



HIV Care Services

FY 2014
(3.1.2014 – 2.28.2015)

Annual Report

Multnomah County
Health Department

Adolescent Health Promotion and STD/HIV/HCV Programs

September 2015

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HIV Care Services Annual Report EXECUTVIVE SUMMARY

FY 2014

HIV Care Services administers the Health Resources Services Administration (HRSA) Ryan White Part A grant to the Portland Metropolitan Area. The Part A grant provides funding to local contractors who provide a range of services to persons living with HIV/AIDS.

Transitional Grant Area (TGA)

HIV cases in the TGA as of 12.31.2013

4,741

TGA Grant Amount

$3,538,417

Service Categories funded

- Ambulatory
- Health Ins
- Mental Health
- Dental
- Substance Abuse Trt
- Med Case Mgt
- Early Intervention
- Housing
- Psychosocial
- Food

Number of Ryan White Contractors in the TGA

11

Service Category with largest % of award

Medical Case Management

represented 35% of award

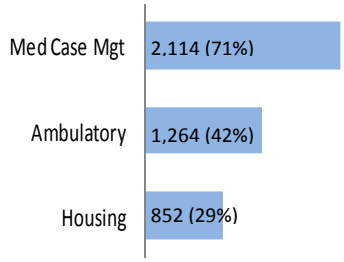
Number of Ryan White Part A clients served

2,979

Number of NEW Ryan White Part A clients

361

Top 3 Services utilized by the most number of clients

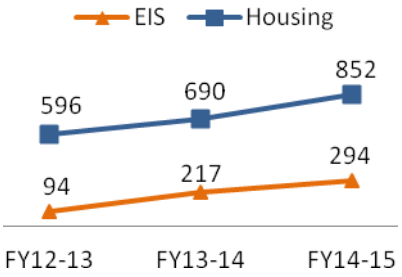


Percentage of RW clients Medically Engaged

76%*

*Goal = 90%

Service Categories where number of clients have increased since 2012



Service Category with the highest percentage of Medical Engagement

Mental Health (91%)*

*The only service category to exceed the TGA goal of 90%

The most commonly cited unmet need

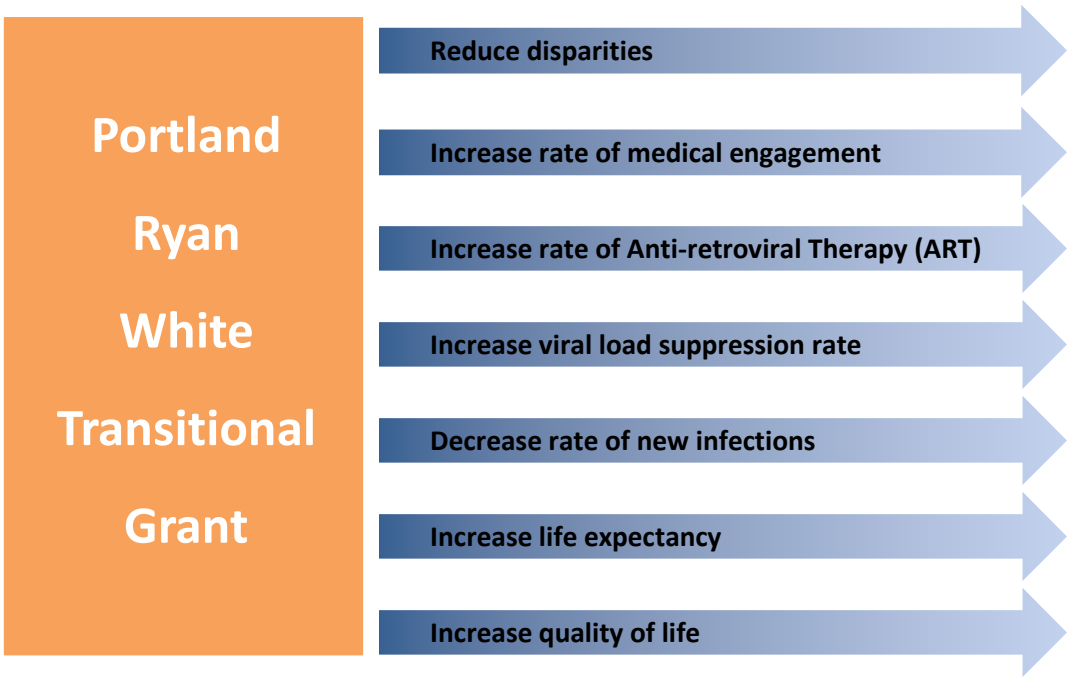
Dental Care (23%)*

*As reported by the OMMP for 2011-2012

INTRODUCTION

The highest concentration of HIV/AIDS cases in Oregon is in the Portland Metropolitan area, with the majority of cases located in Multnomah County. Through a continuum of HIV care that includes both core medical services and support services, the Portland Ryan White Transitional Grant area (TGA) is dedicated to the provision of high quality services to individuals affected and living with HIV/AIDS.

Local AIDS Service Organizations (ASO) work in a climate of unstable federal funding and complex grant requirements to provide services and reach communities most impacted by this disease. The following are Portland TGA goals which are the centerpiece of what makes this work incredibly important:



This report examines the current state of HIV in the Portland metropolitan area, details clients served, describes services provided, and highlights the unmet needs that existed during FY 2014 (March 1, 2014 to February 28, 2015).

Ryan White System

Multnomah County is the Ryan White Grantee for Ryan White Part A federal funds for the Portland metropolitan area. The Multnomah County Health Department HIV Care Services Program administers the Ryan White Part A grant and staffs the Portland Area HIV Services Planning Council. What follows is a description of the federal HIV care system and the system that operates locally in the Portland metropolitan area.

The Federal System

The Ryan White HIV/AIDS Program (RWHAP), first authorized in 1990 as a response to the AIDS epidemic, is administered by the U.S. Department of Health and Human Services (HHS), Health Resources Services Administration (HRSA), HIV/AIDS Bureau (HAB). This program works with cities, states and local community-based organizations to provide services to an estimated 536,000 people each year who do not have sufficient health care coverage or financial resources to cope with HIV.

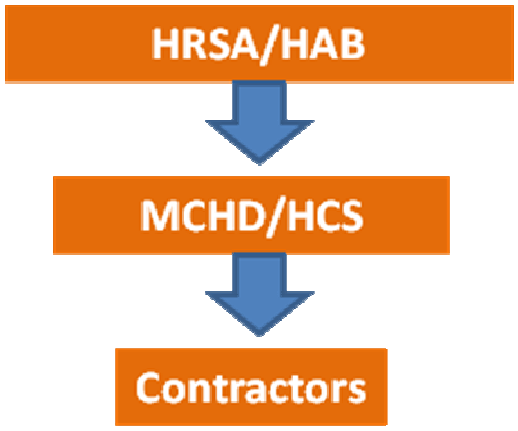
The Ryan White legislation created a number of programs, called Parts, to meet needs for different communities and populations affected by HIV/AIDS. The Portland metropolitan area is a recipient of a Part A Ryan White grant which provides emergency assistance to Eligible Metropolitan Areas (EMA) and Transitional Grant Areas (TGA), geographic locations most severely affected by the HIV/AIDS epidemic. To qualify for EMA status, an area must have reported at least 2,000 AIDS cases in the most recent five years and have a population of at least 50,000. To be eligible for TGA status, an area must have reported 1,000 to 1,999 AIDS cases in the most recent five years and have a population of at least 50,000.

Part A Grant Types		
	EMA	**TGA**
AIDS Cases	2,000	1,000 - 1,999
Population Size	50,000	50,000

The boundaries of EMAs and TGAs are based on the U.S. Census designation of Metropolitan Statistical Areas. During FY 2014, there were a total of 52 Part A grantees across the country; 27 of these grantees including the Portland metropolitan area, were TGAs.

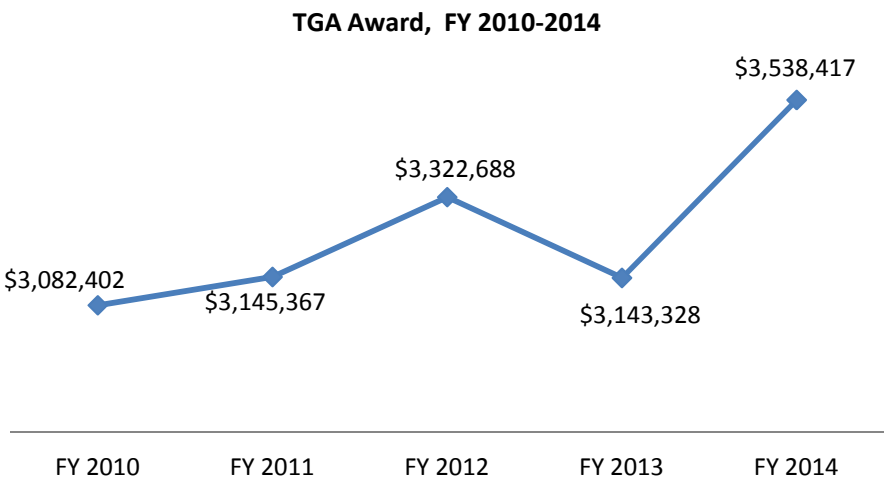
The Local System

For the past 20 years, the Multnomah County Health Department (MCHD), HIV Care Services (HCS) has been the recipient of Ryan White Part A TGA grant funding. The Portland metropolitan area has been federally defined as a TGA. The Portland TGA has a population of 2.3 million, encompasses over 5,000 square miles, and includes a six county area across two states: Clackamas, Columbia, Multnomah, Washington, and Yamhill Counties in Oregon and Clark County in Washington.



