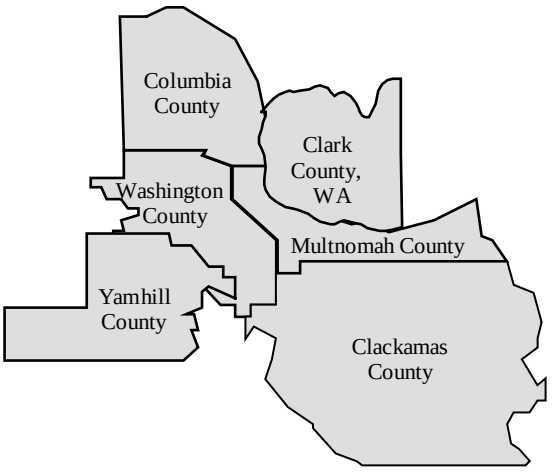
Portland TGA HIV Services Planning Council

Comprehensive Care Plan

2012-2014

Updated for FY 2015

See Section III



VISION: *New cases of HIV/AIDS are rare and all people living with HIV have access to an equitable system of care and support, free from barriers and stigma, that reduces disparities and empowers consumers to manage their own health to the best of their abilities.*

MISSION: *Through community partnerships we create opportunities and advocate for access and continuity of a full range of quality care for all persons affected by HIV.*

Part A, Ryan White Program

Portland HIV Services Planning Council

Portland, Oregon

Foreword

The Portland TGA Comprehensive Plan was originally developed for FY12-FY14. Since a new Statewide Coordinated Statement of Need will be required during FY15 (in calendar year 2016) and since the Part A Comprehensive Plan is based on the needs outlines in the SCSN, Part A has selected to write a brief update of the strategies and activities section III during FY 15. The Grantee and the Planning Council will be activies members of the SCSN development committee that will be led by Program Design and Evaluation Services. After the development of the SCSN, Part A will use that plan to develop its own Part A updated comprehensive plan. See Section III, page 33

I. Where are we now?

A. Description of the local HIV/AIDS epidemic

The Portland TGA has a population of 2.2 million, encompasses over 5,000 square miles, and includes Clackamas, Columbia, Multnomah, Washington, and Yamhill Counties in Oregon and Clark County in Washington. A detailed demographic description of the HIV/AIDS prevalence and HIV/AIDS incidence in the TGA is in Appendix A. As of 12/31/10, there were 4,256 known PLWH/A living in the TGA. Of these, 2,625 have an AIDS diagnosis and 1,631 have an HIV (non-AIDS) diagnosis. During the past three years, 440 new AIDS cases and 466 new HIV (non-AIDS) cases were reported. Between 2006 and 2010, the number of PLWH/A in the TGA increased by 18.1%. This includes a 15.2% increase in the number of PLWA and a 22.9% increase in the number of PLWH in the TGA. Overall, the makeup of PLWH/A in the TGA has remained fairly constant, with only slight increases in women, Hispanics, and older PLWH/A.

Key facts about PLWH/A in the TGA

- 88.8% of PLWH/A in the TGA are men. Within the male population, MSM account for 71.4% of all PLWA, 68.0% of new AIDS cases; 81.8% of PLWH, and 77.9% of new HIV cases.
- Women account for 9.8% of all PLWA, 13.4% of new AIDS cases; 13.4% of all PLWH, and 12.7% of new HIV cases. Within the female population, IDU account for 22.7% of PLWA, 27.1% of new AIDS cases, and 18.0% of PLWH; and heterosexual contact accounts for 62.4% of PLWA, 47.5% of new AIDS cases, and 64.6% of PLWH.
- Whites continue to be the largest racial group affected by HIV/AIDS, accounting for 77.3% of all PLWA, 71.1% of new AIDS cases, and 77.5% of all PLWH.
- Blacks/African Americans account for 8.2% of all PLWA, 8.2% of all PLWH, and make up 8.0 % of new AIDS cases and 8.8% of new HIV cases.
- The Hispanic PLWH/A population continues to increase in the TGA. Hispanics account for 10.6% of all PLWA and 9.5% of all PLWH, but make up 14.5% of new AIDS cases and 13.5% of new HIV cases.
- IDUs (excludes MSM/IDU) account for 8.1% of PLWA, 6.8% of new AIDS cases, and 4.6% of PLWH. MSM/ IDU account for 10.0% of PLWA, 10.0% of new AIDS cases and 7.3% of PLWH.
- Heterosexual contact accounts for 3.6% of all PLWA, 3.9% of new AIDS cases, and 2.1% of PLWH.

- HIV in the TGA continues to primarily impact adults. Persons under age 13 make up only 0.2% of all PLWH/A. In the last three years, there were no new HIV cases and no new AIDS cases in this population. However, youth (aged 13-24) now make up 5.5% of PLWH, 18.6% of new HIV cases and 6.6% of new AIDS cases.
- Just over two-thirds of PLWH/A in the TGA live in Multnomah County (68%), with the remainder dispersed throughout the remaining five counties of the TGA (Washington County, 12%; Clark County, 11%; Clackamas County, 8%; Columbia County, 1%; and Yamhill County. 1%).

Disproportionate impact of HIV/AIDS on certain populations In the Portland TGA, HIV has disproportionately impacted Blacks/African Americans. Blacks/African Americans account for only 2.7% of the population of the TGA but make up 8.2% of PLWH/A – approximately three times higher. With the exception of the Black/African American population, the impact of HIV/AIDS is fairly proportionate to the TGA racial/ethnic populations. While the HIV epidemic has a significant impact on women in the TGA, the majority of PLWH/A continue to be men. In 2010, men made up 49.4% of the population of the TGA, but 88.8% of PLWH/A. The population group with the greatest disproportionate impact in the Portland TGA continues to be men who have sex with men (MSM). It is estimated that MSM make up 1.9% to 5.6% of the population in the TGA (estimates based on 5%-15% of the male population age 18 and older in 2010 being MSM), but account for 75.1% of the PLWH/A population.

Disproportionate impact of co-morbidities and co-existing conditions on PLWH/A The prevalence of co-morbidities is much higher within the PLWH/A population than the general population, greatly increasing the complexity and cost of care within the Ryan White system (see table below). When compared to the general population, rates of sexually transmitted infections, homelessness, lack of insurance, and poverty are significantly higher for PLWH/A. Primary care providers of patients with co-morbidities such as hepatitis C and substance abuse must closely monitor drug interactions and coordinate medications with HIV antiviral therapies. Patients with mental illness often have trouble following treatment regimens, and low-income or uninsured patients often postpone care until conditions are urgent. Case managers spend time locating clients without permanent housing, coordinating appointments, enrolling clients in any available insurance program, and filling urgent needs such as prescription drugs, food, and transportation.

Table 1: 2010 Co-morbidities Among PLWH/A and the General Population in the TGA

Co-morbidity	General Population Prevalence: # / %		PLWH/A Population Prevalence: # / %	
	2010 Cases	2010 Rate	2010 Cases	2010 Rate
Tuberculosis [1, 2]	80	100,000 : 3.6	N/A	100,000 : 112.5 (2001-2010 Av.)
Syphilis [1]	98	100,000 : 4.4	29	100,000 : 764.2
Gonorrhea [1]	926	100,000 : 41.8	62	100,000 : 1,633.7
Chlamydia [1]	7,374	100,000 : 332.9	47	100,000 : 1,238.5
	# of people	% of Population	# of people	% of Population

Hepatitis C [10]	39,869	1.8%	1,064	25%
IDU [3, 4, 5, 13]	22,149	1%	691	16.2%
Other Substance Abuse [3, 4, 5, 13]	294,207	17.4%	1,118	26.3%
Homelessness [3, 4, 6, 7]	37,661 persons in a one-year period	1.7%	643	15.1%
Severe Chronic Mental Illness [8, 9, 11, 14, 15]	177,195	8%	1,366	32.1%
All Mental Illness [3, 4, 8, 9, 14, 15]	509,437	23%	2,928	68.8%
Dual Diagnosis: Substance Abuse & Mental Illness [3, 4, 9, 11, 16]	253,842 persons age 18+	15.0%	1,336	31.4%
No Health Insurance [11, 12, 14]	363,937	16.4%	630	14.8%
Poverty 300% FPL [4,11,12,14]	1,023,304	46.2%	4,137	97.2%
Poverty 100% FPL [4,11,12,14]	268,008	12.1%	2,788	65.5%

[1]Oregon Health Division (OHD), 2010. [2]Clark County Health Department (CCHD), 2010. [3]*2002 Survey for People Living with HIV and AIDS in Oregon*, 2003. [4]Partnership Project & Clark County Case Management Database, 2010. [5]Oregon Office of Alcohol and Drug Abuse County Databooks, 2002. [6]U.S. Conference of Mayors Report, 2007. [7]Clackamas Community Development, 2003-2005 Consolidated Plan. [8]Healthy People 2010. [9]SAMHSA: Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003. [10]CDC Data. [11]MCHD EPIC, FY 2011. [12]2009 American Community Survey. [13]National Development and Research Institutes, Inc. 2003 [14] Annual Client Services Data Report, 2010, MCHD HIV Care Services Program. [15]NIMH; The Numbers Count, 2008. [16]SAMHSA: 2002 Report to Congress.

Unmet Need Estimate for 2010 A measure of unmet need is the number of PLWH/A who do not regularly complete tests to monitor their disease and medication therapy. During calendar year 2010, 80% of people living with HIV, not AIDS (PLWH) and 72% of people living with AIDS (PLWA) in the TGA had at least one CD4 or viral load test reported to the Oregon HIV Surveillance Program (see Unmet Need Table in Appendix B). The demographics of people who know their HIV/AIDS status and were not in care in 2010 are summarized as follows.

- ***Gender:*** In the Portland TGA, 26% of male and 18% of female PLWH/A were not in care.
- ***Race/Ethnicity:*** 24% of white (non-Hispanic), 31% of Black/African American, 32% of Hispanic, 36% of American Indian/Alaska Native, 17% of Asian, 42% of Native Hawaiian/Pacific Islander, and 32% of multiracial PLWH/A were not in care.

- ***Age:*** 20% of PLWH/A age 13-24, 21% age 25-34, 25% age 35-44, 26% age 45-49, and 27% age 50 and over were not in care.
- ***Risk:*** Within the male PLWH/A population, 25% of MSM, 33% of IDU, 31% of MSM/IDU, and 30% of heterosexual risk were not in care. Within the female population, 26% of IDU and 16% of heterosexual risk were not in care.
- ***Foreign-Born:*** 38% of foreign-born PLWH/A were not in care.

During 2010, the Oregon HIV Surveillance unit and HIV Care Services conducted a special study to compare clients participating in Part A services with those in the HIV lab reporting database. Results from the comparison showed that 7.3% of Part A clients did not have at least one CD4 or viral load test in 2009, while 28% did not have CD4 tests at regular intervals (at least two CD4 tests in 2009 with at least 90 days between tests). Though not statistically significant, a slightly higher percentage of Black/African American PLWH/A (33%) did not have CD4 tests at regular intervals in comparison to Whites (28%). In addition, a slightly higher percentage of younger clients (13 – 29 years; 37.1%) did not have CD4s at regular intervals in comparison to older clients (45+ years; 23.6%).

As described in Table 2, the percent of unmet need for PLWA and PLWH has not significantly changed during the past three years. The percent of PLWA with unmet need has stayed relatively stable, with slight fluctuations between 27-29% each year. The percent of PLWH with unmet need has increased slightly this year, from 18% to 20%. The stability of unmet need for PLWA can be attributed to the TGA's collaborative system that links individuals with AIDS from emergency rooms and social service programs to ongoing medical care. The slight rise in unmet need for PLWH may be attributable to local increases in unemployment, poverty, and funding cuts to HIV and other social service providers.

Table 2. Portland TGA Estimates of Percent of Unmet Need, Calendar Years 2008 – 2010

Population	CY 2008		CY 2009		CY 2010	
Pop. Of PLWH vs PLWA (who know their status)	**#**	**%**	**#**	**%**	**#**	**%**
PLWA	2,238	63%	2,331	63%	2,372	62%
PLWH	1,311	37%	1,348	37%	1,425	38%
All PLWH/A	3,549	100%	3,679	100%	3,800	100%
Who Received Care	**#**	**%**	**#**	**%**	**#**	**%**
PLWA	1,599	71%	1,695	73%	1,704	72%
PLWH	1,070	82%	1,105	82%	1,136	80%
Who Did *Not* Receive Care	**#**	**%**	**#**	**%**	**#**	**%**
PLWA	639	29%	636	27%	668	28%
PLWH	241	18%	243	18%	289	20%

The Portland TGA has conducted an analysis of unmet need within specific demographic populations to identify trends for people who are disproportionately out of care. Percentages given are the averages of the percentages from 2008, 2009, and 2010.

To complete a CD4 or Viral Load Test

Population with greater likelihood		*Population with lesser likelihood*	
PLWH	83%	72%	PLWA
Females	82%	76%	Males
Whites	78%	70% and 71%	Hispanics and Blacks
MSM	77%	67% and 70%	IDU and MSM/IDU
Females w/ Hetero Risk	84%	74%	Females IDU

Early Identification of Individuals with HIV/AIDS (EIIHA)/Unaware Estimate for CY 2010

As of 12/31/10, data from Oregon and Washington States show that there were 4,256 persons diagnosed with HIV infection within the Portland TGA. Using the CDC national estimate that 20.1% of people living with HIV are undiagnosed, it is estimated that there were an additional 1,071 undiagnosed individuals in the TGA who were unaware of their status as of 12/31/10, resulting in a total of 5,327 PLWH/A in the TGA (Local Undiagnosed = [p/(1-p)] x N = (.201/.799) x 4,256 = 1,071).

