence from Part A Planning Council

Role of planning bodies and other entities

Since 2012, Oregon has had an integrated statewide planning group, which takes a syndemic approach to address all parts of the status-neutral continuum. The mission of this group, the End HIV/STI Oregon Statewide Planning Group (OSPG), is to regularly identify strengths, needs, gaps, and service priorities, resulting in a comprehensive plan that will support people in Oregon living with, affected by, or at risk for HIV/STI and syndemic issues to live healthy lives. OSPG includes members representing all Ryan White service areas, diverse geographic regions of the state, and a variety of disciplines. In recognition of the need to amplify the voices of groups who are currently underrepresented and impacted by HIV, OSPG is currently only accepting membership applications from people in Oregon who are Black, African American, or African immigrants; Hispanic or Latinx; transgender women; or people of color who are living with HIV. Interested people not meeting those criteria are welcome to participate as partners rather than voting members.

The HIV Planning Services Council is dedicated to improving the quality of life for those infected and/or affected by HIV/AIDS, and to ensuring that members of our community play lead roles in planning and assessment of HIV resources. The HIV Planning Services Council, a 30-member community involvement group, is a decision-making body that plans the delivery of medical and social services in Clackamas, Columbia, Multnomah, Yamhill, Washington, and Clark Counties. The Planning Council accomplishes this by deciding how federal funds will be spent by setting priorities and allocating funds to programs serving people living with or affected by HIV/AIDS and through involving the community in assessing PLWH healthcare and social service needs. The council is composed of diverse individuals including service providers, public health officials and at least 33% people living with HIV/AIDS. Members must live within Multnomah, Washington, Clackamas, Yamhill, Columbia Counties in Oregon, and Clark County in Washington State.

Oregon Health Authority staff, as the Part B grantee, were responsible for coordinating the planning process, including needs assessment, planning meetings, developing feedback mechanisms, and writing and submitting the final document.

Multnomah County Health Department staff, as the Part A grantee, were responsible for ensuring full participation of Part A Planning Council members, assisting with needs assessment, developing goals and objectives, and reviewing and providing feedback on the document.

Both entities were responsible for providing a Letter of Concurrence on the final documents from their respective planning bodies.

Collaboration between RWHAP Parts A-D and Part F

Representatives from RWHAP Parts A-F are active participants in OSPG and the Part A Planning Council.

Engagement of people with HIV

People living with HIV were involved in all stages of the process, including needs assessment, priority setting, development of goals and objectives, and implementation, monitoring, evaluation, and quality improvement.

Needs assessment:

- Oregon has participated in the HIV Medical Monitoring Project since 2007. MMP data are used to gain a deeper understanding of health-related experiences and needs of PLWH in Oregon. The project collects data from PLWH to provide a wide array of locally and nationally representative estimates of behaviors and clinical outcomes of persons in care for HIV; describe health-related behaviors; determine accessibility and use of prevention and support services; increase knowledge of the care and treatment provided; and examine differences by geographic area, patient characteristics, and access to social determinants of health. MMP includes PLWH who participate in RWHAP-funded services and those who do not.
- Oregon regularly surveys PLWH participating in RWHAP programs, such as CAREAssist (Oregon's AIDS Drug Assistance Program), Parts A and B case management, and the Oregon Housing in Opportunities Program (OHOP), and uses those data to understand PLWH needs, as well as to improve programs. We also conduct periodic special evaluation studies to better understand specific needs, such as PLWH needs around pharmacy access or viral suppression support.
- Part A conducted the bi-annual Client Experience Survey in 2021. Results are used to help identify priorities and service gaps.
- PLWH participated in meetings, listening sessions, and community town halls.

Priority setting, development of goals/objectives, and implementation, monitoring, evaluation, and QI processes:

- In Summer 2022, Oregon conducted 10 in-depth individual interviews with PLWH to obtain in-depth, detailed information about specific priorities for the five-year integrated plan.
- PLWH are active participants in the Part A Planning Council and OSPG, where many of these activities take place; both groups include PLWH in leadership positions, including as co-chair and on Operations and Planning Committees. The Part A Planning Council goes through the HRSA-mandated Priority Setting & Resource Allocation (PSRA) process each year, which includes needs assessment and identification of priorities.
- Direct invitations were made to PLWH through Ryan White Programs, community-based organizations, and social media to review the draft plan and provide input on goals, objectives, and priorities during the Public Comment period.

Key priorities

Oregon conducted a Community Opinions Survey along with its Public Comment period on the draft plan in September 2022. A link to the survey and an Executive Summary of the plan were posted on the End HIV Oregon website and we conducted broad recruitment for participation in both. In addition, we conducted a Listening Session in late July 2022 to solicit responses from a statewide sample of professional partners and community members (n=35) to gather preliminary data and test the survey questions.

Forty-four people responded to our Community Opinions Survey (43 in English, 1 in Spanish), including people from the following demographics:

- 14% identified as PLWH, 84% said they were HIV negative, and 2% preferred not to say
- 48% work for state or local public health, 30% work for a CBO, 16% were community advocates, and 7% identified in other ways (e.g., academic medical setting, public school employee, FQHC provider)
- 59% identified as white, 30% as Latino/a/x, 4.5% as Black/African American, 2% as Middle Eastern/North African, 2% as American Indian/Alaska Native, and 4.5% preferred not to say
- 68% identified as female, 30% as male, and 2% preferred not to say
- 34% said they were 55 or older, 23% were age 45-54, 23% were 35-44, 18% were 25-34, and 2% were under 25 years old
- 43% live in the Portland metro area, 32% in the Willamette Valley, 9% in Eastern Oregon, and 4% each live in Coastal, Central, and Southern Oregon. One person (2%) said they lived in Oregon, region unspecified.

The top priorities identified in the Community Survey and Listening Session were nearly identical:

Priority Strategies to <u>Prevent</u> New HIV/STI	**Community survey**	**Listening session**
Provide testing to more people as part of routine care	**52%**	**58%**
Provide treatment & prevention services for people with HIV/STI infections and their sex partners (e.g., expanding/supporting disease intervention & partner services for people with HIV/STI)	**45%**	**36%**
Create more partnerships that support a syndemic focus (e.g., housing, substance use, mental health, etc.)	**45%**	**42%**
Expand PrEP use (the pill that prevents HIV) to people who need it most	**43%**	**61%**

Red = Over 50% of respondents endorsed this priority

Priority Strategies to Treat HIV/STI:	Community survey	Listening session
Develop rapid ART start programs across Oregon (e.g., access to same-day HIV treatment or treatment within 7 days of diagnosis)	**59%**	**75%**
Increase access to medical care and case management through increased telehealth options, transportation support, etc.	**50%**	**47%**
Create more partnerships that support a syndemic focus (e.g., housing, substance use, mental health, etc	**41%**	**53%**

Red = Over 50% of respondents endorsed this priority

Priority Strategies to Eliminate Stigma:	Community survey	Listening session
Provide education and training for health care staff on stigma, discrimination, unconscious bias, HIV, and sexual orientation/gender identity	**73%**	**78%**
Promote U=U (the fact that people living with HIV on effective treatment with an undetectable viral load CANNOT spread HIV to sex partners	**50%**	**47%**
Continue to diversify the public health workforce and transfer resources to communities most affected	**41%**	**44%**

Red = Over 50% of respondents endorsed this priority

Additional themes that emerged were:

- An emphasis on reaching priority populations through community engagement, outreach, and collaboration with community-based organization with strong ties to the priority populations
- A need to focus on access to care, including language access and access for rural populations

Community members said that End HIV Oregon has been most successful in the areas of:

- education, training, and information sharing
- shifting the focus to priority populations
- stigma reduction

Community members said that the areas where End HIV Oregon efforts need to improve include:

- improved services for PLWH (e.g., improving staff turnover, better access to SDOH)
- more education, training, and resources

The Part A Planning Council conducts the federally-mandated Priority Setting and Resource Allocation process each year. The Planning Council's Service category priorities for FY23-24 are:

- Mental Health - more access to culturally specific providers was specifically called out
- Housing - rent assistance and case management

- Food - access, transportation, healthier options

Ten PLWH who engaged in in-depth qualitative interviews in 2022 identified the following priorities for PLWH, particularly those newly diagnosed:

- Mental health services – specifically, experienced counselors, a mentoring program, and access to an on-call support system
- Education about HIV
- Support with adherence to medications

Access to good medical care

Updates to other strategic plans

Oregon is not an Ending the HIV Epidemic (EHE) jurisdiction. Based on community input, we branded our 2017-2021 Integrated Plan as the End HIV/STI Oregon Initiative, a shared venture of community partners statewide and the Oregon Health Authority. We view our 2022-2026 plan as an update to our first End HIV Oregon plan – a process that is iterative – and will continue to use the End HIV Oregon brand for external communications about the plan (e.g., annual reports to the community, which are released every year on World AIDS Day; information provided on the End HIV Oregon website).

Section III. Contributing Data Sets and Assessments

Data Sharing & Use

Oregon collects, analyzes, and reviews a wide range of data on an ongoing basis, including surveillance, program evaluation, administrative, and needs assessment data. A full list of data sources/Needs Assessment Inventory is available in Appendix 1.

OHA maintains data sharing agreements with the following entities for the following purposes:

- Local public health authorities for the purpose of disease reporting and follow-up. Communicable disease data, including for HIV and other reportable STI, is collected via the Oregon Public Health Epidemiologic Users System (ORPHEUS).
- Various health systems (e.g., Kaiser, OHSU, Providence Health Systems) for collecting medical record data for patients living with HIV who are participating in the HIV Medical Monitoring Project.
- Northwest Portland Area Indian Health Board, Tribal Epi Center, and individual tribal nations for formalizing how OHA will work with tribal partners on outbreak response and for defining parameters for a data linkage between HIV surveillance and the tribal registry.
- Regional CBO partners/Part B subrecipients (HIV Alliance, Eastern Oregon Center for Independent Living) and Part A grantee (Multnomah County Health Department) for sharing data through CAREWare and conducting matches to share viral load data.
- OHA Health Analytics for access to the All Payer All Claims dataset and Hospital Discharge Dataset to conduct special studies, including frequency and predictors of HIV/STI testing and PrEP usage and characteristics of individuals diagnosed with HIV in inpatient settings.
- U.S. Department of Health & Human Services for routine matching of Oregon's HIV/AIDS case registry to the National Death Index and for reporting individual-level HIV testing data (Evaluation Web).

Multnomah County Health Department maintains data sharing agreements with the following entities for the following purposes:

- OHA data use agreements for:
    - EISO and HGAP ORPHEUS surveillance data access, entry, and use for newly diagnosed PLWH care coordination and HIV surveillance data analytics.
    - CAREAssist data use and import into CAREWare for RW client insurance, FPL and eligibility coordination and analytics.
- ORPHEUS data use agreements between Multnomah, Washington, Clackamas, and Yamhill local public health authorities for surveillance laboratory data import into CAREWare for RW client care coordination purposes and TGA RW client linkage to care, unmet need, and viral load analytics.
- Organized Health Care Agreement (OCHA) across TGA RW funded agencies for data sharing within CAREWare and for CAREWare data import from local provider specific medical, case management and housing data systems (e.g., EPIC, Service Point, PROVIDE) for purposes of cross-RW provider client care coordination and client services and outcomes analysis, including disparities seen by client characteristics.

Epidemiologic Snapshot

Oregon has developed user-friendly data dashboards that summarize key aspects of the HIV epidemic in Oregon. The dashboards are a digital version of the 2021 Epidemiological Profile. Readers are encouraged to visit the dashboards for more detailed information, graphic representations, and the ability to query on specific characteristics of interest and time periods. Key facts from the Epi Profile are presented below.

HIV Prevalence

From 1981 to 2020, 10,912 Oregon residents were diagnosed with HIV; in 2020, 7,962 people were living with diagnosed HIV in Oregon. We estimate that another 1,296 people in Oregon are living with HIV but are unaware of their status. Key facts about people living with HIV in Oregon:

- Assigned sex at birth and gender: 88% of PLWH in Oregon are male; 12% are female. Oregon began collecting more complete information on gender in 2018; only 52% of PLWH have a reported gender from 2011-2022. Therefore, references in the Epi Snapshot section to males or females refer to assigned sex at birth.
- Age: Median age for PLWH in Oregon is 51 years for males and 50 years for females. The prevalence of HIV is greatest among persons 50-59 years. Overall, 55.3% of people living with HIV are 50 years or older. More than two-thirds of PLWH in Oregon (64%) are long-term survivors (diagnosed for 10 years or more).
- Race/ethnicity: There are racial inequities in HIV prevalence. Prevalence among Black/African Americans (775.3/100,000) is four times higher than for white Oregonians (181.9/100,000), the largest group of PLWH in Oregon at 72%. Prevalence of HIV is 193.5/100,000 among Hispanic/Latino/a/x residents, 164/100,000 among American Indian/Alaska Natives, 135.6/100,000 among Native Hawaiian/Pacific Islanders, and lowest among Asians at 88.7/100,000.
- Behavioral characteristics:
    - MSM: Among males with HIV, sex with men is the most common reported route of transmission, with 74% reporting MSM only and another 11% reporting MSM and injection drug use risk.
    - Injection drug use: 23% of females report IDU; 6% percent of males report injection drug use only, 11% of males report MSM/IDU
    - Different-gender sex (MSW or WSM): 60% of females report sex with a male; 3% of males report sex with females and no other transmission risk. Data for genders other than male or female are currently unavailable.
    - Unknown risk: 13% of females and 6% of males have unknown transmission routes for HIV.
    - Perinatal exposure: 3% of females and 1% of males were exposed perinatally or under the age of 13 years.
    - Blood product exposure: Exposure through blood products alone has become rare in Oregon, with fewer than 1% of all male or female PLWH reporting this transmission route.
- Clinical characteristics: In 2020, 90% of PLWH had a CD4 or viral load test; 77% of PLWH living in Oregon were virally suppressed. Rates of viral suppression were lower among:
    - people under 40 years of age

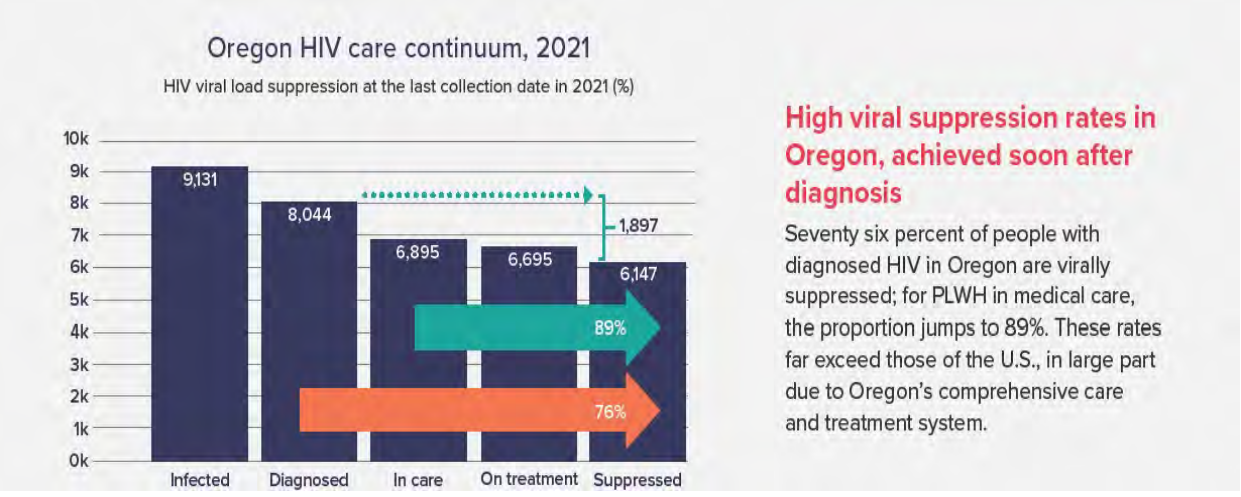
    - Black/African American people
    - people who inject drugs
    - people living in rural and frontier regions
    - people with unstable housing prior to their diagnosis
- Geographic region: At the end of 2020, 46% of PLWH lived in Multnomah County, Oregon's most populous county. Another 40% lived in other mixed urban/rural counties, and 14% lived in rural counties. By ZIP code, 80% lived in urban areas, 19% in rural areas, and <2% in frontier areas.
- Socioeconomic characteristics[2]:
    - Education: 11% have less than a high school diploma, 22% are high school graduates, 38% have some college, and 29% have a bachelor's degree or higher.
    - Food Insecurity: 16% reported past-year food insecurity.
    - Household income: 34% live in households at or below the poverty threshold.
    - Homelessness: 8% experienced homelessness in the previous 12 months.
- Behavioral health needs[3]:
    - Substance use: 41% reported injection and/or non-injection drug use in past 12 months, 15% reported binge drinking in past 30 days, and 30% are current tobacco users
    - Mental health: 21% reported depression and 25% reported anxiety in past 2 weeks
    - Intimate partner violence: 44% reported lifetime prevalence of intimate partner violence.

HIV Care Continuum

Ensuring people living with HIV are aware of their status, rapidly linked to care, retained in care, and virally suppressed are critical steps to improving health outcomes and ending new HIV transmissions in Oregon. Oregon has a much higher proportion of PLWH in care and virally suppressed than the U.S., but there is still much work to do to ensure the estimated 1,296 people living with HIV but unaware of their status are diagnosed, and that all people living with HIV benefit from high quality care, free of stigma and discrimination. Furthermore, inequities exist along the care continuum that must be addressed. Differences in HIV care continuum outcomes by demographic and other characteristics can be explored by visiting Oregon's online HIV Epi Profile 2021 care continuum dashboard or by viewing the table in Appendix 3; they will also be discussed at length throughout this Integrated Plan.

[2] Socioeconomic data are taken from the Oregon HIV Medical Monitoring Project, 2015-2020 data, not from ORPHEUS. As one of 23 project areas in the U.S., the Oregon HIV Medical Monitoring Project (MMP) aims to gain a deeper understanding of health-related experiences and needs of PLWH in Oregon.

[3] Socioeconomic data are taken from the Oregon HIV Medical Monitoring Project, 2015-2020 data.



HIV Incidence

Oregon is considered a low incidence state for HIV, with an annual average of 209 new HIV diagnoses between 2016-2020, and 200 cases diagnosed in 2021.[4] Overall, rates of new HIV diagnoses have fallen during 2011-2020 (an average annual percent change of 6%, p<.001); 2,255 Oregon residents were diagnosed with HIV during that period.

Our 5-year End HIV Oregon goal from 2017-2021 was 180 new HIV diagnoses per year (or about 4 diagnoses per 100,000 Oregonians). In 2020, overall rates met the 5-year goal, with 180 newly diagnosed cases (4.2/100,000). However, these rates were likely artificially low because fewer people sought health care due to COVID-19. Moreover, there are large racial and ethnic inequities in new diagnoses. Oregonians who are Black/African American, American Indian/Alaska Natives, Native Hawaiian/Pacific Islander, and Hispanic or Latino/a/x have higher than average HIV diagnosis rates, while Oregonians who are White, Multiracial, or Asian have lower than average rates.

Characteristics of people newly diagnosed with HIV between 2011 to 2020 include:

- Assigned sex at birth and gender: Rates of diagnosis decreased among males from 11.3 to 7.6 diagnoses per 100,000. The rate of new HIV diagnoses among women remained stable (1.4 to 1.0/100,000).
- Age: The median age at diagnosis was 35 years for males and 38 years for females. The rate of new diagnoses declined significantly among males age 40-49 and 50-59 years.
- Race/ethnicity: Black/African American people experienced a diagnosis rate nearly 5 times higher than other racial/ethnic groups (23.2/100,000); for comparison, rates among Hispanic/Latino/a/x people and white people were 8.7 and 4.9/100,000, respectively. Black/African American females were disproportionately represented among new HIV diagnoses. There were fewer than 10 new diagnoses each year among all other racial and ethnic groups; rates among American Indian/Alaska Natives and Native Hawaiian/Pacific Islanders were higher than the Oregon average.
- Behavioral characteristics: MSM accounted for 68.6% of new HIV diagnoses, with a downward trend from 2011 to 2020. Approximately 1 in 10 males lacked enough

[4] Case rates in 2020-2021 should be interpreted with caution due to the disruptive effect of the COVID-19 pandemic.

information to assign a transmission category. Among females, IDU accounted for 25.7%, sex with males 45.5%, and unknown risk accounted for 28.4%. Since 2013, there has been an overall increasing trend in the number of new diagnoses reporting past injection drug use. A decrease in the number of PWID diagnosed in 2020 was observed, but this may be due to reduced testing opportunities and other services.

- Geographic region: 44% of new cases were Multnomah County residents, a proportion that has decreased from 47.8% (2011-2015) to 40.3% (2016-2020). An average annual percent decrease of about 5% was observed during this period for the Tri-County Portland metropolitan region (from 68.6% during 2011-2015 to 63.2% during 2016-2020). In contrast, new HIV diagnoses in Oregon counties outside of the Tri-County region were stable.

People at Risk for HIV Infection

Oregon participates in the National HIV Behavioral Surveillance survey, locally known as Chime In, which surveys one of three Portland-area populations at risk of HIV infection each year on a rolling basis: MSM, people who inject drugs, and low income heterosexuals. These populations match the populations most represented in our HIV incidence data. Additional priority populations, including those identified in clusters, will be discussed in the Priority Populations section. Because of how data are collected, information reported in broad population groups does not always consider intersectional identities. The data in the following sections should be viewed as one dimension of a more complex and nuanced lived experience.

Gay, Bisexual, and Other Men Who Have Sex with Men (MSM): A sample of Portland-area MSM (n=424) who participated in Chime In in 2017 provided information about HIV/STI testing, risk, and protective behaviors. Nearly all (95%) had been tested for HIV at least once, 66% had tested for an STI in the preceding 12 months, and 69% of those not known to be HIV-positive had tested for HIV in the preceding 12 months.

Sixty percent of participants reported casual condomless anal sex in past 12 months. Among the 84% who self-reported as HIV-negative, most (88%) had heard of PrEP, 51% discussed taking PrEP with a health care provider, and 24% had used PrEP in the past 12 months. Among PrEP-eligible MSM, the most common reasons given for not taking PrEP were low risk perception (34%), lack of knowledge (25%), and cost (10%). Most PrEP users reported no challenges with taking it; the most common challenges (reported by 25% or fewer users) were remembering to take a daily pill, attending clinic visits, and questions about whether risk justifies ongoing PrEP use. Similarly, the top reasons for stopping PrEP were changes in risk/risk perception (48%), challenges refilling prescriptions (42%), and insurance changes (32%).

A formative assessment for the Chime In 2020 cycle included qualitative feedback from professional and community key informants. Key informants identified the following resource needs among MSM: LGBTQ mental health support and suicide prevention; addiction services; sexual health services for trans MSM; free and low cost STI and HIV testing resources; PrEP access; LGBTQ inclusive housing; and a "one stop shop" for BIPOC MSM catering to their specific needs. Younger MSM mentioned the need for safe housing along with scholarship and college assistance programs. Professional key informants said that requests for some specific resources increased during the COVID-19 pandemic, including mental health support, food boxes, and clean and safe shelter. Key informants also made specific recommendations about

collecting gender identity and sexual behavior data in a more respectful and trauma-informed way, providing information and resources specific to TMSM, and creating and distributing a list of trans-friendly providers and spaces.

People who Inject Drugs (PWID): A sample of Portland-area people who inject drugs (PWID) (n=540) who participated in Chime In in 2018 provided information about HIV/STI testing, risk, and protective behaviors. Sixty percent of survey participants identified as male, 38% female, 1% transgender. Most experienced socioeconomic challenges, with 76% reporting being unhoused in past year, 49% reporting annual income < $10,000, and 56% with a high school degree or less. Almost all (97%) reported at least 1 adverse childhood event; at least half reported 6 or more ACEs – much higher rates than Oregon overall. Almost half screened positive for serious mental illness and criminal justice involvement was common (89% arrested or held ever; 50% in the past year).

Healthcare access and utilization was common: 86% were insured, 80% reported a usual source of medical care, and 80% had a past-year healthcare visit.

Seventy nine percent reported injecting more than once per day, 68% reported multiple injection partners in the past year, and 73% reported sharing needles or other equipment with others, although most who reported sharing said they did so rarely. Past-year skin and soft tissue infections were common, reported by 60%.

Almost everyone (98%) reported getting clean needles at some point in the past year, most commonly from a needle or syringe exchange, through secondary exchange (e.g., someone else got needles at a SEP), or from a pharmacy or drugstore.

Related to primary prevention, 39% said they had injected in from of a non-user, 20% had explained injecting to a non-user, and 7% had injected someone for the first time.

Overdose experiences were common, with 26% experiencing a past-year overdose and 74% witnessing one. Most (83%) said they had carried Naloxone at some point, including 59% who said they currently had Naloxone. Eighty percent obtained Naloxone through a community organization, such as Outside In.

About half (49%) of participants had received substance use treatment in the past year and another 29% wanted treatment but were unable to access it. Among heroin/opioid users, 54% had used medication assisted treatment (MAT) in the past year; 28% wanted but were unable to access MAT. Barriers to treatment included lack of space (47%), cost (30%), scheduling (20%), or "other reasons" (56%).

IDU-related stigma prevented some participants from accessing needed services, including an emergency room (29%), methadone or suboxone treatment (15%), wound clinic (13%), and HIV/STI testing (12%).