HCS manages the grant by providing contract monitoring, administrative oversight, training, and database management to contracted service providers who work directly with person's living with HIV/AIDS (PLWH/A). HCS also works closely with a local planning body, the HIV Services Planning Council, comprised of community members committed to making responsible decisions about how Ryan White federal funds are spent, the delivery of medical and social services and assessing the health care and social services needs of PLWH/A.

During FY 2014, HCS received $3,538,417 in Part A service funds. While the pattern of TGA Part A funding has fluctuated over the past four years, three increases and one decrease, the general trend over this period of time can be characterized as an increase. During this time period there was a 15% increase in funding.

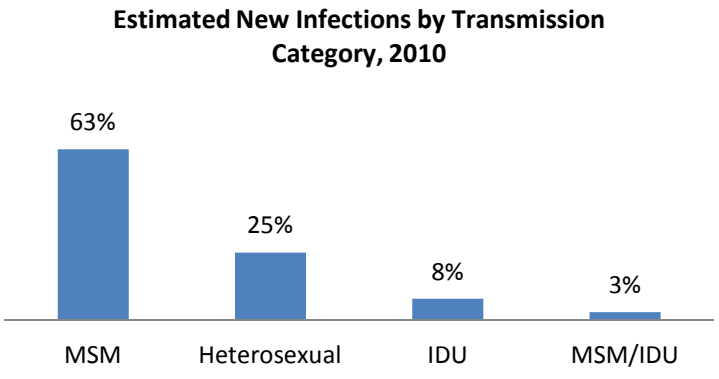


HIV Prevalence

Prevalence is the number of people living with HIV at a given time, such as at the end of the year. Since HIV disease does not produce immediate symptoms there may be people living with HIV who are not aware they have contracted the disease. For this reason, HIV prevalence data is often an estimate, because it includes people who are both aware and unaware of their diagnosis.

Nationwide

The Centers for Disease Control & Prevention estimate that more than 1.2 million people in the United States were living with HIV at the end of 2011. Despite concerted efforts toward reducing stigma, forging ahead with innovative prevention programs, and educating about the link between viral load suppression and transmission, approximately 47,500 individuals became newly infected with HIV in the US in 2010. The HIV new diagnosis rate across the county has remained relatively stable at about 50,000 infections per year since the mid-1990s. Certain groups, including African Americans, Latinos and gay and bisexual men of all races/ethnicities, continue to be disproportionately affected by HIV.



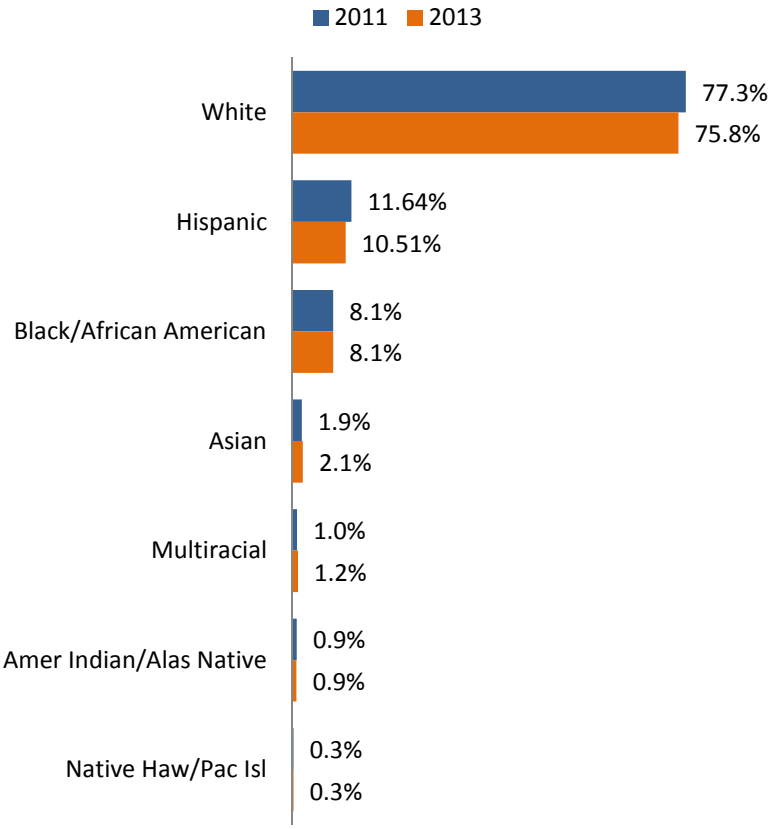
Estimates suggest that men who have sex with men (MSM) represent approximately 4% of the male population in the United States but male-to-male sex accounted for two-thirds (63%) of all new infections in 2010.

In the United States, about 13,712 people diagnosed with AIDS died in 2012. To date, an estimated 658,507 people diagnosed with AIDS in the United States have died.

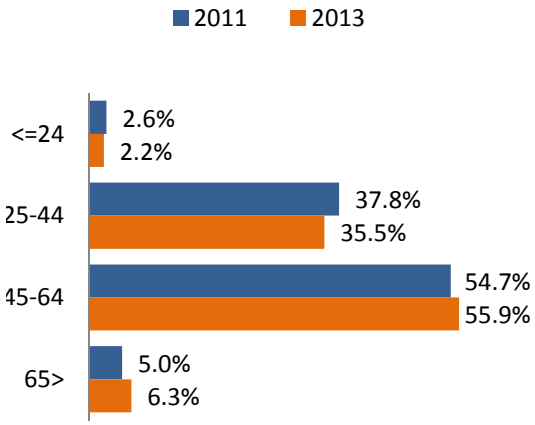
HIV in the Portland TGA

The number of persons living with HIV and AIDS (PLWH/A) in the Portland TGA has continued to grow. As of 12/31/13, a total of 4,741 PLWH/A resided in the TGA—a 19.4 % increase since 2008, an 8% increase since 2011. The demographic profile of the individuals living with HIV/AIDS in the TGA has stayed relatively stable over the past three years. For example, African American clients represented 8.1% of all cases as of 12/31/2011 and three years later African American clients represented 8.1% of all cases as of 12/31/2013. During the past three years, 210 new AIDS cases and 388 new HIV, non-AIDS, cases were diagnosed.

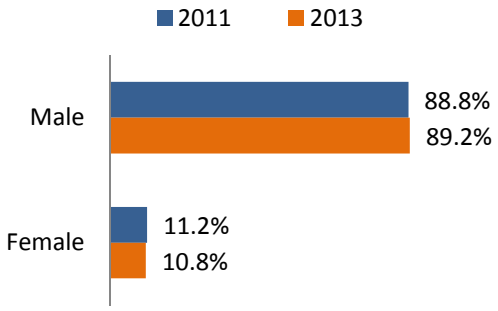
Percentage of TGA HIV/AIDS Cases by Race/Ethnicity, 2011 & 2013



Percentage of TGA HIV/AIDS Cases by Age Grp, 2011 & 2013



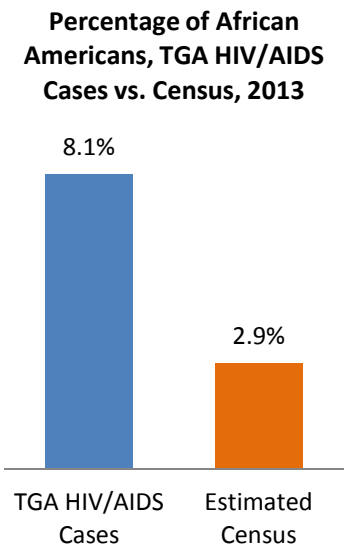
Percentage of TGA HIV/AIDS Cases by Gender, 2011 & 2013