B. Description of Current Continuum of Care

How Ryan White funded care/services interact with non-Ryan White funded services to ensure continuity of care The HIV care/service inventories for Ryan White funded and non-Ryan White funded organizations serving the TGA are included in Appendix C. In the TGA, the continuum of care is integrated through both planning activities and service delivery. Representatives of both Ryan White and non-Ryan White funded programs serve on the Council and act as key resources to inform the Council about services, special population needs, and gaps in capacity. Council members and grantee staff also participate in other planning activities (e.g. ADAP and HOPWA Advisory Groups, Oregon HIV/Viral Hepatitis/STI Integrated Planning Group). This communication ensures a common understanding of resources and service needs. The service provider system has a strong record of collaboration to ensure continuity of care for PLWH/A. This collaboration is evidenced in such activities as a coalition of public and private providers that delivers HIV case management services; a Case Management Network that brings primary care and social service providers together for information sharing and for education to improve the service system; and Ryan White/mainstream providers that have jointly applied for and received other grants for services to PLWH/A. Throughout the Part A service system, providers ensure that all other resources available to the client are considered in determining eligibility and need for Part A support.

The TGA continuum of care goals for FY 2012 are preventing new infections; finding HIV+ people who need care and treatment services; engaging HIV+ people in care and treatment services; and retaining HIV+ people in care and treatment services. Council guidance requires that historically underserved populations including women, children, youth, and racial/ethnic minorities be served at least in

proportion to their representation in the HIV/ AIDS prevalence. The system of care emphasizes access to care and retention in care for newly affected, emerging, and underserved groups through HIV prevention services, early intervention services (EIS), primary care, case management, and support services. An overview of the continuum care includes:

HIV counseling and testing, and prevention services Publicly-funded outreach, counseling, testing and referral services target at-risk groups including men who have sex with men (MSM), racial/ethnic minorities, substance abusers, youth, and women. Service locations include health department community test sites and STD clinics, correctional facilities, drug treatment agencies, and other high-risk community settings (e.g. needle exchange sites, bars serving MSM, a social center for gay/bi/trans individuals, and community events). Rapid testing is available at many test sites and is regularly available for the general population at a local AIDS service organization. Prevention strategies include locally funded needle exchange services, risk reduction counseling as part of Part A case management, condoms available at all Part A program sites, and behavioral counseling to those who come to Multnomah County Health Department for STD and HIV testing.

Primary care A full range of primary care services are provided through a combination of public and private health systems and community-based agencies, including various private providers; two VA medical clinics; Our House of Portland, a community provider that delivers services for advanced stage PLWA; and several substance abuse treatment and mental health providers targeting vulnerable populations affected by HIV. For uninsured clients and clients with limited coverage, Ryan White programs provide a safety net, including two HIV specialty medical clinics, the HIV Health Services Center (HHSC) at Multnomah County Health Department and the HIV Clinic at Oregon Health & Science University (OHSU). These two clinics serve over 1,400 PLWH/A. Other Part A primary care services include three community dental clinics; two mental health providers; and two substance abuse treatment agencies.

Access services – early intervention services (EIS) and medical case management In FY 2012, Part A EIS will enroll at least 90 recently diagnosed PLWH/A and other PLWH/A who have not successfully engaged in primary medical care. To recruit clients, two programs work with a network of service providers that serve as key points of entry to care for PLWH/A. One program is in a community based organization that provides HIV counseling and testing and has established relationships with substance abuse and mental health treatment programs, detox centers, correctional facilities, homeless shelters, health and social service agencies serving youth and racial/ethnic minorities, and local health department HIV prevention programs and STD clinical services. The other program is located within the Multnomah County Health Department's STD disease intervention specialist (DIS) program which provides partner notification services to all who test positive for HIV or any other reportable sexually transmitted infection in Multnomah County. Medical case management services for 2,000 PLWH/A are coordinated with the major medical health systems and funded by both mainstream and Part A resources. Services are provided through a collaborative effort that includes private hospital systems, community-based organizations, and local and state health and social service programs. At the HIV Health Services Center, case management services are offered as part of a medical home model where medical case managers are part of the care team assigned to each client.

Support services Support services promote retention in medical care and assist clients in meeting basic needs. These services are provided through a combination of public agencies and private, community-based organizations. The online TGA *HIV/AIDS Resource Guide* lists over 150 agencies that provide a wide range of housing services, emergency services (food, care supplies, clothing, etc.), and services for youth and children. Part A funds support services to address gaps in the mainstream systems, including housing assistance/education, home-delivered meals, and psychosocial support. Part A and HOPWA housing services are well coordinated and follow a Housing First model where clients have significant goals to work toward while they are housed, e.g., substance abuse issues, mental health, and/or employment. Clients receive support from many parts of the care system to stabilize their lives.

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

Over the past several years the TGA has experienced significant, on-going reductions in funding for clinical and non-clinical services for PLWH/A. In Oregon, Medicaid reimbursement for dental care has been reduced by 10% and mental health services are being increasingly targeted to those with the most severe need, restricting the ability to provide preventive counseling. The HIV Health Services Clinic continues to face increased pressure to raise productivity with decreases in case management staffing during a time of increasing case loads. In response to recent state budget shortfalls, the State of Washington anticipates cutting more than $5 million from HIV services, which will eliminate basic insurance coverage and increase co pays, leaving some clients uninsured and some who will only receive support to cover antiretroviral medications. This change will eliminate coverage of non-HIV related medications for clients without insurance. It will also end community services and dental care for PLWH/A, along with support for specific HIV prevention strategies in rural counties. Basic needs funding in the TGA has also seen a trend of fiscal cuts over the past few years and both the overall social service system and the Part A program are being overwhelmed with clients whose needs are severe and ongoing, a phenomenon that has been exacerbated during the recent economic downtown. Additionally, the recent CDC shift of resources to areas of greatest HIV prevalence will reduce HIV Prevention funding to Oregon by 50% over the next four years. This means that a larger portion of support for linkage to care may need to come from care funding in the Portland TGA.

The Planning Council has responded to service gaps resulting from these reductions in state and local funding. Outpatient medical care is ranked as the first priority, receiving the second largest funding allocation. Dental care is targeted for increased funding every year and also typically receives reallocations of unspent funds from other service categories and HRSA approved carryover funds. Funding for early intervention services continues to focus on ensuring recently diagnosed clients are linked to medical care, and on reaching out-of-care PLWH/A. Identifying these clients and ensuring adequate funding for their medical care directly addresses unmet needs in the TGA. Ongoing MAI funding for navigation services as a part of medical case management assists Black/African American and Hispanic clients in dealing with complex barriers to participation in care, and additional funds were allocated to medical case management to include navigation services for other immigrants/ refugees. Providers consistently report that substance abuse and mental illness decrease clients' ability to maintain care. Council guidance specifies that all services assist clients with harm reduction strategies wherever feasible and increased funds have been allocated to mental health services. Additional funds were also allocated to medical case management services to help clients with coordination of care and maintenance of insurance through the significant changes in Medicaid services, medical insurance pools

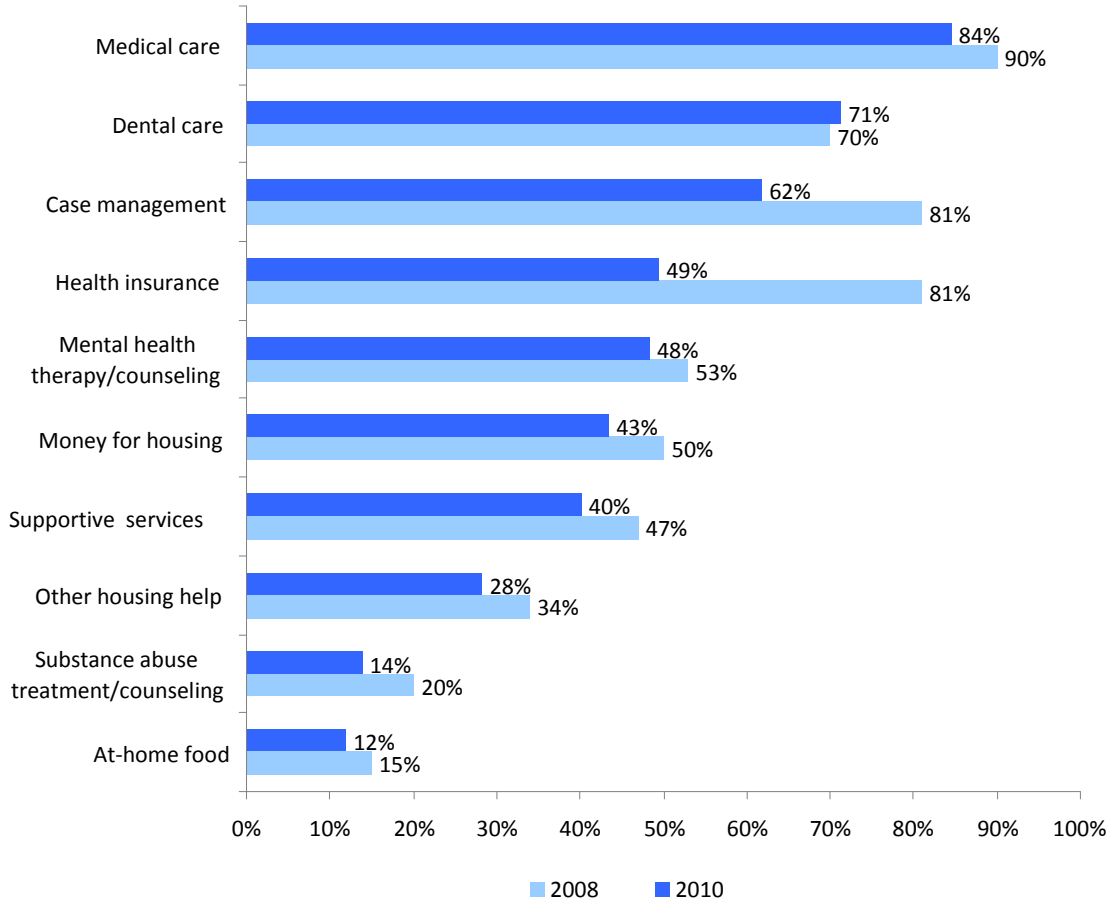
and the establishment of coordinated care organizations in Oregon. In FY 2013, the Council will consider how to address service gaps brought about by the reduction in HIV Prevention funds.

C-G. Description of Care and Prevention Needs, Gaps and Barriers to Care, and Priorities for Allocation of Part A Funds

Primary care and support service needs, gaps and barriers to care HIV Care Services and the Planning Council utilized results from 2010 client surveys and community forums to assess the service needs and gaps of PLWH/A in the Portland TGA. Annual survey distribution alternates between surveying case management agencies and all the other agencies. The 2010 *Client Satisfaction and Needs Assessment* (*CSNA*) asked clients at 8 agencies (including outpatient medical, mental health, early intervention, dental care, housing, psychosocial services, substance abuse treatment and home delivered meals) if they had needed 10 specific services in the past year, and whether they always received the services when they needed them. Those who had not always received services when needed were considered to have a service "gap."

The top three services clients identified as needing were medical care (84%), dental care (71%), and case management (62%). Almost half of clients identified needing health insurance (49%) and mental health therapy/counseling (48%). Figure 1 (next page) shows needs reported in 2008 and 2010. Compared to 2008, respondents in 2010 reported lower levels of need in every service category except dental care. The most noticeable decreases in needs were in health insurance (81% in 2008 and 49% in 2010) and case management (81% in 2008 and 62% in 2010). See Figure 1 next page.

Figure 1. Respondent needs in the past 12 months - 2008 vs. 2010



Reported service needs varied across different client subgroups:

- Homeless clients and clients with *depression, anxiety, or other emotional issues* were more likely to identify needing all services with the exception of health insurance.
- Clients with *substance abuse issues* were more likely to identify needing case management, mental health therapy/counseling, and support services.
- Clients with *no income* were more like to report needing health insurance, dental care, financial assistance for housing, and other housing help.
- Clients *from Multnomah County* were more likely than clients outside Multnomah County to identify needing health insurance, support services, and other housing help.
- Clients who were *incarcerated* in the past three years were more likely to identify needing substance abuse treatment, mental health therapy/counseling, case management, and financial assistance for housing.
- *Younger* clients were more likely to report needing substance abuse treatment and health insurance while *older* clients were more likely to report needing at-home food services.
- *Latino* clients were more likely to report needing health insurance.
- Both *Latino* and *African American* clients were more likely to report needing at-home food services.

Two perspectives were used to analyze service gaps. First, analysts calculated a "population perspective" to determine the percent of PLWH/A experiencing a gap compared to the overall PLWH/A population. Then a second analysis was done to calculate the percent of PLWH/A experiencing a gap who reported needing the service. So, while only 22% of PLWH/A in the TGA face a gap in financial housing help, of the individuals who reported needing this service, 53% either had difficulty or were unable to access this service when needed. Table 3 provides the top six service gaps/difficulties from both perspectives. The needs and gaps identified in the CSNA were also consistent themes in the 2010 community forums sponsored by the Planning Council.