Sexual behaviors that might lead to increased risk for HIV/STI transmission included multiple sex partners (50%), condomless sex with a casual partner (37%), and transactional sex (9%). About 1 in 3 (34%) had tested for STIs in the past year and self-reported positivity was low (1%

positive for syphilis and 3% positive for GC or chlamydia). Only 15% of PWID reported awareness of PrEP and <1% reported past-year PrEP use.

Eighty five percent had ever tested for HIV and 86% for HCV. HCV prevalence was high, with 44% self-reporting HCV infection and 24% testing positive on site through the Chime In survey. HIV prevalence was low, with 2% testing HIV positive.

Low income heterosexuals: A sample of low income heterosexuals from the Portland-area people (n=421) who participated in Chime In in 2019 provided information about HIV/STI testing, risk, and protective behaviors. Participants were 18-60 years old, reported past-year sex with the opposite gender, and no past-year injection drug use. Sixty-one percent of survey participants identified as female, 82% as heterosexual or straight, 49% reported annual income of less that $12,500, and 35% experienced past-year homelessness.

Almost all participants (96%) reported at least 1 adverse childhood event; at least half reported 4 or more ACEs – much higher rates than Oregon overall. Criminal justice involvement was common (56% arrested or held ever; 23% in past year). IDU was an exclusion category but use of non-injection drugs was common (73%) and 35% reported heavy episodic drinking.

Thirty percent reported distress levels consistent with "at least one past 12-month mental disorder and serious impairment," 37% had accessed mental health services in the past year, and 23% wanted mental health services but were unable to get them; the most reported barriers were not knowing where to go (40%), cost (33%), lack of insurance (33%), and lack of transportation (33%).

Access to basic healthcare was common, with 84% insured, 86% reporting a usual source of medical care, and 85% reporting a past-year healthcare visit.

About half (52%) reported multiple sex partners, 43% reported condomless sex with a casual partner, and about 10% reported transactional sex. Seventy one percent reported ever testing for HIV, 30% were aware of PrEP, and 1% had used PrEP in the past year. About 75% were unable to correctly identify the meaning of U=U.

Most (91%) self-identified as low risk for HIV, but risk perception and behavior weren't always concurrent. Among the 357 participants who believed they were low risk, many reported past-year transmission risks, including condomless sex with a casual partner (40%), meth use (20%), and transactional sex (8%). Few of the individuals who perceived themselves to be at high risk for HIV had heard about PrEP (3 of 11, 27%).

Participants identified a higher risk for STI than HIV, with 84% saying they were low risk, 13% medium, and 3% high. However, only 44% had past-year testing for STI; 6% tested positive for chlamydia, 4% for GC, and less than 1% for syphilis. A majority reported being very or somewhat willing to use home STI testing; participants were most supportive of urine testing and least supportive of anal swabbing.

In summary, these priority populations have different prevention needs:

- PrEP awareness and use was low among PWID (15% aware, <1% use) and low income heterosexuals (30% aware, 1% use), whereas most MSM were aware (88%) and 22% reported past-year use.
- PWID and low-income heterosexuals reported high levels of trauma, criminal justice involvement, serious mental health issues, and lack of access to social determinants of health (e.g., housing, education) that may increase their risk of HIV/STI transmission.
- Among all populations, perception of HIV risk, PrEP and other HIV/STI knowledge, and PrEP and U=U awareness may be misaligned.
- As with Oregonians overall, access to basic health care and insurance is common among these populations and provides a foundation for the delivery of HIV/STI prevention and treatment services.

Priority populations

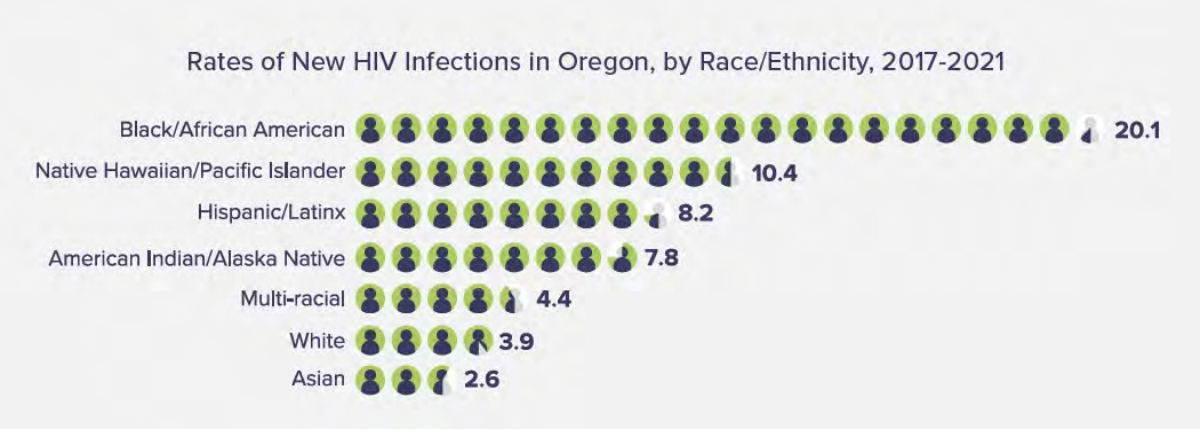
In addition to the three populations discussed above, Oregon has identified the following populations as the highest priority for prevention, testing, and referral to status-neutral services: people with sexually transmitted infections, particularly syphilis and rectal gonorrhea; Black/African American people; Latino/a/x people; people experiencing houselessness; people using methamphetamine; and transgender women. Additional populations with elevated HIV incidence, though low overall numbers, include rural people, American Indian/Alaska Natives, and Native Hawaiian/Pacific Islanders. Youth are another priority population, with low overall HIV case numbers but high rates of syphilis, gonorrhea, and chlamydia.

Through their planning processes, Part A called out three specific populations for attention within the Part A care service area that overlap with the 12 populations designated in this plan: Black/African-American PLWH, Latinx PLWH, and PLWH with IDU exposure mode. These populations were selected based on a combination of health outcomes, Portland TGA MAI eligibility, and previous Early Identification of Individuals with HIV/AIDS (EIIHA) priority populations.

Part B care service's priority populations for EIIHA are MSM, PWID, and Latinx individuals.

People in racial/ethnic groups experiencing higher rates of HIV diagnosis[5]:
It is Oregon's goal to eliminate HIV inequities, leading with race and ethnicity. Priority populations include racial and ethnic groups experiencing higher rates of new HIV diagnosis. People living in Oregon who are Black/African American, American Indian/Alaska Natives, Native Hawaiian/Pacific Islander, and Hispanic or Latino/a/x have higher than the state HIV diagnosis rate (4.7 per 100,000 Oregonians), while Oregonians who are White, Multiracial, or Asian have lower than average rates.

[5] OHA's HIV/STD/TB Section is developing a statement on the use of race and ethnicity data, which is not final at this printing. The principles guiding the use of these data include acknowledgment of the role of racism and structural oppression in creating racial and ethnic inequities and the intention to present data by race/ethnicity in a manner that considers this social and cultural context.



Black/African American people: Rates of new HIV and syphilis diagnoses are much higher than other racial and ethnic groups. People who are Black/African American also have the highest proportion of HIV testing (54.3%, 2016-2019 data). Females comprised 1 in 4 new HIV diagnoses among Black/African Americans (24%) between 2011-2020; this compares to 11% new female HIV diagnoses among white people and 8% among Hispanic/Latino/a/x people.

Latino/a/x people: People who identify as Hispanic or Latino/a/x have higher rates of HIV and syphilis. For many years, Latino/a/x people in Oregon were disproportionately likely to be diagnosed late in their HIV infection, but this inequity is no longer observed. However, only 38.5% of Hispanic/Latino/a/x people have ever been tested for HIV.

American Indian/Alaska Natives: Although overall numbers of AI/AN people diagnosed with HIV each year are low (on average, fewer than 5), rates are high. Overall, 49.3% of AI/AN people in Oregon have ever been tested for HIV.

Native Hawaiians/Pacific Islanders: Although overall numbers of NH/PI people diagnosed with HIV each year are low (on average, fewer than 5), rates are high. Overall, 40.7% of NH/PI people in Oregon have ever been tested for HIV.

People with sexually transmitted infections: Oregon is experiencing a syphilis epidemic. In 2020, there were 1,320 syphilis cases, and infections increased 60% between 2015 to 2020. Oregon was ranked 11th in the nation for congenital syphilis cases. In addition, there were 6,410 gonorrhea cases, and 15,856 chlamydia cases reported in 2020. HIV/STI co-infection is common.

Populations identified in clusters: We identified three priority clusters in 2021; key case/cluster characteristics included people experiencing houselessness, people using methamphetamine, and transgender women. There was an increase in people outside of the Portland metropolitan area who were involved in the clusters.

People who live in rural and frontier areas: People who live in rural or frontier areas of Oregon are more likely to be diagnosed late in their HIV infections. Although overall numbers remain low, HIV and STI are on the rise in rural Oregon, including in counties that have previously reported no HIV infections. Although only 15% of syphilis cases were diagnosed in rural areas, the greatest increase in syphilis diagnoses from 2019-2020 (21% increase) occurred in rural and frontier areas of Oregon.

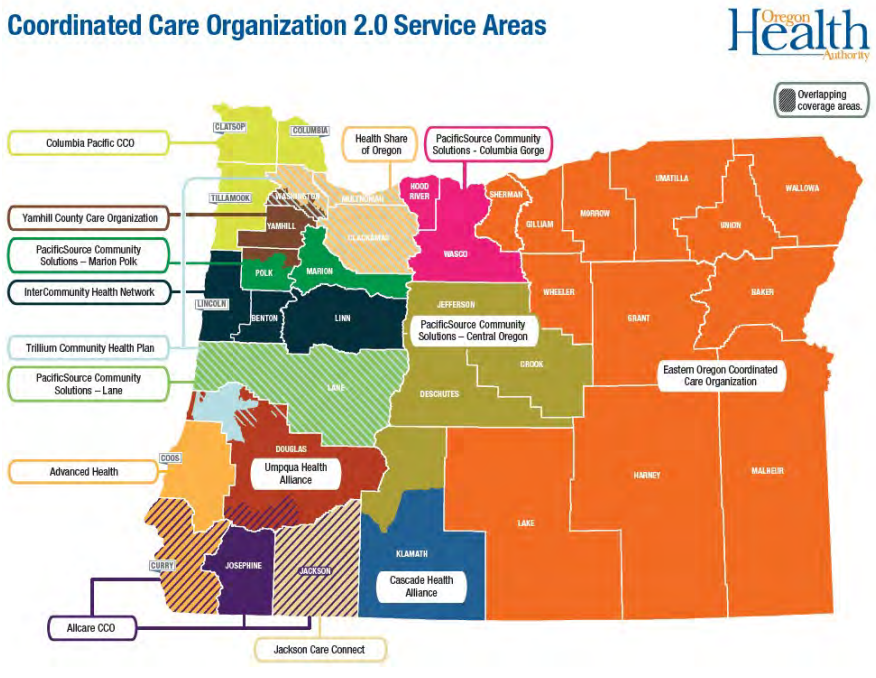
Youth:
Youth age 13-24 are designated as a priority population in the National HIV/AIDS Strategy. Because of low overall numbers, Oregon considers people age 29 and under to be youth for the purposes of HIV/STI prevention and care. From 2011-2020, people between the ages of 20-29 years have had higher incidence rates of syphilis, gonorrhea, and chlamydia than other age groups. Among Oregonians ages 18-24 years, only 32% say they've ever been tested for HIV. About 65 new HIV infections were identified in people age 29 or under in 2019 and 2020.

HIV Prevention, Care and Treatment Resource Inventory

Oregon's HIV prevention and care system includes a wide range of funded and leveraged resources and is built on a strong healthcare system, with 94% of Oregonians covered by health insurance. This proportion has increased about 10% from before Oregon's implementation of the Affordable Care Act's Medicaid expansion and is expected to increase further upon implementation of Oregon's 2022 law that increases Oregon Health Plan (Medicaid) eligibility to adults age 19-25 and 55 and older, regardless of immigration status. Many prevention services, including HIV/STI testing and PrEP, are covered by health insurance, although there is wide variation in co-pays, out-of-pocket costs, and coverage of labs and other ancillary services. HIV and STI treatment is an essential health service covered by all plans. CAREAssist provides co-pays and open-formulary pharmaceutical coverage to people living with HIV whose income is ≤550% FPL – this generous eligibility criterion ensures the broadest coverage for PLWH in Oregon and is a key to our high viral suppression rates.

About half of Oregonians are covered by private health insurance. Oregonians access HIV and STI prevention and care services at leading medical facilities, private medical practices, academic teaching hospitals, Federally Qualified Health Centers, and community clinics. Oregon's AIDS Education & Training Center, part of the Mountain West AETC, offers education and training, clinical consultation, and capacity building assistance on prevention, diagnosis, and treatment of HIV and commonly associated co-morbidities, such as viral hepatitis, STIs and substance use disorders, to health care professionals and organizations across Oregon, ensuring high-quality prevention and care services across public and private systems throughout the state.

About 25% of Oregonians are covered by the Oregon Health Plan (OHP), Oregon's Medicaid Program. Oregon Health Plan services are delivered through Coordinated Care Organizations (CCOs), which provide the same prevention and care benefits to members.



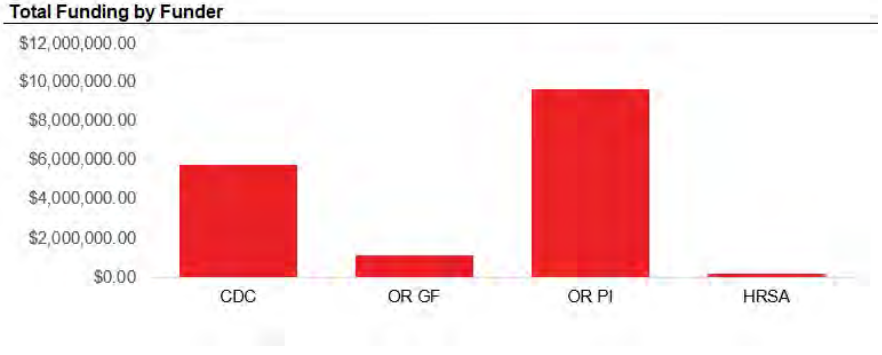
Oregon's HIV/STI care and prevention infrastructure works with and within these foundational healthcare systems. Oregon has one Part C clinic, the HIV Health Services Center, located in Portland. Local public health authorities (LPHA) provide HIV/STI care and prevention services in Oregon's 36 counties, in collaboration with a network of non-medical community-based organizations, including Cascade AIDS Project, Eastern Oregon Center for Independent Living, and HIV Alliance – Oregon's three main subrecipients. Additional community-based organization partners provide specific services, such as behavioral health (e.g., Quest Center for Integrative Health) or food & nutritional services (e.g., Ecumenical Ministries of Oregon), and/or services to specific communities (e.g., Familias en Acción, Outside In).

Oregon does not receive Ending the HIV Epidemic (EHE) funding. Our HIV care and prevention system is funded through a network of federal and local grants, state general fund, program income, and 340B rebate dollars. Leveraged resources include services funded through Oregon's Public Health Modernization Program, a $30 million state investment designed to build public health capacity, resilience, response, and recovery. Public health modernization dollars support the public health workforce, communications systems, and communicable disease response, among other foundational capacities.

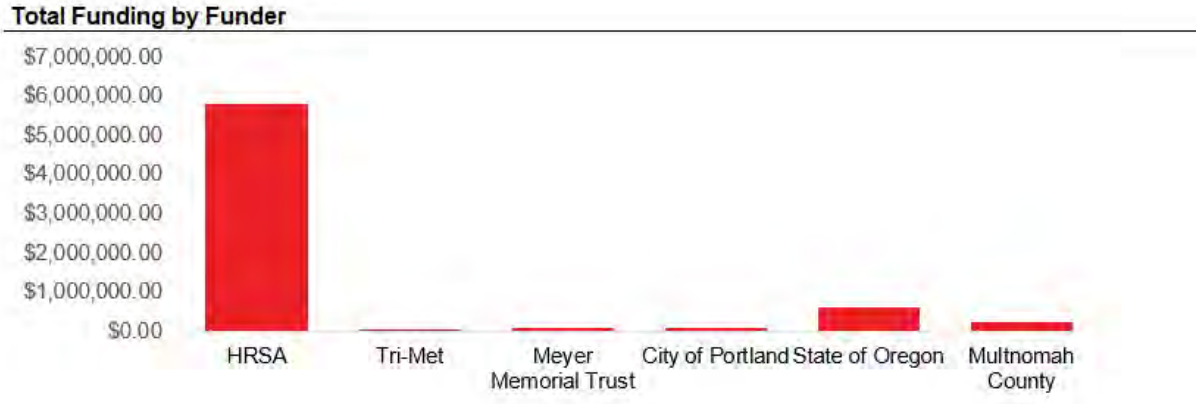
Oregon also ensures coordination of HIV prevention, care and treatment resources and substance abuse prevention and treatment resources, including opioid settlement funds, State Opioid Response grants, Measure 110 funds (also known as the Drug Addiction Treatment & Recovery Act), and other sources. Leveraging and coordination is a key strategy for enhancing outcomes in a small state. Concrete examples of coordinated services are included throughout this plan. One example is Oregon's PRIME Plus program (Peer Recovery Initiated in Medical Establishments + Infectious Disease Testing and Linkage to Care), which is a harm reduction-based peer recovery support program funded through State Opioid Response grant funding. PRIME+ peers work with people who are using substances and people who are at risk of overdose and health issues related to substance use, including HIV, viral hepatitis, and sexually transmitted infections. Many are out of medical and behavioral care and treatment. Currently, 26 PRIME+ peer teams (58 peers) provide peer support in 24 Oregon counties, including urban, rural, and frontier settings. PRIME+ has served nearly 3,000 clients.

A complete resource inventory is available in Appendix 4. At-a-glance funding by funder is provided below for statewide HIV prevention, Part A care services, and Part B care services. The major funders of Oregon's HIV care continuum services are HRSA, Program Income (listed below as OR PI), NASTAD, and CDC.

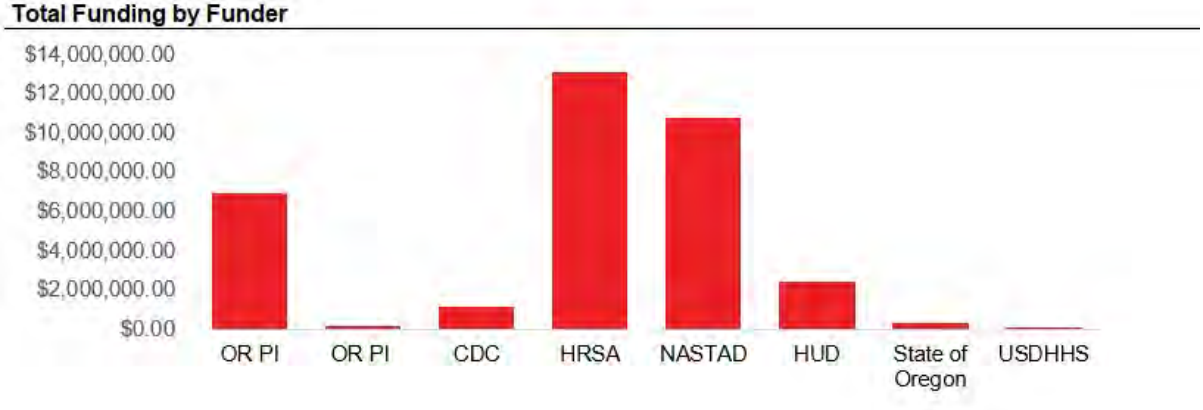
Oregon HIV Prevention, 2022



Oregon HIV Care & Treatment Services (Part A), 2022



Oregon HIV Care & Treatment Services (Part B), 2022



Strengths and gaps

The following section describes the strengths, gaps, and challenges in Oregon's HIV/STI prevention, care, and treatment resources, organized by key strategies of the four pillars of diagnose, prevent, treat, and respond.

DIAGNOSE

HIV Awareness

Strengths:

- End HIV Oregon brand recognition – Oregon branded its 2017-2021 Integrated Plan as End HIV Oregon, and has broad community support for its vision, mission, and strategies. A website launched in December 2016 (www.endhivoregon.org) and annual progress reports shared with the community on World AIDS Day have helped maintain visibility. More than 45 community partners have signed on to End HIV Oregon; these partners have access to Ambassador Kits that contain awareness resources and receive monthly social media posts and content to support their awareness activities. A July 2022 community listening session provided guidance on revamping End HIV Oregon materials to be more responsive to community needs.
- Strong regional CBO partners – Oregon has three key subrecipient agencies that serve the entire state with status-neutral services (Cascade AIDS Project, Eastern Oregon Center for Independent Living, and HIV Alliance), as well as many other CBO partners that promote HIV awareness in specific communities. Activities include an annual AIDS Walk sponsored by Cascade AIDS Project and World AIDS Day, various Awareness Days, and PRIDE activities sponsored by agencies and communities across the state throughout the year.
- Community-led education and outreach: OHA and local public health authorities (LPHAs) across Oregon are developing more formal partnerships with community-based organizations. Funded organizations include CBOs serving priority populations, including Black/African Americans, Latino/a/x, people who use drugs, people experiencing houselessness, people engaged in transactional sex work, transgender and nonbinary people, and youth.

Gaps/Challenges:

- Community-led education and outreach: This is both a strength and a gap. Although Oregon has increased the number and type of partners funded to conduct HIV/STI education and outreach, we need to do better. Inequities persist along the status neutral continuum. This work is most effectively developed and implemented by community, for community.
- Community partnerships that support a syndemic focus: While Oregon does have some partnerships with agencies serving people experiencing housing instability, behavioral health issues, intimate partner violence, and other structural issues, these need to be expanded and deepened to increase understanding and identify additional opportunities for partnership.
- Barriers to optimizing use of digital tools: Policies at some local public health authorities prevent the use of social media and other digital tools for HIV/STI awareness and outreach, as well as core public health functions like partner services.

HIV Testing

Strengths

- Free, confidential HIV testing available statewide: Publicly-funded HIV testing is offered in a variety of settings statewide, including LPHAs, community-based organizations, and in community settings like syringe exchange programs, prisons and jails, alcohol and drug treatment centers, in mobile health units, and at community events often co-hosted by partner CBOs. Oregonians can find testing in their community on the End HIV Oregon website, which links to the CDC's testing page.
- Home-based HIV self-testing options available: At the beginning of the COVID-19 pandemic, Oregon fast-tracked its mail-order home testing program, Take Me Home. Take Me Home, a partnership between OHA and Building Healthy Online Communities, offers a free mailed, rapid HIV self-test kit to any Oregonian who has not received one in the past 12 months. Options for mailed HIV/STI self-collection kits are also available on a more limited basis. Positivity rates for home testing have consistently been higher than OHA-funded clinic-based and outreach testing every year since 2020.
- Integrated HIV/STI testing: Oregon's HIV Early Intervention Services & Outreach (EISO) Program emphasizes integrated HIV/STI testing for all clients with an HIV or STI diagnosis and their contacts. EISO programs support outreach services in 12 higher-prevalence Oregon counties and in the tribal lands of the Confederated Tribes of Siletz Indians to encourage people who may have undiagnosed HIV infection to get tested
- Easy access to HIV testing data: Oregon provides user-friendly data dashboards on clinic-based and at-home self-testing.

Gaps/Challenges:

- Lack of testing during COVID-19: Public and private testing decreased during the two years of the COVID-19 pandemic and are still not at pre-pandemic rates as of this writing. Lack of access to testing may have created a "backlog" of people needing tested, some of whom may be HIV-infected, unaware of their status, and transmitting HIV.
- Missed opportunities for routine testing in medical settings: A population-based cross-sectional study of administrative claims data in Oregon found that approximately 5% of insured Oregonians had HIV testing in the past year (2016), but only 2% had integrated HIV/STI testing.
- Limited HIV/STI testing at emergency departments: Oregon has seen an increase in new diagnoses identified in emergency departments and during inpatient hospitalizations. Routine testing in these settings, particularly EDs, could identify cases earlier among people who may not perceive themselves at risk and may not be testing elsewhere. OHSU has a grant from Gilead to provide HIV testing in their emergency room; results from this pilot project may inform efforts in other agencies and jurisdictions.
- Limited HIV/STI testing in carceral settings: HIV/STI testing is limited in Oregon's complex carceral setting, particularly in jails. Relationships and systems are being developed to provide a foundation for HIV/STI testing and other services in more carceral settings across the state.

HIV/STI Partner Services

Strengths:

- Increased resources for partner services statewide: HIV/STI partner services are available in all 36 counties of Oregon, delivered through local public health authorities (LPHAs) or subcontractors. Jurisdictions with EISO funds (12 counties, 1 tribal nation) have additional resources for partner services and ancillary services. New CDC funds in 2022 will double the number of disease intervention specialists and DIS supervisors at the local level from 32 to 65.
- Tribal partnerships: Oregon has been in discussions with the Northwest Portland Area Indian Health Board (NPAIHB) and Tribal Epi Center to move forward with supporting partner services in Indian country, including support of the DIS workforce. In 2021, NPAIHB conducted a needs assessment with tribes to determine their needs and gaps. OHA and NPAIHB also conducted a tribal registry data match of HIV/STI diagnoses for quality improvement.
- Revamped DIS training: Oregon is launching a new training curriculum for DIS, in partnership with the National Coalition of STD Directors (NCSD), including a tribal-specific training and workforce training needs assessment.
- Integrated case surveillance database: Unlike many other states where disease surveillance databases are more siloed, Oregon uses a homegrown case surveillance database, Orpheus, which is inclusive of both HIV and STIs. This allows for more effective monitoring of co-morbidities. For example, DIS interviewing new STD cases in people with a previous HIV infection can engage in conversations around linkage to HIV care and viral suppression, and provide needed referrals.
- Partner services billing supports sustainability: OHA, LPHAs, and CBO partners have been working with consultant, Health Management Associates, to implement billing for HIV/STI partner services and other clinical services. A thorough assessment revealed opportunities to bill Oregon Medicaid and other insurance carriers for certain partner services activities when these services are performed by DIS who are certified community health workers. OHA continues to work with HMA to provide capacity-building support to LPHA and CBO partners interested in generating more sustainable sources of revenue for HIV and STI prevention.