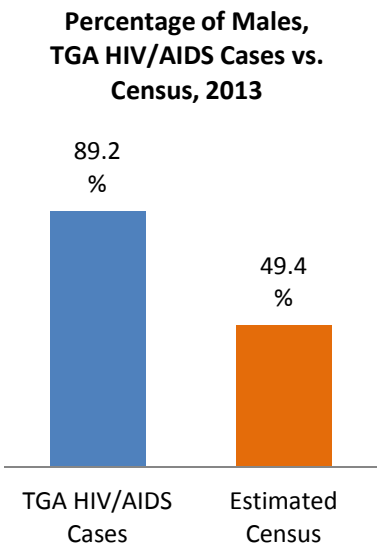


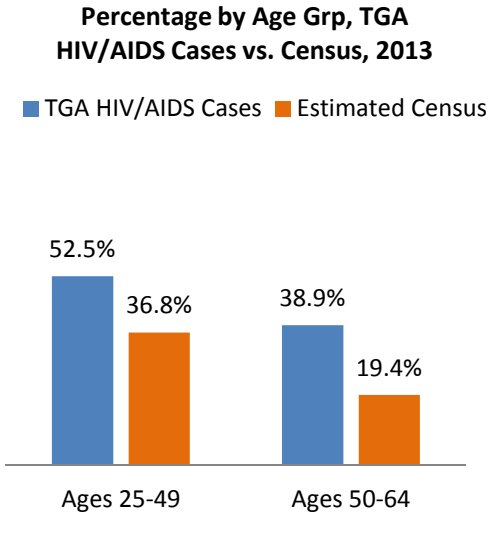
Disparities are differences in incidence, prevalence, mortality and burden of diseases that exist among specific populations. The comparison between those individuals who live in the TGA geographic area

and those individuals who are living with HIV/AIDS in the TGA will provide a snapshot of which groups might be disproportionately affected by HIV/AIDS or bear the burden of the disease.

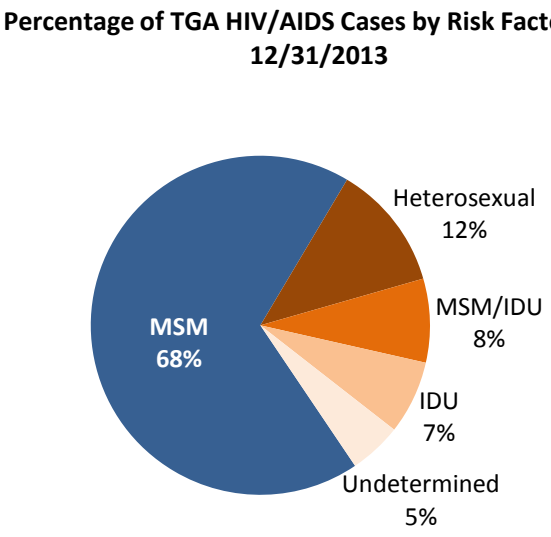
According to epidemiologic data collected as of 12/31/13, 24.2% of PLWH/A in the TGA are persons of color, 89% are men and 52% are between the ages of 25-49. Compared to 2013 *estimate* Census data (error range +/- .1% to .3%) for the TGA, African Americans, males, and individuals between the ages of 25-64 were found to be over-represented in the population of individuals living with HIV/AIDS. The data shows a health disparity for these groups of individuals disproportionately affected by this disease.







According to HIV/AIDS Surveillance case data, 67.5 % of PLWH/A are men who have sex with men (MSM), 7.0% are persons who inject drugs (IDU), 8.3% are MSM/IDU and 9.2% report heterosexual contact as their mode of transmission. Other populations disproportionately burdened by the HIV epidemic include those who are unstably housed and persons with a history of incarceration. The latest data show that 64.9% of PLWH/A in the TGA live in Multnomah County, followed by 13.3% in Clark County, 12.4% in Washington County, 7.6% in Clackamas County, 1.3% in Yamhill County and 0.6% in Columbia County.



Service Delivery in the TGA

Part A funding is used to provide a continuum of care to PLWH/A and their families who reside in the TGA. This continuum of HRSA-defined services is divided into two general categories: core medical services and support services. Core services are generally clinical services and those deemed necessary for managing HIV infection. These include outpatient medical care, health insurance, oral health care, mental health and substance abuse treatment, medical case management, and early intervention services. Support services are those deemed necessary for maintaining engagement into medical care and include housing, psychosocial support, and food/home delivered meals.

Part A HIV Services

The HIV Services Planning Council is dedicated to improving the quality of life for those infected and/or affected by HIV and to ensuring members of our community play a lead role in planning and assessment of HIV resources. The Council is the decision-making body that determines which services are needed, prioritizes these services and how the Part A award is allocated across the service categories.

During FY 2014, the TGA funded a total of seven core services and three support services. See Appendix A for a full list of HRSA approved funded service categories and a description of each service.

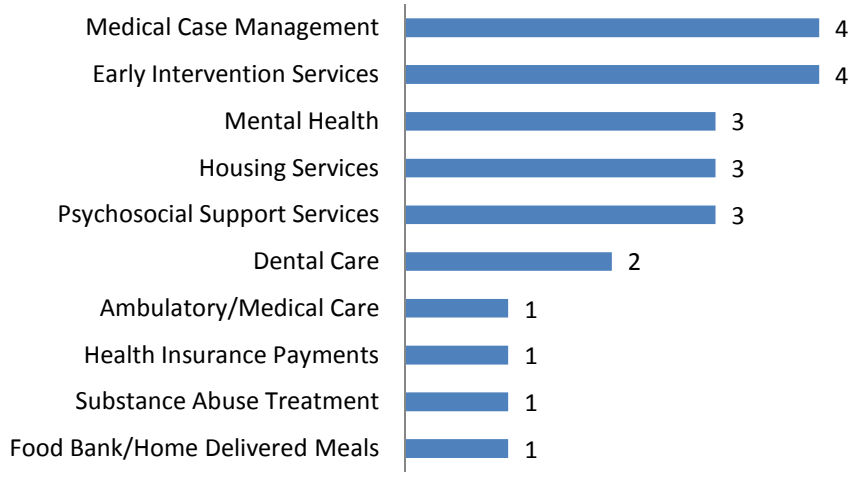
In addition to executing needs assessments, priority setting and resource allocations, the Planning Council also evaluates the efficiency of the administrative mechanism.

FY 2014 Ryan White Part A Allocations by Service Category

Service Category		Allocation Amount	% of Total Award
Core Medical Services	Ambulatory/Medical Care	$613,271	17%
	Health Insurance Payments	$28,000	1%
	Mental Health	$136,831	4%
	Dental Care	$399,167	11%
	Substance Abuse Treatment	$24,781	1%
	Medical Case Management	$1,238,307	35%
	Early Intervention Services	$222,521	6%
Support Services	Housing Services	$553,542	16%
	Psychosocial Support Services	$281,112	8%
	Food Bank/Home Delivered	$40,885	1%

Part A Service Coordination

While the Planning Council makes decisions around priorities and allocations, the grantee (HCS), presides over the process to select contractors who provide these services to the larger community. During FY 2014, HCS contracted with a total of eleven organizations to provide an array of services from ten HRSA-defined core and support services to PLWH/A clients who reside in the TGA.



Of the eleven contractors who provided services to the PLWH/A community in the Portland TGA, six were funded to provide services from more than one Part A funded service category.

Clients who accessed services from these eleven contractors often received services from multiple contractors. During FY 2014 there were a total of 2,979 clients who received at least one Ryan White Part A funded service. About one out of every three clients (37%) received services from more than one contractor. With a coordinated referral system and relationship building that occurs throughout the fiscal year, contractors have comprehensive knowledge of the services provided across all eleven contractor sites.

It is important to note that the Part A array of services does not represent a closed system of care. Though some clients may only access services from one Part A contractor or across multiple Part A contractors, there are also clients who access services from providers outside this system.

The Data System

Per the Ryan White grant requirements, the contractors collect client-level data via CAREWare (CW), which is a free software system supported by HRSA. CAREWare has been used since January 2014. In the Portland TGA, CAREWare is set up as a one client-one record system (networked). This means all contractors who serve the same client in CW view the same client record therefore data collection efforts can be spread through the whole system. Also, CW is set up to collect data through manual data entry (direct) from six contractors and automatically brought in (imported) from four contractors. One contractor provides aggregate level data for HIV testing services only which is not recorded in CW. All client and service data presented in this report from the Portland TGA came from CAREWare.