Table 3. Top 6 Service Gaps/Difficulty – Service and Population Perspective

Population Perspective		**Service Perspective**	
Service, % Reporting a Gap		**Service, % Reporting Gap**	
1. Financial assistance for housing	22%	1. Financial assistance for housing	53%
2. Dental care	17%	2. Other housing help	50%
3. Other housing help	14%	3. At home food services	39%
4. Mental health therapy or counseling	10%	4. Dental care	24%
5. Support services	8%	5. Mental health therapy or counseling	21%
6. Health insurance	7%	6. Supportive services	20%

Similar to service needs, all service gaps were smaller in 2010 compared with 2008, except in the financial assistance for housing category (19% in 2008 vs. 22% in 2010). The service gap for case management decreased from 15% in 2008 to 6% in 2010, and dental care decreased from 24% to 17%. The gap for mental health therapy decreased from 15% in 2008 to 10% in 2010, and the gap for supportive services also decreased from 15% to 8%.

There were a small set of differences in gaps/difficulties among client subgroups:

- Homeless clients were more likely to report gaps/difficulties in financial assistance with housing;
- Clients with no income were more likely to report gaps/difficulties in accessing dental care;
- Clients from outside Multnomah County were more likely to report gaps/difficulties in accessing financial assistance for housing and mental health therapy/counseling; and
- Female clients were more like to report gaps/difficulties in accessing at-home food services.

Overall, the gap assessments from 2010 show that the Ryan White system of care is doing well in ensuring key health care services for many PLWH/A in the Portland TGA. However, many PLWH/A are heavily dependent on public systems, and significant gaps in access to specialty/ supportive services continue to exist. This is particularly true as the economy continues to create higher need among PLWH/A while decreasing the availability of services offered by local mental health, housing, substance abuse, and other providers.

Prevention service needs, gaps and barriers to care Within the Part A system, prevention services are a key component of the Early Identification of Individuals with HIV/AIDS (EIIHA) strategy. The Portland TGA has identified four goals within its EIIHA strategy to achieve the overarching goal of reducing the spread of HIV:

1) HIV prevention messages and methods are pervasive throughout the community and HIV testing will be considered an acceptable, widespread cultural norm;
2) All individuals will be able to obtain HIV testing, receive their results, have their partners tested, and receive appropriate referrals to care;
3) All individuals will be able to access high quality, culturally competent HIV care services; and
4) Cultural and structural barriers to HIV diagnosis and engagement in care will be identified and reduced.

Each goal fully supports the intent of the EIIHA strategy to ***make individuals who are unaware of their HIV status aware***. By increasing prevention messages and creating a cultural norm of HIV testing, the TGA will increase awareness of HIV, and more individuals will practice prevention methods and get tested to know their HIV status. Developing strategies and practices to ensure that all individuals have access to HIV testing, are able to receive their results, and are able to refer their partners for testing will also work to make individuals who are unaware of their HIV status aware. While goal number three, access to care, assumes that individuals are already aware of their status, it directly supports the referral and linkage phases of the EIIHA strategy and will work to ensure that PLWH are receiving care and support to stop the progression of their disease, support disclosure of HIV status, and prevent its spread to future partners. Finally, working to reduce cultural and structural barriers to HIV diagnosis and engagement in care will increase awareness and enable more individuals in communities that are currently facing disparities in access to services and disease burden, to get tested and become aware of their HIV status.

An analysis of disparities in access and services was a significant factor in the identification of target groups and the development of a corresponding plan for the EIIHA. Last year the Portland TGA and its Part B counterpart conducted an in-depth analysis on late-testers. Data from 2009 show that approximately 37% of all new diagnoses in the TGA were late (defined as individuals who are diagnosed with or progress to AIDS within 12 months of diagnosis). Upon further examination, data revealed that certain subgroups are experiencing significant disparities in testing/diagnosis: 44% of male IDU, 68% of male unknown risk, 72% of male presumed heterosexual, 51% of foreign-born Hispanics, and 44% of Black/African American MSM were late diagnosis clients. In addition to testing, disparities were found with linkage to care for many of the same subgroups. In 2009, 94.9% of all new HIV cases had a subsequent CD4 or VL lab test done. Of the new cases that did not have a visit within 90 days of diagnosis, 30% were IDU or MSM/IDU, and of those not getting a subsequent visit within 6-12 months after the initial 90 day visit, 28.6% were IDU or MSM/IDU, and 14.3% had undetermined risk. An analysis of race/ethnicity showed that 50% of all new Black/African American cases and 30.4% of all new Hispanic cases did not receive a visit in 90 days after diagnosis followed by a visit 6-12 months later, though all newly diagnosed Hispanic cases and 91.7% of Black/African American cases did receive at least one CD4 or VL test subsequent to diagnosis. To address this disparity, the Portland TGA has identified *Active IDU*, *African American and Hispanic MSM*, and *Partners of PLWH* as target groups with individualized strategies. An understanding of the individual needs, barriers and gaps of all nine target groups is important in a comprehensive approach to connecting every unaware person living with HIV to the care they need.

Active IDU There are several barriers that delay diagnosis for IDU including a low perception of risk for HIV among IDU on the west coast, a hesitancy to seek any type of health care services due to stigma around drug use, high rates of poverty and lack of insurance, and more pressing survival issues such as food and shelter. If a person does test for HIV, informing them of their status is also very challenging. Many IDU have transient lifestyles, are in and out of jail/prison, or lack permanent housing, and many suffer from mental health issues in addition to substance abuse.

Recovering IDU In addition to the barriers described above, such as low perception of risk, stigma associated with drug use, and poverty, many recovering IDU are hard to locate due to homelessness or transitions in and out of corrections and/or treatment facilities, and some may not be ready to learn their HIV status early in recovery process.

Hispanic MSM Economic burdens and survival issues may rank higher in the priority list for this population than HIV diagnosis and care. Lack of insurance and/or legal status in this country present another barrier for Hispanic MSM in the area. These issues are compounded by cultural challenges and the stigmatization of MSM and HIV in the Hispanic community that result in fears about testing and being "outed". A recent study of newly diagnosed Latinos in Oregon reflected a social norm of not accessing medical care unless one is sick; 43% of respondents got HIV tested because they were ill, including seven who were tested at a hospital when their HIV disease was likely very advanced.

Black/African American MSM As with Hispanic MSM, Black/African American MSM experience economic burdens, lack of insurance, and survival issues that may rank higher in their priority list than HIV diagnosis and care. These issues are compounded by unique cultural challenges, stigma and the fear of being ostracized by family and friends. Pervasive distrust of government and health institutions within the African American community prevents many men from seeking services.

MSM using public sex venue Cultural attitudes and practices within public sex venues, such as high rates of alcohol and drug use, limited verbal communication, and a focus on "hot" sex, are barriers to the disclosure of HIV status and risk reduction actions. In addition, misperceptions about serosorting increase risk and reduce disclosure. MSM that participate in these high risk behaviors must overcome a sense of denial and/or fear to seek testing and learn their results. Priority needs include increased awareness of risk and a shift in cultural norms.

Young MSM (13-24) There are a number of cultural and developmental barriers that prevent awareness of status within this population. Young MSM often have misperceptions of risk such as: older male partners will disclose status, HIV status can be determined by physical appearance, and HIV is a disease solely of older gay men. All of these reduced perceptions of risk reduce motivation to test. The perception that HIV is now a manageable disease decreases the sense of severity of the consequences of HIV infection, and thus decreases motivation to test. Many young MSM are still struggling with their sexual orientation and coming out to health providers can be another barrier to testing and engaging in care. Finally, MSM youth often face additional issues such as homelessness, lack of family supports, lack of insurance and poverty. Within the Portland TGA there is a high prevalence of homeless youth, and young MSM are known to engage in survival sex, an activity that is highly stigmatized and hard to disclose to health providers. Priority needs for this population include outreach, education, and support services to address basic needs.

Infants of infected mothers and pregnant women Oregon has adopted an effective model of HIV screening for pregnant women where HIV testing is included in the standard blood panel run for prenatal care, and pregnant women have to actively "opt-out" of getting a test. However, a constant challenge is maintaining the system in light of funding cuts and changes in insurance rules and regulations. The main cultural challenge and priority need within the TGA is working to ensure that populations with documented disparities in access to prenatal care are able to obtain these services to ensure timely testing and, if positive, receive HIV medication to prevent neonatal transmission. While access to prenatal care is not the responsibility of Part A, its providers work with prenatal providers and outreach services to support this work.

Partners of PLWH The biggest priority need of this population is open communication between serodiscordant partners about status and safer sex negotiation. Barriers in communication are the current cultural challenges related to disclosure and stigma of HIV. Partners may be completely unaware that they are at risk for HIV, a situation that is particularly evident in minority populations as a result of the stigmatization of MSM. Some partners of PLWH have an inaccurate perception of risk due to beliefs about the transmission of HIV by PLWH who have undetectable viral loads.

Moderate- and low-risk individuals The largest need for this group is the full implementation of standards of care that include routine testing and preventive measures as part of regular health care and insurance coverage. Inconsistent support/messaging from health care providers, along with the resistance of primary care providers to test lower risk individuals for HIV delays diagnosis for this population. This group needs increased outreach to change cultural norms and perceptions of HIV and HIV testing to support awareness, disclosure and engagement in care.

Capacity development needs resulting from disparities in the availability of HIV-related services in underserved and/or rural communities

The Portland TGA has identified six populations that require special attention from the Part A service system: women; youth (aged 13-24); PLWH/A aged 50 and older; refugees and immigrants; PLWH/A with a dual diagnosis of mental health and substance abuse; and recently incarcerated PLWH/A. A description of each population's demographics, unique challenges, and service gaps follows.

Women make up 11.2% of PLWH/A in the Portland TGA. Approximately 40.6% of all women living with HIV/AIDS in the TGA are racial/ethnic minorities. Among women, the primary method of transmission is heterosexual contact, accounting for 63.6% of all women living HIV/AIDS, and 62.1% of new HIV cases and 47.5% of new AIDS cases (1/1/08-12/31/10); followed by IDU, accounting for 20.4% of all living HIV/AIDS cases and 12.1% of newly diagnosed HIV cases and 27.1% of AIDS cases. Women from minority populations are more likely to be infected with HIV/AIDS through heterosexual contact than White women. These trends are mirrored within the female Part A client population, where a higher percentage of female clients (43.7%) are from minority populations than male clients (26.6%), and the most commonly reported risk factors are also heterosexual contact (73.5%) and IDU (19.6%). Female Ryan White clients are significantly poorer than men, with 75.1% at or below 100% of the Federal Poverty Level (FPL), compared to 64.4% of men. In 2010, 27.6% of female Ryan White clients received Medicaid, 9.0% were uninsured, and 15.2% lacked permanent housing (up from 13.9% in 2009). A higher

percentage of female clients received support services in 2010 (20.1%) compared to male clients (10.7%).

There are several unique challenges around provision of and access to care for women. Female PLWH/A tend to have higher poverty rates and are likely to forego their own health care needs in favor of children and other family members in their care. Previous needs assessments in the TGA have found that women reported proportionately higher needs for psychosocial support services, referral services, emergency financial assistance, outpatient substance abuse treatment, and child care, and were more likely to need emergency rent/utilities and housing assistance. Additionally, women who depend on employment to support their families are more likely to lack adequate transportation and childcare than other PLWH/A in the TGA. Psychosocial support services directed to female PLWH/A should be delivered through multi-service agencies that are designed to meet the particular needs of women and that are perceived as accessible. All services for female PLWH/A must be gender and culturally appropriate, and childcare should be available to clients while they are receiving other services.

Youth aged 13-24 years Youth 13-24 comprise 2.6% of the HIV/AIDS cases in the TGA, but they comprise 5.5% of the HIV cases, and accounted for 23.6% of newly diagnosed HIV(non-AIDS) cases between 1/1/09 and 12/31/10. The majority of these new cases (82.1%) occurred in persons aged 20-24, indicating that infection is occurring in their late teens and early twenties when many may begin to explore their sexuality and some participate in high-risk activities. The demographics of this population are particularly important as they can provide insight into the future composition of PLWH/A in the TGA. As of 12/31/10, 80.5% of PLWH/A aged 13-24 were men and 19.5% were women, compared to 88.8% and 11.2% in the TGA overall. The diversity of this population continues to increase: 57.5% are white (compared to 77.5% in the TGA overall), 14.2% are Hispanic (10.2% in the TGA) and 15.9% are Black/African American (8.2% in the TGA), making this subgroup more diverse than the overall PLWH/A population in the TGA. The risk breakdown for this population is as follows: 64.6% MSM, 2.7% IDU, 6.2% MSM/IDU, 10.6% heterosexual, 13.2% Mother with HIV, and 2.7% with no risk reported.

Access to primary care is a significant issue for youth because they are less likely to have health insurance, have high rates of poverty, and are likely to deny or minimize the severity of their HIV disease. Youth need targeted outreach and high quality case management to link and then maintain their engagement in care, which is often a challenge since many do not have stable addresses, and may be out of contact with providers for long intervals. They also require culturally appropriate outpatient substance abuse treatment, psychosocial support services, emergency financial assistance, and housing to mitigate need and access disparities. Support services directed to youth should be delivered through multi-service agencies that youth perceive as safe, accessible and appropriate to their particular needs.