Gaps/Challenges:

- Low contact indices: The number of contacts named for HIV and early syphilis has declined. Among EISO counties, the contact index for HIV was .72 in 2019, but decreased to .48 in 2021. Similarly, the contact index for EISO counties for early syphilis was .58 in 2019 but decreased to .35 in 2021. Declines are likely due to a combination of individual-level and systems-level factors, including the unwillingness of cases to engage in interviews or to name partners, distrust of the public health system, the impact of COVID-19, and the low number of health departments that allow for field work or interviews outside of a clinic setting.
- Staff shortages due to COVID-19: Partner services can be resource intensive. As seen across the nation, much of the HIV/STI partner services network was redeployed into COVID-19 contact tracing during the pandemic. Agency shut-downs and curtailed field operations created additional challenges. Meanwhile, syphilis is at epidemic levels in Oregon. HIV/STI coinfection is common, and many people newly diagnosed with HIV and STI face structural barriers and lack access to social determinants of health, making them complex, time-intensive cases to work.
- Partner services in the digital era: Digital partner services (DPS) are an essential tool in the modern disease investigation toolbox (including and most importantly the use of

texting). Some LPHAs have restrictions on the use of DPS tools. OHA is working with EISO grantees to ensure some level of DPS policies and procedures are in place. In cases where that is not possible, OHA encourages subcontracting with a community-based organization who can conduct DPS. Orpheus access for subcontractors is an ongoing challenge being addressed through a pilot project to test the feasibility of expanding access beyond LPHAs.

- Coordination across systems: Many new HIV and STI cases are diagnosed outside of public sector programs, which requires coordination across multiple systems and individuals. Missed opportunities and delays can occur.

Linkage to Care

Strengths:

- EISO programs continue to improve health outcomes: Since 2018, OHA allocated $29 million to provide early intervention services and quick linkage to HIV medical care in 12 Oregon counties and 1 tribal nation. In 2023, EISO funds are being allocated for a second 4.5 year period to jurisdictions with highest prevalence. Additional jurisdictions in Eastern Oregon are being supported with EIS capacity building funds. Linkage to care within 30 days or fewer has improved since EISO launched.
- Community partnerships identify new cases, increase trust: New partnerships with community agencies can improve linkage to care. For example, Washington County LPHA subcontracts with a federally qualified health centers (FQHC), Neighborhood Health Center, that serves many Latina/o/x and monolingual Spanish-speaking individuals, to support EISO services. Other jurisdictions are partnering with CBOs to provide outreach and education, testing, and patient navigation services.

Gaps/Challenges:

- More cases in more diverse populations: Preliminary data for 2022 indicate that new HIV diagnoses have increased from 2020-2021, are being diagnosed in more areas of the state, and among a broader variety of populations. Some jurisdictions without EISO programs have been experiencing increases in new diagnoses; for example, rural Eastern Oregon reported 6 new HIV diagnoses in 2021 and 6 in the first 6 months of 2022, as compared to 3 annual cases in prior years.
- Inequities in linkage to care, even within EISO: Among people newly diagnosed in an EISO jurisdiction, people living outside of the Portland metropolitan area and people experiencing unstable housing were significantly less likely to be linked to care within 30 days.
- System coordination is challenging: A higher proportion of new HIV diagnoses are being identified in emergency departments, through inpatient hospitalizations, and in other non-public venues. This requires a high level of coordination between a variety of systems, programs, and individuals, which can result in delays in care and missed opportunities when not well-executed.

PREVENT

PrEP

Strengths:

- Policy changes increase access: On July 19, 2021, the federal government announced that almost all health insurers must cover PrEP. This new guidance clarifies that the package of services necessary to start and stay on PrEP, including doctor's visits, labs, and prescription drug costs, should be covered entirely without a co-pay or other cost-sharing to patients.
- Pharmacist-delivered PrEP: A new Oregon law (Oregon House Bill 2958) expanded access to PrEP through pharmacies. This policy change allows pharmacists to prescribe a 30-day supply of PrEP based solely on a negative HIV test result and reimburses them for their services. Having more options to get PrEP through pharmacies may make it easier for groups who have not yet been accessing it, including women, men of color, and rural Oregonians, to get a PrEP prescription. Additionally, HB 2958 mandates that insurers cover PEP and at least one form of PrEP without prior authorization, regardless of whether the prescribing pharmacist is in-network, which will prevent delays in getting needed care.
- PrEP coverage through Medicaid, including for some adults without documentation: The Oregon Health Plan already covered PrEP for members. Another new Oregon law in 2021**,** Cover All People (HB 3352), will now cover preventive health services, including PrEP, among adults without documentation who are age 19-25 and 55 and older through a program called Healthier Oregon.
- PrEP navigation: PrEP navigation services are available in all 36 Oregon counties. PrEP navigators meet with individuals who have questions about PrEP, provide education and adherence support, and help them determine the best health insurance and payment options for accessing PrEP. In October 2022, Eastern Oregon Center for Independent Living began providing PrEP navigation services to people in rural Eastern Oregon. Having local experts delivering PrEP navigation may help increase uptake in this area where it is underutilized.
- PrEP providers available statewide: There are now more than 350 medical providers listed in the Oregon AIDS Education & Training Center's PrEP Provider List.

Gaps/Challenges:

- Need for more supports to maintain PrEP use: Oregon has seen a tenfold increase in people newly diagnosed with HIV who report ever using PrEP since we began collecting those data in June 2016. While it is good news that more people are aware of and accessing PrEP, it is discouraging to see people who self-identified as potential beneficiaries of PrEP, and who even obtained PrEP at one time, seroconverting. This indicates a potential need for more adherence or other support to help people remain on PrEP and prevent infection.
- Pharmacist burnout: Pharmacists, like many other medical providers, were stretched thin during the COVID-19 pandemic. Many are still experiencing stress and burnout and some have left the field altogether. Overall, the removal of barriers to PrEP access through pharmacies is positive, but it may take some time to fully implement, given the ongoing demands on pharmacies and pharmacists. Some Oregon pharmacists have expressed concern that it may be "too soon" (at this writing in mid-2022) to begin full-service PrEP services at community pharmacies.
- Difficulty accessing PEP: Many pharmacies do not stock PEP, which can make accessing it in a timely manner difficult for individuals who need it. Awareness of PEP is lacking among providers in some parts of Oregon, as well.

Syringe Exchange, Harm Reduction, and Safer Sex Supplies

Strengths:

- Condoms & safer sex supplies widely available: LPHAs and CBO partners receive condoms and safer sex supplies like personal lubricant via OHA through CDC prevention funding. In addition, the One at Home Program provides Oregon residents with a free envelope of sexual wellness supplies delivered discreetly to their door, up to twice per 30 days. One at Home, Oregon's condom home-delivery service, has delivered more than 135,000 condoms to people in 35 of 36 Oregon counties. Half of all orders are among people under age 30. Nearly half (48%) of orders were from females, 33% from males, and 11% from nonbinary or transgender people. The race and ethnicity of program participants reflects the population of Oregon overall.
- Determination of Need granted: In 2017, CDC approved Oregon's Determination of Need application, based on our increased risk for viral hepatitis and HIV related to injection drug use. This allows public health programs to direct certain, eligible funds to intensify HIV prevention among communities at risk, expand syringe service access and disposal, and focus on HIV testing and linkage to care.
- Save Lives Oregon Clearinghouse supports syringe exchange: Save Lives Oregon is a collaborative of organizations working across Oregon and in tribal communities to reduce drug-related harm, support the agency of people who use drugs, and end the stigma associated with drug use by providing supplies, training, and resources. Many organizations providing services along the HIV status-neutral continuum access supplies and services through Save Lives Oregon.
- Leveraging of opioid response funding: The PRIME+ Program (Peer Recovery Initiated in Medical Establishments + Infectious Disease Testing and Linkage to Care) is a harm reduction-based peer recovery support program funded through State Opioid Response grant funding. PRIME+ peers work with people who are using substances and people who are at risk of overdose and health issues related to substance use, including HIV, viral hepatitis, and sexually transmitted infections. Many are out of medical and behavioral care and treatment. Currently, 26 PRIME+ peer teams (58 peers) provide peer support in 24 Oregon counties, including urban, rural, and frontier settings. PRIME+ has served nearly 3,000 clients.

Gaps/Challenges:

- Syringe exchange unavailable in some parts of Oregon: 15 Oregon counties (42%) do not have syringe exchange programs; many of these counties are contiguous, leaving parts of the population with no access.
- Federal ban on syringe purchases: Organizations are creative in funding syringe exchange and harm reduction. However, the inability to fund syringes through federal grants creates barriers.
- Definition of paraphernalia: Defining certain items used in harm reduction, such as sterile water, fentanyl test strips, and cottons, creates access barriers.

Treat

Access to Medical Care

Strengths:

- Nearly all PLWH in Oregon have access to insurance and ARTs: Between the Oregon Health Plan, Healthier Oregon, and CAREAssist, which covers insurance co-pays for income-eligible PLWH, nearly all PLWH are insured. In 2021, the CAREAssist Program increased income eligibility to 550% of the federal poverty level; this means individuals with incomes of up to about $70,000/year qualify for services. Individuals who are uninsured and need urgent coverage for prescription medications related to their HIV care may be eligible for up to a 30-day supply through the CAREAssist Bridge Program. For persons who are unable to secure health insurance outside of an open enrollment period or a special enrollment period, CAREAssist can assist with payments for a limited number of medical services and medications necessary for HIV treatment, through the Uninsured Persons Program (UPP). When surveyed, CAREAssist clients overwhelmingly laud the program for its lifesaving services.
- CAREAssist Pharmacy Network: CAREAssist clients can access drugs via a statewide network of 36 brick and mortar pharmacies and/or through two mail-order retail services, which deliver within 24-48 hours through courier or overnight mail.
- Strong provider network: Oregon has one Part C clinic that provides comprehensive care to patients in medical teams that include a provider, nurse, medical assistant, and medical case manager. In conjunction with the AETC, providers from the Part C clinic offer preceptorships to providers across Oregon. The Oregon AIDS Education & Training Center's HIV Provider Directory lists HIV medical providers across the state.
- Rapid ART Starts: The HIV Health Services Center at Multnomah County Health Department (the Part C clinic) provides a rapid ART start program (e.g., within 7 days of diagnosis) for patients in the Portland metropolitan area In 2020, HSC was awarded a three-year HRSA Special Projects of National Significance grant to expand Rapid Start which is now offered to people who are newly diagnosed, new to care, and out of care. Clinic staff currently facilitate 6-8 rapid starts per month with new clients and the program has shown excellent results, with 79% of newly diagnosed clients being virally suppressed within 60 days. CAREAssist supports partners and clients with same day / next day Bridge approval that allows clients, in most cases, to have ARV's in their hands the same day they are seen by a medical provider.
- Statewide training and other provider support available: The Oregon AETC services include didactic in-person and online trainings, provider detailing related to many topics including routine HIV/STI screening and prenatal screening for HIV and syphilis, and several communities of practice for the HIV/STI workforce including a nursing community of practice and a PrEP Navigator community of practice. A new Practice Transformation Lead guides organizations through a change process in primary care delivery to advance quality improvement, patient-centered care, and characteristics of high performing primary care, with the goal of specifically improving outcomes for Black, Indigenous, and Latinx patients.

Gaps/Challenges:

- Access barriers in rural Oregon: Oregon is a largely rural state. For example, the median travel time to HIV care for Medical Monitoring Program participants living in rural ZIP codes was 54 minutes. Three month wait times to see HIV specialists and mental health

providers in Eastern Oregon have been reported, as have two-month delays for mental health medicine refills.

- Dental care available, but underutilized: Although CAREAssist provides coverage for dental care, it is perennially underutilized. CAREAssist has increased dental coverage by initiating a yearly dental drive.
- Rapid ART start programs unavailable to most PLWH: Although the HHSC program has reported excellent outcomes, and CAREAssist Bridge can facilitate implementation of Rapid ART by partners throughout the state, rapid start is mostly unavailable elsewhere. There are challenges replicating it in private health systems, particularly outside of the Portland metropolitan area. Having more Rapid Start Programs across the state would reduce the burden on HHSC and provide more choice for clients.
- Coordination with providers outside the Ryan White system: Medical providers not affiliated with the Ryan White system are less connected with available resources, which can result in delays or gaps in care.

Case Management

Strengths:

- HIV case management available statewide: HIV case management is available throughout the state. Only 4% of Oregon MMP clients surveyed from 2015-2020 reported an unmet need for case management in the preceding 12 months. Case management appeared to remain accessible even during the COVID-19 pandemic: only 4% of Ryan White TGA clients surveyed in 2021 indicated a gap in HIV medical case management services during the pandemic.
- Client satisfaction: Though overarching satisfaction with TGA RW services decreased during the pandemic, client satisfaction increased for several different aspects of case management services, including assistance staying on HIV medications, applying for dental insurance and help understanding HIV labs. Part B will be conducting its client satisfaction/QI survey in 2022; past surveys (pre-pandemic) indicated high levels of client satisfaction.
- Adoption of telehealth/tele-visits: Greater adoption and acceptance of virtual visits makes case management services more available to clients with transportation difficulties or other barriers.

Gaps/Challenges:

- Staff turnover: Ongoing staff turnover at several of the key case management provider agencies can be practically and emotionally difficult for clients. Low wages and high caseloads are contributing factors.
- Telehealth not fully accessed by all: Access to devices and knowledge of how to use tele-health continue to be a barrier for some clients.

Housing:

Strengths:

- Range of housing programs available: Oregon Parts A and B provide a range of housing programs to serve clients with different needs. These include motel/hotel vouchers, short-term housing, long-term housing through HOPWA-funded programs, and new supportive housing for people with behavioral health needs in the Portland area, the Willamette Valley and Southern Oregon, and in Eastern Oregon.
- Transformative benefits reported: Respondents in Part A and Part B supportive housing programs described transformative benefits of achieving stable housing, including tangible successes like completing alcohol and drug treatment, securing employment, or achieving a stable income by applying for benefits.
- More people being housed: From 2020 to 2021, the percentage of Portland TGA RW clients in stable/permanent housing increased from 86% to 91%, the highest level in the past 5 years, despite the percentage of clients with no income also increasing during this period.

Gaps/Challenges:

- High rates of unhoused and housing instability: All parts of Oregon are facing a housing crisis. High rents, low vacancy rates, and loss of affordable housing to gentrification and wildfires has created high rates of unstable housing and houselessness. Clients who experience houselessness experience trauma and require more support to secure and retain housing afterwards.
- Lack of affordable housing: Housing coordinators often struggle to find available units in which to place eligible clients. Affordable housing stock has declined due to high rents, gentrification, low overall vacancy rates, and the destruction of housing units by Oregon wildfires.

Food & Nutrition:

Strengths:

- Oregon's regional food network improves food security: Oregonians can access free food at 1,400 sites and 21 regional food banks across Oregon and SW Washington. The online Food Finder tool provides up-to-date information on communities across the state.
- Identifying food insecurity and linking to resources: Oregon's HIV case managers have been working to strengthen relationships with regional food banks and to better identify PLWH experiencing food security through adoption of the Hunger Vital Sign, as part of the intake process in Part B, and on client surveys in Part A. Four trainings on food security for HIV case managers and other care continuum providers took place in 2022.
- HIV-specific food resources available: In the Portland area, specific food bank and meal delivery resources serving PLWH are available through Ecumenical Ministries of Oregon's HIV Day Center and Daily Bread Express and Our House's Esther's Pantry.

Gaps/Challenges:

- COVID-19 strained system: According to the Oregon Food Bank, rates of food insecurity and hunger in Oregon in 2020 were comparable to those of the 1930s during the Great Depression.

- Barriers to accessing food in rural Oregon: Rural Oregon counties have fewer food pantries and meal sites than urban counties that border the I-5 corridor. Service providers in rural Oregon report that clients experience access problems due to lack of transportation inappropriate food choices, limited hours of operation, income restrictions, citizenship declaration questions, and the number of times individuals can access pantries in a month.
- Inequities/Food justice issues: The Oregon Hunger Task Force reported in 2021 that hunger and food insecurity affect some groups in the state of Oregon disproportionately, including but not limited to families, the elderly, people with disabilities, veterans, and people of color, particularly Black, Latinx, and American Indians.

Behavioral Health Resources

Strengths:

- New funding available: A report from the Oregon Legislature showed that in the 2017-19 biennium, Oregon spent an estimated $470M ($235M/year) on substance abuse prevention and treatment-related services, including prevention, screening and assessment, brief interventions, detoxification, residential, intensive outpatient, outpatient, medication-assisted treatment, primary care/hospital-based interventions, gambling treatment, and recovery and peer-delivered services. The report called for better data collection, collaboration with private and public insurers, and more prevention funding. Additional funds from Measure 110 and opioid settlement funds are now available and will hopefully fill gaps in the current system.
- Robust set of overdose-related services and programs: Services and programs ranging from public awareness campaigns to the Rural Communities Opioid Response Program to X-waivered buprenorphine practitioners are available across Oregon.

Gaps/Challenges:

- High need + access barriers: Oregon ranks among the most challenged states in the nation for substance abuse and mental health conditions, while at the same time ranking among the worst states for access and engagement with care (see Situational Analysis for more detail).
- Low wages, workforce training needs: A 2018 wage analysis of Qualified Mental Health Providers in Oregon found that overall, QMH wages have "significantly failed to keep pace with inflation." The leading reasons respondents gave in this pre-pandemic report for leaving the behavioral health field included poor compensation, lack of organizational support, and burnout. Another 2018 report identified gaps in the Oregon behavioral health workforce's understanding of best practices for the treatment of opioid use disorder with medication-assisted treatment (MAT). The overall highest priority training needs for Oregon's behavioral health workforce identified by supervisors and workers were trauma-informed care, motivational interviewing, co-occurring mental health/substance use disorders, MAT, and DSM-V/ASAM.

RESPOND

Strengths:

- Successful public health response to time-space cluster: A time–space cluster of new HIV infections in the Portland metropolitan area among people who inject drugs (PWID)

and/or people who use any form of methamphetamine included new HIV diagnoses in 2018, 2019, and 2020 in Clackamas, Multnomah, and Washington Counties. Public health response included activating incident command, development and implementation of an enhanced interview tool, outreach testing using dried blood spot kits, and partner engagement – strategies that can be replicated for future investigations.

- Community partnerships: Services designed by and for the community can support prevention, treatment, and outbreak response. People experiencing houselessness and transgender women were among the populations identified in recent HIV case/clusters. New formal, funded partnerships with CBOs serving these populations began in 2022.
- Anti-racism and trauma-informed care training: Providers serving at all points of the HIV care continuum are engaging in anti-racism and trauma-informed care training to ensure high quality services that do no harm to individuals and work to eliminate inequities across populations.
- Telehealth expansion: A Telehealth Readiness Survey sent to HIV/STI partners early in the pandemic (May 2020) indicated high interest in adopting telehealth for HIV/STI prevention, treatment, and outreach, but challenges in implementation. Special needs funding to support capacity-building, along with experience gained through more than two years of COVID-19, has resulted in greater capacity across the state to provide telehealth services. The Rural Broadband Capacity Program, launched with 2020 CARES Act funds, supports infrastructure construction to provide increased broadband capacity internet access for unserved and underserved areas of the state. These advances particularly support services for rural Oregonians and others with transportation or other access challenges.

Gaps/Challenges:

- Public health infrastructure overtaxed during COVID-19: Deployments, increased hours and responsibilities, and staff turnover have left many public health workers burned out and the system overtaxed.
- Public hostility towards government: Negative attitudes towards government make it difficult to accomplish our goals and can be demoralizing to staff. Public mistrust can also lead individuals to be uncooperative with disease investigation and outbreak response.
- Racism persists: Although staff work individually and collectively to create anti-racist services, structural and interpersonal barriers remain, reinforcing the inequities we seek to eliminate.

Approaches and partnerships

Needs Assessment

Needs assessment is ongoing in Oregon. Oregon participates in two special surveillance studies, the Medical Monitoring Project (MMP) and the National HIV Behavioral Surveillance survey (NHBS), which provide annual data related to prevention and care services. In addition, we conduct special studies on an ad hoc basis, including client and community surveys and focus groups. Finally, we augmented these data with individual interviews with PLWH, surveys of community partners, community listening sessions, and solicitation of public comment to ensure that we had broad community input to inform the goals and objectives in this submission. A list of key needs assessment data sources is available in Appendix 1.

Below is a summary of needs assessment data, organized by the four pillars: Diagnose, Prevent, Treat, and Respond to End Inequities.

DIAGNOSE

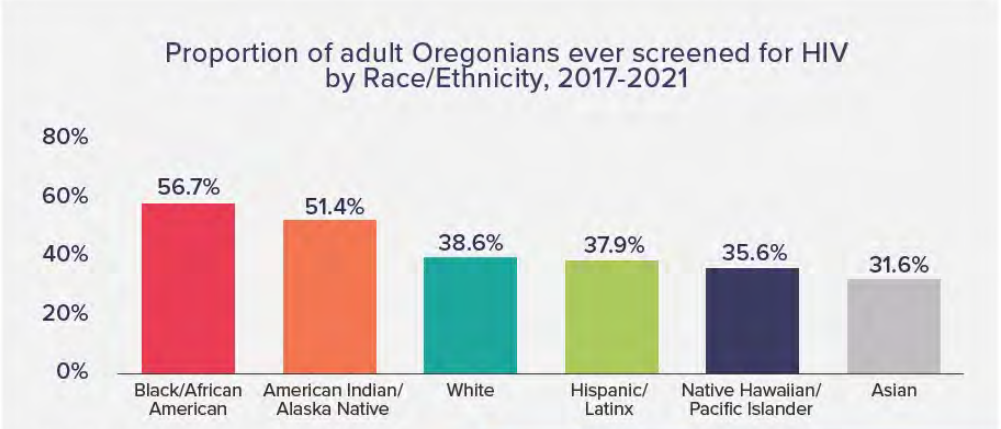
HIV Awareness:

As promoted on www.endhivoregon.org: *everyone has an HIV status, and all Oregonians need to know theirs.* People living with HIV who are aware of their status can take advantage of life-extending medications, live longer, healthier lives, and prevent transmission to sex partners. **We estimate that 1,296 Oregonians living with HIV are unaware of their status**. Community input and needs assessment indicate that HIV awareness is often low in communities facing the greatest inequities. For example, formative research used to develop a media campaign in rural Oregon identified basic HIV information and awareness as a need in rural Oregon. Feedback from community partners serving other priority populations, such as communities of color, also indicate a need for increased awareness of HIV and STI. Raising awareness of HIV through community outreach and education, social media, and other awareness efforts can increase testing and linkage to care for people living with HIV and connect people who are not infected to needed prevention resources.

HIV Testing:

Testing is easy, but too few Oregonians know their HIV status. Only **37.4%** of all adult Oregonians report ever being screened for HIV – far below our goal of **70%.** No racial/ethnic group is close to achieving the goal. Black/African American Oregonians are the most likely to have been tested for HIV, while Asians are least likely. Data by age reveal an additional area of concern: among Oregonians ages 18-24 years, only 32% say they've ever been tested.

Proportion of adult Oregonians ever screened for HIV by race/ethnicity, 2017-2021



No racial/ethnic group is close to achieving the goal. Black/African American people living in Oregon are the most likely to have been tested for HIV, while Asians are least likely. Data by age reveal an additional area of concern: among Oregonians ages 18-24 years, only 28% say they've ever been tested.

Source: BRFSS: 2017-2021

Free, confidential HIV testing is widely available throughout Oregon, at public test sites and through the mail-order, self-testing program, Take Me Home. Oregonians can find testing in their community on the End HIV Oregon website, which links to the CDC's testing page.

In 2021, 6,096 Oregonians received HIV testing through a public test site in Oregon and 31 tested positive (0.5% positivity rate).

More than 1,900 early syphilis and rectal GC infections were diagnosed and treated in jurisdictions with an HIV Early Intervention & Outreach Services (EISO) Program during 2021. A key focus of EISO is to provide integrated HIV/STI testing. Nearly half of people with syphilis and not known to be HIV infected (48%, n=519) were tested for HIV and 12 (2.3%) were newly diagnosed with HIV; 58% of clients with rectal GC and not known to be HIV infected (n=280) were tested for HIV and 10 (3.6%) were newly diagnosed with HIV. These positivity rates are higher than found in other testing venues, making people newly diagnosed with STI a high priority for HIV testing and status neutral follow-up services (linkage to care and treatment, if positive; referral to PrEP and prevention services, if negative).

Partner services is clearly a high-yield strategy for diagnosing new HIV and STI infections, but the public health system may need to rebrand partner services, so they are more understandable and palatable to the public. A recent assessment found that many people recently diagnosed with an STI in Oregon were confused about every aspect of partner services. It is also unclear what effect increased public awareness of public health methods such as contact tracing may have had on partner services in 2020 and throughout 2021. Some members of the public may be more receptive, while others may be more suspicious and concerned about government intrusion.