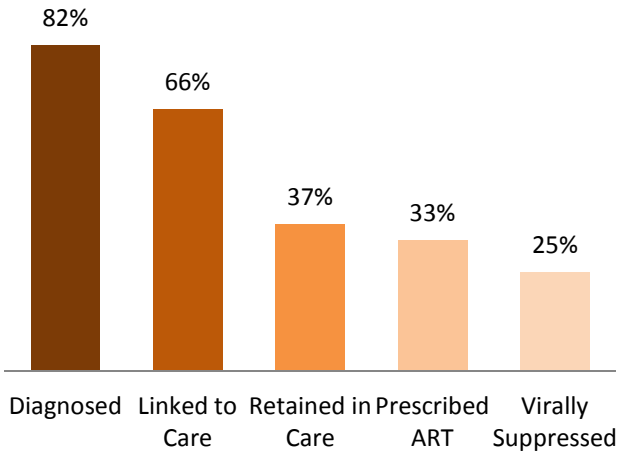
HIV Care Cascade

The HIV treatment cascade—also referred to as the HIV care continuum—is a system to monitor the number of individuals living with HIV who are actually receiving medical care and the treatment they need to achieve viral suppression. It was developed to recognize the various steps necessary for everyone who needs HIV care to remain engaged in it—from an initial stage of getting tested for HIV to being able to suppress the virus through treatment. The system recognizes the new science of viral suppression, which states that when people are engaged in care and taking antiretroviral therapy (ART) to reduce the amount of virus in their body, it makes them less likely to transmit HIV to others.

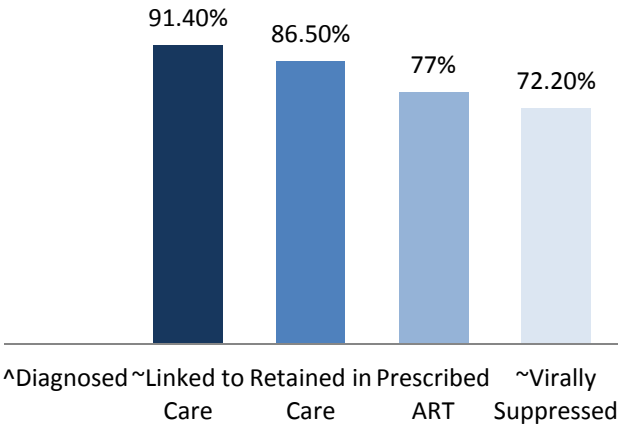
By closely examining these separate steps, policymakers and service providers can pinpoint where gaps may exist in connecting individuals living with HIV to sustained, quality care. If service providers keep track of when patients most commonly drop out, and what populations commonly do so, it can help national, state, and local policymakers and service providers improve systems and services to better support individuals as they move from one step in the care continuum to the next.

The Continuum or Cascade uses a 'waterfall' analysis to look at how many individuals living with HIV are getting tested and diagnosed (this is an estimate generated by the National HIV Surveillance System); of those, how many are linked to medical care; of those, how many are retained in care; of those, how many received ART and; of those, how many are virally suppressed.

National HIV Care Continuum as of 2012



***Portland Area HIV Care Continuum as of 12/31/13**



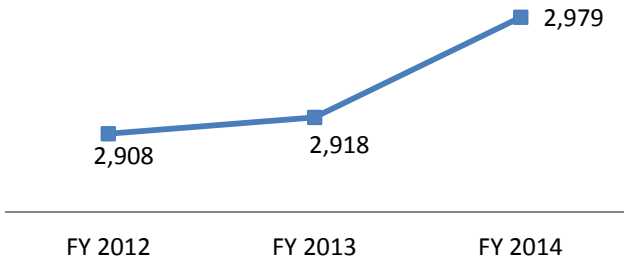
*Clark County, WA data not included.
~Low estimate used.
^Data unavailable.

Compared with the National Care Cascade, where only 25% of Americans living with HIV/AIDS were virally suppressed, efforts in the Portland TGA to link individuals to medical care, retain individuals in medical care and create a large viral suppressed population have been extremely successful. Increasing the number of persons with a suppressed viral load means we can expect a generation of persons living with HIV/AIDS who have an increased quality of life, increased life expectancy, and lower transmission rate than generations previous.

Part A Clients

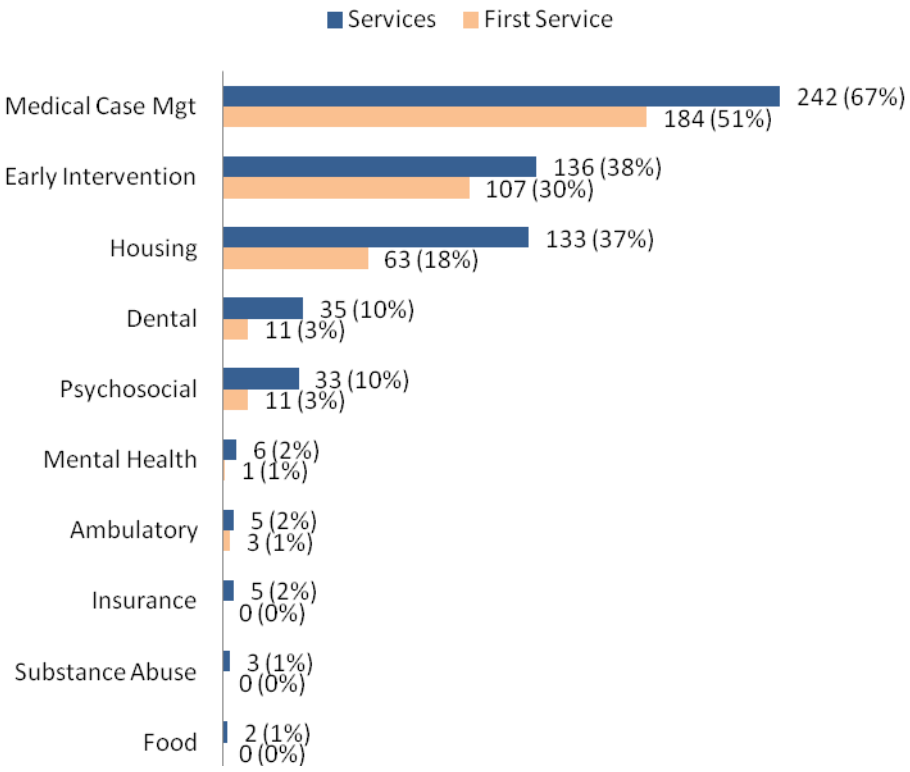
A total of 2,979 clients received at least one Part A service during FY 2014. The number of clients served by the Part A system over the past three years has fluctuated very little, with a slight 2% increase of clients served over this time period.

Number of Part A Clients, FY 2012-2014



This fluctuation is due to clients moving in and out of the Part A system of care. The net increase in clients served over the past three years does very little to quantify or describe *who* is exiting and entering. The analysis that follows will provide insight into those who are new clients to the system as well as those who have exited. Qualitative information that might help us understand *why* individuals are coming and going in and out of the system is beyond the scope of this report.

New Clients Services Accessed vs. First Service Accessed



During FY 2014, there were a total of 361 new clients; those clients who received their first Part A service during the course of the year based on a service dataset that goes back as far as 1/1/1993. The number of new clients represented 13% of the total number of clients (N=2,979) who

received services during this time frame. For approximately half of all new clients, their first point of entry, their first Part A service received, was Medical Case Management (MCM). The point of entry for 30% of all new clients was Early Intervention Services (EIS). This is not surprising since much of the work EIS staff performs revolves around seeking out those who have fallen out of care or are newly diagnosed and often not connected to care. In fact, of the 136 new clients who accessed EIS services, for 107 (79% of EIS clients) individuals, the point of entry into the Part A system was the EIS Program. Both MCM and Housing had high point-of-entry percentages. 76% of all new MCM clients also had an MCM point-of-entry and 48% of all new Housing clients also had a Housing point-of-entry into the Part A system.

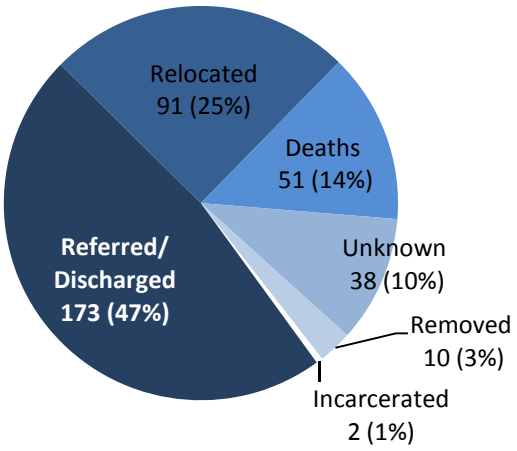
Overall, 36% of all new clients accessed MCM services, followed by EIS (38%) and Housing (37%).

When comparing new clients with those who are not new, new clients were more likely to be:

- Unstably housed
- Ages 44 and under

As new clients came into the Part A service system, existing clients were exiting. During FY 2014, a total of 365 clients exited the Part A service system; 51 (14%) of the exited clients died during the year. The numbers that appear in the pie chart as well as the total number of exited clients is likely an underestimate. It is likely that clients access services and then cease participation in the Part A system without contractors noting their departure within the data system. Additional work will be done by HCS to better estimate the number of exited clients in a future report.