As with the general population, the percentage of ***PLWH/A aged 50 and Older*** has been increasing over the years, and will continue to do so in the future. Currently, 43.3% of PLWA and 29.6% of PLWH are aged 50 and older. This population is expected to grow dramatically in the next few years, as an additional 22.8% of PLWA and 15.6% of PLWH are aged 45-49. Combined, this represents 66.1% of PLWA and 45.2% of PLWH in the TGA. Increases within the 50 and older age category are due to both the success of antiviral medications in treating HIV/ AIDS and increases in the number of persons in this category being diagnosed with HIV/AIDS for the first time. Within this population, as of 12/31/10, 91.3% are male and 8.7% are female. The majority of this population, 84.3%, is white, 7.7% are Black/African

American, and 5.7% are Hispanic. The most common risk factor was MSM (70.2%), followed by heterosexual transmission (8.7%), IDU (8.0%), and MSM/IDU (7.0%).

PLWH/A aged 50 and older face several unique challenges within their care. PLWH/A that have been living with HIV/AIDS for long periods may begin to lose their motivation to continue to follow drug treatment regimes, especially when they experience negative side effects. They are also often faced with the loss of their social networks as partners and friends die of AIDS and other related illnesses. Newly infected patients within this population are often diagnosed late and have already progressed to AIDS. All PLWH/A aged 50 and older face medically complex care that is further compounded by other diagnoses associated with aging. This population has higher rates of infection with drug resistant strains of the virus. In general, PLWH/A aged 50 and older are more socially isolated and have higher rates of depression and loneliness, poverty, housing concerns, and poor nutrition. Gaps in care that are unique to this patient population include customized social support groups; increased outreach, testing, and prevention services to decrease the rates of incidence within this population and bring infected people into care as soon as possible; increased coordination with aging and disabilities services; increased education and awareness of HIV risks and symptoms among primary care/geriatric practitioners; and increased access to specialists for treatment of diagnosis associated with aging.

Immigrants and Refugees In June 2005, the Office of Refugee Resettlement ranked Multnomah County sixth nationally in terms of concentration of refugees compared with the area's general population and the five-year new arrival rate. Though the number of new refugees in the TGA has fallen dramatically due to new legislation, there are currently 456 foreign-born PLWH/A in the TGA. As of 12/31/10 approximately 47% of racial/ethnic minority PLWH/A were foreign born. Within the foreign-born population, 37.8% of PLWH and 16.7% of PLWA are women, and the majority of PLWH/A are between the ages of 30 and 49. Historically, heterosexual contact has been the most common method of transmission within this population, however as of 12/31/10, 45% of foreign-born PLWH/A in the TGA reported MSM and 27.4% reported heterosexual contact. Within the TGA, 56.1% of foreign-born PLWH/A originated from Mexico, 20.8% originated from Africa, and 14.9% originated from Asia.

Foreign-born PLWH/A face a number of unique challenges that create barriers to accessing and remaining in care. Language barriers prevent some clients from initiating and maintaining services as well as receiving quality HIV care. Providers within the TGA do not have the resources to offer their services in the native languages of all of their clients. This challenge has increased dramatically over the past ten years as new waves of immigrants and refugees have arrived. The HIV Health Services Center currently provides services to people who collectively speak over 13 different languages and whose primary language is not English. Language barriers are magnified when clients refuse translation services for fear of being identified as HIV+ within their community. Cultural issues and health literacy levels present another unique challenge to accessing care. Health education messages, patient instructions, and service delivery methods must be tailored to be culturally competent and effective. Finally, immigrants and refugees face many of the same challenges that other PLWH/A populations in the TGA face, including poverty and lack of health insurance.

Two populous groups of foreign-born PLWH/A live in the TGA: Hispanics and Africans. Both national and Oregon state data has shown that Hispanic immigrants are the least likely to have health insurance or a regular source of health care. Many of the foreign-born Hispanics in the TGA are undocumented

immigrants and/or migrant workers, and fear of government institutions and deportation produces another unique barrier to accessing care. Migrant workers face additional barriers to care as they tend to have unstable employment and a transient lifestyle. The African population has a separate set of unique challenges. This population consists of highly isolated and stigmatized communities that are dependent on translation and case management services for care. Many members of the African population are refugees from war-torn nations and must deal with conditions related to post-traumatic stress, malnutrition, and separation from friends, family and traditional ways of life. These challenges have resulted in several service gaps for immigrants and refugees, including translation, and culturally competent services and education materials. Other gaps include access to outpatient medical and oral health care, case management, social supports, resources for prescription and over the counter medicines, and assistance with transportation, housing, food, and basic needs.

Dual Diagnosis of Mental Illness and Substance Abuse Within the TGA, mental illness and substance abuse are found across all gender, race/ethnicity, age, and risk populations. Mental health diagnosis among PLWH/A in the TGA increased from 40% of the population in 2005 to 68.8% of the population in 2010. The percentage of PLWH/A in the TGA with a dual diagnosis of mental illness and substance abuse has increased from 21.1% in 2005 to 31.4% in 2010, however these numbers understate the prevalence of substance use and abuse by PLWH/A with a mental illness, as substance use and abuse is not always diagnosed. An analysis of 2010 service utilization data shows that women and persons with MSM/IDU risk factors have higher rates of mental health service utilization, and persons with MSM/IDU and IDU risk factors have higher rates of substance abuse treatment services than their prevalence in the TGA.

PLWH/A with mental illness and/or substance abuse diagnosis face several challenges to engaging and remaining in care. They are more likely to experience unemployment, homelessness, and poverty than the general population, and have higher rates of incarceration than other PLWH/A. People within this population require treatment by specialists who understand the dynamics of both illnesses, and who are prepared to deal with complex symptoms and behaviors, particularly those related to drug interactions that may create a higher mortality risk when combined with certain antiviral medications. Mental illness and substance abuse can adversely affect the ability of PLWH/A to follow scheduled medical treatment and to adhere to drug treatment regimes. High levels of case monitoring and service coordination are required to reduce the interference of psychiatric disorders, medications, and illegal drugs with HIV medical treatment. These services, particularly mental health, must be designed and delivered in a manner that is culturally appropriate for ethnic and sexual minority populations. As both mental illness and substance abuse are chronic conditions, access to appropriate services must be assured for extended periods, and treatment must be adjusted to varying levels of acuity over time.

Recently incarcerated persons The Oregon Department of Corrections reports that there are currently 66-68 inmates diagnosed with HIV/AIDS in Oregon prisons, and estimates that 1.2-1.8% of their incarcerated population, up to 3.6 times the number of those who self-identified, is infected with the disease. Approximately 60% of their PLWH/A population is released to the TGA each year. Multnomah County Corrections reported that 188 inmates detained at its correctional facilities were identified as PLWH/A during 2010 either through jail testing or self-identification (up from 152 inmates in 2007). However, as in the Oregon State facilities, this is very likely an under-estimate. The HIV Health Services Center, the largest HIV primary care provider in the state, reports that approximately 6% of their clients are incarcerated over the course of a year, with 20- 25% of clients having been incarcerated sometime in

their life. In 2010, the Part A *Client Satisfaction and Needs Assessment* survey found that 9% of respondents had been incarcerated in the past three years. The majority of recently incarcerated PLWH/A face several co-morbidities including poverty, substance abuse, and mental illness. A 2006 survey completed by a local HIV services non-profit found that of its recently incarcerated clients, 25% reported lack of insurance and 40% reported no income. PLWH/A with criminal histories were almost 3 times as likely to report active or past substance abuse (85% vs. 29%) and about twice as likely to report mental health issues (60% vs. 32%), compared to clients without criminal histories.

People with a history of incarceration face many unique challenges in accessing and remaining engaged in medical care and support services: difficulty securing employment and stable housing due to the stigma attached to being an ex-convict; landlord policies prohibiting criminal backgrounds; poor or nonexistent credit, lack of rental and employment histories; and lack of funds for deposits and rent. Lack of health insurance is also a substantial challenge to accessing care. When entering the jail system, inmates are taken off public insurance programs, and upon release must go through a re-application process that can take over six months. Even with insurance, lack of resources for co-payments results in barriers to care. Many former inmates also struggle with mental health and/or substance abuse issues and have limited family and community support systems in place. Statewide, PLWH/A ex-offenders report greater need for medical care, help with prescriptions, substance abuse treatment, mental health counseling, ongoing help with housing, transportation to appointments, and assistance with food, than PLWH/A without recent incarceration. These needs were also identified in the 2010 Part A Client Satisfaction and Needs Assessment survey. Although HIV care providers have reached out to corrections staff throughout the TGA and are available to provide consultation, a significant service gap is the lack of adequate discharge planning.

Priorities for the allocation of Part A funds The Planning Council reviewed and analyzed a broad range of data to determine funding priorities and allocations for increased access to care and reduction of service utilization disparities. Data presentations highlighting service trends and gaps, access and disparity issues for special populations; recommendations for improving services; and group exercises were used to assist the Council in data analysis and decision making. As part of this analysis, the Council reviewed the effectiveness of current services in linking clients to medical care and supporting retention in care. Based on their review of data, the Council approved a consistent set of priorities including seven core services (outpatient medical care, health insurance with drug reimbursement, mental health services, oral health care, substance abuse outpatient care, medical case management, and early intervention services) and three support services (housing services, psychosocial support services, and food/home delivered meals) to fund as integral components to increase access and reduce disparities. Table 4 lists the data sources used by the Council.

Table 4. Range of Data Used by the Planning Council for Prioritization and Allocation

Epidemiological data: Trends/changes in HIV and AIDS incidence and/or prevalence and demographics of PLWH/A; info regarding populations with special needs, including barriers to care and other access issues; data regarding unaware populations; and unmet need for primary care data.
Outcome evaluation data: Client-level health status outcomes – primary HIV medical care, other primary care and support services; system-level outcomes.

Service utilization and cost data: Unduplicated clients and number of service units provided; unit cost for each service and cost effectiveness data; and client demographics by service category
Quantitative/qualitative needs assessment data: TGA client needs assessment, key informant presentations; service gap/barriers; community forums, public testimony and other consumer input
Other relevant data: Co-morbidity, poverty, homelessness, and insurance status data; non-Part A funding streams; and community services.
Key data sources: 2009 Oregon and Washington HIV/AIDS Reporting Systems (HARS); Oregon and Washington Health agencies; county health departments; Medical Monitoring Project, State of Oregon; *Part A Client Satisfaction and Needs Assessment: Results from the 2010 Client Survey;* local HIV/AIDS studies and reports; *2009 STD/HIV/Hepatitis C Program Annual Report; 2008 Statewide Coordinated Statement of Need Report*, and other local service provider reports and studies, including TOURS.

The epidemiological trends detailed earlier in this section of the comprehensive plan were taken into consideration in the priorities and allocations process, as Planning Council members reviewed HIV/AIDS incidence and prevalence data and studies. For example, the state surveillance HIV/AIDS epidemiology data for Oregon and the TGA and a summary of unmet need for HIV medical care were presented to the Council. Examples of data (including service utilization, client satisfaction surveys, and epidemiological trends) the Council used to set priorities and allocate funding to increase access and reduce utilization disparities include:

- There was a 7% increase in the number of individuals receiving Part A services in 2010 compared with 2009.
- The 5 services that most clients reported needing in the past year were part of HRSA's Core Medical Services list, including medical care (84%); dental care (71%); and medical case management (62%), health insurance (49%) and mental health services (48%). The next most needed service was financial assistance with housing (43%),
- The top service gap was reported in financial assistance with housing (21%), followed by dental care (18%). This was the first year in the last five where the percentage of clients who report they are permanently housed has dropped, from 87% in 2009 to 83% in 2010.
- Lower dental care reimbursement rates both from Part F and from Oregon's Medicaid program and the reduction in coverage in Washington State have affected access to dental care for uninsured PLWH/A
- Case management and medical care services continued to see newly infected clients at advanced stages of HIV disease with complex emotional and education needs.
- The TGA's PLWH/A population is aging. Persons aged 50 and older account for 35.1% of all PLWH/A in the TGA, and an additional 20.9% of PLWH/A are aged 45-49.
- The rate of syphilis among PLWH/A is 63 times higher than in the general population, and the rate of gonorrhea infection is 27 times higher. These data support the funding of EIS based at the STD Clinic. Clients with HIV disease who come for STD testing and treatment are given assistance to access HIV medical care/treatment at the same time.
- The percentage of Black/African American clients permanently housed (79%) is lower in comparison to other racial/ethnic groups (86% White clients), and the percentage of Hispanic clients permanently housed has decreased from 90% to its present 83%. Lack of permanent

housing has been associated with poorer medical health outcomes and less adherence to HIV medications.

The Council reviewed extensive data on unaware and out-of-care populations during the priority setting and allocation process, and funding decisions reflect identified gaps. The Council also reviewed Unmet Need data which estimated a 25% unmet need for medical care in Oregon with a higher percentage of PLWA than PLWH having an unmet need. In response to these findings and other data about out-of-care populations the Council highlighted 1) the need for EIS and intensive case management to deal with complex barriers to participation in care; and 2) a comprehensive array of primary care and support services that promote retention in care and adherence to treatment.