In 2021, 911 people in 31 of 36 Oregon counties ordered a test from Take Me Home; 25% were first-time testers and .09% tested HIV positive. As reported in the journal AIDS and Behavior, the service appears to increase access for people who may not seek services in clinics, including first-time testers and people in rural areas.

A June 2022 listening session on home testing and home-based HIV/STI self-collection attended by 49 state, local, tribal, and CBO partners identified interest in obtaining HIV rapid home test kits and home-based HIV/STI self-collection kits for distribution at outreach events and through mobile clinics. Participants said home tests and self-collection kits would address equity issues for populations with access issues, like youth and people experiencing houselessness, and could also be a helpful adjunct to patients receiving services via telehealth.

Routine testing in medical settings is needed to identify people who are unaware of their status, particularly since 10% of males and 28.4% of females newly diagnosed with HIV in Oregon between 2011-202 reported no identifiable risk factors – and, not surprisingly, these individuals were more likely to present with delayed diagnosis (e.g., AIDS diagnosis within 12 months or concurrent with initial HIV diagnosis). However, according to the Oregon Behavioral Risk Factor Surveillance System, only 41.5% of Oregonians have ever been tested for HIV. A population-based cross-sectional study of administrative claims data in Oregon found that approximately 5% of insured Oregonians had past-year HIV testing (2016) in a medical setting, and only 2% had integrated HIV/STI testing.

Testing, diagnosis, and treatment were all affected by the COVID-19 pandemic. New HIV diagnoses appeared to be declining prior to 2020 and fewer new diagnoses were reported in 2020-2021 than expected, likely due to a statewide decrease in testing. As of 2022, HIV testing has still not been restored to pre-pandemic levels, yet preliminary case data for 2022 indicates an increase in new HIV and syphilis diagnoses. It is unclear whether Oregon is seeing a true increase in infections, is playing "catch up" from delayed testing, or both.

Linkage to Care

Between 2016-2020, 72% (747/1,043) of people newly diagnosed with HIV in Oregon were linked to care within 30 days. Overall, linkage to care did not differ by sex at birth, race/ethnicity, or transmission category. People 60 years and older were more likely to be linked to care within 30 days compared to the reference group of people aged 30-39. People living in the tri-county Portland metropolitan area were also more likely to be linked to care within 30 days.

Since launching in 2018, EISO has increased the proportion of newly diagnosed people linked to care in 30 days or less and shortened the time between diagnosis and viral suppression. In 2021, 174 people were newly diagnosed with HIV in Oregon EISO jurisdictions (87% of 201 cases statewide). All were enrolled in EISO; 76% were linked to HIV medical care in 30 days or less compared to 66% from 2013-2017, 79% in 2019, and 86% in 2020. But even within EISO, inequities occur. As mentioned previously, people living outside the tri-county Portland metropolitan area (64% vs 82% tri-county area) were less likely to be linked to care within 30 days, as were clients who were unstably housed (55% vs 83% housed). However, Black/African American clients were more likely to be linked to care within 30 days (92%).

Portland TGA RW Client Experience Survey: Newly diagnosed survey respondents were asked about their service experiences after receiving an HIV diagnosis. Over nine in ten (90% - 94%)

were satisfied with three specific aspects of their linkage to care experiences: HIV case management, HIV medical care and information and referral to other types of needed services. A slightly lower percentage of respondents were satisfied with the two remaining aspects assessed: Information/classes provided on HIV and HIV management and other HIV services received during this period.

PREVENT

Prevention works. Oregon is considered a low incidence state for HIV, with an annual average of 209 new HIV diagnoses between 2016-2020, but high rates of syphilis, gonorrhea, and viral hepatitis threaten to undermine progress to eliminate new HIV infections. Barriers to testing during COVID-19 also may have created reservoirs of undetected infection. Moreover, the large racial and ethnic inequities in new diagnoses must be redressed to meet the goal of eliminating new HIV transmissions. Oregonians who are Black/African American, American Indian/Alaska Natives, Native Hawaiian/Pacific Islander, and Hispanic or Latino/a/x have higher than average HIV diagnosis rates, while Oregonians who are White, Multiracial, or Asian have lower than average rates.

PrEP

PrEP, the pill to prevent HIV, is an effective, evidence-based primary prevention tool that is not yet widely used in Oregon. In 2021, there were 4,531 PrEP users in Oregon, most users were male (92.5%), white (82.7%), and age 25-54 (65.5%). Of more than 23,000 people who tested HIV negative at Oregon public testing sites between 2019-2022, 42% had heard of PrEP, 10% reported currently taking it, and 32% were linked to a PrEP provider.

Although PrEP use has increased steadily since 2012, there are still many Oregonians who could benefit from PrEP who are not on it. Oregon's PrEP-to-Need (PNR) ratio (a ratio of the number of PrEP users to people newly diagnosed with HIV) is 22.77. Lower PNRs reflect more unmet need. PNRs make comparison across groups possible, helping to identify where inequities exist. PNRs by available demographics in Oregon are shown below and reveal inequities for Oregonians who are female, Black, and/or Hispanic/Latinx persist.

Oregon PrEP-to-Need Ratios by Sex, Race/Ethnicity, and Age, 2021

Demographic Group	PNR (higher is better)
Oregon Overall	22.77
Sex:	
Male	23.15
Female	18.83
Race/Ethnicity:	
Black	9.41
Hispanic/Latinx	11.42
White	29.27
Age:	
13-24	24.73
25-34	21.45
35-44	28.86
45-54	17.69
55+	22.06

Source: AIDSVu

Many communities still have little awareness of PrEP. Data from Chime In, Oregon's arm of the National HIV Behavioral Surveillance survey, indicate that while most of the Portland-area MSM who were surveyed had heard about PrEP and about 1 in 4 had used it, only 15% of people who inject drugs and 30% of people participating in the low-income heterosexual survey had heard of PrEP ($\leq$ 1% of PWID or low-income heterosexuals had used PrEP). Communities of color also report a need for greater PrEP awareness. For example, many attendees at a 2022 PrEP training by and for Spanish-speaking medical providers and community health workers, reported they had never heard of PrEP before the training or knew very little about it; they learned that PrEP is safe and effective, and received information about how to access it. Similarly, Black and African American community members at a series of community meetings in 2019 also reported lack of awareness about PrEP and/or skepticism about its safety and efficacy; many had seen television commercials related to harmful PrEP side effects and consequent lawsuits. Finally, hardly any of the rural Oregonians who participated in a formative assessment for a rural media campaign had heard of PrEP.

Oregon's Statewide PrEP/PEP workgroup identified supports for adherence to or maintenance of PrEP as a key need moving forward. As mentioned in the Resource Assessment section, Oregon has seen a tenfold increase in people newly diagnosed with HIV who report ever using PrEP since we began collecting those data in June 2016. While it is good news that more people are aware of and accessing PrEP, it is discouraging to see people who self-identified as potential beneficiaries of PrEP, and who even obtained PrEP at one time, seroconverting. This indicates a potential need for more adherence or other support to help people remain on PrEP and prevent infection. Open-ended interviews with 16 people who were diagnosed with HIV between 2016-2019 and who reported using PrEP on the HIV case report provided some insight into people's experiences taking PrEP. All participants were male-identified MSM. Length of time taking PrEP ranged from 8 days – 3 years. Participants reported high levels of social support and few difficulties with adherence; experiences of PrEP stigma were rare. The most common reason participants stopped taking PrEP was that they could not afford it. Out-of-pocket costs were prohibitive for participants whose insurance did not fully cover PrEP and few reported using drug assistance programs. Changes in insurance coverage appeared to be a particularly dangerous time for PrEP users, as many reported lapses in insurance that caused them to discontinue PrEP use. Some reported seroconverting during these lapses in insurance. Since this study occurred, policy changes have alleviated some financial and insurance-related barriers to PrEP. Still, the main things participants said would have most helped them be successful on PrEP are still relevant: help navigating systems to pay for PrEP and better and earlier information about PrEP availability and how to take it.

The availability of injectable PrEP may offer additional opportunities to increase PrEP use, including rural people, people experiencing houselessness, sex workers, and others with access barriers related to transportation or use of clinics.

PEP, an important secondary prevention tool, can be difficult to access in some parts of Oregon, though no systematic data have been collected on PEP access. OHA added questions to PrEP navigator reporting tools to gather additional information on client barriers.

Primary Prevention: Syringe Exchange, Harm Reduction, and Services for People who Use Drugs

People who use substances are at elevated risk of HIV because of increased sexual risk taking and engagement in transactional sex, as well as direct risk from sharing needles or other equipment.

The Oregon HIV/Hepatitis and Opioid Prevention & Engagement Project (OR-HOPE) is a research study and multi-level intervention focused on 9 mostly rural counties (Douglas, Lane, Clatsop, Columbia, Coos, Curry, Josephine, Lincoln, and Tillamook). OR-HOPE community action teams develop response plans to integrate strategies to address drug use and its consequences and researchers collect data to better understand the dimensions of the problem and its solutions. Among 144 individuals who had injected drugs in the past 30 days, 68% reported homelessness, 51% incarceration in the past 6 months, and high rates of methamphetamine use (either alone or in combination with heroin or other drugs). Risk of disease transmission was high: 50% reported being HCV positive, although only 7 had received HCV treatment in the past 6 months; 45% reported sharing syringes. Lack of transportation, stigma, and fear of arrest were the top barriers to accessing health care; 20% reported a barrier to accessing substance use disorder (SUD) treatment in the past 6 months and 9% reported a barrier accessing buprenorphine.

Qualitative interviews with 52 OR-HOPE participants provided additional data about Oregon's increase in meth use, which include availability and price (meth is cheaper and easier to get), the ability to be productive on meth, and shifting to meth as harm reduction from heroin (e.g., to reduce withdrawal, dependence, and risk of OD). Some participants reported being discharged from opiate use disorder medications because of their meth use, indicating a need for treatment tailored to polysubstance use. Access to SUD treatment is difficult overall because of lack of providers in rural areas, lack of transportation, long wait lists, lack of supportive housing, and treatment interruptions due to incarceration.

There are 45 syringe exchange programs in 22 Oregon counties, and many PWID purchase clean needles in Oregon pharmacies, but barriers exist. Participants in OR-HOPE qualitative interviews said that transportation was a barrier, as were stigma and pharmacy policies, such as requiring ID for purchase of syringes.

The OR-HOPE study team summarize the key needs of people who use drugs (PWUD) in rural Oregon as follows:

- expand access to medications for OUD treatment, including in hospitals, jails, nursing facilities, and EDs
- include both office-based and telemedicine options for OUD treatment
- improve access to SUD treatment facilities
- expand peer community engagement models that include both infectious disease and overdose prevention
- provide services in a range of locales, including hospitals, EDs, primary care, and syringe service programs
- expand harm reduction services, broadly defined, including syringe services programs, naloxone, low barrier housing, SUD treatment and medical care
- expand training for physicians, nurses, pharmacists, and peers across the care continuum

A 2022 rapid assessment in Umatilla County documented the needs of rural PWUD. Many noted the increase in fentanyl use and a diversification of the people using drugs. PWUD cited stigma as a barrier to accessing health care and most were unaware of how to access screening services for infectious diseases, like HIV and HCV. PWUD also noted that substance use treatment is largely unavailable or has long waitlists. Service providers noted that the criminal justice system acts as default detox centers, due to lack of treatment options. Culturally-specific and gender-affirming services were even more difficult to find. Participants noted that telehealth may help increase access post-COVID-19. Most PWUD reported they had naloxone or knew how to find it, and had access to clean needles, mostly from pharmacies. However, pharmacy access was reported as stigmatizing.

A 2018 assessment in Washington County (near Portland) identified the following needs and priorities for PWID: access to sterile needles, naloxone, drug treatment (including detox and MAT), and housing. Barriers included fear of arrest, stigma, eligibility criteria, and limited service hours. PWID shared ideas about how to best implement and promote harm reduction services – including co-locating services in easily accessed places like transit centers, pharmacies, and grocery stores, and using low-tech messaging via fliers and word-of-mouth to advertise service availability.

The Chime In survey provides additional information about PWID in the Portland metropolitan area. Detailed data were provided in the Priority Populations section of this Integrated Plan. Overall, Chime In documents the needs of Portland metropolitan area PWID related to increased information about PrEP and risk reduction information related to IDU and sexual behavior.

A vulnerability assessment conducted in Oregon in 2020 found that some Oregon counties are at increased risk of HIV and HCV outbreaks related to injection drug use. The highest vulnerability counties included both rural (Douglas, Coos, Malheur, and Curry) and urban (Multnomah) counties.

Members of Oregon's End HIV/STI Oregon Statewide Planning Group recommend that harm reduction messaging and interventions for HIV, STI, VH, and other infections consider all substance use, including alcohol use, as a potential risk for HIV/STI transmission, rather than focusing only on injection drug use. Bundled services for people who use substances, such as the peer-based programming provided by U-COPE, which is a collaborative, community-driven project to coordinate and implement a comprehensive set of harm reduction services for PWUD, can be an effective intervention that addresses the syndemic nature of HIV, HCV, substance use, STI, and related conditions.

Primary Prevention: Safer Sex Information & Supplies

Stigma-free HIV, STI, and sexual health information are essential. Lack of awareness or comfort discussing these topics is a key barrier to ending new HIV/STI infections.

Youth are an important group for primary prevention. According to the Oregon Student Health Survey, 30% of 11th graders and 4% of 8th graders report having ever had sex; 54% of 11th graders and 55% of 8th graders say they used a condom the last time they had sex.

Casual condomless sex was common among the priority populations who participate in the Chime In survey, reported by 60% of MSM, 43% of low-income heterosexuals, and 37% of PWID. (See Priority Populations section for more detail).

Condomless vaginal or anal sex with an HIV-negative or unknown status partner was uncommon among Oregon MMP participants, only reported by 5%. With high viral suppression rates in Oregon, as well as potential partner PrEP use, the risk of HIV transmission from PLWH who know their HIV status is low. (See U=U section for more detail.)

TREAT

Treatment saves lives. Eighty-five percent of PLWH in Oregon who are aware of their HIV status are in medical care, 82% are on treatment, and 77% are virally suppressed. These rates exceed those of the U.S., but Oregon has work to do to address inequities and ensure all PLWH, including the 15% who are currently out of care, have access to high-quality care, free of stigma and discrimination. Specifically, rates of viral suppression are lower among young people (under age 40), Black/African American people, people who inject drugs, people living in rural and frontier regions, and people with unstable housing prior to their diagnosis.

Oregon's Ryan White Program, in conjunction with other medical and social services, works to address many structural and practical barriers to treatment. The CAREAssist Program provides life-saving drugs to approximately 4,000 PLWH in Oregon each year; approximately 33% of PLWH living in the Part A service area (74% of all TGA RW clients) and 48% living in Part B are enrolled in Ryan White HIV case management services. Still, 44% of HIV Medical Monitoring Project participants reported at least one unmet service need in the past 12 months, including 34% who reported an unmet medical need and 23% an unmet social service need. PLWH who identify as bisexual, aged 18-24, living below the poverty line, unemployed, and/or having any type of disability are more likely to report an unmet social service need.

Portland TGA RW Client Experience Survey: Additional needs assessment questions were added to the Part A client satisfaction survey conducted in 2021 to better identify unmet medical and social service needs during the COVID pandemic, in addition to TGA Ryan White client satisfaction with services. Service gaps ranged from 15% for emergency financial assistance to 2% for HIV medical care among clients that indicated need for a specific service. However, further analysis revealed that BIPOC clients were more likely to experience unmet service needs across multiple areas than white clients, including social support, in-home care, food assistance, transportation, HIV case management, mental health, and service navigation services. Respondents with disabilities were more likely to experience service gaps in social support, transportation, and pharmacy services. Respondents under 55 years of age were more likely to experience social support and mental health service gaps, while those over 55 were more likely to experience addictions and recovery service gaps. Lastly, LGB+ respondents were more likely to experience unmet dental needs in comparison to heterosexual respondents.

PLWH needs related to specific service categories are as follows:

Access to High-Quality, Culturally-Responsive Medical Care:

All but one PLWH surveyed between 2015 and 2020 as part of the Oregon HIV Medical Monitoring Project (MMP) had health insurance, and only 6% reported an insurance gap in the past 12 months. Despite the high proportion of insured, 41% reported using an emergency room for their own health care needs in the past 12 months, which may indicate a gap in service or some difficulty accessing usual sources of care.

More than half of PLWH in Oregon (55%) are 50 years or older, and many have comorbid conditions that need ongoing medical management, requiring coordination between HIV specialists, primary care providers, and other medical specialists. A 2013 survey found that 81% of CAREAssist clients had one or more chronic medical conditions in addition to HIV; 38% had three or more comorbid conditions. While these data are old, they likely represent a lower threshold, as the PLWH population continues to age.

Most MMP participants reported being very satisfied with the HIV medical care they are receiving. Males, gays/lesbians, people over age 40, and long-term survivors are more likely be very satisfied, while those aged 25-39, living below the poverty line, and with more barriers to social determinants of health (SDOH) or any behavioral health issues are less likely to report being "very satisfied" with HIV medical care.

Those who are not "very satisfied" with their HIV medical care are less likely to be on HIV medications, be adherent to ARTs, be virally suppressed, and receive a past year syphilis screening. They are also more likely to miss a medical appointment, use the ER, and have an AIDS diagnosis.

There are few Spanish-speaking medical or behavioral health providers available in Oregon to serve monolingual Spanish speaking clients.
Portland TGA RW Client Experience Survey: While only 2% of RW TGA clients surveyed in 2021 said that they experienced a gap in HIV medical service during the pandemic, 18% of survey respondents indicated that their medical care service use had decreased, as opposed to 10% of respondents that indicated a service use increase. RW TGA respondents with disabilities were more likely to report medical service use increase (14%) during the pandemic than PLWH without disabilities (5%). Additionally, the primary adverse life experiences clients indicated impacted their ability to access care included: depression, anxiety, and mental health issues (34% of respondents); major life stressors (e.g., job/housing loss) (17%); social isolation (17%); homelessness (13%); drug and/or alcohol addiction (12%); and having no source of income (12%).

Case Management Services: Only 4% of MMP participants reported an unmet need for case management services in the past 12 months.

Portland TGA RW Client Experience Survey: About 9 out of 10 survey respondents (86%) indicated that they needed case management services during the pandemic. Consistent with MMP, 4% of RW TGA clients surveyed in 2021 specified a gap in HIV medical case management services out of those that needed it. BIPOC RW respondents were more likely to report a case management service gap (7%) than white RW respondents (3%). Net medical case management service use by respondents accessing these services remained relatively neutral during this period, with 2% more clients reporting case management service use increase over decreased service use. RW TGA respondents with disabilities (26%) and those under 55 years of

age (23%) were more likely to report an increase in case management service use during the pandemic than PLWH without disabilities (13%) or respondents over 55 (14%). Though overarching satisfaction with TGA RW services decreased during the pandemic, client satisfaction increased for several different aspects of case management services, including assistance staying on HIV medications, applying for dental insurance and help understanding HIV laboratory results.

COVID-19: As of April 2022, 12.8% of PLWH in Oregon had been diagnosed with COVID-19 compared to 16.8% of the Oregon population, 8.8% required hospitalization, and 3.1% died. Black (11.1%), American Indian/Alaska Native (2.6%), Native Hawaiian/Pacific Islander (0.5%) and Latinx (23.6%) people living with HIV have been disproportionately affected by COVID-19. Counties with the highest rates of PLWH diagnosed with COVID were Multnomah, Washington, Clackamas, Marion, Lane, and Jackson.

Dental Services: 21% of MMP participants reported an unmet need for dental services in the past 12 months. CAREAssist provides dental coverage to non-Oregon Health plan clients through MODA Dental Delta, but this resource has been consistently underutilized. The program conducts a Dental Drive each year to inform clients of the service and increase enrollment. Qualitative interviews conducted with 10 CAREAssist clients in Summer 2022 indicate mixed awareness of dental services. Among the 4 who had not used dental services, one was unaware of the service, one couldn't find a provider in their rural area, and two were afraid of being stuck with bills exceeding what CAREAssist would pay.

Portland TGA RW Client Experience Survey: Close to four in five survey respondents (82%) indicated a dental service need during the pandemic. In comparison to MMP participants, a lower percentage of TGA RW survey respondents (9%) reported a gap in dental care out of those that needed this service. However, respondents indicated a net dental service utilization decrease during this period, with 26% of respondents saying dental service use decreased compared to 16% replying their dental service use had increased. LGB+ clients were more likely to report an oral health care gap than heterosexual clients, while respondents with disabilities were more likely to increase service use.

Drug & Alcohol Treatment Services: Fifteen percent of MMP participants reported binge drinking in the past 30 days, 41% reported using non-injection drugs and 6% reported using injection drugs in the past 12 months.

Only 3% of MMP participants reported an unmet need for A&D treatment services in the past 12 months; however, this need is most certainly under-reported. People who need A&D treatment services may be less likely to participate in the MMP survey and people who need A&D treatment may not recognize their need for those services. Also, as reported in other sections of this plan, Oregon is ranked 50th in the U.S. for access to addiction treatment services.

Portland TGA RW Client Experience Survey: Close to half of all survey respondents (48%) indicated a need for addictions and recovery support services during the pandemic. A higher percentage of TGA RW clients reported a service gap for these services (10%) out of those that needed this service than reported by MMP participants. Respondents over 55 years of age were more likely to report a service gap (16%) than younger clients (7%). Among clients responding to SUD treatment satisfaction questions, close to 1 in 5 respondents indicated it took 7 weeks or

more to access outpatient treatment services (21%) and inpatient treatment services (17%). While satisfaction across SUD peer support, outpatient and inpatient treatment services remained high in 2021 (over 9 in 10 respondents indicating satisfaction with different SUD treatment aspects), under 90% of respondents were satisfied with 3 aspects of **inpatient treatment services**: staff understanding/respecting client sexual orientation (85%); staff understanding/respecting client cultural/ethnic background (85%); and being supported in HIV management (77%).

Food Assistance: 8% of MMP participants reported an unmet need for personal food assistance services and 6% reported an unmet need for meals or food delivery services in the past 12 months.

Portland TGA RW Client Experience Survey: Close to two-thirds of survey respondents (64%) indicated they needed food assistance services during the pandemic. Like MMP participants, 8% of TGA RW client respondents reported a gap in food assistance out of those that needed it. BIPOC respondents were more likely to experience a food assistance gap (12%) than white respondents (4%). Food assistance was the primary service where respondents indicated an overall net service use increase during the same period, with 2 out of 5 respondents (38%) saying that their food assistance service use had increased. Over half of respondents (53%) had experienced food insecurity in the past year, with BIPOC respondents (62%); transgender/gender diverse respondents (74%); respondents under 55 years of age (61%); and respondents with disabilities (67%) were more likely to report food insecurity. Additionally, 7% of respondents indicated that inability to afford food had been a barrier to accessing HIV medical care. Qualitative analysis revealed that clients with disabilities spoke more often to food transportation barriers; respondents experiencing homelessness commented more often on gaps in safe food storage and preparation; and BIPOC respondents provided the most feedback on being denied or ineligible for food benefits.

Housing Assistance:
6% of MMP participants reported an unmet need for shelter or housing services in the past 12 months, a rate that is likely artificially low due to survey selection bias. Housing instability has risen in Oregon and people who experienced houselessness prior to HIV diagnosis are more likely to be virally unsuppressed.

Portland TGA RW Client Experience Survey: Over three in five survey respondents (61%) indicated that they needed housing assistance services during the pandemic. A higher percentage of RW TGA respondents reported a gap in housing assistance (11%) out of those that needed these services than MMP respondents. Housing assistance represented the third highest net service used by respondents during the same period, with 27% of respondents indicating housing service use increased in comparison to 15% indicating a decrease in service use. Respondents under 55 were more likely to report housing assistance use increases during the pandemic. Additionally, 1 in 3 respondents (35%) felt uncertain about their housing stability over the next 12 months, regardless of their current housing status. Transgender/gender diverse respondents (66%) and respondents with disabilities (48%) were more likely to be uncertain about their future housing status. Respondents with disabilities were also more likely to report homelessness in the past 2 years (23%) and indicate that this interfered with HIV medical care access (17%).

Part A Client Data: Laboratory data for all clients receiving RW funded services in the TGA in 2021 also revealed that clients that are temporarily or unstably housed clients are less likely to have met need (86%) and be virally suppressed (78%) than clients that are stably housed (93% and 92% respectively). This long observed inequity became even more pronounced between 2020 and 2021 as more RW clients gained housing stability.

Intimate Partner Violence: Lifetime prevalence of intimate partner violence is common among people living with HIV in Oregon: 44% of MMP participants report lifetime prevalence of IPV. Although IPV is a construct that can mean different things and can be measured in different ways, this rate appears to be much higher than the general population overall. The CDC estimates that 1 in 4 women and 1 in 10 men have experienced "contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact." Unhealthy relationship patterns can start early, which is why primary prevention is so important: 4% of Oregon 11th graders reported past-year physical violence by a boyfriend/girlfriend/ partner and 12% reported a partner "trying to control or emotionally hurt" them.

Mental Health Services: One in four MMP participants reported moderate or severe anxiety in the past 2 weeks, and 13% reported symptoms consistent with major depression; 10% of MMP participants reported an unmet need for mental health services in the past 12 months. CAREAssist clients who participated in qualitative interviews in Summer 2022 said that access to quality mental health services was the most important thing someone newly diagnosed with HIV needs to be healthy.