Exited Clients by Enrollment Status



Demographic characteristics are important indicators of the types of clients served in order to help identify where there is need within the community and compare the numbers from the local client population to a broader sample such as the state or federal government. For a full account of the demographic breakdown of Part A clients, see Appendix B.

The most recent surveillance data shows the demographic profile of all HIV cases who were living in the Portland TGA as of 12/31/2013. Comparing this profile with the profile of the clients who are receiving Part A services in the TGA will illustrate any disparities that exist. Of the 4,741 individuals who are living

with HIV/AIDS in the TGA, 66% or 2,979 are Part A clients. Rates of Part A service usage varies across demographic groups.

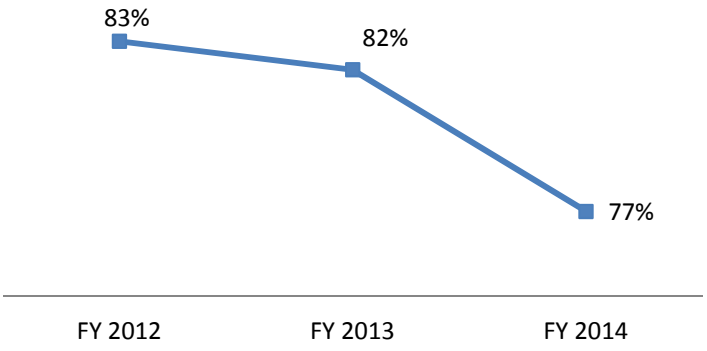
The proportion of overall cases versus the proportion of Part A clients for each demographic category will show how representative the clients are with respect to the epidemic. For example, 8.06% of all cases were individuals who self-identified as African American; this result is comparable with the proportion of African American clients who received Part A services (8.88%). A conclusion can therefore be drawn that African American clients are represented proportionate to the epidemic in the TGA. No significant differences were found along any of the demographic characteristics; therefore, clients who received Part A services during the FY 2014 were representative of the individuals who live with HIV/AIDS in the Portland TGA. See appendix C for this numeric comparison.

Other than demographic data pertaining to a client's income, housing status and insurance status were also collected.

These client characteristics coupled with the demographic categories above are often the language used to describe a disproportionate impact on a particular subgroup of individuals. For, example, historically MSM individuals have been disproportionately affected by this disease. We can also say individuals who are unstably housed, below the federal poverty level (FPL), without insurance, and African American men and women have also been disproportionately affected or are over-represented groups of individuals affected by HIV.

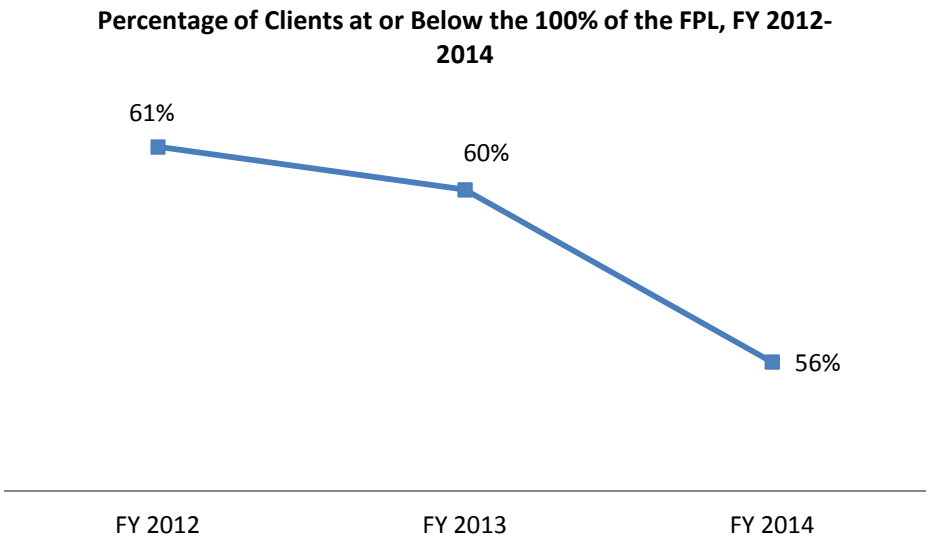
Often housing stability, income and insurance status are determinants of health outcomes. In the absence of stable housing, sufficient income and insurance, maintaining, improving and addressing a major health issue becomes infinitely more challenging. For this reason, we are particularly interested in a client's status along these three dimensions and are also interested in the associations between these factors and service utilization.

Percentage of Stably Housed Clients, FY 2012-2014



The definition of stable housing includes renting or owning a room, apartment or house, permanent residency with family or residing in a unit with a rent subsidy. Common rent subsidy programs include Section 8, public housing, Supportive Housing for formerly homeless individual, and Housing Opportunities for People Living with HIV/AIDS (HOPWA).

Ryan White services are designed to provide quality services to eligible, low-income PLWH/A. Therefore, client-level summary data should in fact show a high percentage of individuals who are at or below the federal poverty level. During FY 2014, over half of all Part A clients (56%) had an annual household income at or below 100% of the Federal Poverty Level.



Clients who report no health insurance have fluctuated over the past three years. During the past contract year, 11%, or 323 clients reported no health insurance at the end of FY 2014. A portion of Part A funds were allocated to medical case management to provide assistance with enrolling people in insurance. During the 2nd year of the Affordable Care Act (ACA) implementation, Oregon changed enrollment systems from Cover Oregon to Healthcare.gov. This meant that Ryan White staff and other Application Assisters had to conduct outreach to people living with HIV to ensure they enrolled in insurance a second time. This change caused additional work and used additional resources.

Part A funded staff played a key role in getting almost 100% of all AIDS Drug Assistance Program (ADAP) ADAP clients enrolled in insurance. The Oregon and Washington ADAP programs facilitate access to medications through paying for health insurance premiums and co-pays, providing comprehensive medical insurance to clients as well as lowering the cost of medications to the program. Medical Case Managers and Application Assisters provided in-depth knowledge of enrollment to ensure uninterrupted medical insurance coverage and coordination of care. Medical Case Managers and Application Assisters also provided assistance in Spanish to reduce access barriers.

The following table shows unstable housing, income less than federal poverty level and lack of health insurance by all the various demographic categories. These results only include differences that were statistically significant at a p value of <0.05. An **√** in the table indicates a demographic category who was more likely to have unstable housing, income under 100% of the FPL or no insurance compared to the other group or groups in that category. For example, transgender and female clients were more likely to have an income equal to or below 100% of the FPL compared to males. In FY 2014, 100% of the FPL for a one person household was $11,670; for a two person household it was $15,730.

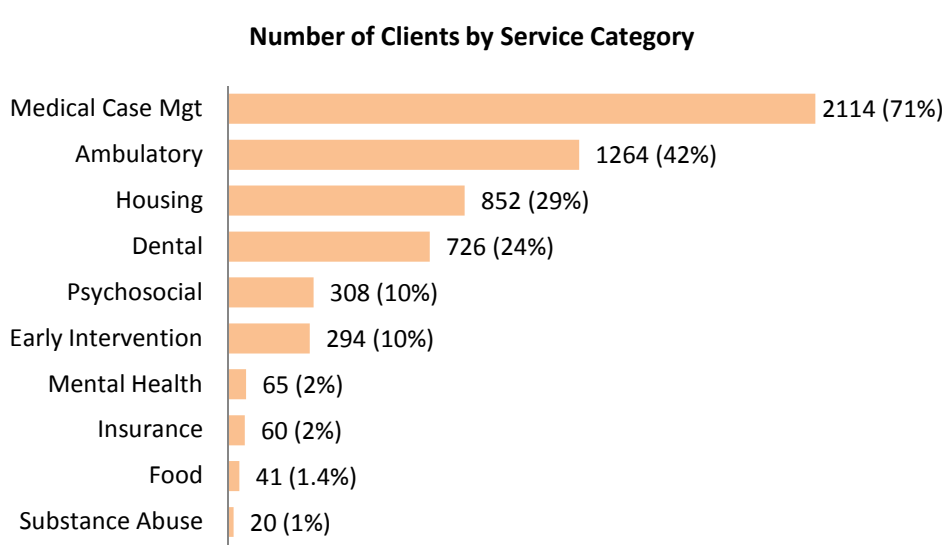
Demographic Group	Unstable housing	Income ≤100% FPL	No Insurance
Gender			
Male	-	-	-
Female	-	✓	-
Transgender	-	✓	-
Race			
White	-	-	-
Black/African American	-	✓	-
Hispanic/Latino	-	-	-
Other	-	✓	-
County of Residence			
Multnomah County	-	✓	-
Outside Multnomah County	-	-	-
Age			
≤24	✓	✓	-
25-44	-	✓	-
45-64	-	-	-
64>	-	-	-
Risk Group			
MSM	-	-	-
Non-MSM	-	✓	-
Income			
≤100%	✓	n/a	-
101-200%	-	n/a	✓
≥201%	-	n/a	-
Housing Status			
Stable/Permanent	n/a	-	-
Temporary	n/a	✓	-
Unstable	n/a	✓	-
No Insurance			
Insured	-	✓	n/a
Uninsured	-	-	n/a

Based on the results displayed above, an income below 100% FPL had the most pervasive impact across all of the demographic categories. Throughout the analysis, there were several subgroups who were

more likely to have lower incomes than others. The absence of a check mark does not mean the issue is not important for a specific group; it simply means that a member of that group might be less likely to have the other characteristic. For example, clients with stable/permanent housing are less likely to have an income below 100% FPL than those who are temporarily or unstably housed.