Table 5, below provides a description of the FY 2012 service category priorities and allocations based on the Portland TGA grant award.

Table 5. FY 2012 Portland TGA Service Category Allocations

Priority	*Service Category*	*Allocation*
	Core Services	
1	Outpatient Medical Care	$743,040
2	Health Insurance	$32,485
3	Mental Health Services	$158,849
4	Oral Health Care	$332,264
5	Substance Abuse Treatment Services-Outpatient	$36,527
6	Medical Case Management	$906,885
6	Medical Case Management-MAI populations	$118,967
7	Early Intervention Services	$152,300
	Support Services	
8	Housing Services	$483,720
9	Psychosocial Support Services	$264,410
10	Food/Home-Delivered Meals	$42,210
Total		**$ 3,271,657**

H. Evaluation of 2009 Comprehensive Plan

From a process perspective, there were challenges that we will address in the 2012 Comprehensive Care Plan. The work plan was overly detailed and difficult to monitor, creating barriers to follow-up and planning and implementing new strategies. Some objectives stretched well beyond the control of the Ryan White Part A program, and were therefore beyond the reach of program staff to influence. Too

many new projects were envisaged and staffing in the HIV Care Services program became an issue as one research analyst returned to school and another was promoted. Combined, the research analyst vacancy lasted 15 months and delayed addressing some objectives. We are now fully staffed. Here are highlights of the successes and challenges in implementing the comprehensive plan over the past three years, organized by our four core goals.

Goal 1: Preventing New HIV Infections

- Success: The Oregon legislature passed a bill to remove requirement for specific informed consent process for HIV testing (while retaining obligation of the provider to inform patient of test and give patient opportunity to decline). This policy change will remove one of the barriers present to implementing routine "opt-out" testing in ERs and other medical sites. TGA service providers, health organizations, and community advocates were actively engaged in support of this legislation.
- Challenge: Prevention is not the core mission of any of our contractors in delivering the services funded by the Planning Council. For that reason, there are challenges around keeping prevention services in the forefront of service delivery, particularly where clients have multiple, complex service needs. Because Prevention is not a specific funded service, it has also been difficult for either grantee staff or contractor staff to carve out the resources to develop a package of consistent prevention messages and interventions that can be integrated into service delivery.
- Challenge: As this 3-year cycle for the comprehensive plan came to a close, a new significant challenge came into play as the CDC changed the formula for allocating HIV prevention funding to the states, leading to a loss of nearly $700,000 (23% cut) for Oregon in FY 2012 and similar cuts in Washington. Oregon will lose an additional $625,000 to $780,000 over the next four years. The Planning Council will need to consider the impact of the loss of these funds on services in the coming years.

Goal 2: Finding HIV+ People Who Need Care and Treatment Services

- Success: Enrollment in the Ryan White Part A system of care went from 2,548 in FY 2008 to 2,768 in FY 2010, an additional 220 clients with access to core and support services. This reflects a well coordinated system of care that promotes access through multiple avenues. In 2010 our Ryan White service providers were one of two community groups recognized at an annual Public Health Heroes event in Multnomah County. Providers were honored for their ability to make a significant difference in the lives of the individuals they serve, for the strength of their holistic models of care, and for their effort to work collaboratively across public and private organizations and with the community.

Goal 3: Engaging HIV+ People in Care and Treatment Services

- Success: EIS projects are effective in finding, supporting and engaging in care the newly diagnosed as well as clients who have fallen out of care. In FY 2010, 80% of new EIS clients were engaged in medical care and just 5% were lost to follow-up.
- Success: Coordination across the care system has led to the effective use of new technologies to support engagement in care. The HIV/AIDS Hotline is now connected with an on-line, searchable resource guide to identify service providers in all six counties of the TGA. In addition, the EIS program based at Multnomah County is now able to check the State Surveillance system to see if clients who test positive, and are referred to care, complete the referral as evidenced by a viral load test result in the database. In addition, the disease intervention specialists have begun to use texting as a way to

contact individuals for disease follow-up and partner contact. They have found texting to be a very successful strategy among all demographic groups - age, gender and race/ethnicity.

Goal 4: Retaining HIV+ People in Care and Treatment Services

- Success/Challenge: The Council understands the benefits that stable housing brings to retention in care for PLWH/A. While the TGA has received a 13% increase in funding from FY 2008 to FY 2011, housing services received a 40% increase (from $337,435 to $473,091). Needs assessment data show improvement in access to housing for PLWH/A in the Part A system of care. In the 2008 needs assessment, 50% of respondents needed financial assistance for housing, while in the 2010 needs assessment, this need affected 42% of respondents. However, the service gap remained consistent with 19-22% of clients having difficulty getting services when needed.
- Success: The Planning Council also allocated a 28% increase in funding for oral health care between FY 2008 and FY 2011 ($249,685 to 320,105) and recent needs assessment data has also shown improvement in access to the service. In both 2008 and 2011 needs assessment data showed that 70% of respondents needed the service, but the service gap decreased from 24% to 17% in FY 2010. Additionally, there has been increased access to preventive care over the past three years. In FY 2008 only 62% of oral health care clients had at least one preventive care visit, in F Y2011 this had increased to 78 %.
- Success: In October 2011 the Part A/C/D HIV Health Services Center (HHSC) received the NQC Quality Award for QM infrastructure development. The HHSC provides medical care and support services to over 1,000 clients within the context of a Health Department initiative called Building Better Care (BBC), which focuses on team-based care and rigorous, continuous quality improvement efforts. In 2007, the Department's primary care clinics and the HHSC joined a regional primary care renewal collaborative to address systemic problems that affected the delivery of quality health care. Developing an infrastructure to incorporate the Institute of Medicine Model for Improvement at the care team level has resulted in an environment where all HHSC staff are engaged in developing viable, sustainable solutions to both team and clinic-wide patient care quality and safety issues.
- Success: During a recent site visit, the Joint Commission surveyors determined that the Building Better Care model (patient centered medical home) at Multnomah County Health Department was so well developed that, without a formal application initiated by us, they advocated for having our program certified by the Joint Commission as a “Patient Centered Medical Home.” The HIV Health Services Center, funded through Parts A and C, is included in this designation. This certification designates the Health Department as an organization that provides patient care that is patient-centered, comprehensive, coordinated, accessible, safe and of high quality. Nationally, there are only 20 organizations with this designation from the Joint Commission.
- Challenge : One challenge that lays ahead is monitoring the transition in Oregon from traditional Medicaid to care offered through the new Coordinated Care Organizations (CCOs). CCOs are akin to Accountable Care Organizations as delineated by the Affordable Care Act. The first CCO will begin operations August 1, 2012 and will integrate behavioral health and physical health care. Dental care will be added in 2014. Many of the implementation details are being still being worked out, including what interventions and services will be included in the global budget. Care Services will continue to monitor the transition and advocate for inclusion of the support services necessary to keep PLWH/A healthy and engaged in care.

II. Where do we need to go?

The HIV Planning Council's vision is for a Portland TGA in which new cases of HIV/AIDS are rare and all people living with HIV have access to an equitable system of care and support, free from barriers and stigma, that reduces disparities and empowers consumers to manage their own health to the best of their abilities.

A. Meeting the challenges of the 2009 Comprehensive Plan

The goals, strategies, and activities in the 2012 Comprehensive Plan are more realistic – fewer in number and simpler to track. The plan reflects the impact of health care reform both locally and nationally. Given the shifting nature of health care provision in the next three years, the objectives of the 2012 Comprehensive Plan include continuation of current work that addresses the goals of NHAS and the SCSN, along with keeping abreast of new policies and making necessary adaptations. In doing so, this plan is designed to help guide the transition in the HIV health care system in the TGA.

In order to meet the challenge of a stronger continuum of care in the face of shrinking prevention resources, the TGA has initiated a TGA Intergovernmental HIV Planning group to assess prevention and care in the TGA counties and develop strategies to work across county borders more effectively. This group will also address the challenge faced in the 2009 Comprehensive Plan of creating consistent prevention messages across the six counties and integrating prevention and care.

The TGA recently received HOPWA funding to provide housing assistance to 60 additional households along with employment assistance. These funds will help continue to meet the challenge of unmet need for housing in the TGA. In addition, as CCOs begin to integrate dental care into their CCO services, it is expected that this integration will reduce the unmet need for dental care in our population.

B. Comprehensive Plan Care Goals & Strategies

The overall goals of the Portland TGA align with those of the SCSN, which in turn reflect the National HIV/AIDS Strategy.

TGA Goal 1. Preventing New HIV Infections *(NHAS Strategy: Reducing New HIV Infections, Increasing Coordination of HIV Programs*)

- Implement comprehensive prevention activities for PLWH/A.
- Provide access to antiretroviral therapy to reduce community viral load.

TGA Goal 2. Finding HIV+ Individuals who need Care and Treatment Services (*NHAS Strategy: Increasing Access to Care, Reducing HIV-Related Health Disparities, Increasing Coordination of HIV Programs*)

- Create a universally accessible system of HIV testing which integrates linkage to care and partner testing.
- Identify and reduce cultural and structural barriers to HIV diagnosis and engagement in care.
- Strengthen linkages with substance abuse, mental health, corrections and housing services to ensure common knowledge of testing and linkage resources.
- Strengthen relationships with STD providers and Disease Intervention Specialists to identify clients who may be out of care.

TGA Goal 3. Engaging HIV+ People in Care and Treatment Services *(NHAS Strategy: Increasing Access to Care, Improving Health Outcomes for People Living with HIV)*

- Promote access to services that help PWLH/A be successful in their HIV care – including health insurance, primary care, housing, basic life needs and employment assistance.
- Integrate motivational interviewing and harm reduction strategies into all services to promote access to services for people regardless of their readiness to change behaviors.

TGA Goal 4. Retaining HIV+ People in Care and Treatment Services *(NHAS Strategy: Improving Health Outcomes for People Living with HIV, Reducing HIV-Related Health Disparities)*

- Provide access to comprehensive primary medical care for all PLWH/A, including access to antiretroviral therapy, following the Patient Centered Medical Home model.
- Provide focused assistance to populations with identified disparities.
- Implement and promote self management programs and tools for clients.
- Develop strong linkages between systems of care including housing and HIV care.
- Develop leadership among PLWH/A in the TGA.

C. Goals regarding individuals *Aware* of their HIV status, but not in care (Unmet Need)

Goals 2 and 3 above address those clients who are HIV positive but not in care. The Portland TGA will continue to promote access to all services, with special focus on clients with multiple barriers such as mental health and substance abuse diagnoses. In addition, our goal is that all STD programs follow-up with all clients who are diagnosed with an STD to ask if they know their HIV status and/or their partners' HIV status and to offer testing and/or linkage to care.

D. Goals regarding individuals Unaware of their HIV Status (EIIHA)

The Portland TGA has identified the following sub-goals within its EIIHA strategy:

- HIV prevention messages and methods are pervasive throughout the community and HIV testing is considered an acceptable, widespread cultural norm;
- All individuals can obtain HIV testing, receive their results, have their partners tested, and receive appropriate referrals to care;
- All individuals have access to high quality, culturally competent HIV care services.
- Cultural and structural barriers to HIV diagnosis and engagement in care are identified and reduced.

All of these sub-goals are further delineated in the strategies and activities in Goal 1. By increasing prevention messages and creating a cultural norm of HIV testing, the TGA will increase awareness of HIV, and more individuals will practice prevention methods and get tested to know their HIV status. Systems to ensure that PLWH/A are receiving care and support will stop the progression of their disease, reduce viral load and prevent the spread of disease to future partners. Finally, working to reduce cultural and structural barriers will increase testing and engagement in care among communities facing disparities.

E. Proposed solutions for closing gaps in care

The most recent assessment revealed large gaps in access to dental care and housing. The Planning Council will continue to fund dental care and increase funds when available. As mentioned above, HIV Care Services and the Planning Council will also track integration of dental services into the new CCOs as

they develop. The Planning Council will also continue to make Housing services the most highly funded of the support services in the TGA. The NHAS calls out housing as a key service necessary for increasing access and improving outcomes for Ryan White clients. The Portland TGA will also advocate for Housing to be added as a core service for Ryan White Part A funding to allow more flexibility in the funding allocated to Housing services.

F. Proposed solution for addressing overlaps in care

Based on currently available data there are no significant overlaps in care in the Portland TGA. However, clients report confusion regarding the roles of multiple case managers funded by different federal, state and local sources. The Part A case managers ask clients about other programs from which they receive assistance and communicate with staff from those programs to coordinate care for the client. Within the TGA, Parts A and B have been very careful to clarify the different roles of the CAREAssist (ADAP) case worker and the Part A medical case manager. Case managers funded by various parts of the Ryan White legislation will meet at least yearly to discuss coordination with the goal of eliminating service duplication.