Portland TGA RW Client Experience Survey: Over two-thirds of survey respondents (68%) self-reported experiencing depression, anxiety, and other mental health conditions over the past two years, while 16% identified that they had a cognitive disability. Over one-third of respondents (34%) indicated that their mental health interfered with their HIV medical care access. White respondents, LGB+ respondents, those under 55 and respondents with disabilities were more likely to report experience mental health conditions, while respondents under 55 or with disabilities were more likely to report this impacting their HIV care access. Despite 66% of respondents indicating that they had a mental health service need, 10% of these respondents could not access these services during the pandemic, similar to MMP participants. Additionally, 27% of respondents needing services reported that their mental health service use decreased during the pandemic, as opposed to 23% indicating service use increase. BIPOC respondents and those under 55 years of age were more likely to report a mental health service gap, while LGB+ respondents, those under 55 and respondents with disabilities were more likely to report a service use increase.

Peer Support for PLWH: 9% of MMP participants reported an unmet need for HIV peer group support services in the past 12 months.

Smoking Cessation Services: Thirty percent of MMP participants are current tobacco users.

Social Determinants of Health: Oregon MMP created a 10-item index of social determinants of health, which included these items: education level, health literacy, poverty, food insecurity, gap in insurance coverage, ER visit, homelessness, need for transportation help, criminal justice

involvement, and history of sexual and/or physical intimate partner violence. 25% of MMP participants reported one SDOH, 27% reported 2 SDOH, 14% reported 3 SDOH, and 17% reported 4 or more SDOH. Compared with PLWH who reported none of the SDOH indicators, PLWH with 1 or more SDOH had worse care outcomes related to missed medical appointments, adherence, and achievement of durable viral suppression in a dose-dependent fashion (e.g., more items, worse outcomes).

Stigma & Discrimination:
Almost 1 in 4 (24%) of MMP participants reported experiencing any type of HIV-related discrimination.

HIV stigma is defined as the median score on a 10-item scale ranging from 0 (no stigma) to 100 (high stigma) that measures four dimensions of HIV stigma: personalized stigma, disclosure concerns, negative self-image, and perceived public attitudes about people living with HIV. The median HIV stigma score was 39%.

Since 2015, MMP has monitored stigma among all HIV-diagnosed adults using a more comprehensive scale that captures 4 dimensions of stigma: personalized stigma, disclosure concerns, negative self-image, and public attitudes about people with HIV: 58% report personalized stigma, 75% report disclosure concerns, 31% report negative self-image, and 57% report stigma about public attitudes about people with HIV.

Portland TGA RW Client Experience Survey: The adverse client experiences of HIV stigma or discrimination and social isolation were added to this survey for the first time in 2021. Over two in five respondents (44%) reported experiencing social isolation and one in four respondents (24%) experienced HIV stigma or discrimination in the past two years; 17% of respondents indicated that social isolation interfered with HIV care access, while 8% indicated that HIV stigma and discrimination did. LGB+ respondents and those with disabilities were more likely to report social isolation, while gender diverse/transgender respondents, those under 55 years of age and respondents with disabilities were more likely to report experiencing HIV stigma. Respondents with disabilities were more likely to report that both social isolation and/or HIV stigma/discrimination interfered with HIV care access.

STI Screening:
Co-infection with HIV and other STI is common in Oregon. Oregon and national screening recommendations include screening for HIV, syphilis, chlamydia, and gonorrhea up to four times a year in the highest risk groups including MSM with multiple sex partners, people with previous STI diagnoses, and some people who use recreational drugs, especially methamphetamine. Pregnant women should be screened twice during pregnancy and once at delivery. However, 34% of MMP participants had not received syphilis screening in the past 12 months and 71% had not been screened for gonorrhea or chlamydia.

We analyzed 2015-2016 MMP data to assess what facility-level and individual-level factors are associated with syphilis screening among PLWH. As presented in the journal, Sexually Transmitted Diseases, we found that patients receiving care from facilities with written STI screening policies were far more likely to be screened for syphilis in the past year compared to those who received care from facilities without written policies (94% vs. 43%). Despite

individual providers' commitment to systematic screening, results show that having written policies had the strongest effects in predicting syphilis screening.

Transportation Assistance:
6% of MMP participants reported an unmet need for transportation assistance in the past 12 months.

Portland TGA RW Client Experience Survey: Over half of survey respondents indicated they needed transportation services (56%) during the pandemic. A higher percentage of RW TGA respondents reported a transportation gap (10%) among those that needed these services than MMP respondents. BIPOC respondents and respondents with disabilities were more likely to indicate unmet transportation needs, while respondents with disabilities reported transportation service utilization increased during the pandemic. Survey respondents with disabilities were also more likely to comment on food transportation barriers experienced.

U=U/Treatment as Prevention:
MMP has included a set of questions about U=U for the last three years (2018-2020). More than three-quarters (78%) of respondents have heard that having an undetectable viral load means that you will not pass on HIV to sexual partners; the proportion has steadily increased from 67% in 2018 to 89% in 2020.

Knowledge of U=U varies by demographic subgroup. Nearly all respondents in the youngest age group (18-29) reported yes (92%), while the remaining age group proportions decreased with age, with only 75% of 50 and over respondents reporting yes. Latinx respondents were the most likely race/ethnic group to report yes (86%); Black respondents were the least likely (65%). MSM were more likely (83%) than non-MSM (68%) to report yes.

There is a general positive trend with knowing about U=U and education status; as education increases, the likelihood of reporting yes increases. The highest education group, those with any post graduate education, had the highest reporting yes (85%). Those living below the poverty line were less likely to report yes about U=U knowledge than those above the poverty line (73% vs. 82%). There were no significant associations between clinical characteristics (e.g., adherence, viral suppression, and CD4 counts) and knowledge about U=U.

Patterns in serosorting attitudes were also observed. Respondents who agreed with the statement, "*If my partner tells me he or she is HIV positive, I'm more likely to have unprotected sex with him or her*" (84%) were more likely to report yes to knowledge about U=U than those who did not agree (76%). Similar patterns were observed for "*If my partner tells me he or she is HIV positive, we don't have to worry about using condoms*" (86% vs 76%), "*If I have an undetectable HIV viral load, I am more likely to have unprotected sex*" (89% vs 72%), and "*Having an undetectable HIV viral load means I can worry less about having to use condoms*" (90% vs 72%). The behavior questions are hard to interpret – people might say they are NOT less likely to use condoms because they are concerned about STI or pregnancy, rather than having skepticism about U=U. Qualitative data gathered through PLWH interviews in Summer 2022 helped contextualize data gathered from MMP. All 10 PLWH who participated said they had heard the information that being undetectable meant they could not transmit HIV to sex partners;

however, 7 had not heard of the term U=U. Eight said they "believed" that U=U was true; two equivocated or were somewhat skeptical, asking "*is it 100% definitive*?"

Vision Services:
Glasses and other vision aids are needed by many PLWH, a population that is aging. Three of ten CAREAssist clients who participated in qualitative interviews in Summer 2022 mentioned that the lack of vision benefits was a challenge, as eye exams and glasses are costly.

RESPOND

Ending new HIV transmissions in Oregon requires partnerships across multiple systems and communities. Inequities exist along the HIV status neutral continuum. Eliminating inequities requires a refocusing of resources to communities where the need is greatest. This means regularly analyzing our data to identify disparities and inequities, sharing data with community members in a timely manner, and leading with race/ethnicity. Detecting outbreaks and clusters of new infections through enhanced surveillance is an essential part of an effective response to HIV/STI; strong community partnerships are also required to quickly respond, providing treatment and prevention resources, and implementing policy responses to limit transmission.

Overall needs related to HIV/STI response:

Tools and training to respond effectively to clusters: A 2022 listening session with about 50 state, local, and tribal colleagues indicated interest in using dried blood spot testing and other at-home rapid HIV and HIV/STI self-collection test kit, as well as a need for training and technical assistance in setting up processes and systems for managing these new testing processes. As discussed previously, these tools were used effectively in a 2019 response to a time-space cluster of new HIV diagnoses among PWID in the Portland metropolitan area, but the tools have not been used in other parts of the state. OHA is working with LPHA partners to develop and implement policies and procedures for scaling up use of these tools across Oregon.

Public Health Modernization, including increased workforce capacity: State and local public health workforces are strained because of deployments for ongoing pandemic response, departures/vacancies, and staff burnout. At this writing, in 2022, there are a significant number of open positions in Oregon's State, local and CBO HIV/STI programs. Oregon LPHA leaders report ongoing and significant challenges in recruiting, hiring, and retaining qualified staff. Training related to contact tracing and disease investigation is an ongoing need. Tribal partners indicated a need for tribal-specific training in these areas.

PRIME Plus Expansion: As described previously, State Opioid Response funding has been used to pilot, develop, and expand peer-delivered harm reduction programming in urban, rural, and frontier area of Oregon. PRIME Plus has created positive change among participants: decreasing illicit drug use at 30 days, decreasing ER visits, and increasing HIV testing. New pilots focusing on HCV telehealth and bundled services for PWUD in a rural county are underway. However, only 24 of 36 Oregon counties have a PRIME Plus program and challenges like staff turnover and workforce shortages limit the capacity of existing programs.

Priorities

The key priorities identified in the needs assessment are as follows. These are organized by pillar, although many are cross-cutting.

DIAGNOSE:

- Increase opportunities for routine HIV/STI testing
- Expand and support DIS and partner services

PREVENT:

- Increase access to PrEP

TREAT:

- Expand rapid start ART
- Increase access to medical care and case management (includes language access, transportation, telehealth)
- Promote U=U

RESPOND TO END INEQUITIES:

- Expand partnerships that support a syndemic focus
- Provide education and training for health care staff on stigma, discrimination, unconscious bias, HIV, and sexual orientation/gender identity issues

Actions taken

The following actions were taken during the needs assessment process to address identified needs and barriers:

- ➔ **Anti-racism training:** Working collaboratively with Ryan White Part A and Ryan White Part B in Oregon, the Oregon AETC contracted with anti-racism – trauma informed care, www.ar-tic.org, to provide baseline training to the HIV prevention and care workforce across the state. A majority of HIV care and prevention staff (231) funded by Ryan White Parts A and B attended an eight-hour training on Doing (Less) Harm and applying an anti-Racist lens to systems change. The goal will be to create a "strategic plan" for next steps across all agencies to support the systems change necessary to ensure services are accessible and responsive to the communities most in need. In addition, the Part A Planning Council and End HIV/STI Oregon Statewide Planning Group, as well as individual grantees and subrecipients, engaged in formal anti-racism training.
- ➔ **CAREAssist Dental Drive:** CAREAssist provides dental coverage to non-Oregon Health plan clients through MODA Dental Delta, but this resource has been consistently underutilized. The program conducted a Dental Drive to inform clients of the service and increase enrollment. In July 2022, the program sent out 1,099 applications to eligible, non-enrolled clients, yielding 102 new members (9%). Enrollment is ongoing.
- ➔ **CBO equity grants:** The Oregon HIV Program participated in a cross-program Oregon Health Authority Request for Grant Applications (RFGA) process to recruit and award funds to community-based organizations. OHA awarded grants to 7 CBOs serving priority populations – including Black/African Americans, trans and nonbinary individuals, people experiencing homelessness, people who inject drugs and/or use substances, people engaged in sex work, and youth – to conduct education, outreach, and needs assessment.
- ➔ **Food security assessment and implementation plan:** In response to Oregon MMP data indicating high rates of food insecurity among PLWH, planning groups called for an assessment of food insecurity challenges and resources for PLWH in Oregon, which was conducted in 2020-21. Oregon then hired a consultant to develop an implementation plan

in 2022. As part of that plan, Ryan White Parts A and B implemented a series of trainings for case managers, Part B implemented the Hunger Vital Sign as part of its acuity scale, and Part A included the Hunger Vital Sign in its Client Experience Survey.

- ➔ **Outreach & education in Eastern Oregon** – The Eastern Oregon Center for Independent Living conducted a multifaceted media campaign in Eastern Oregon, aimed at increasing HIV awareness and HIV testing behaviors. The campaign ran from April – July 2022, driving the highest volume of traffic to the End HIV Oregon website experienced since the website's launch in 2016.
- ➔ **Partner services training:** Oregon conducted digital partner services trainings, provided additional capacity building assistance with representatives from CDC – Division of STD Prevention, and initiated work with National Coalition of STD Directors to develop and implement a tribal DIS training.
- ➔ **PrEP and PEP accessibility:** A swim lanes exercise at the Statewide PrEP Connect conference helped identify gaps in linkage between PrEP providers and services. New questions on PrEP navigator reporting forms provide a way to collect data on client barriers to PEP and PrEP access.
- ➔ **PrEP and PEP training for pharmacists:** OHA established a memorandum of understanding with Oregon State University College of Pharmacy to support training for pharmacists and pharmacy technicians on pharmacist prescribed PEP and PrEP and the AIDS Education & Training Center conducted pharmacist training to establish baseline knowledge.
- ➔ **Rapid/Immediate ART Start Community of Practice:** In response to the need and demand for rapid/immediate start ART across Oregon, the AETC planned and launched a 6-month community of practice for providers/clinic staff to develop and adopt policies and procedures for rapid start, and to learn about best practices for implementation.
- ➔ **Self-test and self-collection HIV/STI test kits:** Growing interest in distribution of self-testing and self-collection test kits by LPHAs and CBOs led to the implementation of a training and listening session on the topic. OHA is currently finalizing guidance for the use of self-test and self-collection test kits.

Section IV. Situational Analysis

Overview of strengths, challenges and identified needs related to HIV prevention & care

Our vision is an Oregon where new HIV and STI transmissions are eliminated and Oregonians with HIV live long, healthy lives, free from stigma and discrimination.

Structural, systemic, and social issues impact our ability to achieve our vision. Health inequities exist at multiple points along the HIV care continuum and are key drivers of the HIV and STI syndemic. Cross-cutting issues, like those discussed in this Situational Analysis, can prevent or facilitate access to comprehensive prevention services, timely HIV diagnosis, linkage to care, and sustained, effective treatment for people living with HIV and STI. Members of priority populations are often most impacted by these cross-cutting issues.

Behavioral Health:
According to the latest National Survey on Drug Use and Health, Oregon has among the highest prevalence of mental health and substance use issues in the U.S.

MHACBO **Summary,**
NSDUH December 2021 Report (2019-2020, n=135,000, ages 12 and older) U.S. State Rankings

summary

Oregon	Percent of population, ages 12 and older	U.S. Rank Among States	
Illicit Drug Use Disorder Past Year	9.04%	1st in U.S.	TOP:Highest State
Needing but not Receiving Treatment for SUDs	18.08%	50th in U.S.	TOP: Worst State
Any Mental Illness Past Year	27.33%	2nd in U.S.	TOP 10: Very High
Serious Mental Illness Past Year	7.15%	3rd in U.S.	TOP 10: Very High
Illicit Drug Use in the Past Month	21.17%	2nd in U.S.	TOP 10: Very High
Marijuana Use in the Past Year	27.82%	2nd in U.S.	TOP 10: Very High
Marijuana Use in the Past Month	19.26%	2nd in U.S.	TOP 10: Very High
Illicit Drug Use other than Marijuana in the Past Month	4.25%	3rd in U.S.	TOP 10: Very High
Rx Opioid misuse Past Year	4.46%	1st in U.S.	TOP:Highest State
Heroin use in the Past Year	0.56%	11th in U.S.	Higher State
Cocaine use Past Year	2.37%	7th in U.S.	TOP 10: Very High
Methamphetamine use Past Year	1.93%	1st in U.S.	TOP:Highest State
Alcohol use in the Past Month	56.34%	10th in U.S.	TOP 10: Very High
Alcohol Use Disorder	12.34%	5th in U.S.	TOP 10: Very High
Cigarette Use Past Month	15.60%	31st in the U.S.	Near U.S. Average
Serious Thought of Suicide Past Year	6.80%	2nd in the U.S.	TOP 10: Very High
Attempted Suicide Past Year	0.54%	21st in the U.S.	Near U.S. Average
Major Depressive Episode Past Year	9.84%	5th in the U.S.	TOP 10: Very High

summary table credit, Mental Health & Addictions Certification Board of Oregon

Substance Use & Treatment:
The most recent National Survey on Drug Use and Health shows alcohol and drug use is high in Oregon, and worsening: 9% of teens and adults were addicted to drugs in 2020 and about 12% of Oregonians age 12 and older reported an alcohol problem. Combined, nearly 1 in 5 Oregon teens and adults reported a problem with alcohol and other drugs, the 2nd worst rate in the nation. The rate of alcohol addiction nearly doubled in 2020; 56% of Oregonians reported any past-month alcohol use.

Oregon's methamphetamine problem is also getting worse. In 2019, about 1% of teens and adults used meth, the sixth highest rate in the country. That jumped to nearly 2% in 2020, the worst ranking nationwide. Overdoses related to methamphetamine and other stimulants have been increasing since 2016.

Oregon ranks

- 1st in the nation for prevalence of methamphetamine and prescription opioid misuse

- 2nd in the nation for percentage of the population (12 and older) with past year illicit drug use disorder (IDUD) (9.0%) and
- 3rd in the nation for prevalence of SUD (18.2%)

Meanwhile, Oregon ranked last in the U.S. in 2020 for access to treatment for drug addiction, with 18% of teens and adults unable to get treated, compared with nearly 9% in 2019. The Oregon Capital Chronicle and Oregon Public Broadcasting report on the strains to Oregon's treatment systems, worsened by the COVID-19 pandemic. In 2021, Oregon lost about 150 beds for adults and children; only one adolescent program remains in the state.

Bacterial infections due to injection drug use increased six-fold between 2008 and 2018. While this increase was mostly due to opioid use, hospitalizations related to stimulant use increased the most – a 15-fold increase.

Opioid crisis/Overdoses: Opioid use, specifically, has increased dramatically. Overdoses of all causes involving single or multiple drugs increased during 2020. Nearly 700 people in Oregon died from a drug overdose in 2020, a 30% increase from 2019. Comparing the 12 months prior to the pandemic (March 2020) to the 12 months ending September 2021, Oregon experienced a 73.8% increase in provisional overdose deaths, compared to 39.2% nationally. The number of provisional overdose deaths involving synthetic opioids increased 358% (from 98 to 449) and psychostimulants rose 90% (from 290 to 550).

According to Oregon's 2020 SUDORS data on overdose deaths, 84% involved methamphetamine, heroin, or fentanyl used alone or in combination with other drugs. Only 2.7% of individuals who died of drug overdose were being treated for a substance use disorder (SUD) at the time of death and Naloxone was only administered in 11.5% of opioid-involved deaths.

The highest rates of overdose deaths in Oregon occurred among middle aged people (aged 35 – 44 or 45 – 54), Black individuals, and people experiencing homelessness.

Overdose deaths have also increased among people living with HIV. Whereas the proportion of deaths due to HIV disease decreased, fatal overdoses among PLWH increased from 10 in 2020 to 16 in 2021, a rate higher than the general population in Oregon. In 2021, 80% of fatal overdoses among PLWH were associated with methamphetamine; 20% were associated with heroin and fentanyl. Rates were higher among males, American Indian/Alaska Natives, and Black/African Americans; fatal overdoses were observed among all age groups.

Oregon established a prescription drug monitoring program in 2009 to reduce the misuse of prescription opiates, and opiate prescriptions per capita have dropped. Still, in 2019-2020, Oregon had the highest rate of misuse per capita of prescription opioids in the country, with 4.46% of Oregonians reporting misuse of prescription drugs.

However, multiple opioid overdose prevention funding sources have provided opportunities for prevention and treatment. For example, the State Opioid Response grants have funded the PRIME Plus peer program and other harm reduction services in urban and rural communities across Oregon. Several awareness campaigns and 10 overdose-related projects and services are available across Oregon.

Measure 110 (also known as the Drug Addiction Treatment & Recovery Act), approved by voters in 2020, decriminalized drug possession and funneled $31 million into treatment programs; in addition, 60% of the funds were allocated for harm reduction, and 15% for housing assistance.

Mental Health Needs & Service Use:
Oregon has the 2nd-highest rate in the U.S. of teens and adults with any mental illness (about 27% of the population); 20% of the population received past-year mental health services. Oregon ranks 3rd for serious mental illness (7% of Oregonians), 5th for major depressive episode (9.8% of Oregonians), and 2nd for serious thoughts of suicide in the past year.

COVID-19: The COVID-19 pandemic taxed the public health system and its people. The Public Health Workforce Interests and Needs Survey (PH-WINS), conducted between Sept 2021-Jan 2022 found that more than half of public health employees report at least one symptom of PTSD and 25% report 3 or 4 symptoms, indicating probable PTSD. Nearly 1 in 3 public health employees said they were considering leaving their organization in the next year. Many public health executives experienced threats, bullying, and harassment, adding to deteriorating morale. Additional surveys (a 2020 survey and a MMWR released in late 2021) report similar findings.

Specific impacts to STI Programs reported by a National Coalition of STD Directors survey included staff deployments throughout the two years of the pandemic, clinic closures, delays in providing DIS services, STI test kit shortages, diminished lab capacity, and "severe burnout as DIS pivot from COVID-19 investigations and contact tracing back to STD intervention and partner services work."

Criminal Justice Involvement: Oregon has an incarceration rate of 555/100,000 people, with about 24,000 people incarcerated in state, local, federal, youth, or other types of facilities at any point in time. People can cycle quickly in and out of jails; each year, about 42,000 unique people are booked into local Oregon jails. Racial inequities in incarceration are well-documented and persist in Oregon: whites are underrepresented, while Black/African Americans, Latinos/Latinx, and American Indian/Alaskan Natives are overrepresented.

The Center for HIV Law & Policy states: "Each year, an estimated one in seven persons living with HIV pass through a correctional or detention facility. At the end of 2010, state and federal prisons held over 20,000 people living with HIV. The rate of HIV among prisoners is 5 to 7 times that of the general population. HIV rates are highest among Black prisoners." Studies have linked the mass incarceration of Black Americans with increased risk of HIV acquisition in Black communities.

Some PLWH are first diagnosed in a correctional setting. Other PLWH face an increased risk of discontinuity of care both during incarceration and once they are released from correctional settings; recent incarceration is independently associated with worse health outcomes and increased use of emergency services among PLWH in care. PLWH released from jails and prisons face numerous challenges to successful linkage and retention in HIV treatment and care, including lack of adequate housing, lack of health insurance post-release, difficulty securing employment, behavioral health issues, and the experience of multiple, intersecting stigmatized identities.

Four percent of Oregon MMP participants report incarceration in the 12 months preceding the survey.

Food Insecurity: In 2019, Oregon was ranked as the 20th hungriest state in the US, with 12.9% of Oregonians reporting food insecurity and 5.4% reporting hunger. Early post-pandemic estimates indicate dramatically worse hunger rates due to COVID-19: "[COVID] has brought the state to levels of food insecurity not seen before." Hunger and food insecurity affect some groups in the state of Oregon disproportionately, including but not limited to families, the elderly, people with disabilities, veterans, and people of color, particularly Black, Latinx, and American Indians. Many studies link food insecurity to poor health outcomes for PLWH, including viral nonsuppression; food insecurity is also associated with greater vulnerability to HIV acquisition. Ensuring adequate food and nutrition is, therefore, an important strategy for achieving goals along the entire HIV status-neutral continuum.

Health Insurance: In 2019, the Oregon Health Insurance Survey found that 94% of Oregonians were covered by health insurance, about a 10% increase from before Oregon's implementation of the Affordable Care Act's Medicaid expansion. According to the survey, nearly half (49%) of Oregonians are covered by private group policies. About one-quarter (25%) receive health coverage through the Oregon Health Plan, which includes Medicaid, the Children's Health Insurance Program and the Breast and Cervical Cancer Treatment program. Another 15% have Medicare coverage, 4% have individual coverage, and 6% are uninsured. As of July 1, 2022, a new law was implemented, requiring further expansion of Oregon Health Plan eligibility to adults age 19-25 and 55 and older, regardless of immigration status. Before the 2022 expansion, it was estimated that 1 in 4 Oregonians were covered by OHP. Many prevention services, including HIV/STI testing and PrEP, are covered by health insurance, although there is wide variation in co-pays, out-of-pocket costs, and coverage of labs and other ancillary services. CAREAssist provides co-pays and open-formulary pharmaceutical coverage to people living with HIV whose income is ≤550% FPL.

Housing: Safe, decent, and affordable housing provides a critical foundation for PLWH to access medical care and supportive services, begin and stay on HIV treatment, and achieve viral suppression. A systematic review of more than 150 high-quality studies found that lack of stable housing was almost universally associated with worse health outcomes for PLWH; housing assistance was associated with better outcomes. Rising housing costs, low vacancy rates, and loss of affordable housing stock due to gentrification and wildfires have created a statewide housing crisis, as mentioned previously in this Plan. Behavioral health issues, including mental health conditions and addictions, present additional barriers to clients trying to secure and maintain stable housing in an extremely difficult market.

Intimate Partner Violence: As noted earlier, 44% of PLWH in Oregon report a lifetime history of IPV. IPV can affect HIV prevention and care at all points of the HIV care continuum. For example, IPV can increase risk of HIV infection by limiting a person's ability to negotiate safer sex and safer drug use. IPV can prevent the ability to engage in HIV medical care and other social services for PLWH, and to stay adherent to ART. HIV status can be leveraged by an abusing partner and status disclosure may increase the risk or severity of IPV. Women and LGBTQ individuals of all genders experience high rates of IPV. Within the LGBTQ community, transgender people and bisexual men and women face higher rates of sexual violence. Key

informant interviews with subject matter experts identified a need for more IPV/sexual assault resources tailored for people in same-sex relationships, and for MSM of color, specifically. Providers also reported a lack of formal collaborations between IPV and HIV/STI providers and identified a need and desire for cross-training.