Part A Services

Part A funding supports a continuum of HIV care services aimed to help clients achieve positive health outcomes. As such, the examination of client service utilization patterns provides insight into client needs and ability to access services within this continuum. As a reminder, care providers not funded by Part A are not accounted for in this report. During FY 2014 a total of 2,979 clients received Part A services. Many of these clients received services across multiple categories, therefore if a client received both Dental and Food services they would be counted in both categories in the chart above. Trend analysis pertaining to how the number of clients served in each service category over time is examined in each service category section that follows.



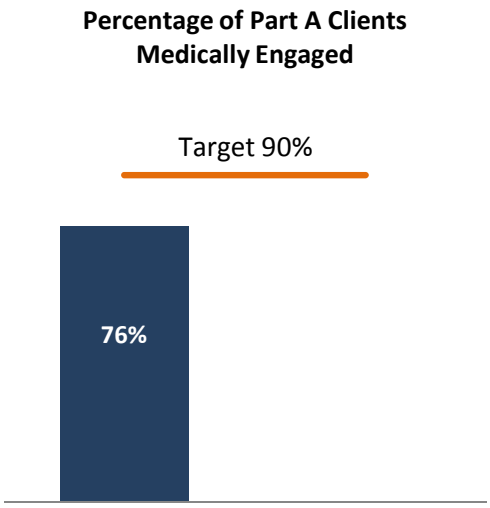
The following sections include, by service category, a profile of clients who have accessed HIV care services, their medical outcomes as well as service-specific outcomes. An outcome is a change that is expected to take place as a result of involvement or participation. In this instance, an outcome is a change that is expected as a result of accessing Part A services.

Central to the Ryan White program is the premise that Ryan White Part A funding will create a needed bridge toward connecting and sustaining clients in medical care. This focus on medical engagement is central to goals outlined by HRSA and the HIV/AIDS National Strategy and is crucial toward improving the quality of life for those living with HIV/AIDS. Medical engagement is linked to viral suppression which is linked to increased quality of life, better health outcomes, and reduction of viral transmission. Medical engagement was measured for the TGA overall as well as for each service category.

Portland TGA Medical Engagement Outcomes

As HRSA emphasizes a medical model of care and a care system which supports engagement and retention in medical care, client maintenance in medical care is an expected outcome. Beginning in FY 2013 HCS used the HRSA HIV/AIDS Bureau definition of medical engagement: any client who had medical visits in both the first and second half of the fiscal year that were at least 90 days apart. Clients who did not have a medical visit in the first half of the year are not included in the calculation. Medical data used to calculate all medical engagement outcomes originated from the only Part A funded medical provider as well as two contractors who provide Part A Medical Case Management (MCM) services. The Early Intervention Services (EIS) category calculates medical engagement slightly differently which will be explained in the EIS Outcomes section.

During FY 2014 a total of 1,664 clients were included in the medical engagement outcome measurement, due to the fact that these clients received one medical service documented in the CAREWare data system during the first half of the fiscal year. Of these clients, 1,259 clients also received a medical service in the second half of the fiscal year. Thus the medical engagement outcome percentage for the TGA during FY 2014 was 76%, below the TGA benchmark of a 90% rate of engagement.



For FY 2014, an engagement percentage of 90% would translate into 1,498 clients with a medical service in the second half of the year, which is a 239 increase from the actual number of clients engaged (1,259). The 90% benchmark target is one established by the TGA three years ago in FY 2012. This target has also recently been adopted by the National HIV/AIDS Strategy for the United States; which outlines a 90% target for medical engagement by the year 2020. Because of the adoption of a new data system and a change to the medical engagement definition in FY 2013, three year trends cannot be made at this time. However, a comparison across the past two years shows a slight decrease in Medical Engagement from 78% to the current 76%.

Clients who were medically engaged were more likely to be:

- Multnomah County residents
- Not insured
- Stably housed

In an effort to understand why this rate for the Portland TGA is lower than the benchmark there has been discussion around the need or lack of need for clients who are virally suppressed to visit a medical provider more than once a year. There has also been discussion around expanding the definition of a medical visit to include consultation with a client on the phone when medical status is stable. This topic will further be discussed in the next section, where medical outcomes, Medical Care services and viral load will be examined.

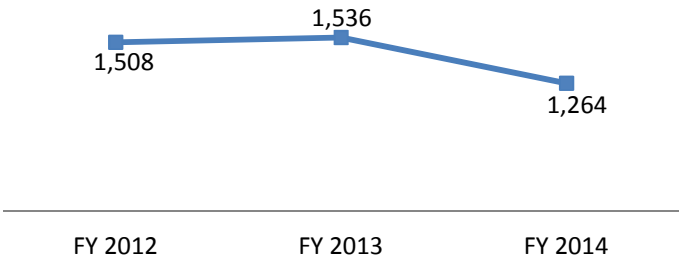
Ambulatory/Medical Care

Medical care provision, the cornerstone of the Part A Continuum, is central to the improvement of health outcomes, quality of life, and reduction of HIV transmission. In the Part A TGA, Medical Care is provided by one contractor who also provides most of its medical care clients with Medical Case Management (MCM).

Ambulatory/Medical Care Description
Provision of primary and HIV medical care at specialty clinics that follow national standards of care for the treatment of HIV. Care includes diagnosis and treatment of physical and mental health conditions, medication management and adherence counseling, medical care coordination, and referral to other specialty providers and linkage to case management services.

Over the past three years there has been a decline in the number of clients who received Part A Medical Care. From FY 2012 to FY 2014 there was a 16% decline, from 1,508 clients served in FY 2012 to 1,264 served in FY 2014. While this trend could potentially be explained by the fact that the allocation for Medical Care decreased by a comparable 18%, a data issue could also be contributing factor in the decline of clients served.

Medical Care Clients, FY 2012-2014



During FY 2014, HCS collected data from the Medical Care Part A contractor in a different way from years previous. In order to more accurately describe the trend in Medical Care clients served, comparison of data between FY 2014 and FY 2015 will be available next year.

When comparing Part A clients who have received Medical Care services with those who did not, Part A Medical Care clients were more likely to be

- Multnomah County residents
- Between 25-44 years old
- Not insured or publically insured
- Under 100% of the federal poverty level
- Stably housed

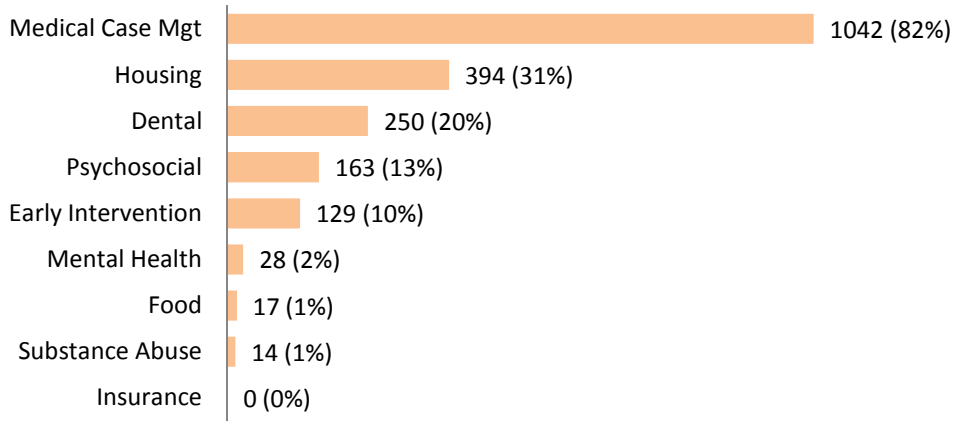
All walk-ins were triaged. Upon screening, if a new patient indicated that they had an urgent medical issue, they were immediately triaged by a nurse and seen by a provider the same day if needed. These efforts contributed to quickly engaging new clients in care.