G. Proposed coordination efforts

Coordination with Ryan White Part B including ADAP (CAREAssist) The case management programs in Parts A and B share information about their referral processes, client information, and documentation to determine if clients have successfully followed through on referrals and have been linked to care. Occasionally residents of non-TGA counties are tested by providers in the TGA. In these instances, case managers in the TGA refer clients to Part B services, working closely with Part B colleagues to ensure that client needs are met. Many Part A clients are linked to insurance assistance through the CAREAssist program when they engage in medical care and medical case management. In Oregon, Part A case managers work closely with Part B CAREAssist case workers to ensure that all required documentation is submitted with each application. In Clark County, Part A case managers also receive direct funding for case management from the Washington Part B program. Case managers in Oregon and Washington monitor clients' access to ADAP services and also assist with ensuring that eligibility documentation is current for both Parts A and B. During the next year, Part A, Oregon's Part B and CAREAssist will pilot efforts to establish a joint eligibility documentation system, to meet the HRSA requirement to verify each client's eligibility at six month intervals, thus reducing duplication of effort and burden on clients and providers.

In addition to coordination on these direct services, Part A staff participate on the ADAP Advisory Board and the Oregon Integrated Planning Group (IPG). Through Part A funded Early Intervention services (EIS), Disease Intervention Specialists work with state health partners to access an electronic laboratory database which documents laboratory tests (CD4 and VL). Staff use the data to assess linkage to care. Also, Part A medical providers function as mentors to medical providers in Oregon and Washington through AETC trainings. Participation in these trainings results in increased quality of care provided by physicians who may see a small number of HIV+ patients. The trainings also help establish relationships which encourage ongoing consultation.

Coordination with Parts C and D and STD Programs The Multnomah County Health Department houses the HIV Health Services Center (HHSC), the only clinic in Oregon that receives Ryan White Part A, C, and

D funding. The HHSC is co-located in the same building as the County's STD Clinic and the Part A EIS Disease Intervention Specialist Program, facilitating communication and collaboration among the programs and enabling a warm handoff of clients from testing to primary medical care. Staff from the Part A, C, and D programs work closely with EIS and prevention partners to share information about barriers and trends. Furthermore, HHSC clinicians have been trained in risk reduction counseling with their HIV+ patients. This creates the opportunity to identify patients whose sexual partners may be at risk for HIV. When partners of HHSC patients are in the clinic, staff from the STD Clinic can be called in to provide on-site rapid testing.

Coordination with Prevention The Part A program works closely with the state and local prevention and disease control programs in the Portland TGA to identify PLWH/A. Care Services staff (Part A grantee) and HIV Prevention staff are co-located within the STD/HIV/Hepatitis C Program of the Multnomah County Health Department. Processes for active referrals between testing sites and Part A medical and case management providers are well established. Prevention and Care Services staff coordinate community events and outreach activities and share educational and awareness materials. In addition, these staff participate in planning groups including the Part A Planning Council and the Oregon Conference of Local Health Officials HIV subcommittee.

Care Services staff work closely with prevention programs to ensure that front line staff are knowledgeable about services for PLWH/A in the TGA and are trained to refer clients to the most appropriate service based on location, income, insurance status, co-morbidities, language, or other special needs. Part A service providers and prevention programs identify gaps in services for shared clients, conduct parallel quality improvement initiatives and collaborate on research projects. The EIS program enables the Disease Intervention Specialists to maintain regular contact with and provide support for newly diagnosed individuals until they are well-established in a medical home.

Coordination with Part F Part F providers in the TGA include the AETC and the Oral Health Initiative. Part A and the AETC are in regular contact regarding training opportunities. The local AETC representative and a Care Services staff member both participate in the IPG and are able to use that forum to ensure cooperation on projects. The AETC also communicates with a wide variety of private providers of HIV care and treatment. Through their communication network, Part A is able to disseminate information to a broad range of private providers. The HIV Health Services Center is the on-site AETC training partner for primary care providers throughout the northwest. The OHSU Russell St Dental Program is the Part F grantee for oral health services and it is also a Part A provider. As such the two Parts leverage funding to provide the most comprehensive oral health care possible for clients in the Portland TGA.

Coordination with Private Providers As mentioned above the HIV Health Services Center is the AETC training site for primary care providers throughout the TGA. Those trainings help introduce private providers to the Ryan White continuum of care. In addition, private providers are on the mailing list for HIV Planning Council meetings. The AETC also helps by disseminating care system information to private HIV medical care providers as needed. In addition, a representative from the Oregon Primary Care Association attends the IPG and collaborates with the Ryan White system to encourage coordination with private providers. The Part A medical case management system is a public and private cooperative

effort which places case managers in some of the largest private medical care systems in the TGA including, Sisters of Providence, Good Samaritan, and Legacy Emanuel health clinics.

Coordination with Substance Abuse Treatment The care system works in concert with local substance abuse providers to encourage clients to test, through pilot projects to provide rapid testing at substance abuse treatment centers, and through a recent NIDA project on training of peer health workers to provide health education and harm reduction messages to clients using needle exchange services. Harm reduction programming is available through multiple sites in the TGA, partially supported by Ryan White funds. These contractors provide a strong link to mainstream substance abuse programming in the region. In addition, Care Service staff will continue their participation at the Adult Mental Health and Substance Abuse Advisory Board meetings.

Coordination with Medicare, Medicaid, CHIP and CHCs On an ongoing basis, all Part A primary care and case management providers take responsibility for linking clients with these programs whenever possible to ensure that Part A funds are used as funds of last resort. Over the next three years, the Planning Council and Care Services staff will have a particular focus on learning about and working with the new Oregon structure of Coordinated Care Organizations overseeing the physical, behavioral and dental care of Medicaid clients, in addition to addressing upcoming changes as national health care reform continues to be rolled out through 2014. The Council and staff will represent the interests of PLWH/A to ensure a smooth transition for our clients.

III. How will we get there? 2012-2014

See next section for update for FY2015-16

A-D. Strategies, plans and activities

The strategies, plans, and activities (including responsible parties) for each of the TGA's four primary goals are delineated below, along with timelines for conducting each activity. All activities attempt to close gaps in care across the continuum. Goal 1 focuses on strategies, plans and activities for those who are ***Unaware*** of their HIV status as well as people who are at high risk of infection, but not yet infected. Goals 2 and 3 focus on strategies, plans and activities for finding and engaging those who are ***Aware*** of their status but either not in care at all, or not well engaged in care, and then retaining those clients in care. Goals 3 and 4 specifically address the continuum of care to engage and retain people in care.

The strategies, plans, and activities represent work to be accomplished with the subpopulations identified by HRSA, including adolescents, injection drug users, homeless, and transgender. Our main AIDS service organization, Cascade AIDS Project (CAP), has extensive experience in providing age-appropriate support to children, adolescents, and their parents, and one of our two publicly funded medical providers, OHSU, is well-known for its pediatric HIV care. Harm reduction is incorporated into services to meet active injectors "where they are at" to engage in services. Improved coordination of housing case management and medical case management, in addition to a new HOPWA grant, have strengthened the system's ability to address housing needs, and the psychosocial service provider, the HIV Day Center, is organized specifically around life needs for homeless individuals. Transgender advocacy in Portland is strong, especially in the provision of health care (for all regardless of HIV status). Basic Rights Oregon has a transgender health advocacy and training program, and two FQHCs (Outside In and Multnomah County Health Department) actively prioritize transgender services and cultural

competency. MCHD and OHSU systems both received the highest level of approval in LGBT culturally competent care by the Human Rights Campaign's national Health Equity Index.

The strategies, plans, and activities also focus on work to be accomplished with other subpopulations of special interest in the TGA, including racial and ethnic minorities, the recently incarcerated, men who have sex with men, women, recent immigrants/refugees, and individuals dual diagnosed with mental illness and substance abuse.

GOAL 1 Preventing New HIV Infections

Local and State health department partners, other government and municipal entities, and community-based partners lead the varied efforts to implement HIV prevention strategies for high risk and general populations--from needle exchange to comprehensive sexuality education in schools.

Strategy: Implement comprehensive prevention activities for PLWH/A

Activity	Responsible Party	Timeframe
Distribute free condoms to PLWH/A at Part A provider sites.	Care Services	Summer 2012 and ongoing
Refer PLWH/A to Healthy Relationships intervention (provided by Cascade AIDS Project) to support HIV status self-disclosure skills.	Part A providers*, Prevention programs STD Programs	Ongoing
Require MAI funded patient navigator activities to address disclosure issues among Hispanic and Black/African American communities to reduce further transmission.	Care Services	Ongoing
Assess PLWH/A for transmission risk behavior and provide counseling or referral to risk reduction counseling.	Part A medical, case management and EIS providers	Ongoing

*****(see Appendix C)

Strategy: Support increased access to antiretroviral therapy to reduce community viral load

Activity	Responsible Party	Timeframe
Disseminate information about the availability of Ryan White funded medical services and ADAP (CAREAssist) coverage for medications, focusing on populations of highest risk .	Care Services	Ongoing
Support medication adherence interventions delivered by Part A providers.	Care Services Planning Council	Summer 2012 and ongoing
Develop and disseminate culturally competent educational materials on impact of suppressed viral load on transmission.	Care Services Prevention Programs	Spring 2012
Develop and disseminate information to community using traditional and social media, to increase use of the HIV Resource Hotline by non Ryan White providers and clients not yet engaged in Ryan White services, with specific focus on minority populations.	Care Services	Fall 2012

GOAL 2 Finding HIV+ Individuals who need Care and Treatment Services

Local and State health departments, private health care facilities, and community-based partners lead the efforts to implement accessible targeted HIV testing and routine HIV testing at sites most likely to find undiagnosed individuals who don't actively seek testing.

Strategy: Implement a universally accessible system of HIV testing which integrates linkage to care and partner testing.

Activity	Responsible Party	Timeframe
Conduct post test counseling and public health investigation of all new cases of HIV, including active EIS support until client engagement in medical care is verified.	Part A EIS providers Prevention Programs	Summer 2012 and ongoing
Contact and offer HIV and STD testing to all identified partners of new HIV cases, and to partners of PLWH/A subsequently diagnosed with an STD. Offer HIV testing to partners of PLWH/A coming to Part A HIV Clinics.	STD Program	Ongoing
Develop and disseminate consistent messages around HIV, HCV and STD testing and linkage to care.	Care Services Part B Prevention Program	By Fall 2013
Monitor HIV test result data monthly to ensure all newly diagnosed HIV cases receive their test results.	STD program	Ongoing

Strategy: Identify and reduce cultural and structural barriers to early HIV diagnosis and engagement in care

Activity	Responsible Party	Timeframe
Conduct joint prevention and care planning and mutual capacity building to ensure seamless integration between organizations and jurisdictions across TGA, and to develop consistent prevention messages and actively support clients from testing through engagement and retention in care.	6 local county health departments Part A providers Non-RW providers	Spring 2012 and ongoing
Provide consistent HIV, HCV and STD testing information to Part A primary care sites, drug and alcohol treatment, mental health settings, and other service locations.	Care Services Prevention Programs	Winter 2012
Work with the State HIV Program and the Oregon Health Authority to advocate for standards of care that include routine HIV, STD and HCV testing and preventive measures in the state's basic minimum plan for new health insurance policies as well as Coordinated Care Organizations.	Care Services Community Partners (CAP, LGBT Health Coalition)	Spring 2012 and ongoing
Assess and address PLWH/A safety and ability to fully participate in group services with initial focus on mental health and substance abuse services.	Care Services Community Partners	Winter 2012

Strategy: Strengthen linkages with substance abuse, mental health, corrections and housing services to ensure common knowledge of testing and linkage resources.

Activity	Responsible Party	Timeframe
Disseminate information about the availability of Ryan White funded medical services and ADAP (CAREAssist) coverage for medications to staff and clients at agencies providing substance abuse, mental and behavioral health services.	Care Services	Ongoing
Support HBV vaccination and HIV, STD, and HCV testing at substance abuse, mental health, corrections or housing service providers.	Prevention Programs Care Services Part D Program	Fall 2013
Disseminate information about the HIV Resource Hotline .	Care Services	Fall 2012
Promote linkages between behavioral health and physical health in creation of CCOs. Lead and participate in public policy discussions regarding the impact of CCOs on PLWH/A .	Care Services	Summer 2012 and ongoing
Support EIS services that reach clients in corrections.	Care Services HIV Planning Council	Ongoing

Strategy: Strengthen relationships with STD providers and disease intervention specialists to identify clients who may be out of care.

Activity	Responsible Party	Timeframe
Assess STD clinic clients already diagnosed with HIV for need to re-engage in HIV care and refer to EIS.	STD program	Ongoing
Provide EIS until re-engagement is verified.	Part A EIS providers	Ongoing

GOAL 3 Engaging HIV+ People in Care and Treatment Services

Strategy: Promote access to services that help PWLH/A be successful in their HIV care – including health insurance, primary care, housing, basic life needs and employment assistance

Activity	Responsible Party	Timeframe
Support HIV medical case management, with attention to special populations e.g. Hispanics, African Americans, refugees.	Care Services HIV Planning Council	Ongoing
Develop procurement for specialized services to support clients with mental illness.	Care Services	Summer 2012
Promote provision of employment services funded by HOPWA SPNS grant through participation in grant advisory committee.	Care Services	January 2012-December 2014

Strategy: Integrate motivational interviewing and harm reduction strategies into all services for PLWH/A to promote access to services for people regardless of their readiness to change behaviors

Activity	Responsible Party	Timeframe
Provide Motivational Interviewing training for Part A providers.	Care Services	Fall 2012 – Fall 2013
Require Part A funded Substance Abuse providers to include harm reduction strategies in service delivery.	Care Services	Ongoing

GOAL 4 Retaining HIV+ People in Care and Treatment Services

Strategy: Provide access to comprehensive primary medical care for all PLWH/A, including access to antiretroviral therapy, using the Patient Centered Medical Home model and provide support for clients to remain in care.