LGBTQ+ Equality and Discrimination: According to the Human Rights Campaign 2021 State of Equality Index, Oregon is ranked among states working towards innovative equality, which means it has a broad range of protections to ensure equality for LGBTQ+ people, including comprehensive non-discrimination laws, safer school policies, and healthcare access for transgender people. They recommend that advocates focus on the implementation of laws and advance innovative legislation that addresses the needs of vulnerable populations. While this is positive, findings from the GLSEN 2019 National School Climate Survey demonstrate that Oregon schools were still not safe for most LGBTQ secondary school students, many LGBTQ students in Oregon did not have access to important school resources, such as an LGBTQ-inclusive curriculum, and were not fully protected by supportive and inclusive school policies (e.g., students report being punished for same-sex public displays of affection, not being allowed to use locker rooms or bathrooms that align with gender identity). In 2022, Healthy Relationships curricula delivered in Oregon schools by community partners funded by OHA have been aggressively challenged because the curricula includes LGBTQ relationships and content.

Queer communities, particularly trans individuals, often report a lack of access to social determinants of health. For example, LGBT people of most races and ethnicities show higher rates of poverty than their cisgender straight counterparts (22% vs. 16%); poverty rates were as high as 30% for trans people and cis bisexual women.

Oregon is experiencing steady growth among older adults, including LGBTQ+ people. Based on estimates from the Oregon BRFSS, approximately 3.4% of Oregonians aged 55 and older identify as lesbian, gay, or bisexual (LGB) which includes 3.2% of women and 3.8% of men. This is higher than the national estimate of 1.3% – 2% for this age group. According to the Oregon LGBTQ+ Older Adult Survey, nearly 60% of Oregon's LGBTQ+ older adult participants have experienced discrimination within the last year and nearly a quarter (24%) of LGBTQ+ older adult participants have experienced elder abuse in the past year. The survey concludes that LGBTQ+ older adults in Oregon are an underserved yet resilient population and provides a list of recommendations for planning for the aging of the LGBTQ+ population in Oregon.

Racism and Anti-Racism: Racism has been formally acknowledged as a public health crisis at the national, state, and local levels. Structural and interpersonal racism is a fundamental cause of health inequities and disease, including HIV, STI, VH, and other syndemic conditions. Across the country and in Oregon, racial and ethnic minority populations experience higher rates of poor health and disease in a range of other health conditions, as well, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts. The life expectancy among Black/African Americans is four years lower than that of White Americans. In Oregon, we see these inequities reflected in HIV/STI data. The Oregon Health Authority has set a ten-year goal to eliminate health inequity in Oregon; partner agencies have set similar goals. Eliminating inequities, by leading with race, is the foundation of eliminating new HIV/STI transmission in Oregon.

Rurality: Rural Oregon faces unique vulnerabilities related to HIV and STI, including barriers to health care, stigma, and lack of access to basic resources like housing, transportation, and food. Many rural and frontier areas of Oregon lack medical services, including primary and specialty care, dental and mental health care, and prenatal care.

Areas of Oregon with Greatest and Least Unmet Medical Service Needs, 2021

Greatest Unmet Need Areas	2021	2020	Least Unmet Need Areas	2021	2020
Warm Springs	24	34	Portland SW	79	79
East Klamath	26	27	Tigard	71	70
Port Orford	26	30	Portland NE	71	70
Cascade Locks	27	25	Lake Oswego	71	71
Glendale	27	30	Sisters	70	69
Swisshome/ Triangle Lake	27	27	Oregon City	69	69
Chiloquin	29	30	Eugene/University	69	69
Drain/Yoncalla	29	28	Corvallis/Philomath	69	68
Yachats	29	31	Bend	69	69
Powers	32	30	Beaverton	69	68

table credit: OHSU Office of Rural Health, 2021; 0=least access; 90=best access

Nearly all Eastern Oregon counties, and much of Southern Oregon and the Coast, are designated as Governor's Health Care Shortage Areas.

Compared to people living in the Portland metropolitan area, rural Oregonians are less likely to use PrEP, more likely to be diagnosed late in their HIV infection, and less likely to be virally suppressed once diagnosed. Rural Oregonians talked candidly about the challenges they face in a formative assessment, including surveys and focus groups, conducted in 2020-2021. Many said they had never been offered HIV testing but would be tested if presented with the opportunity. Four key themes that arose from the assessment: access to healthcare is difficult; stigma fuels misconceptions about HIV; rural Oregonians need basic information about HIV; and the best motivation for rural Oregonians to get tested is to protect the community. Very few rural Oregonians who participated in the formative surveys and focus groups were aware of PrEP and data show PrEP is underutilized among rural Oregonians. Recommendations included activities and messaging to normalize HIV and offer HIV-related and sexual health services within the context of other health services.

Almost 1,500 PLWH live rurally and another 100 (n=92) live in frontier areas; PLWH in rural areas were less likely to be virally suppressed than people living in urban areas, posing possible transmission risk to the community, as well as potential for poorer health outcomes among those individuals. New HIV diagnoses are on the rise in rural Oregon, as mentioned through this plan. Although only 15% of syphilis cases were diagnosed in rural areas, the greatest increase in syphilis diagnoses from 2019-2020 (21% increase) occurred in rural and frontier areas of Oregon. Poverty, non-injection use of methamphetamine, and heavy drinking were negatively and significantly associated with durable HIV viral suppression among MMP participants who lived in a rural ZIP code.

Sex Work: People who exchange sex for money, drugs, housing, or other resources have increased vulnerability to HIV and STI acquisition for a variety of reasons. Individuals in this

very diverse group may be more likely to engage in risky sexual behaviors (e.g., sex without a condom, sex with multiple partners) and substance use as part of their livelihood and may be more vulnerable to nonconsensual sex and violence. Those who exchange sex more regularly as a source of ongoing income are at higher risk for HIV than those who do so infrequently.

Oregon NHBS data showed that, among a sample of women of low socioeconomic status in Portland, Oregon, transactional sex was characterized by marginalized identities, homelessness, childhood trauma, sexual violence, substance use, and sexual vulnerability to HIV/STI. Multi-level interventions that address these social, behavioral, and trauma-related factors and increase access to biomedical HIV prevention are critical to the sexual health of women who engage in transactional sex. In addition, as the Oregon Sex Workers Committee states: "criminalization of sex workers and their clients makes it harder to address victimization, creates underground markets and increases the opportunity for predatory individuals to commit abuses against the most marginalized people in societies."

STI Epidemic: Among the highest priority for HIV testing and referral to status-neutral services (e.g., PrEP, linkage to HIV care) are people with a syphilis or rectal gonorrhea diagnosis; this is a key part of our HIV Early Intervention Services & Outreach (EISO) Program. Oregon's STI rates, as reported throughout this plan, are increasing and the DIS workforce experienced unprecedented strain during the first two years of the COVID-19 pandemic.

Viral Hepatitis: Hepatitis C Virus (HCV) reporting in Oregon began in 2005 and by 2015, there were nearly 60,000 reported cases. In 2017, Oregon had the 4th highest prevalence of HCV and 2nd highest HCV-related mortality in the country. Persons under 30 years of age account for half of all acute (new) HCV infections in Oregon. Among chronic HCV cases, two-thirds are 45-64 years of age and most liver cancer cases, HCV-related hospitalizations and HCV-related deaths occur in this age group. American Indians/Alaska Natives and Black/African Americans in Oregon experience significant HCV-related inequities. HCV affects all Oregon counties, but most Oregon counties have few prescribers of HCV antivirals relative to the number of people with HCV. Oregon's Viral Hepatitis Collective meets monthly to discuss implementation of strategies to prevent new infections, decrease inequities, decrease medical care costs, and improve health outcomes.

Priority populations

Oregon's goals and objectives are written with our vision of ending inequities in mind. Our priority populations include an expanded version of those prioritized in the National HIV/AIDS Strategy. Oregon is focused on ending new HIV transmissions by using a syndemic lens, and by leading with race/ethnicity. Prioritizing community partnerships, shifting resources to communities of color and other communities experiencing inequities, and supporting community-led needs assessment, education, outreach, and ability to respond to clusters and outbreaks are themes woven through all goals and objectives.

Oregon's priority populations are listed alphabetically below, with the recognition that many people have intersectional identities; these are not mutually exclusive groups.

- American Indian/Alaska Natives
- Black/African American people

- Gay, bisexual, and other men who have sex with men (MSM)
- Latino/a/x people
- Native Hawaiian/Pacific Islanders
- People experiencing houselessness/unstable housing
- People who inject drugs (PWID)
- People who live in rural or frontier areas
- People who use methamphetamine
- People with sexually transmitted infections, particularly syphilis and rectal gonorrhea
- Transgender, nonbinary, and gender diverse people, with a focus on transgender women
- Youth

Section V. Oregon Goals and Objectives, 2022-2026

DIAGNOSE

Testing is easy but too few Oregonians know their HIV status. Many people in Oregon still receive their diagnosis years after infection, often because of the onset of an illness that might have been prevented with early testing and treatment. Knowing one's HIV status creates opportunities for people to enjoy better health and longer life – and protect partners from transmission. Oregon aims to increase overall awareness of HIV and STI, especially among communities facing inequities, to increase HIV and STI testing, and to expedite linkage to care for people who test positive. Our goal is for everyone with HIV and STI to be diagnosed as early as possible.

Five-Year Goals/Expected Impact on the HIV Care Continuum:

- Increase the number of people who know their HIV status by 87%.
- Eliminate racial/ethnic disparities in HIV testing, ensuring that at least 70% of all groups report having been tested at least once in their lifetimes.
- Increase the number of people linked to medical care within 30 days of HIV diagnosis by 25%.

Objective 1.1 Increase awareness of HIV/STI, especially among priority populations (e.g., people experiencing inequities along the HIV care continuum)

1.1.1 Expand community-designed and -led education and outreach programs
1.1.2 Develop and implement community awareness materials/media to provide education about comprehensive sexual health; options for prevention, testing, care, and treatment; and HIV/STI-related stigma reduction
1.1.3 Partner with agencies and programs serving priority populations to integrate HIV/STI education, information, and referrals into their existing programming and services

Objective 1.2 Increase proportion of adult Oregonians who have ever been tested for HIV from 37.4% to 70%

1.2.1 Leverage and promote HIV/STI partner services
1.2.2 Build local capacity to implement self-testing and self-collection testing strategies
1.2.3 Promote routine and integrated HIV/STI testing among Medicaid clients
1.2.4 Conduct health care provider education to ensure widespread routine HIV testing and integrated HIV/STI testing
1.2.5 Expand availability of HIV testing in Emergency Departments

Objective 1.3 Increase proportion of newly diagnosed individuals linked to care within 30 days from 72% to 90%

1.3.1 Support statewide early intervention services, which provides a status-neutral approach to HIV testing by offering linkage to prevention services for people who test negative and immediate linkage to care for people who test positive
1.3.2 Strengthen partnerships between private and public medical providers and health care systems
1.3.3 Ensure culturally competent and linguistically appropriate services are available to newly diagnosed individuals

Outcome Measures & Data Sources:

- # of newly diagnosed persons with HIV (Oregon HIV Surveillance System)
- % of adult Oregonians who report ever having been tested (Behavioral Risk Factor Surveillance System)
- % newly diagnosed persons with HIV linked to care within 30 days (Oregon HIV Surveillance System)

PREVENT

Prevention works. Through a combination of behavioral and biological interventions, we aim to eliminate new HIV transmissions in Oregon. There are pronounced racial and ethnic inequities in new HIV diagnoses in Oregon that need to be redressed and eliminated through community-driven solutions. PrEP, PEP, syringe services programs, access to condoms and other sexual health supplies, and education and outreach are all key prevention strategies. In addition, we know that HIV and other STI must be addressed together – we will increase STI-focused HIV prevention strategies, like integrated HIV/STI testing, partner services, and delivery of status-neutral services through EISO and other programs.

Five-Year Goals/Expected Impact on the Status-Neutral Approach and HIV Care Continuum:

- Decrease new diagnoses of HIV to 150 cases/year[6]
- Decrease new diagnoses of syphilis 24% to <1,000 cases/year
- Eliminate congenital syphilis cases
- Decrease new diagnoses of gonorrhea among youth age 19 and under by 35% (from 462 cases/year to <300)
- Eliminate racial/ethnic inequities in new HIV diagnoses
- Eliminate racial/ethnic inequities in new early syphilis diagnoses

Objective 2.1 Increase PrEP prescriptions by 200%,[7] with a focus on priority populations

2.1.1 Increase the number of providers trained to prescribe PrEP and listed on the PrEP Provider Directory
2.1.2 Increase PrEP awareness among priority populations
2.1.3 Increase PrEP uptake and successful use among priority populations
2.1.4 Increase ability of Oregon pharmacies to dispense PrEP and PEP

Objective 2.2 Decrease new HIV diagnoses among people who use drugs

2.2.1 Expand access to clean syringes, injection equipment, and bundled harm reduction services for people who use drugs
2.2.2 Expand resources for people who use non-injection drugs, particularly methamphetamine
2.2.3 Support integration of HIV/STI prevention services into substance use disorder services
2.2.4 Expand provider training about addiction, harm reduction, and the needs of PWUD to reduce stigma and create fewer barriers for PWUD to access medical care and other services

Objective 2.3 Decrease new HIV and STI diagnoses among youth age 29 and under

2.3.1 Provide comprehensive sexual health services in SBHCs and community clinics

[6] Our goal is to eliminate new HIV infections, but our 2021-2026 goal is to regain the ground lost during COVID (getting to 180 cases/year) and then decrease that amount by 17% to 150 cases/year. Since we simultaneously aim to increase testing, this seems like an ambitious goal.

[7] From 2,347 (2019 data) to 7,027—50% of the 14,054 Oregonians who could benefit from PrEP, as estimated by CDC.

2.3.2 Increase the number of schools who have adopted and are implementing LGBTQ supportive policies and practices
2.3.3 Coordinate resources, messaging, and programming to promote sexual health and HIV/STI prevention across government systems and programs serving youth

Objective 2.4 Expand community-level primary prevention strategies

2.4.1 Expand access to condoms and other prevention supplies
2.4.2 Support and expand use of social media/marketing outreach
2.4.3 Develop, support, expand culturally-specific models of prevention
2.4.4 Expand access to PEP

Objective 2.5 Support & expand STI screening, prevention, and treatment

2.5.1 Conduct provider education through practice transformation and through other educational opportunities
2.5.2 Support use of innovative testing strategies and expedited partner therapy
2.5.3 Identify and scale up new and promising practices to prevent congenital syphilis
2.5.4 Ensure that all people treated for syphilis and rectal gonorrhea receive HIV testing and referral to PrEP
2.5.5 Increase access to STI/HIV screening, prevention, and treatment in correctional settings, including jails and prisons

Outcome Measures & Data Sources:

- # of new diagnoses, by priority population
- # of medical providers listed on PrEP Provider Directory, # of new providers added, geographic coverage of provides (OHA Administrative Data)
- # of PrEP prescriptions (AIDSVu, Oregon All Payer/All Claims Data)
- # of syringe services programs (OHA Administrative Data)
- # of schools with LGBTQ supportive policies and practices (Oregon Department of Education data)
- # of pharmacists and pharmacy technicians who have received approved training for pharmacist prescribed PEP and PrEP, # of unique pharmacy locations who have trained staff, by county (OHA Administrative Data)
- # of LPHAs and CBOs with capacity to conduct dried blood spot testing for HIV/syphilis/HCV and self-collected HIV/STI testing (OHA Administrative Data)

TREAT

Treatment saves lives. Early diagnosis and linkage to HIV medical care, along with services to address structural barriers to treatment, support the development and maintenance of viral suppression. As a chronic condition, people living with HIV need ongoing support to maintain viral suppression and to achieve positive health outcomes across the life-course. This includes services tailored for older PLWH and long-term survivors, who comprise a growing proportion of PLWH and have special needs. Wide promotion of U=U messaging is also an important element of ending new HIV transmissions in Oregon. U=U reduces stigma for PLWH and supports the key strategy of treatment as prevention.

Five-Year Goals /Expected Impact on the HIV Care Continuum:

- Increase the proportion of PLWH who are virally suppressed by 17% (from 77% to 90%)
- Eliminate racial/ethnic inequities in viral suppression rates

Objective 3.1 Expand rapid start ART programs across the state, ensuring newly diagnosed people can start ARTs within 7 days

3.1.1 Support and promote the CAREAssist Rapid Bridge Program for newly diagnosed people
3.1.2 Expand clinical capacity to provide rapid start ART statewide
3.1.3 Align public-private systems statewide to ensure a no-wrong-door approach to red carpet, 1 to 1 early intervention services for newly diagnosed
3.1.4 Ensure rapid start ART and early intervention service expansion focus on underserved geographic areas and are responsive to identified priority populations with increased care access barriers

Objective 3.2 Identity and engage or reengage 50% of PLWH who are out of care (OOC) or never in care (NIC)

3.2.1 Conduct annual audit of Surveillance data to identify PLWH who are out of care/never in care. Share lists with LPHA/EISO Programs for follow-up
3.2.2 Identify and address barriers for individuals who are OOC and NIC, in coordination with community partners
3.2.3 Conduct outreach and provide education to CAREAssist clients who are not regularly filling medications and/or not in case management and out of care

Objective 3.3 Retain all people in care and eliminate inequities by addressing social and structural barriers

3.3.1 Provide health insurance/access to medical care and pharmaceuticals through the CAREAssist Program for underinsured or uninsured people
3.3.2 Stabilize housing among PLWH
3.3.3 Ensure food security among PLWH
3.3.4 Ensure income stability among PLWH
3.3.5 Ensure all RWHAP service providers regularly attend and participate in anti-racist and trauma- informed care learning and implementation
3.3.6 Increase access to medical care and other services for PLWH
3.3.7 Ensure linkage to care for people exiting correctional settings

Objective 3.4 Retain all people in care and eliminate inequities by addressing HIV stigma

3.4.1 Promote U=U

3.4.2 Develop and support opportunities for PLWH leadership, ensuring inclusion of a diversity of PLWH voices and experiences

3.4.3 Increase options for whole-person care and supportive services tailored to older PLWH, long-term survivors, and PLWH with disabilities

3.4.4 Provide education and training for health care staff on stigma, discrimination, unconscious bias, HIV and sexual orientation and gender identity (SOGI) issues

3.4.5 Address psychosocial and behavioral health needs of PLWH

3.4.6 Enforce and support legal and policy solutions to address stigma

Outcome Measures & Data Sources:

- % of newly diagnosed people receiving ART within 30 days of diagnosis (Oregon HIV Surveillance Data)
- % of newly diagnosed people receiving ART within 30 days of diagnosis (Oregon HIV Surveillance Data)
- % of newly diagnosed people achieving viral suppression within 90 days (Oregon HIV Surveillance Data)
- % of PLWH virally suppressed (Oregon HIV Surveillance Data)
- % of PLWH reporting HIV-related stigma (Oregon HIV Medical Monitoring Project)
- All measures by race/ethnicity, gender, age, urban/rural residence, reported HIV risk factor, other SDOH (as available)

RESPOND

Ending new HIV transmissions in Oregon requires partnerships across multiple systems and communities. Inequities exist along the HIV status neutral continuum. Eliminating inequities requires a refocusing of resources to communities where the need is greatest. This means regularly analyzing our data to identify disparities and inequities, sharing data with the community in a timely manner, and with race/ethnicity. Detecting outbreaks and clusters of new infections through enhanced surveillance is an essential part of an effective response to HIV/STI; strong community partnerships are also required to quickly provide treatment and prevention resources and implement policy responses to limit transmission.

Five-Year Goals/Expected Impact on Status Neutral Approach:

- Eliminate racial & ethnic inequities along the HIV care continuum
- Increase the number of people in networks affected by rapid transmission who know their HIV diagnosis, are linked to medical care, and are virally suppressed, or who are engaged in appropriate prevention services (e.g., PrEP, syringe services programs)

Objective 4.1 Direct resources to communities where the need is greatest, focusing on ending inequities by leading with race and ethnicity

4.1.1 Support community-developed and community-led interventions across the status-neutral continuum through direct grants (CBO Equity grants, End HIV Oregon mini-grants, LPHA-CBO relationships)

4.1.2 Support the Youth Advisory Committee for youth-led needs assessment and project implementation

4.1.3 Provide technical assistance and other requested support to partners working with priority populations to amplify current efforts in other areas of the syndemic

4.1.4 Ensure a sustainable future for LPHAs and CBOs providing HIV and STI testing and treatment by building capacity to bill Medicaid and other insurance providers for services

Objective 4.2 Increase capacity and implementation of activities for detecting and responding to HIV clusters and outbreaks

4.2.1 Analyze HIV surveillance data to detect transmission clusters and monitor HIV drug resistance and HIV genetic diversity

4.2.2 Support lab testing, including strategies for testing in non-clinical settings

4.2.3 Support use of dried blood spot testing for use in responding to HIV clusters and outbreaks

4.2.4 Rebuild the electronic laboratory reporting functionality to streamline and automate the manual export and cleaning of molecular lab data from Orpheus to prepare it for import into eHARS

Objective 4.3 Ensure data equity and accessibility of data for use by the community

4.3.1 Develop a policy statement that details how HIV/STI data on race/ethnicity will be collected, analyzed, framed, and reported from Oregon surveillance

4.3.2 Analyze all data by race/ethnicity and other demographics, including indicators of structural and social determinants of health, wherever possible. Share data with the

community in a timely manner, in easily understandable formats, and framed with an anti-racist lens

4.3.3 Support community-led data collection to identify needs, priorities, and strategies and solicit community input to help interpret surveillance data

Outcome Measures & Data Sources:

- HIV care continuum measures (HIV testing, HIV diagnosis, linkage to care, viral suppression) by race/ethnicity (Oregon HIV Surveillance System)
- Number and type of funded partnerships with community groups (Oregon administrative data)
- Cluster and outbreak data (Oregon Surveillance Program administrative data)

Updates to other strategic plans used to meet requirements

Not applicable. Oregon is not an EHE jurisdiction and did not use other plans to meet the requirements of the Integrated Plan and SCSN.

Section VI. Implementation, Monitoring, and Jurisdictional Follow Up

Implementation Approach

The Oregon Health Authority, which is the Part B grantee and Prevention/Surveillance grantee, is responsible for ensuring implementation, monitoring, and follow up of all activities listed in this integrated plan. However, OHA can only accomplish this in partnership with Multnomah County Health Department, the Part A grantee, and with the guidance of our community planning bodies, the OSPG and the Part A Planning Council.

Implementation

Oregon has developed the following tools and procedures to assist with implementation of the plan:

- We have distilled the plan's goals and objectives into a Strategy Map that will be updated at-least annually and widely shared with partners and community members (Appendix 5)
- Beginning in January 2023, Part B and Prevention staff will use a Smartsheet to track progress on plan activities. An OHA staff member will coordinate with MCHD staff to track Part A progress.
- Oregon reports on our high-level goals and objectives using the user-friendly End HIV Oregon data dashboards.
- Each OSPG meeting includes updates on the plan and, as needed, workshopping of ideas. We use a standard presentation template to show where the presentation content fits into the plan. Presenters also receive presenter guidelines to help them draw explicit connections between their presentation content and the Integrated Plan. The 1st meeting of each calendar year includes an update on the previous year's accomplishments and any changes to the plan.
- The Part A Planning Council reviews plan objectives bi-annually and discusses them as part of their federally-mandated processes (such as the Priority Setting & Resource Allocation [PSRA]).
- OHA will require contracted partners responsible for plan activities to report on progress during regular contract administration meetings.

Monitoring

OHA and MCHD staff will review the plan and its strategy map on a quarterly basis; updates will be provided at each OSPG meeting and biannually (or, as requested) to the Part A Planning Council. As always, needs assessment and planning are ongoing.

OHA and Part A staff will meet formally at an Annual Monitoring Meeting to review the plan together and make updates. Informal meetings will take place regularly, as needed, throughout the year. Updates to the plan will be released each year in conjunction with Oregon's annual End HIV Oregon progress report, which is our high-level report to the community about our progress related to integrated plan goals. Each year, on World AIDS Day, this progress report is published in English and Spanish on our End HIV Oregon website and is shared widely through our networks and social media.

The Annual Monitoring Meeting, involving Part A, Part B, and Prevention/Surveillance, will be held in late summer each year, to ensure time for community planning bodies to review updates and provide input, and for information to be included in the annual Progress Report, released annually on World AIDS Day. This meeting will include a review of relevant data and data systems, analysis of performance measure data, development/updating of plans for including planning bodies in the monitoring (e.g., developing specific agendas/agenda items for planned planning body meetings), and an evaluation of the planning process (e.g., reviewing needs assessment data and community planning body demographics to ensure appropriate diversity and inclusion, planning additional, ongoing needs assessment activities).

OHA and Multnomah County Health Department will provide updates to CDC and HRSA as part of routine monitoring of awards.

Evaluation

Process evaluation – OHA staff review progress on goals, objectives, and activities on a quarterly basis, including review of:

- Smartsheet data related to completion of work plan tasks
- Administrative data that provide a quantitative perspective on progress (e.g., contracts, grants, and MOUs; # of self-test kits ordered; CAREAssist enrollment stats)
- Evaluation data that provide a qualitative perspective on progress (e.g., client satisfaction surveys, interviews and focus groups with clients and providers, partner and community member feedback)

Outcome evaluation – OHA's Surveillance staff tracks End HIV Oregon metrics and updates the End HIV Oregon data dashboards on an at-least annual basis.