Similar to the trend in Medical Care clients, medical care visits have also decreased during the past three years. Visits have decreased by 17%, but again, in order to verify that this downward trend is valid, another year's worth of data needs to be collected and compared. During FY 2014, a total of 1,264 clients received a total of 6,404 medical care visits; a Medical Care client received an average of 5.1 visits during the past year. In FY 2013 this average was 4.8 and in FY 2012 this average was 5.1. This result demonstrates that over the past three years, the number of medical visits per client have varied very little, perhaps an indication that the medical needs of clients have remained relatively consistent across the years.

Clients who received a higher number of Medical Care visits were more likely to be:

- Residents of Multnomah County
- Non-white
- Under 100% of the federal poverty level
- Stably housed

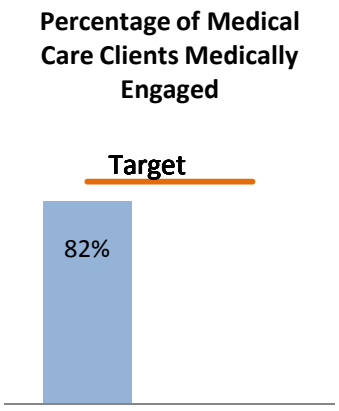
Most of all the clients who receive Part A Medical Care (82%) also received Medical Case Management (MCM). Because the only Part A medical contractor also receives medical case management funds, it is apparent why this percentage of client overlap between the two services is high. Approximately one-third (31%) of Medical Care clients also received Housing Services and 20% also received Dental Services.



Outcomes

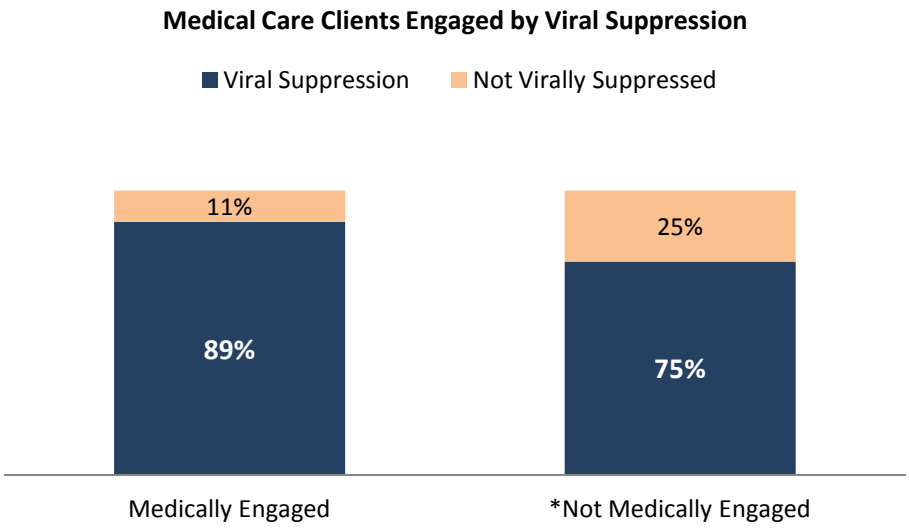
The provision of Medical Care to individuals who are living with HIV is expected to have several positive effects. Outcomes for Medical Care can be divided into three categories: (1) medical engagement, (2) progression to AIDS and viral suppression and (3) health screenings for tuberculosis (TB), syphilis and a pap smear for female clients.

Using the calculation of Medical Engagement, as discussed earlier in this report (see page 15), the Medical Engagement outcome for Medical Care clients was 82%; out of 1,264 medical care clients, 1,093 received at least one medical care visit within the first six months of FY 2014 and were thus counted in the denominator. Of the clients in the denominator (n=1,093), 891 also received a medical care visit within the last six months of FY 2014 and were counted in the numerator. Although, this outcome is useful toward understanding the number and percentage of clients who are medically engaged, it is not as descriptive about the clients who are *not* engaged, in particular those who are unaccounted for in the Medical Engagement calculation (1,264 medical clients, 1,093 counted in the calculation; which leaves 171 clients).



Engagement in medical care is important as it is often vital toward the goal of achieving and maintaining viral suppression. HCS has access to client-level viral load data for only those clients who received Part A medical care services, therefore additional analysis around the correlation between medical engagement and viral suppression can only be conducted with medical care clients.

Viral load status reflects the level of virus in the body; the higher the viral load the more virus is in the body which adversely affects the immune system and makes the virus transmissible. For this reason, medical care and adherence to HIV medications aims to suppress the virus. In general, a viral status of 200 copies or less is the definition of viral suppression. The following analysis will attempt to shed light on the following questions: 1) What is the viral suppression rate of those clients medically engaged? 2) What is the viral suppression rate of those clients not medically engaged? 3) Where medically engaged clients more likely to be virally suppressed?



*Defined as clients who were not medically engaged combined with clients who were not counted in the medical engagement measurement.

The HAB definition of medical engagement only considers those who received a medical care service within the first six months of the fiscal year (see page 15 for the HAB definition of medical engagement). For purposes of understanding the intersection of engagement and viral suppression, a re-definition of the HAB medical engagement measures includes an expansion of those not medically engaged. This expansion combines both those not medically engaged (as accounted for in the HAB

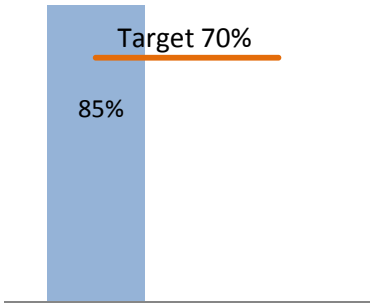
measure, n=202) with those left out of the measure (not accounted for in the HAB measure, n=171) because medical care was provided only during the second half of the fiscal year. The combination of these two groups of individuals yields a total of 373 clients, 30% of all clients who received a medical service. We now have two distinct groups for whom viral suppression can be compared: those clients who met the medical engagement definition (n=891, 70%) and those who did not (n=373, 30%).

According to this revised definition, of the clients who were medically engaged, 89% were also virally suppressed; of the clients not engaged, 75% were virally suppressed. Clients who were Medically Engaged were more likely to be virally suppressed compared with clients not medically engaged. This finding supports the research pertaining to the validity of this HRSA engagement outcome measurement in that past research has found a positive correlation between viral suppression and medical engagement. This does not mean all clients who were engaged were also virally suppressed nor does it mean all clients not engaged had high viral loads.

When comparing Part A clients who were both engaged (according to the revised definition) and virally suppressed with those who were not, the former clients were more likely to be:

- Multnomah County residents
- Below 100% of the federal poverty level

Percentage of Medical Care Clients with VL Suppression



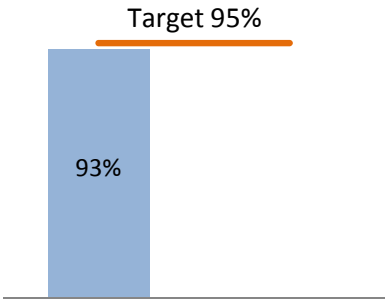
We have examined the combined analysis of medical engagement and viral load to find that those who are medically engaged are more likely to be virally suppressed. Viral suppression, untangled from medical engagement is also an outcome and relates directly to the health status of those living with HIV and transmissibility of HIV to those uninfected. The viral suppression outcome is one that exceeded the benchmark target of 70% and demonstrates that even though the medical engagement target was not met, 85% of all clients who received medical care are virally suppressed. The rate of viral suppression was also 85% for the previous fiscal year (FY 2013).

When comparing Part A Medical Care virally suppressed clients with those who were *not* suppressed, Part A Medical Care clients *not* suppressed were more likely to be:

- Transgender
- Unstably housed
- Ages 44 and under
- Under 100% of the federal poverty level

The other health indicator outcome is progression to AIDS. During FY 2014 there were no Medical Care clients who progressed to AIDS.

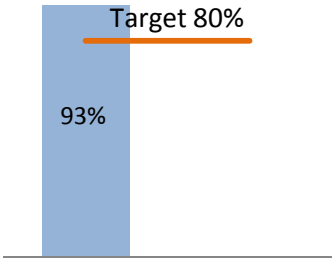
Percentage of Medical Care Clients with a Syphilis Screen



The final category of outcomes for Medical Care revolves around health screenings. Syphilis is a sexually transmitted disease which is often a co-infection for people living with HIV. Genital sores caused by syphilis make it easier to transmit and acquire HIV infection sexually. There is an estimated 2- to 5-fold increased risk of acquiring HIV if exposed when syphilis is present. The syphilis screening rate is 93% for all clients who receive Part A medical care. Syphilis screening rates have been in the 90th percentile during the past three years; a testament to the systemic processes in place to assure clients are screened.