Activity	Responsible Party	Timeframe
Promote development of medical homes for PLWH/A through Ryan White funding for ambulatory care.	Care Services	Ongoing
Activity	**Responsible Party**	**Timeframe**
Refine tracking system to ensure all medical care clients are seen in medical clinics or contacted at least every 6 months.	Care Services	Fall 2012 and Ongoing
Promote STD and hepatitis C prevention education and screening for PLWH/A.	Prevention Programs Care Services Part B	Summer 2012 and Ongoing
Support hepatitis C treatment access for co-infected PLWH/A through Part A funding for ambulatory care.	Care Services HIV Planning Council	Ongoing
Analyze data from ambulatory care to ensure that patients for whom ARVs are medically appropriate are able to access medications.	Care Services Part A medical providers	Ongoing
Monitor progress of CCO development and impact on provision of care for PLWH/A.	Care Services	Summer/Fall 2012
Advocate for early inclusion of dental care in CCOs. Monitor CCOs where dental care has been included from the onset.	Care Services	Fall 2012
Provide on-site Part A medical case management services to support access and retention to medical care and ancillary services that help people stay in care	Care Services and Part A providers	Ongoing
Develop linkage with Aging and Disability Services to enhance coordination of care for PLWH/A over 50.	Care Services	Winter 2012

Strategy: Provide focused assistance to populations with identified disparities

Activity	Responsible Party	Timeframe
Continue to support HIV medical case management navigation services, with attention to special populations, e.g. Refugees, Hispanics, African Americans	Care Services HIV Planning Council	Ongoing
Develop specialized services focusing on people with severe persistent mental illness, including those with co-occurring substance abuse disorder	Care Services Part A providers	Summer 2012
Update and disseminate Spanish Resource Guide	Care Services	Winter 2012

Strategy: Support self management programs

Activity	Responsible Party	Timeframe
Participate in Self Management Collaborative in coordination with Oregon Primary Care Association	Care Services	Through Winter 2012

Activity	Responsible Party	Timeframe
Support community agencies to provide self management workshops, including Positive Self Management Program.	Care Services	2012-2013
Share self management curricula among providers, e.g., corrections transition program, Part B case management	Care Services	Winter 2012

Strategy: Develop strong linkages between systems of care including housing and HIV care

Activity	Responsible Party	Timeframe
Participate in Housing Authority of Portland SPNS grant advisory committee to increase integration between "mainstream" housing and employment services and those specifically designed to serve PLWH/A.	Care Services	Spring 2012 – Winter 2014
Advocate for Housing as a HRSA/HAB core service in Ryan White reauthorization .	Care Services Part A providers Part B	Spring/Fall 2012

Strategy: Develop leadership among PLWH/A in the TGA

Activity	Responsible Party	Timeframe
Coordinate leadership training opportunity for PLWH/A	Care Services Planning Council Region X HIV/AIDS Resource Coordinator	Summer 2013

See next page for updated Section III

III. How will we get there?

A-D. Strategies, plans and activities

The strategies, plans, and activities (including responsible parties) for each of the TGA's four primary goals are delineated below, along with timelines for conducting each activity. All activities attempt to close gaps in care across the continuum. Goal 1 focuses on strategies, plans and activities for those who are ***Unaware*** of their HIV status as well as people who are at high risk of infection, but not yet infected. Goals 2 and 3 focus on strategies, plans and activities for finding and engaging those who are ***Aware*** of their status but either not in care at all, or not well engaged in care, and then retaining those clients in care. Goals 3 and 4 specifically address the continuum of care to engage and retain people in care.

The strategies, plans, and activities represent work to be accomplished with the subpopulations identified by HRSA, including adolescents, people who inject drugs , people experiencing homelessness, and those who are transgender. The largest AIDS service organization, Cascade AIDS Project (CAP), has extensive experience in providing age-appropriate support to children, adolescents, and their parents, and the Ryan White Care Continuum maintains a close relationships with Oregon Health and Sciences University Medical Center, the primary provider of all pediatric HIV care in Oregon. Harm reduction is incorporated into services to meet active injectors "where they are" to engage in services. Improved coordination of housing case management and medical case management, in addition to a recently completed HOPWA grant, have strengthened the system's ability to address housing needs. One of the psychosocial service providers, the HIV Day Center, is organized specifically around life needs for homeless individuals. Transgender advocacy in Portland is strong, especially in the provision of health care (for all regardless of HIV status). Basic Rights Oregon has a transgender health advocacy and training program, and two FQHCs (Outside In and Multnomah County Health Department) actively prioritize transgender services and cultural competency. MCHD received the highest level of approval in LGBT culturally competent care by the Human Rights Campaign's national Health Equity Index.

The strategies, plans, and activities also focus on work to be accomplished with other subpopulations of special interest in the TGA, including racial and ethnic minorities, the recently incarcerated, men who have sex with men, women, recent immigrants/refugees, and individuals dually diagnosed with mental illness and substance abuse. Services specifically focusing on long-term survivors are also planned for FY2016.

GOAL 1 Preventing New HIV Infections

Local and State health department partners, other government and municipal entities, and community-based partners lead the varied efforts to implement HIV prevention strategies for high risk and general populations--from needle exchange to comprehensive sexuality education in schools.

Strategy: Implement comprehensive prevention activities for PLWH/A

Activity	Responsible Party	Timeframe
Distribute free condoms to PLWH/A at Part A provider sites.	Care Services	Ongoing
Refer clients who are interested in PrEP programs to medical	Part A providers	Ongoing

providers, and PrEP programs in the TGA, including at the STD Clinic and at Cascade AIDS Project	Prevention programs, STD Programs	
Include discussion of disclosure issues in MAI funded patient navigator activities with Hispanic and Black/African American communities to reduce further transmission. to address	Care Services	Ongoing
Assess PLWH/A for transmission risk behavior and provide counseling or referral to risk reduction counseling.	Part A medical, case management and EIS providers	Ongoing

Strategy: Support increased access to antiretroviral therapy to reduce community viral load

Activity	Responsible Party	Timeframe
Disseminate information about the availability of ADAP (CAREAssist in Oregon and EIP in Washington) assistance to help pay for health insurance premiums and co-pays for medications, and medical visits. .	Care Services	Ongoing
Support medication adherence interventions delivered by Part A providers.	Care Services Planning Council	Ongoing
Assess use of the HIV Resource Guide and on-line resources by Ryan White providers and clients. Assess possibility of combining HIV Resource Guide with other resource publications such as Street Roots Guide.	Care Services and Cascade AIDS Project	Fall 2015

GOAL 2 Finding HIV+ Individuals who need Care and Treatment Services

Local and State health departments, private health care facilities, and community-based partners lead the efforts to implement accessible targeted HIV testing and routine HIV testing at sites most likely to find undiagnosed individuals who don't actively seek testing.

Strategy: Implement a universally accessible system of HIV testing which integrates linkage to care and partner testing.

Activity	Responsible Party	Timeframe
Conduct post test counseling and public health investigation of all new cases of HIV, including active EIS support until client engagement in medical care is verified.	Part A EIS providers	Ongoing
Contact and offer HIV and STD testing to all identified partners of new HIV cases, and to partners of PLWH/A subsequently diagnosed with an STD. Offer HIV testing to partners of PLWH/A coming to Part A HIV Clinics.	STD Program EIS Providers	Ongoing
Continue to assess pilot project of testing clients in county jail during booking process. If positivity is low, discontinue.	Care Services Multnomah County Corrections Health	FY 2015
Monitor HIV test result data monthly to ensure all newly	STD program	Ongoing

diagnosed HIV cases receive their test results.		

Strategy: Identify and reduce cultural and structural barriers to early HIV diagnosis and engagement in care

Activity	Responsible Party	Timeframe
In preparation for SCSN, participate in joint prevention and care planning increase integration between organizations and jurisdictions across TGA, to develop consistent prevention messages and actively support clients from testing through engagement and retention in care.	6 local county health departments Part A providers Non-RW providers	Spring 2016
Provide consistent HIV, HCV and STD testing information to Part A primary care sites, drug and alcohol treatment, mental health settings, and other service locations.	Care Services Prevention Programs	Ongoing
Work with the State HIV Program and the Oregon Health Authority to advocate for universal testing in primary care sites.	Care Services Community Partners AETC, Oregon Primary Care Association Oregon Health Authority	Ongoing
Work with Mental Health and Addictions program to address challenges for PLWH/A in accessing residential substance abuse treatment.	Care Services HIV Planning Council	Winter 2015

Strategy: Strengthen linkages with substance abuse, mental health, corrections and housing services to ensure common knowledge of testing and linkage resources.

Activity	Responsible Party	Timeframe
Disseminate information about the availability of Ryan White funded medical services and ADAP (CAREAssist) coverage for medications to staff and clients at agencies providing substance abuse, mental and behavioral health services.	Care Services	Ongoing
Advocate for universal HIV testing and appropriate immunizations through all CCOs	Care Services	Ongoing
Advocate for public health funding for non-CCO STD and HCV testing sites	Care Services STD Program	Ongoing
Promote linkages between CCOs and Ryan White providers and advocate for increased coverage of services needed by PLWH/A, e.g. HIV medical case management.	Care Services	Ongoing

Strategy: Strengthen relationships with STD providers and disease intervention specialists to identify clients who may be out of care.

Activity	Responsible Party	Timeframe
Assess STD clinic clients already diagnosed with HIV for need to re-engage in HIV care and refer to EIS.	STD program, EIS providers	Ongoing
Provide EIS until re-engagement in medical care is verified.	Part A EIS providers	Ongoing

GOAL 3 Engaging HIV+ People in Care and Treatment Services

Strategy: Promote access to services that help PWLH/A be successful in their HIV care – including health insurance, primary care, housing, basic life needs and employment assistance

Activity	Responsible Party	Timeframe
Support HIV medical case management, with attention to special populations e.g. Hispanics, African Americans, refugees.	Care Services HIV Planning Council	Ongoing
Advocate for Multnomah County General Fund to support employment services for PLWH/A previously funded by HOPWA SPNS grant.	Care Services	Jan 2015 ongoing

Strategy: Integrate motivational interviewing and harm reduction strategies into all services for PLWH/A to promote access to services for people regardless of their readiness to change behaviors

Activity	Responsible Party	Timeframe
Provide information about recurring MI training opportunities for providers	Care Services	Ongoing
Require Part A funded providers to include harm reduction strategies in service delivery.	Care Services	Ongoing

GOAL 4 Retaining HIV+ People in Care and Treatment Services

Strategy: Provide access to comprehensive primary medical care for all PLWH/A, including access to antiretroviral therapy, using the Patient Centered Medical Home model and provide support for clients to remain in care.

Activity	Responsible Party	Timeframe
Promote development of medical homes for PLWH/A through Ryan White funding for ambulatory care.	Care Services	Ongoing
Provide and participate in training in Trauma Informed Care and support Trauma Informed organizational assessment	Care Services RW Providers	Training 12/1/2015, org assessments in 2016
Refine tracking system to ensure all medical care clients are seen in medical clinics or contacted at least every 6 months. Increase frequency of outcome measures reports to all	Care Services	Six month reports will be sent out in 2015, ongoing

RW providers.		
Support hepatitis C treatment access for co-infected PLWH/A through Part A funding for ambulatory care.	Care Services HIV Planning Council	Ongoing
Support co-pays for specialty drugs via ADAP programs	Care Services	Ongoing
Provide information to clients regarding insurance choices that maintain affordability of ARVs (as opposed to classification as specialty medications)	Care Services Part A case management providers	Ongoing
Provide on-site Part A medical case management services to support access and retention to medical care and ancillary services that help people stay in care	Care Services and Part A providers	Ongoing
Develop linkage with Aging and Disability Services to enhance coordination of care for PLWH/A over 50.	Care Services HIV Planning Council	Ongoing
Advocate for additional medical services for ADAP clients, e.g. dental and/or vision care	Care Services ADAP Advisory Committee	Dental care offered as of 2015. Vision care advocacy ongoing

Strategy: Provide focused assistance to populations with identified disparities or special needs

Activity	Responsible Party	Timeframe
Continue to support HIV medical case management navigation services, with attention to special populations, e.g. Refugees, Hispanics, African Americans	Care Services HIV Planning Council	Ongoing
Develop specialized services focusing on people with severe persistent mental illness, including those with co-occurring substance abuse disorder	Care Services Part A providers	
Assess possibility of supporting Spanish version of Street Roots Guide.	Care Services	Winter 2015-16
Develop psychosocial services for long-term survivors	Care Services HIV Planning Council	FY 2016

Strategy: Support self management programs

Activity	Responsible Party	Timeframe
Support community agencies to provide self management workshops annually, including Positive Self Management Program.	Care Services	2015-16

Strategy: Develop strong linkages between systems of care including housing and HIV care

Activity	Responsible Party	Timeframe
Participate in planning for HIV Housing Continuum regional meetings	Care Services	Summer-fall 2015

Continue to advocate for Housing as a HRSA/HAB core service in Ryan White reauthorization. Participate in Ryan White Workgroup monthly calls.	Care Services Part A providers Part B	Ongoing

Strategy: Develop leadership among PLWH/A in the TGA

Activity	Responsible Party	Timeframe
Develop additional opportunities for PLWH/A to participate in planning services, e.g, short term committees to develop surveys, updating resource lists	Care Services Planning Council	FY 2015

End of Updated Section

E. Description of activities to implement coordination with all other programs

The staff at HIV Care Services participate in multiple coordinating workgroups and planning bodies including the State Integrated Planning Group and the Part B ADAP CAREAssist Advisory Board. In addition, Care Services is located in the STD, HIV and Hepatitis C Program at Multnomah County Health Department. This integrated program allows for coordinated planning and implementation of STD and HIV services.