Improvement, Reporting & Dissemination

Needs assessment and review of data are ongoing, and responsibility for these activities is shared between OHA, MCHD, and a wide range of subrecipients and community partners through our planning groups. Individual programs and agencies collect data and evaluate their programs and processes on a regular basis. Overall quality improvement processes for Oregon's Integrated Plan include:

- quarterly review of plan goals, objectives, strategies, and progress on activities by OHA and MCHD staff
- update on plan progress and solicitation of feedback at each OSPG meeting. Feedback is documented in meeting notes.
- annual Plan Review meeting between OHA and MCHD that includes review of relevant data and recommendations for revisions and improvements to plan
- sharing of suggested revisions and improvements to plan with planning groups; formalize revisions based on community input.
- document revisions and improvements in annual progress report published annually on End HIV Oregon website and shared widely with partners, community members, and people living with HIV.

Updates to other plans used to meet requirements

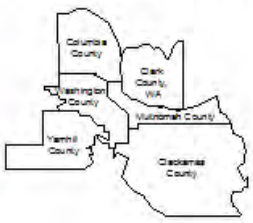
Not applicable. Oregon is not an EHE jurisdiction.

Section VII: Letters of Concurrence

Portland Area HIV Services Planning Council

Advocacy and planning for people affected by HIV in the Portland metro area

Ryan White Program, Part A



Dear Karen Gooden, Western Branch Chief at HAB, HRSA

The Portland TGA HIV Services Planning Council concurs with the following submission by the Oregon Health Authority on behalf of RWHAP Part A, RWHAP Part B, and Prevention & Surveillance in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The Portland TGA HIV Services Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

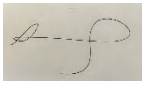
The Portland TGA HIV Services Planning Council reviewed the plan and provided substantive input over the course of its development. Specifically, Planning Council members and the Part A grantee provided data and information in the early development of the plan, received updates at Planning Council meetings about Plan development throughout 2021-2022 and provided input, reviewed the entire written plan and provided input on a google doc during September 2022, and received a final opportunity to provide input and have questions answered prior to the concurrence vote. Part A and Part B/Prevention staff met monthly throughout the planning process to ensure coordination.

Our plans for reviewing and updating this integrated plan are detailed on page 66-67 of the Plan. In brief:

Part A, Part B, and Prevention/Surveillance staff will meet formally at an Annual Monitoring Meeting to review the plan together and make updates. Informal meetings will take place regularly, as needed, throughout the year. The Annual Monitoring Meeting, involving Part A, Part B, and Prevention/Surveillance, will be held in late summer each year, to ensure time for community planning bodies to review updates and provide input.

Updates to the plan will be released each year in conjunction with Oregon's annual End HIV Oregon progress report, which is our high-level report to the community about our progress related to integrated plan goals. Each year, on World AIDS Day, this progress report is published in English and Spanish on our End HIV Oregon website and is shared widely through our networks and social media.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Signature:  Date: 11/2/22

Bri Williams, Portland TGA Planning Council Chair

November 22, 2022

Dear Mr. Buchanan and Mr. Jackson:

The End HIV/STI Oregon Statewide Planning Group (OSPG) concurs with the following submission by the Oregon Health Authority on behalf of RWHAP Part A, RWHAP Part B, and Oregon Prevention & Surveillance in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The OSPG has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The OSPG reviewed the plan and provided substantive input over the course of its development. Specifically, OSPG members provided data and information in the early development of the plan; received updates and provided input at OSPG meetings about Plan development throughout 2021-2022; reviewed the entire written plan and provided input on a Google Document during September 2022; and received a final opportunity to provide input and have questions answered prior to the concurrence vote. Part A and Part B/Prevention staff met monthly throughout the planning process to ensure coordination.

Our plans for reviewing and updating this integrated plan are detailed on page 66-67 of the Plan. In brief:

Part A, Part B, and Prevention/Surveillance staff will meet formally at an Annual Monitoring Meeting to review the plan together and make updates. Informal meetings will take place regularly, as needed, throughout the year. The Annual Monitoring Meeting, involving Part A, Part B, and Prevention/Surveillance, will be held in late summer each year, to ensure time for community planning bodies to review updates and provide input.

Updates to the plan will be released each year in conjunction with Oregon's annual End HIV Oregon progress report, which is our high-level report to the community about our progress related to integrated plan goals. Each year, on World AIDS Day, this progress report is published in English and Spanish on our End HIV Oregon website and is shared widely through our networks and social media.

The signatures below confirm the concurrence of OSPG with the Integrated HIV Prevention and Care Plan.

Community Co-Chair Signature: DocuSigned by: F37602B7F4AF48C...

Name: Michael Thurman-Noche

State Co-Chair Signature: DocuSigned by: Myriam Polanco-Allen 7C5BFD6D09444B1...

Name: Myriam Polanco-Allen

Appendix 1: Needs Assessment Inventory

Appendix 1: Oregon HIV/STI/VH Needs Assessment Inventory (September 2022)

I. Quantitative Data Sources (e.g., surveys, reportable disease data, program utilization data)

Data Source	Populations	Types of Data Collected	Other Considerations	Key Domains
AIDSVu	People with a PrEP prescription	PrEP use	National data – not consistent with Oregon APAC data but reliably available on an annual basis. Used for End HIV Oregon metrics.	Prevent
All Payer All Claims Data (APAC)	People with a medical claim (public/private) related to HIV/STI/HCV	HIV/STI/HCV testing and treatment, PrEP use, health insurance, health care utilization	Delays in accessing data make APAC unreliable for annual metrics, consistent & ongoing evaluation	Test, Prevent, Treat, Respond
Behavioral Risk Factor Surveillance System (BRFSS)	Oregon population age 18+	HIV testing Other health behavior	Methodological limitations related to phone surveys	Test, Prevent
CDC HIV testing program data	People who test for HIV through public programs	Testing location, results	Public testing represents a minority of people who test for HIV in Oregon	Test
Census	Oregonians	Variety of demographic measures, SDOH	Useful for contextualizing all other measures	Test, Prevent, Treat, Respond
Chime In/National HIV Behavioral Surveillance System (NHBS)	Rotating populations every 3 years: MSM, PWID, low-income heterosexuals	HIV/STI testing, PrEP knowledge and use, wide range of behaviors, SDOH measures	Portland metro area only Annual data collection—population-specific data every 3 years	Test, Prevent, Respond
Early Intervention Services & Outreach (EISO)	People enrolled in EISO (newly diagnosed with HIV, diagnosed with STI, partners of people with HIV/STI, people	Incidence, prevalence, care patterns, PrEP referrals, HIV/STI co-infection/(missed) opportunities for prevention, linkage to care	Some challenges with validity of PrEP data	Test, Prevent, Treat, Respond

	tested through outreach testing)			
End HIV Oregon Community Opinions Survey	Community members, HIV/STI treatment and prevention partners, PLWH	Community priorities for testing, prevention, and treatment	Convenience sample with wide recruitment. Survey available in English and Spanish at endhivoregon.org between Sept 1-Sept 23. N=41 participants	Test, Prevent, Treat, Respond
End HIV Oregon Listening Session	Community members, HIV/STI treatment and prevention partners	Community priorities for testing, prevention, and treatment	Convenience sample of key partners, with good representation of state, LPHA, CBO partners, and community across Oregon. N= 32 respondents	Test, Prevent, Treat, Respond
HIV Medical Monitoring Project (MMP)	People living with HIV	Wide range of care and behavior measures, stigma & discrimination, SDOH	Small overall N participate each year. Response bias due to low response rate, though data are weighted to be representative. Add local Qs each year. national data at: https://www.cdc.gov/hiv/statistics/systems/mmp/index.html	Treat, Respond
HIV/STD Prevention Telehealth Interest and Readiness Survey Summary, July 2020 (pdf):	HIV/STI prevention partners	Attitudes and capacity to adopt telehealth services for HIV/STI clients	Surveys of 26 HIV/STI Prevention partners – 20 LPHAs and 3 external agencies	Prevent, Treat, Respond
National Coalition of STD Directors' Survey	Health department STD Program staff	Public health workforce issues	A summary of findings from surveys of health department STD programs and DIS in their ongoing response to the COVID-19 pandemic	Respond
National Survey on Drug Use and Health	Oregon data from national survey	Drug use – prevalence, behaviors, access issues	Statewide data from national survey helps contextualize needs and barriers	Prevent, Treat
OHOP/HOPWA/Housing	People living with HIV (w/ housing needs)	Housing needs and use, other SDOH	Multiple programs with different measures HOPWA EHE Planning Tool: https://ahead.hiv.gov/resources	Treat, Respond
Oregon Health Insurance Survey	Oregonians	Insurance coverage, health care needs	Contextual data related to health insurance landscape	Treat, Respond

Oregon HIV Surveillance Data (eHARS, ORPHEUS)	People who test positive for HIV	Testing location & date, CD4 and viral load results, time to viral suppression, HIV cluster detection and response data,	See HIV Surveillance Report, Supplemental Reports, and Data Tables: https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html for additional data	Test, Prevent, Treat, Respond
Oregon's Local Public Health Workforce Report, 2021	Leaders at 30 LPHAs	Public health workforce & system capacity issues	Conducted May-Aug 2021	Respond
Oregon Older Adult LGBTQ+ Survey	LGBTQ+ Oregonians age 55+	Variety of measures, including PLWH-specific. Stigma, discrimination, SDOH	Full report TBA –	Test, Prevent, Treat, Respond
Oregon STI surveillance data	People who test positive for STI	Testing location & date, participation in partner services, HIV testing & results (true?)	Syphilis, GC, chlamydia, other STI Rectal GC data may have reliability issue – not all clinicians swab for rectal/not all labs mark samples accurately	Test, Prevent
Oregon Student Health Survey	Oregon youth, 8th & 11th grades	Sexual knowledge & behavior, substance use, trauma/ACEs, other health behaviors	Only includes youth who attend school	Prevent
Other related surveillance data (TB, HCV, COVID-19)	People with TB, HCV, HBV, COVID-19	People with HIV or vulnerable to HIV who are coinfected with TB, HCV, HBV, COVID-19.		Prevent, Treat, Respond
Portland TGA Client Experiences Survey	PLWH receiving services in the TGA	Access to care, needs, trauma-informed care, challenging life situations	500+ Ryan White TGA clients	Treat, Respond
Public Health Workforce Interests and Needs Survey (PH-WINS)	Public health professionals	Workforce needs	Conducted Sept 2021-Jan 2022	Respond

Ryan White HIV/AIDS Program data	People living with HIV (enrolled in RHWAP Programs)	Program utilization, needs & unmet needs, care & treatment needs/outcomes/costs, health insurance coverage, income	People enrolled in ADAP (statewide, large population) People enrolled in HIV case management (Part B easily accessed; Part A CAREWare is different—no interface) Program service reports: https://hab.hrsa.gov/data/data-reports	Treat, Respond
Syringe services program (SSP) data	People who inject drugs, use SSP	# SSP clients, # syringes exchanged	Program data from 45 SSPs in 22 Oregon counties. Limited to counties with SSP.	Prevent
Take Me Home Program (self-testing & self-collection data)	People who use home test kits for HIV/STI testing	HIV/STI testing	Small N, data collection is voluntary and therefore incomplete	Test
Vital statistics (Oregon, National Death Index, Social Security Death Master File)	People with HIV (who have died)	HIV mortality data, disparities, coinfections		Treat, Respond
Vulnerability assessment	People who inject drugs	Estimated areas most vulnerable to IDU-related outbreaks	Mathematical modeling used to predict vulnerability to IDU-related outbreaks of acute HCV. Useful, but unclear how transferrable data are to HIV	Prevent, Respond

Qualitative Data Sources (e.g., focus groups/interviews, community forums, evaluations, crowdsourcing/public comment)

Data Source	Populations	Types of Data Collected	Other Considerations	Key Domains
CAREAssist (ADAP) Client Interviews & Focus Groups	CAREAssist clients	2019: needs & barriers related to pharmacy 2022: U=U, service priorities	Small Ns to collect in-depth information about timely topics of interest; used to implement programs or policies	Treat
Community Listening Sessions with Black/African American Community in Portland	Black/African American community members and partners	Opinions, barriers, strengths, and priorities related to HIV testing, PrEP, and stigma	3 listening sessions facilitated by contracted community member. Convenience samples. Identified themes for developing programs and outreach messaging.	Test, Prevent, Respond
End HIV Oregon Community Opinions Survey	Community members, HIV/STI treatment and prevention partners, PLWH	Community priorities for testing, prevention, and treatment	Convenience sample with wide recruitment. Survey available in English and Spanish at endhivoregon.org between Sept 1-Sept 23. Open-ended questions addressed strengths, challenges, and needs of priority populations. N=41 participants	Test, Prevent, Treat, Respond
End HIV Oregon Listening Session	Community members, HIV/STI treatment and prevention partners	Community priorities for testing, prevention, and treatment	Convenience sample of key partners, with good representation of state, LPHA, CBO partners, and community across Oregon. N= 32 respondents. Discussion solicited opinions on End HIV Oregon direction in the next 5 years.	Test, Prevent, Treat, Respond
Experiences of PrEP Use among People Recently Diagnosed with HIV	People who seroconverted after PrEP use, MSM	Knowledge, attitudes, behavior related to PrEP, unmet needs, health care use, stigma	Small N of urban MSM (n=16), though representative of population using PrEP. Some data related to access may have changed due to recent policy/legislative changes. (May 2020)	Prevent, Respond
Food Security Resource Assessment	Oregonians, especially those living with HIV	Food security, food needs & resources among PLWH	Includes key informant interviews, synthesis of secondary data sources, focus groups with IPG members, polling data from case managers. Additional region-specific KII planned for 2022.	Treat, Respond

Harm Reduction for People who Use Drugs Needs Assessment	PWID and providers who serve them in Washington County	Qualitative data related to needs, barriers, feasibility, and recommendations for services	2 discussion groups with key informant and professional partners (43 people) 110 1:1 interviews with key informants (n=12), professional partners (n=40), and PWID/clients of agencies serving PWID (n=58) Data collected May-August 2018 in & around Washington County	Prevent, Respond
HIV/STI Partner Services Assessment	People with recent STI diagnosis enrolled in EISO	Knowledge, attitudes, behavior related to partner services	Conducted in EISO counties	Test, Prevent, Treat, Respond
Latinx Sexual Health Focus Groups	Latinx Adults in Benton, Linn, and Jackson Counties	Knowledge, attitudes, and behavior related to HIV, STI, and sexual health	5 focus groups conducted in Linn and Benton Counties (42 Latinx adults, 2 rural and 2 urban groups, English & Spanish); 6 groups conducted in Jackson County (41 Latinx adults, 3 in English, 3 in Spanish) Data collected in 2017.	Test, Prevent, Respond
OR-HOPE	PWID, people who use drugs	Interviews related to prevention and treatment needs, testing	Research study and multi-level intervention focused on 9 mostly rural counties (Douglas, Lane, Clatsop, Columbia, Coos, Curry, Josephine, Lincoln, and Tillamook). Includes qualitative data	Test, Prevent, Treat, Respond
PrEP Connect Data	Partners participating in 3 PrEP Connect meetings	PrEP knowledge, awareness, implementation barriers and strategies	Statewide group of providers and community members invested in expansion of PrEP use	Prevent, Respond
Rural Oregon Formative Media Assessment	Rural Oregonians	Knowledge, attitudes and behavior related to HIV, especially testing & PrEP	Online focus groups and surveys. Market research, not PH assessment	Test, Prevent, Respond
Ryan White Part A Client Focus Groups	PLWH living in Portland metro (Part A)	Satisfaction with services, unmet needs, suggestions for improvement	4 groups of PLWH consumers—East County, Beaverton, NE PDX, downtown (N=25). Mostly cis, white men; some women, Latinx, and unstably housed folks	Treat

Ryan White Part A Priority Setting & Resource Allocation Process	PLWH living in Portland metro (Part A)	Service priorities	Part A planning Council members, BIPOC data team members, community members	Treat
Self-Testing/Self-Collection Kit Listening Session	HIV/STI prevention partners	HIV testing needs	June 2022 listening session on home testing and home-based HIV/STI self-collection attended by 49 state, local, tribal, and CBO partners	Test, Respond
U-COPE Rapid Needs Assessment of PWID in Umatilla County	PWID in Umatilla County	Facilitator, barriers, ideas for improving access to health care, SUD treatment, screening, peer, and harm reduction services	Secondary data review. Interviews with 20 service providers, 20 clients. Data collected in Feb 2022	Test, Prevent, Respond

Appendix 2: End HIV/STI Oregon Community Opinions Survey

Thank you for taking 5-10 minutes to share your thoughts about ending new HIV/STI transmission in Oregon.

We envision an Oregon where new HIV and STI infections can be eliminated and where all people living with HIV and/or STI have access to high-quality care, free from stigma and discrimination.

A key pillar of End HIV Oregon is eliminating inequities.

End HIV Oregon is in the process of updating its 5-year plan to end new HIV/STI transmissions in Oregon. The full plan will be available in December 2022. You can read an Executive Summary and the draft Goals & Objectives at www.endhivoregon.org.

1. **What do you consider the top priorities for <u>preventing</u> new HIV/STI infections? (please choose three)**

- provide testing to more people as part of routine care
- provide more testing to priority populations through outreach
- support community-developed and led sexual health education & awareness messaging
- provide treatment & prevention services for people with HIV/STI infections and their sex partners (e.g., expanding/supporting disease intervention & partner services for people with HIV/STI)
- expand PrEP use (the pill that prevents HIV) to people who need it most
- focus on PrEP adherence for those already on PrEP (the pill that prevents HIV)
- increase syringe exchange & harm reduction programs
- create more partnerships that support a syndemic focus (e.g., housing, substance use, mental health, etc.)
- other, please specify: _____

2. **What do you consider the top priorities for <u>treating</u> HIV/STI infections? (please choose three)**

- develop rapid ART start programs across Oregon (e.g., access to same-day HIV treatment or treatment within 7 days of diagnosis)
- train more HIV medical providers
- expand housing supports for PLWH
- expand other (non-housing) structural supports for PLWH (e.g., access to food, transportation)
- integrate behavioral health supports mental health and substance use treatment) into other Ryan White Programming
- create more partnerships that support a syndemic focus (e.g., housing, substance use, mental health, etc.)
- expand the use of peer navigators and community health workers
- increase access to medical care and case management through increased telehealth options, transportation support, etc.

- other, please specify: _____

3. **What do you consider the top priorities for <u>eliminating HIV/STI stigma</u>? (please choose three)**
    - increase the number and type of partnerships that support a syndemic focus (e.g., housing, substance use, mental health, etc.)
- promote U=U (the fact that people living with HIV on effective treatment with an undetectable viral load CANNOT spread HIV to sex partners)
- develop opportunities for PLWH leadership, ensuring a diversity of PLWH voices and experiences
- provide education and training for health care staff on stigma, discrimination, unconscious bias, HIV, and sexual orientation/gender identity issues
- address psychosocial and behavioral health needs of PLWH
- enforce and support legal and policy solutions to address stigma (could include LGBTQ+ school policies, HIV decriminalization, etc.)
- ensure prevention and care services are anti-racist and trauma-informed
- continue to diversify the public health workforce and transfer resources to communities most affected
- other, please specify: _____

4a. How do we ensure that our collective efforts to end HIV/STI transmissions in Oregon will reach the people who need them most?

4b. In your personal or professional experiences, what has the End HIV Oregon initiative done well for any of the priority populations?

4c. Where can we improve?

5. **About you**:

My role in HIV/STI services in Oregon is best described as:

- work for state or local public health
- work for a community-based organization that focuses on HIV/STI
- work for a community-based organization that focuses on a specific cultural or ethnic community
- work for a behavioral health organization
- work for health care/managed care/FQHC/provide clinical services
- community advocate
- other, please specific: _____

I am a person living with HIV

- Yes
- No
- Prefer not to say

My race/ethnicity is best reflected by: (choose as many as apply)

- American Indian and/or Alaska Native
- Indigenous Mexican, Central and/or South American
- Black or African American
- Hispanic or Latino, Latina, Latinx
- Middle Eastern and/or North African
- Native Hawaiian or Pacific Islander
- White
- Prefer not to say

My age group is:

- under 25
- 25-34
- 35-44
- 45-54
- 55 or older
- Prefer not to say

I live in this region of Oregon:

- Central Oregon
- Coastal Oregon
- Eastern Oregon
- Portland metro area
- Southern Oregon
- Willamette Valley (e.g., broadly defined as I-5 corridor below Portland/above Medford)
- Other, please specify: _____

My gender is … (Check all that apply)

- Woman/girl
- Man/boy
- Non-binary
- Agender/no gender
- Don't know/Questioning
- Other, please specify
- Prefer not to say

I am transgender.

- Yes
- No
- Don't know/Questioning
- Prefer not to say

THANK YOU!

Prioridades comunitarias - acabar con las nuevas transmisiones de VIH y ETS en Oregon

Gracias por tomar 10 minutos para compartirnos sus comentarios respecto a la iniciativa de acabar con las nuevas transmisiones de VIH y ETS en Oregon.

Visualizamos un Oregon donde las nuevas infecciones de VIH y ETS puedan eliminarse y donde todas las personas que viven con VIH y/o ETS tengan acceso a atención de buena calidad, sin estigmas ni discriminación.

Un pilar clave de "Oregon, acabemos con el VIH" (End HIV Oregon) es eliminar las inequidades.

El programa End HIV Oregon o, en español, "Oregon, acabemos con el VIH", está en proceso de actualizar su plan de cinco años para acabar con las nuevas transmisiones de VIH y ETS en Oregon. El plan completo estará disponible en diciembre de 2022. Puede leer un resumen exclusivo y el borrador de las metas y objetivos aquí: www.endhivoregon.org/es.

1. **¿Cuáles considera que son las prioridades principales para <u>prevenir</u> las nuevas infecciones de VIH y ETS? (elija tres)**

- Proporcionar pruebas a más personas como parte de la atención médica de rutina
- Proporcionar más pruebas a las poblaciones prioritarias a través del compromiso con la comunidad
- Apoyar los mensajes de concientización y educación de salud sexual desarrollados y dirigidos por la comunidad
- Proporcionar tratamiento y servicios de prevención para personas con infecciones de VIH y/o ETS y sus parejas sexuales (por ejemplo, expandir/apoyar la intervención de la enfermedad y los servicios para parejas de personas con VIH y/o ETS)
- Expandir el uso de PrEP (la pastilla que previene VIH) para las personas que más lo necesitan
- Enfocarse en la adherencia al PrEP (la pastilla que previene el VIH) de las personas que ya la consumen
- Incrementar los programas de servicios de jeringas y reducción de daños
- Crear más asociaciones que apoyen un enfoque sindémico (por ejemplo, vivienda, uso de sustancias, salud mental, etc.)
- Otro, favor de especificar: _____

2. **¿Cuáles considera que son las prioridades principales para <u>tratar</u> las infecciones de VIH y ETS? (elija tres)**

- Desarrollar programas de inicio rápido de terapia antirretroviral (TAR) en todo Oregon (por ejemplo, acceso a tratamiento de VIH en el mismo día o tratamiento dentro de 7 días posteriores al diagnóstico)
- Capacitar a más proveedores médicos de VIH
- Expandir los apoyos de vivienda para PLWH (personas que viven con VIH)

- Expandir otros apoyos estructurales (no de vivienda) para PLWH (por ejemplo, acceso a comida y transporte)
- Integrar apoyos de salud conductual (salud mental y tratamiento para uso de sustancias) en otros programas Ryan White
- Crear más asociaciones que apoyen un enfoque sindémico (por ejemplo, vivienda, uso de sustancias, salud mental, etc.)
- Expandir el apoyo de compañeros y de trabajadores comunitarios de salud
- Aumentar el acceso a atención médica y gestión de casos a través del incremento de las opciones de telesalud, apoyo con el transporte, etc.
- Otro, favor de especificar: _____

3. ¿Cuáles considera que son las prioridades principales para <u>eliminar</u> el estigma del VIH y las ETS? (elija tres)

- Incrementar el número y tipo de asociaciones que apoyan un enfoque sindémico (por ejemplo, vivienda, uso de sustancias, salud mental, etc.)
- Promover U=U (el hecho de que las personas que viven con VIH, que llevan un tratamiento eficaz y tienen una carga viral indetectable NO PUEDEN propagar el VIH a sus parejas sexuales)
- Desarrollar oportunidades de liderazgo para personas que viven con VIH, asegurando una diversidad de voces y experiencias de PLWH
- Proporcionar educación y capacitación acerca de estigma, discriminación, prejuicios inconscientes, VIH y problemas de orientación sexual/identidad de género para el personal de atención médica
- Abordar las necesidades de salud psicosocial y conductual de las personas que viven con VIH
- Reforzar y apoyar soluciones legales y políticas para abordar el estigma (podría incluir políticas LGBTQ+ para escuelas, descriminalización del VIH, etc.)
- Asegurar que los servicios de prevención y atención sean antirracistas y sensibles al trauma
- Seguir diversificando la fuerza laboral de la salud pública y transfiriendo los recursos a las comunidades más afectadas
- Otro, favor de especificar: _____

4a. ¿Cómo podemos asegurar que nuestros esfuerzos colectivos para acabar con la transmisión de VIH y ETS en Oregon llegarán a las personas que más los necesitan?

4b. De acuerdo con sus experiencias personales o profesionales, ¿Qué ha hecho bien la iniciativa "Oregon, acabemos con el VIH" (End HIV Oregon) por cualquiera de las poblaciones prioritarias?

4c. ¿En qué áreas podemos mejorar?

5. **Acerca de usted**:

Mi función en los servicios de VIH y ETS en Oregon se describe mejor como:

- Trabajador de salud pública estatal o local
- Trabajador de una organización comunitaria que se enfoca en VIH/ETS
- Trabajador de una organización comunitaria que se enfoca en una comunidad cultural o étnica específica
- Trabajador de una organización de salud conductual
- Trabajador de atención médica, cuidado controlado, centro de salud federalmente calificado (FQHC) o proveedor de servicios clínicos
- Defensor de la comunidad
- Otro, favor de especificar: _____

Soy una persona que vive con VIH

- Sí
- No
- Prefiero no decir

Mi identidad racial/origen étnico se describe mejor como: (elija todas las que correspondan)

- Indígena americano y/o nativo de Alaska
- Indígena mexicano, centroamericano y/o sudamericano
- Negro o afroamericano
- Origen hispano o latino
- De Medio Oriente y/o del Norte de África
- Nativo de Hawái u otras islas del Pacífico
- Blanco
- Prefiero no decir

Mi grupo de edad es:

- Menor de 25
- 25-34
- 35-44
- 45-54
- 55 o mayor
- Prefiero no decir

Vivo en esta región de Oregon:

- Centro de Oregon
- Costa de Oregon
- Este de Oregon
- Área metropolitana de Portland

- Sur de Oregon
- Willamette Valley (por ejemplo, ampliamente definido como el pasillo I-5 al sur de Portland/norte de Medford)
- Otro, favor de especificar: _____

Mi género es… (Marque todas las opciones que correspondan)

- Mujer/chica
- Hombre/chico
- No binario
- Agénero/sin género
- No sé/Lo estoy cuestionando
- Otro, favor de especificar
- Prefiero no decir

Soy una persona transgénero.

- Sí
- No
- No sé/Lo estoy cuestionando
- Prefiero no decir

¡GRACIAS!

Appendix 3: Oregon HIV Continuum of Care by Demographics, 2020

Oregon HIV continuum of care, 2020

Demographics	Group	PLWH	In Care	On ARVs	Suppressed	In Care %	On ARVs %	Suppressed %
Assigned sex at birth	Female	937	790	766	727	84%	82%	78%
	Male	7,025	5,979	5,800	5,379	85%	83%	77%
Age group	0-12	16	14	14	13	88%	85%	81%
	13-24	122	102	99	90	84%	81%	74%
	25-29	368	291	282	255	79%	77%	69%
	30-39	1,398	1,129	1,095	980	81%	78%	70%
	40-49	1,654	1,352	1,311	1,220	82%	79%	74%
	50-59	2,504	2,180	2,115	2,005	87%	84%	80%
	60+	1,900	1,701	1,650	1,543	90%	87%	81%
Race/ethnicity	American Indian / Alaska Native	76	64	62	55	84%	82%	72%
	Asian	179	144	140	137	80%	78%	77%
	Black / African American	645	522	507	459	81%	79%	71%
	Hispanic / Latinx	1,122	941	914	869	84%	81%	77%
	Multiracial	154	127	123	109	82%	80%	71%
	Native Hawaiian / Pacific Islander	24	20	19	17	83%	81%	71%
	White	5,762	4,951	4,807	4,460	86%	83%	77%
Transmission risk men	Heterosexual contact	196	150	146	141	77%	74%	72%
	MSM only	5,208	4,498	4,363	4,110	86%	84%	79%
	MSM/PWID	746	622	603	520	83%	81%	70%
	Other	18	15	15	12	83%	81%	67%
	Perinatal	42	35	34	31	83%	81%	74%
	PWID only	417	338	328	284	81%	79%	68%
	Unknown	398	321	311	281	81%	78%	71%
Transmission risk women	Heterosexual contact	563	483	469	461	86%	83%	82%
	Other	1	1	1	1	100%	97%	100%
	Perinatal	31	26	25	23	84%	81%	74%
	PWID only	216	173	168	148	80%	78%	69%
	Unknown	126	107	104	94	85%	82%	75%
Region by county	Frontier	93	70	68	60	75%	73%	65%
	Rural	944	764	741	679	81%	79%	72%
	Urban	3,674	3,141	3,047	2,826	85%	83%	77%
	Urban/Rural	3,251	2,794	2,710	2,541	86%	83%	78%

Appendix 4: Oregon HIV Prevention, Care & Treatment Resources Inventory

HIV Prevention, Care and Treatment Resource Inventory

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression
HRSA	Ryan White Part A	Multnomah County Health Department	$4,182,627.00	Cascade AIDS Project, Ecumenical Ministries of Oregon, OHSU partnership Project, OHSU Russell Street Dental, Quest Center, MCHD HIV Health Services Center, MCHD Behavioral Health	Early Intervention Services (EIS) , Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals , Medical Case Management, including Treatment Adherence Services, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Food Bank/Home Delivered Meals, Housing, Non-Medical Case Management Services, Psychosocial Support Services	✓	✓	✓	✓	✓
HRSA	Ryan White Part F	OHSU Russell Street Dental	$97,098.00	-	Oral Health Care			✓		
Tri-Met	Tri-Met bus tickets	Cascade AIDS Project	$35,000.00	-	Medical Transportation			✓		
Meyer Memorial Trust	MMT	Cascade AIDS Project	$70,000.00	-	Housing			✓		✓
City of Portland	Home Forward short term rent assistance	Cascade AIDS Project	$69,451.00	-	Housing			✓		
State of Oregon	Mental Health Grant	Cascade AIDS Project	$603,908.00	-	Housing			✓		✓
City of Portland	HUD Care Continuum	Cascade AIDS Project	$24,960.00	-	Housing			✓		✓
Multnomah County	County general fund	Cascade AIDS Project	$250,000.00	-	Home and Community-Based Health Services			✓		✓
HRSA	Ryan White Part C	Multnomah County Health Department	$811,624.00	-	Early Intervention Services (EIS)					
HRSA	Ryan White Part D	Multnomah County Health Department	$374,930.00	-	Outpatient/Ambulatory Health Services	✓	✓	✓	✓	✓
HRSA	Ryan White Part F Community Based Dental partnership Project	Oregon Health & Science University	$280,905.00	-	Oral Health Care			✓		
HRSA	Ryan White Part F Dental Reimbursements	Oregon Health & Sciences University	$58,235.00	-	Oral Health Care			✓		

HIV Prevention, Care and Treatment Resource Inventory

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression
OR PI	Ryan White Program Income	HIV Alliance	$1,083,333.00	-	Housing			✓		
OR PI	Ryan White Program Income	Eastern Oregon Center for Independent Living	$778,728.00	-	Housing			✓		✓
OR PI	Ryan White Program Income	Social Determinant Solutions	$10,000.00	-	Capacity building/technical assistance			✓		✓
OR PI	Ryan White Program Income	Familias en Accion	$253,990.00	Educate ya	Capacity building/technical assistance	✓	✓	✓	✓	✓
OR PI	Ryan White Program Income	Eastern Oregon Center for Independent Living	$250,000.00	-	Outreach Services	✓	✓			
OR PI	Ryan White Program Income	Health Management Associates, Inc	$178,304.00	-	Capacity building/technical assistance	✓	✓	✓		
OR PI	Ryan White Program Income	Civic Communications, LLC	$55,156.00	-	Capacity building/technical assistance	✓	✓	✓	✓	✓
OR PI	Ryan White Program Income	Coates Kokes	$179,400.00	-	Social marketing campaigns, Social media strategies	✓	✓			✓
OR PI	Ryan White Program Income	Multnomah County Health Department	$4,248,373.00	Cascade AIDS Project, Ecumenical Ministries of Oregon, OHSU partnership Project, OHSU Russell Street Dental, Quest Center, MCHD HIV Health Services Center, MCHD Behavioral	Medical Case Management, including Treatment Adherence Services, Mental Health Services, Oral Health Care, Substance Abuse Outpatient Care, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing, Non-Medical Case Management Services			✓		✓
CDC	National HIV Behavioral Surveillance	Oregon Health Authority	$500,000.00	Portland State University	Surveillance	✓	✓	✓		
CDC	HIV Medical Monitoring Project	Oregon Health Authority	$673,353.00	Multnomah County Health Dept: PDES	Surveillance	✓	✓	✓	✓	✓
OR PI	Ryan White Program Income	Multnomah County Health Dept: PDES	$92,877.00	-	Other Professional Services	✓	✓	✓	✓	✓
HRSA	Part B Base Grant	Oregon Health Authority	$6,586,378.00	-	AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals , Home and Community-Based Health Services , Medical Case Management, including Treatment Adherence Services, Oral Health Care, Emergency Financial Assistance, Medical Transportation, Non-Medical Case Management Services		✓	✓	✓	✓
NASTAD	NASTAD-ADAP	Oregon Health Authority	$10,004,056.00	Speridian	AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals , Other Professional Services		✓	✓	✓	✓
NASTAD	NASTAD-Community Services	Oregon Health Authority	$747,652.00	EOCIL, HIV Alliance, Portland Street Medicine, Marie Equi Institute, Haymarket Pole Collective, A6, Oasis of the Rogue Valley, Ant Farm, Slavic Community Centers of the NW, CORE, Cultivate Initiatives, DATAHS, Educate Ya, Juntos LLC, Our Bold Voices, Quest, Something Positive for Positive People, 4th Dimension Recovery, Wallace Medical	Early Intervention Services (EIS) , Outreach Services, Psychosocial Support Services , Capacity building/technical assistance, Community mobilization, Social marketing campaigns	✓	✓	✓	✓	✓
HUD	HOPWA	Oregon Health Authority	$657,515.00	Cascadia Behavioral Health, Cascade AIDS Project	Housing		✓	✓		
HUD	HOPWA	City of Portland	$1,745,975.00	Central City Concern, Cascade AIDS Project	Housing			✓		
State of Oregon	general fund	Oregon Health Authority	$330,590.00	-	Outpatient/Ambulatory Health Services, Housing			✓		✓
USDHHS	LIHEAP	Oregon Health Authority	$90,000.00	-	Low income home energy assistance			✓		✓
HRSA	Ryan White Part F	Oregon AIDS Education & Training Center	$150,000.00	-	Capacity building/technical assistance	✓	✓	✓	✓	✓
HRSA	Ryan White Part F Dental Reimbursements	Lane Community College	$89,080.00	-	Oral Health Care			✓		
HRSA	340B Rebates	Oregon Health Authority	$6,318,962.00	-	AIDS Drug Assistance Program Treatments		✓	✓	✓	✓

HIV Prevention, Care and Treatment Resource Inventory

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression
CDC	Integrated HIV Surveillance and Prevention Funding for Health Departments	Oregon Health Authority	$2,500,170.00	Clackamas County Health Department, Deschutes County Health Department, Jackson County Health Department, Lane County Health Department, Marion County Health Department, Multnomah County Health Department, Washington County Health Department	Outreach Services, Referral for Health Care and Support Services , Capacity building/technical assistance, Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Perinatal HIV prevention and surveillance,, Prevention for persons living with diagnosed HIV infection, Social marketing campaigns, Social media strategies, Surveillance, Syringe services programs, Testing, PEP/PrEP referrals, Testing (self and self-collected)	✓	✓			
CDC	DIS Workforce Development Funding	Oregon Health Authority	$1,000,000.00	(Set 1 of 2) Baker County Health Department, Benton County Health Department, Clatsop County Health Department, Columbia County Health Department, Coos County Health Department, Crook County Health Department, Douglas Public Health Network, Gilliam County Health Department, Grant County Health Department, Harney County Health Department, Hood River County Health Department, Jefferson County Health Department, Josephine County Health Department	HIV transmission cluster and outbreak identification and response, Partner services, Testing, PEP/PrEP referrals	✓	✓			
CDC	DIS Workforce Development Funding	Oregon Health Authority	$1,340,700.00	(Set 2 of 2) Klamath County Health Department, Lake County Health Department, Lincoln County Health Department, Malheur County Health Department, Morrow County Health Department, North Central Public Health District, Polk County Health Department, Tillamook County Health Department, Umatilla County Health Department, Union County Health Department, Wheeler County Health Department, Yamhill County Health Department	HIV transmission cluster and outbreak identification and response, Partner services, Testing, PEP/PrEP referrals	✓	✓			
OR GF	State General Fund	Oregon State Public Health Laboratory	$350,000.00	NA	Testing	✓				
OR GF	State General Fund	Molecular Testing Lab	$62,500.00	N/A	Testing, Testing (self and self-collected)	✓				
OR GF	State General Fund	Clackamas County Health Department	$54,472.00	N/A	Outreach Services, Referral for Health Care and Support Services , Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Social media strategies, Syringe services programs, Testing, PEP/PrEP referrals, Testing (self and self-collected)	✓	✓			
OR GF	State General Fund	Deschutes County Health Department	$17,334.00	N/A	Outreach Services, Referral for Health Care and Support Services , Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Social media strategies, Syringe services programs, Testing, PEP/PrEP referrals, Testing (self and self-collected)	✓	✓			
OR GF	State General Fund	Jackson County Health Department	$22,111.00	N/A	Outreach Services, Referral for Health Care and Support Services , Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Social media strategies, Syringe services programs, Testing, PEP/PrEP referrals, Testing (self and self-collected)	✓	✓			

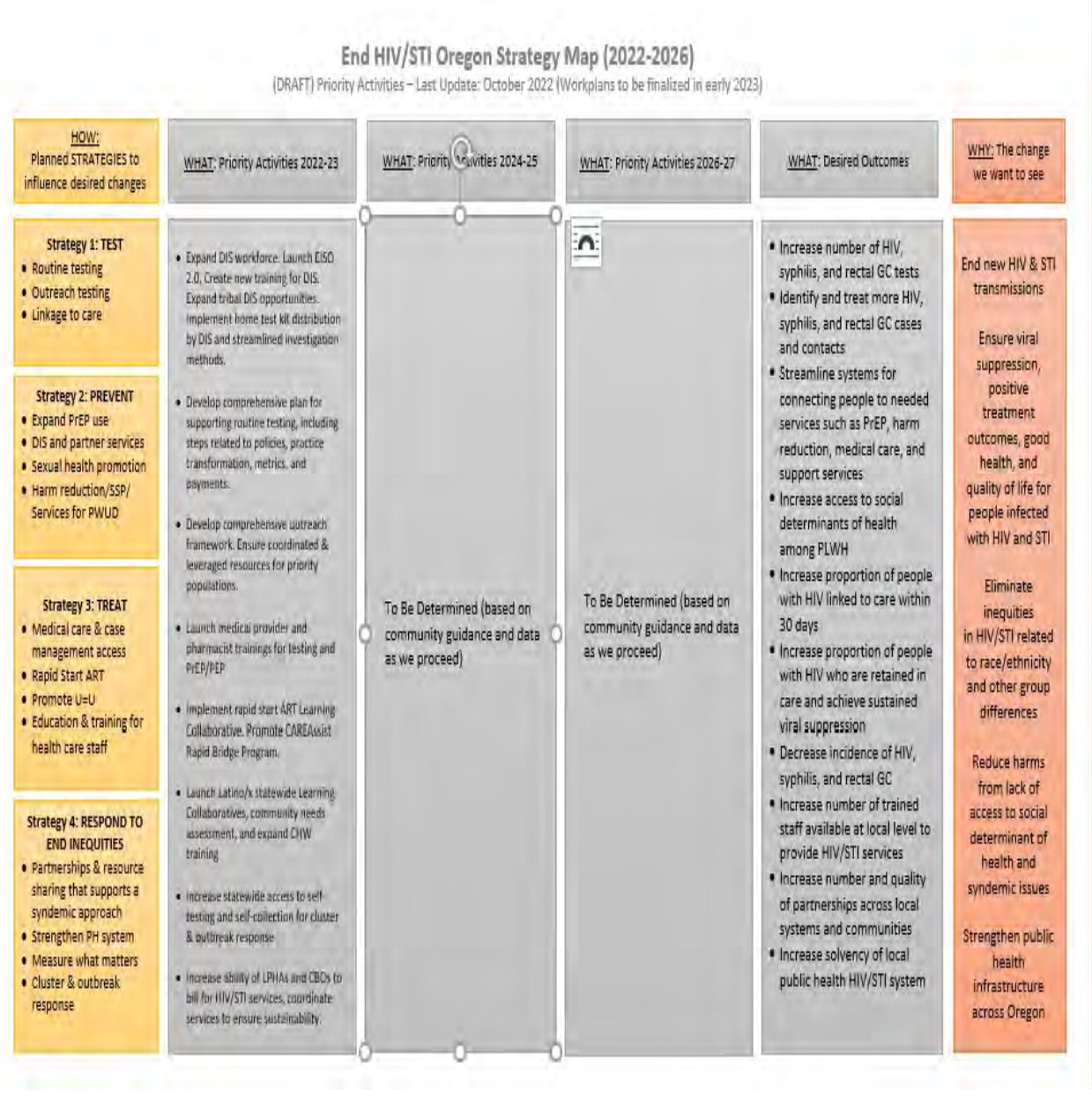
HIV Prevention, Care and Treatment Resource Inventory

OR GF	State General Fund	Lane County Health Department	$41,539.00	N/A	Outreach Services, Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Social media strategies, Syringe services programs, Testing, PEP/PrEP referrals, Testing (self and self-collected)	✓	✓			
OR GF	State General Fund	Marion County Health Department	$53,249.00	N/A	Outreach Services, Referral for Health Care and Support Services , Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Social media strategies, Syringe services programs, Testing, PEP/PrEP referrals, Testing (self and self-collected)	✓	✓			
OR GF	State General Fund	Multnomah County Health Department	$281,023.00	N/A	Outreach Services, Referral for Health Care and Support Services , Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Social media strategies, Syringe services programs, Testing, PEP/PrEP referrals, Testing (self and self-collected)	✓	✓			
OR GF	State General Fund	Washington County Health Department	$90,272.00	N/A	Outreach Services, Referral for Health Care and Support Services , Community engagement, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Social media strategies, Syringe services programs, Testing, PEP/PrEP referrals, Testing (self and self-collected)	✓	✓			
CDC	Comprehensive High-Impact HIV Prevention Programs for Community-Based Organizations	HIV Alliance	$441,625.00	N/A	Referral for Health Care and Support Services , Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Testing, PEP/PrEP referrals	✓	✓			
CDC	Comprehensive High-Impact HIV Prevention Programs for Community-Based Organizations	Cascade AIDS Project	$441,625.00	Familias en Accion	Referral for Health Care and Support Services , Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Testing, PEP/PrEP referrals	✓	✓			
OR PI	Ryan White Program Income	Oregon AIDS Education and Training Center	$710,189.00	N/A	Other Professional Services, Capacity building/technical assistance	✓	✓	✓	✓	✓
OR PI	Ryan White Program Income	HIV Alliance	$418,907.00	N/A	Outreach Services, Referral for Health Care and Support Services , Testing, PEP/PrEP referrals, PEP/PrEP navigation	✓	✓			
OR PI	Ryan White Program Income	Cascade AIDS Project	$317,742.00	N/A	Outreach Services, Referral for Health Care and Support Services , Testing, PEP/PrEP referrals, PEP/PrEP navigation	✓				
OR PI	Ryan White Program Income	HIV Alliance	$100,000.00	N/A	Early Intervention Services (EIS) , Outreach Services, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Testing, PEP/PrEP referrals	✓	✓	✓		
OR GF	State General Fund	Jackson County Health Department	$8,347.00	N/A	Syringe services programs	✓				
OR GF	State General Fund	HIV Alliance	$92,710.00	N/A	Syringe services programs	✓				
OR GF	State General Fund	Lincoln County Health Department	$4,948.00	N/A	Syringe services programs	✓				
OR GF	State General Fund	Benton County Health Department	$10,738.00	N/A	Syringe services programs	✓				
OR GF	State General Fund	Deschutes County Health Department	$1,815.00	N/A	Syringe services programs	✓				
OR GF	State General Fund	Outside In	$49,500.00	N/A	Syringe services programs	✓				
OR GF	State General Fund	Washington County Health Department	$2,589.00	HIV Alliance	Syringe services programs	✓				
HRSA	Part A grant award	Multnomah County Health Department	$168,447.00	Cascade AIDS Project	Early Intervention Services (EIS)	✓	✓	✓		
OR PI	Ryan White Program Income	Deschutes County Health Department	$431,784.00	HIV Alliance	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Testing, PEP/PrEP referrals	✓	✓	✓		
OR PI	Ryan White Program Income	Jackson County Health Department	$210,313.00	N/A	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Testing, PEP/PrEP referrals	✓	✓	✓		

HIV Prevention, Care and Treatment Resource Inventory

OR PI	Ryan White Program Income	Lincoln County Health Department	$1,003,717.00	Benton County Health Department, Linn County Health Department, Confederated Tribes of Siletz Indians	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, PEP/PrEP referrals	✓	✓	✓
OR PI	Ryan White Program Income	Multnomah County Health Department	$5,240,641.00	Clackamas County Health Department, Washington County Health Department, Latino Network, Cascade AIDS Project, Quest Center for Integrative Health	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Testing, PEP/PrEP referrals	✓	✓	✓
OR PI	Ryan White Program Income	Lane County Health Department	$831,966.00	HIV Alliance	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Testing, PEP/PrEP referrals	✓	✓	✓
OR PI	Ryan White Program Income	Marion County Health Department	$373,605.00	HIV Alliance	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Prevention for persons living with diagnosed HIV infection, Testing, PEP/PrEP referrals	✓	✓	✓

Appendix 5: End HIV/STI Oregon Strategy Map, 2022-2026



Appendix 6: Submission Checklist

CY 2022 – 2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section I: Executive Summary of Integrated Plan and SCSN				
1. Executive Summary of Integrated Plan and SCSN	New Material	Click or tap here to enter text.	*3*	Click or tap here to enter text.
a. Approach	New Material	Click or tap here to enter text.	4	Click or tap here to enter text.
b. Documents Submitted to Meet Requirements	New Material	Click or tap here to enter text.	5	Click or tap here to enter text.
Section II: Community Engagement and Planning Process				
1. Jurisdiction Planning Process	New Material	Click or tap here to enter text.	5	Click or tap here to enter text.
a. Entities Involved in Process	New Material	Click or tap here to enter text.	6	Click or tap here to enter text.
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material	Click or tap here to enter text.	8	Click or tap here to enter text.
c. Role of Planning	New Material	Click or tap here to	9	Click or tap here to

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Bodies and Other Entities		enter text.		enter text.
d. Collaboration with RWHAP Parts – SCSN Requirement	New Material	Click or tap here to enter text.	9	Click or tap here to enter text.
e. Engagement of People with HIV – SCSN Requirement	New Material	Click or tap here to enter text.	10	Click or tap here to enter text.
f. Priorities	New Material	Click or tap here to enter text.	11	Click or tap here to enter text.
g. Updates to Other Strategic Plans Used to Meet Requirements	Choose an item.	Click or tap here to enter text.	13	Click or tap here to enter text.
Section III: Contributing Data Sets and Assessments				
1. Data Sharing and Use	New Material	Click or tap here to enter text.	14	Click or tap here to enter text.
2. Epidemiologic Snapshot	New and Existing Material	HIV Continuum of Care, Oregon, 2020, Table	15	Data dashboards available online
3. HIV Prevention Care and Treatment Resource Inventory	New Material	Appendix 4: resource tables	24	Resources Tables available in Appendix 4
a. Strengths and Gaps	New Material	Click or tap here to enter text.	27	Click or tap here to enter text.
b. Approaches and	New Material	Click or tap here to	38	Click or tap here to

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Partnerships		enter text.		enter text.
4. Needs Assessment	New Material	Needs Assessment Matrix: Appendix 1	38	Full detail of needs assessment sources in Appendix 1
a. Priorities	New Material	Click or tap here to enter text.	52	Click or tap here to enter text.
b. Actions Taken	New Material	Click or tap here to enter text.	53	Click or tap here to enter text.
c. Approach	New Material	Click or tap here to enter text.	53	Click or tap here to enter text.
Section IV: Situational Analysis				
1. Situational Analysis	New Material	Click or tap here to enter text.	55	Click or tap here to enter text.
a. Priority Populations	New Material	Click or tap here to enter text.	61	Click or tap here to enter text.
Section V: 2022-2026 Goals and Objectives				
Goals and Objectives Description	Choose an item.	Click or tap here to enter text.	62	Click or tap here to enter text.
a. Updates to Other Strategic Plans used to Meet Requirements	New Material	Click or tap here to enter text.	69	Built on 2017-2021 Oregon Integrated Plan

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up				
1. 2022-2026 Integrated Planning Implementation Approach	Choose an item.	Click or tap here to enter text.	70	Click or tap here to enter text.
a. Implementation	Choose an item.	Click or tap here to enter text.	70	Click or tap here to enter text.
b. Monitoring	Choose an item.	Click or tap here to enter text.	70	Click or tap here to enter text.
c. Evaluation	Choose an item.	Click or tap here to enter text.	71	Click or tap here to enter text.
d. Improvement	Choose an item.	Click or tap here to enter text.	71	Click or tap here to enter text.
e. Reporting and Dissemination	Choose an item.	Click or tap here to enter text.	71	Click or tap here to enter text.
f. Updates to Other Strategic Plans Used to Meet Requirements	Choose an item.	Click or tap here to enter text.	71	Click or tap here to enter text.
Section VII: Letters				

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
of Concurrence				
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	New Material	Click or tap here to enter text.	72-73	Click or tap here to enter text.
3. RWHAP Part B Planning Body Chair or Representative		Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
4. Integrated Planning Body	New Material	Click or tap here to enter text.	72-73	Click or tap here to enter text.
5. EHE Planning Body	Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.