Multnomah County Health Department will be a major participant in one of the first Coordinated Care Organizations in Oregon. Care Services staff will participate in recommending participants for the consumer advisory board overseeing the work of the CCO. They are also called upon to provide input regarding the specific needs of PLWH/A that should be covered in the global budget for the CCO, and what essential services will be required of all insurance companies participating in the health insurance exchange. In addition, staff are also monitoring the impact of Affordable Care Act funding in our TGA. For example, a small clinic in Yamhill County has received funds to expand services and transforms its service model to a patient centered medical home. Part A case managers in that county will be working with that clinic to assess whether more HIV+ clients might now be able to receive their HIV medical care through that clinic, and avoid the two hour trip into Portland.

Care Services staff and HIV Prevention staff participate in the Integrated Planning Group which is a statewide advisory group to the HIV/STD/TB section of the Oregon Health Authority. Staff are members of the Prevention & Care Committee (chairperson) and the Coordination of Care Committee. Meetings are held quarterly to review CDC, HRSA and HOPWA guidance and requirements, to provide input for planning documents, review data, and identify best practices and current gaps in services.

Staff also participate in the Care Assist (Oregon ADAP) Advisory Board to provide input on new policies, assist with communication to consumers, provide suggestions for improvements and assist with coordination of policies, procedures and data collection. This board also provides an opportunity to provide a coordinated response from Portland Part A and Oregon Part B regarding the CAREAssist program. In addition staff will be members of a sub-committee to plan for probable changes resulting from implementation of Oregon's health transformation and then with federal health reform.

STD HIV and Hepatitis C program managers at Multnomah County Health Department (MCHD) coordinate activities across programs in order to most effectively use grant funding, assign staff appropriately and maximize efficiency. Coordinating meetings are held every two months and provide opportunities for problem solving and information sharing along with ensuring consistent communication with community partners.

Care Services and HIV Prevention at MCHD recently held an Intergovernmental TGA HIV Planning meeting with staff representing HIV care and prevention at all the six county health departments in the TGA. The goal is to solidify a regional focus to prevention planning around the geographic area of the TGA and to promote coordination of prevention and care activities in this six county area. The initial meeting was to share information, identify areas of common concern, and begin the process of creating a unified strategic plan. Based on the results of that meeting, the second step will be a community

forum to brainstorm about what it would take to further reduce new infections and provide a robust continuum of care in our region. This second meeting is planned for fall 2012. The goal is also to identify new partners in other sectors such as business and education to help move forward on implementing the National HIV/AIDS Strategy.

F. How plan addresses Healthy People 2020 Objectives

Part A services are coordinated with HIV prevention and treatment programs throughout the TGA to address the Healthy People 2020 (HP 2020) goal of preventing HIV infection and its related illness and death. To illustrate the relationship between HP 2020 HIV objectives and the TGA's Part A plan for continued services, the response has been formatted according to the four HP 2020 HIV themes.

Diagnosis of HIV Infection and AIDS HP 2020 objectives HIV-1 though HIV-8 focus on the reduction of the number of new HIV/AIDS cases among adolescents and adults. Goal 1 of the Comprehensive Plan aligns directly with these objectives. Part A services that support these objectives include: 1) Integrated HIV prevention behavioral interventions at medical care, EIS and case management sites; 2) Coordinated care and prevention/EIS for high risk, disproportionately affected communities; 3) Partner referrals to HIV testing and care; 4) Referral/linkage between community HIV testing and STD/TB/Hepatitis screening and treatment; 5) Referral and linkage systems to encourage early access to care; and 6) Prenatal HIV testing linked with referral to specialist care at OHSU for pregnant women. In addition, the MAI programs specifically target population groups with greater proportions of late diagnoses.

Death, Survival and Medical Healthcare After Diagnosis of HIV Infection and AIDS HP 2020 objectives HIV-9 though HIV-12 focus on medical care and health status of PLWH/A. Goals 2 and 3 of the Comprehensive Plan address these objectives through better identification of those groups who are not entering care, or who are falling out of care after diagnosis. Increased access to testing and ensuring linkage to care for those who are tested, increases the likelihood that PLWH/A will be diagnosed earlier and begin medications earlier in their disease. Goal 4 of retaining clients in care works toward these objectives by addressing the need for consistent, ongoing medical care to provide a long and healthy life through ongoing monitoring of health status and early detection and treatment of medical issues. Part A services that support these objectives include: 1) Standards of care and quality assurance protocols at medical provider sites; 2) Both Part A medical sites have MD's who teach other providers on PHS guidelines in coordination with the local AETC; 3) Case management programs that assist enrollment in health insurance programs; 4) Robust linkages with Oregon and Washington ADAP programs to ensure PLWH/A have access to medications; 5) Support services (housing, food, transportation) to sustain participation in care; 6) Culturally specific navigation programs to assist clients with access and retention in care; and 7) A peer program that helps clients engage in mental health and substance abuse treatment services.

HIV Testing HP 2020 objectives HIV-13 though HIV-15 focus on HIV testing. Goal 2 aligns with the HIV testing objectives in Healthy People 2020 through collaboration with testing sites and increased referrals from testing into care. Part A services that support these objectives include: 1) Increased testing opportunities at community based HIV/STD testing sites; 2) Partner testing at HIV medical clinics; 3) Coordinated referral mechanisms between Part A and Prevention programs throughout the TGA; and 4) Non-Part A health department prevention programs provide HIV testing and counseling at drug treatment and needle exchange sites.

HIV Prevention HP 2020 objectives HIV-16 though HIV-18 focus on HIV prevention. Goal 1 of the Comprehensive Plan focuses upon preventing new infections through HIV prevention education and reducing the possibility of transmission. Part A services that support these objectives include: 1) Ongoing relationships with programs that reduce drug harm; 2) Counseling and support groups address risk reduction; 3) Condoms are available through Part A contractors; and 4) Behavioral risk reduction counseling for PLWH through case management, psychosocial services and medical care.

G. How plan addresses the SCSN

The goals of this Comprehensive Plan are shared with the Oregon SCSN and many of the activities outlined in the SCSN will be implemented in the Portland TGA concurrently with their implementation throughout the State. In addition, as one county in the Portland TGA is located in the State of Washington, the TGA Comprehensive Plan also aligns with the more recently developed (April 2012) SCSN goals for the State of Washington, as provided below,

- **Use technology and data systems to enhance HIV care delivery** –The Portland TGA will continue to use the electronic HIV Resource Guide to provide information about available resources in the community. During this comprehensive plan period, efforts will be made to increase usage of that resource. In addition, several activities in the plan require regular monitoring of data to ensure that newly diagnosed individuals are linked to care, that HIV medications are prescribed and available, and that clients are engaged in medical care.
- **Empower PLWH to be active participants in their health care and to be community leaders** – The Portland TGA will implement at least one leadership training opportunity for PLWH/A during the first year of the plan. In addition, self management training workshops will be supported throughout the TGA.
- **Integrate HIV services into Washington's medical and human services continuum of care** - Clark Co, WA is a key partner in the joint project between HOPWA and the Ryan White system to identify other "mainstream" systems of care which PLWH/A may access.
- **Ensure access to quality health care and HIV medications for all people living with HIV in Washington** – Through our Clark Co partners, we will monitor medical services.
- **Improve the integration of prevention and care services for persons living with HIV** – the efforts to disseminate consistent messages around HIV testing and linkage to care in Goal 1 are consistent with this goal, as is the effort to ensure that testing information is available at all Part A sites, and strengthening the coordination of testing and linkage to care. Additionally, the six county planning group is directly related to this goal.

H. How plan is coordinated with the Affordable Care Act (ACA)

The plan addresses the Affordable Care Act through its support of patient centered medical homes as well as the attention to health care transformation in Oregon. The Coordinated Care Organizations being created in Oregon in 2012 mirror the Accountable Care Organizations planned for in the ACA. Thus, by working with organizations who are part of the CCOs in Oregon, the TGA will be well prepared for changes to be put in place when ACA is fully implemented nationally in 2014. In addition, Care Services staff will participate in the CAREAssist Advisory Board subcommittee to plan ahead for a shift to working with the health insurance exchange which will provide a broader choice of insurance coverage for

PLWH/A. The plan is to create HIV specific educational materials to help clients make their choices and reduce the challenges of transitioning between insurance providers.

One of the two HIV clinics funded by Ryan White has already been designated a Tier 3 patient centered medical home and has fully implemented physician panels of patients and a team-based approach. The other Ryan White-funded clinic is already offering integrated behavioral health and chronic disease support within their clinic structure, has established a patient registry, and tracks patient preventive screenings and immunizations.

I. How plan addresses the goals of the National HIV/AIDS Strategy

Please refer to section II. B. Comprehensive Plan Care Goals for a description of the linkages between the Portland TGA goals and strategies and the National HIV/AIDS Strategy.

IV. How Will We Monitor Our Progress?

A. Description of the TGA plan to monitor and evaluate progress

Care Services staff will monitor our progress in achieving the goals of the Comprehensive Plan in two ways – by reviewing the results of the activities outlined in the plan and by reviewing client level data, population data, and needs assessment data regarding PLWH/A and services in the TGA. The activities outlined in the plan will be reviewed quarterly. Care Services staff will take the lead on reviewing progress and report back to the Operations Committee of the Planning Council on successes, challenges and barriers, and any follow-up to address challenges. An annual assessment of the progress on the plan will be scheduled with a report back to the full Planning Council.

Care Services staff will also conduct a comprehensive review of data regarding Part A clients, services, needs, and PLWH/A in the TGA to inform our assessment of progress in achieving plan goals. The staff meets regularly to assess data collection for the TOURS client-level database, which has improved our ability to monitor services and track clinical and program outcomes. The TOURS database is an unduplicated data set containing client demographics, service utilization, and outcomes data from all Part A providers. Each year, during the late spring/early summer the team completes a critical review of the annual data for the previous grant year. These data are used to create score sheets for each service category. The score sheets compile utilization and outcomes data, narrative report information and data from the client satisfaction surveys and needs assessment. Score sheets are then presented to the Planning Council for use in their priority setting and resource allocation process. As a part of creating these score sheets, Care Services staff assess the quality of the data, and make plans to address needed improvements in data collection or reporting tools.

Care Services' partnership with the Oregon Health Authority HIV/STD Surveillance unit provides us with HIV testing, prevalence and incidence data for the TGA. The Surveillance unit also tracks the percentage of PLWH/A who receive laboratory tests (CD4/VL) at appropriate intervals. These surveillance systems provide invaluable information about the demographic characteristics and exposure categories of HIV/AIDS cases in the TGA. Using this data allows us to track shifts in the epidemic over time and monitor how our programs are impacting the epidemic. These data will be especially useful in assessing the impact of our EIIHA initiatives and the long term goals of reducing the number of new infections and reducing the percentage of new infections who are diagnosed with, or progress to AIDS within the first

twelve months. In conjunction with the Oregon Health Authority HIV/STD Surveillance unit, Part A will monitor progress on NHAS metrics including:

- Number of new infections
- Proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis
- Proportion of Part A program clients who are in continuous care
- Number of Part A clients with permanent housing
- Proportion of HIV diagnosed gay and bisexual men with undetectable viral load
- Proportion of HIV diagnosed Blacks with undetectable viral load
- Proportion of HIV diagnosed Latinos with undetectable viral load

In addition, we will track:

- Viral load suppression among PLWH/A
- Percentage of newly diagnosed HIV cases with AIDS within 12 months of diagnosis
- Percentage of PLWH/A who are subsequently reported with a sexually transmitted disease
- Met/unmet need – proportion of living Oregon case and living Oregon residents with HIV who have had a CD4 of viral load test in the last 12 months.

Finally, each year the Planning Council and Care Services staff engage in a process of reviewing needs assessment data from a variety of sources. The TGA conducts the following activities:

- An annual needs assessment, asking PLWH/A about the services they need the most, services they may be having a difficult time receiving, and the barriers they are facing in accessing the services.
- An annual Part A client satisfaction survey to assess how well the service system and provider agencies are meeting the clients' needs.
- Community forums provide an opportunity for the Council to further explore themes identified in the needs assessment and to hear from consumers about their experiences regarding access to HIV services.

Reports on each of these needs assessment activities are provided to the Council. In addition, the Oregon Health Authority is participating in a national multi-year study examining the care that PLWH/A receive, the Medical Monitoring Project (MMP). The MMP collects data on access and barriers to care, unmet care and service needs, quality of treatment, co-morbidities, and patient behaviors (related to sex and drug risk) for individuals receiving HIV care in Oregon. Periodic reports on this study are provided to the Council and Care Services staff. All of these data inform the assessment of our progress on engaging and retaining clients in care.