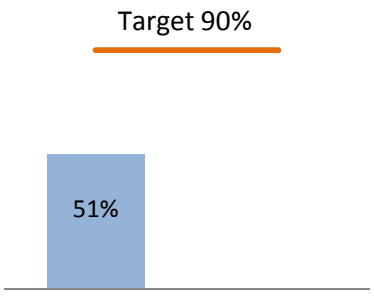
Tuberculosis cases have been declining since 1992. Most recent national co-infection rates with HIV were 8.6%. During 2013, over nine million people nationwide were diagnosed with TB, and 1.1 million of these people were also living with HIV. Despite a decrease in reported TB cases, the disease remains a serious threat, especially for people living with HIV/AIDS because TB infection and HIV infection can work together to make an individual very sick. Worldwide, TB is the leading cause of death among people living with HIV. Similar to the syphilis screening rate, Medical Care clients were also screened for TB at the rate of 93%. This rate exceeds the benchmark target of 80%, which is lower than the benchmark set for syphilis screening.

Percentage of Medical Care Clients with a TB Screen



The final health screening outcome for Medical Care clients is the rate at which female clients receive a Pap smear as a check for signs of cervical cancer and evaluation of the health of the cervix. Cervical screening is particularly important for women who are living with HIV because the incidence of cervical intraepithelial neoplasia (non-cancerous and curable) is four to five times more likely to develop in this population.

Percentage of Medical Care Clients with a Pap



A study examining the rate of pap smears amongst women living with HIV, reported that as few as one-fourth do not get an annual pap smear despite seeing a primary care provider during that time period. For clients who receive Part A Medical Care a similar pattern of low pap smear rates emerge. Although, not as dismal as one-fourth, out of a total of 151 female clients who received Medical Care, one-half (51%) of all female Medical Care clients received a pap smear during FY 2014.

When comparing Part A Medical Care clients who had a pap smear with those who did not, Part A Medical Care clients with a pap smear were more likely to be:

- White
- Stably housed
- Virally suppressed
- Multnomah County residents

Health Insurance Payments

The landscape of health insurance has changed drastically in the past three years. Changes have occurred both at the state and federal level to impact the needs of clients as it pertains to Health Insurance. In FY 2012, funding was re-allocated to this service category due to changes in Washington State which increased the demand for Health Insurance assistance. The following year, FY 2013, the Affordable Care Act (ACA) was partially responsible for a decrease in need for this service since many clients were newly enrolled in Medicaid and qualified health plans. During the past year, new systemic changes were reported, and the ACA continues to impact clients and services provided.

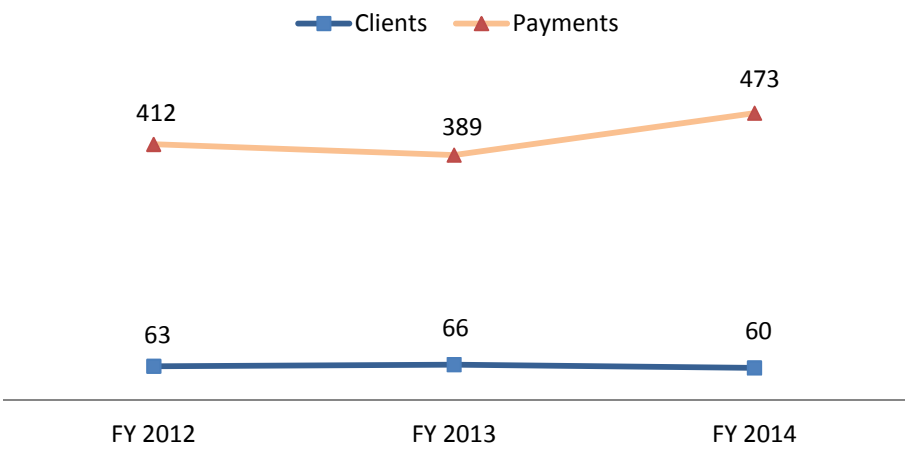
Health Insurance Description

Health insurance funds pay for health insurance premiums, co-pays and deductibles for clients who live in the TGA. Part A funds in this category are only being utilized for Clark County, Washington residents. CAREAssist through Part B provides similar services for Oregon TGA clients.

It is beneficial to have an in-person assister stationed where case manager services were provided…We work closely with clients to ensure they have insurance and health care providers.

During FY 2014, a total of 60 clients or 2% of the total number of Part A clients served received at least one Health Insurance service. This number represents a mere 5% decrease from the 63 clients served during FY 2012.

Number of Health Insurance Clients and Payments, FY 2012-2014

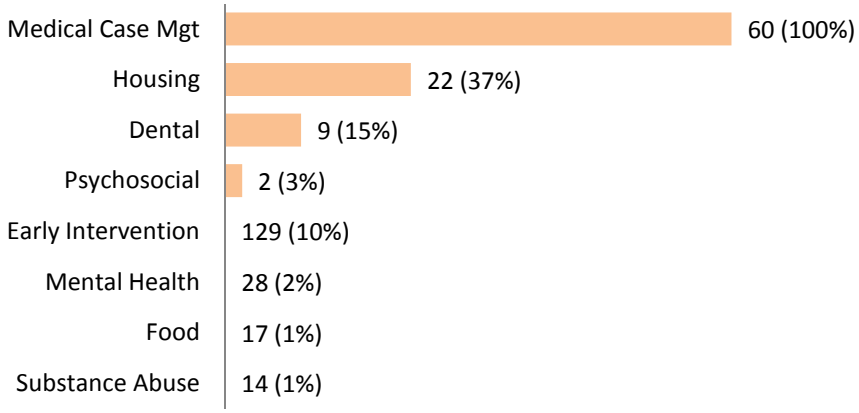


Although, the number of clients served has slightly decreased over the past three years, the number of Health Insurance payments

has increased by 15%. These payments can be broken down into three general categories: co-payments, premium payments and deductibles. Approximately 383 payments, or 81%, were made toward co-pays, 19% premiums and <1% deductibles. A similar distribution of Health Insurance services was also seen in FY 2013 with the majority of payments used to cover insurance co -pays.

Despite the fact that the number of clients receiving Health Insurance payments has slightly decreased over time, clients served and units provided have always exceeded contractual goals. During the past year the number of clients served was 182% of the target goal of 33 clients and the number of health insurance payments were 270% of the target goal of 175 payments.

Number of Health Insurance Clients by Service Category

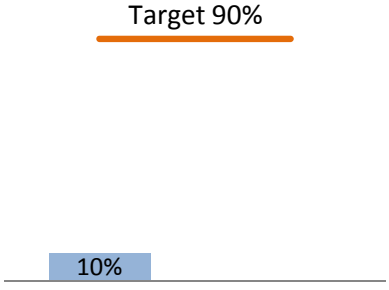


All clients who received Health Insurance payments also received Medical Case Management services, which is the only instance in which all clients who received a particular service also received an additional Part A service. A total of 37% of clients who received Health Insurance payments also received Housing services and 15% received Dental services.

Outcomes

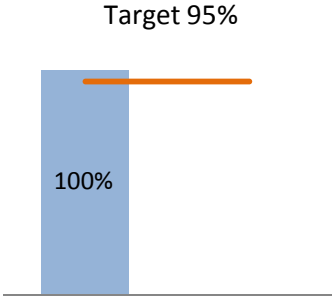
Outcomes measured for this service category include: medical engagement and lapse in insurance coverage.

Percentage of Health Insurance Clients Medically Engaged



Medical Engagement for those clients who received Health Insurance Payment assistance was the lowest across all the service categories and well below the benchmark target of 90% and TGA wide medical engagement rate of 76%. The low medical engagement rate was likely impacted by incomplete data provided by the contractor

Percentage of Health Insurance Clients with No Lapse in Coverage



providing this service. To what extent this low rate can be attributed to poor data quality, is unknown at the writing of this report.

All clients who received Health Insurance Payments reported that they experienced no lapse in insurance coverage. This is an especially crucial outcome and measure of program performance, because compromised health insurance coverage can be potentially detrimental to the health outcomes of individuals who are on a treatment regimen and require frequent medical monitoring.

Mental Health

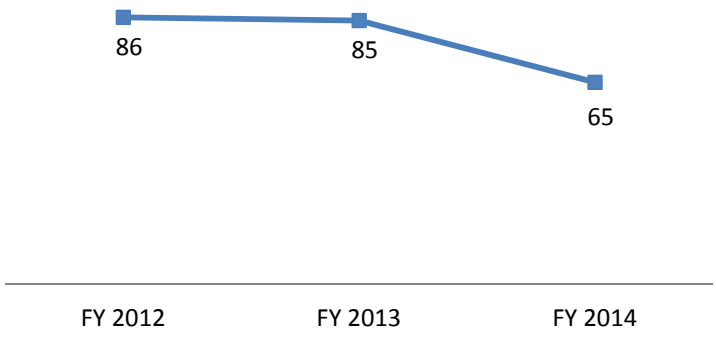
Mental health issues are very common amongst all Americans, not just those living with HIV. In 2012, about one in five American adults experienced a diagnosable mental illness. For individuals living with HIV, mental health issues can compromise medication adherence, medical engagement, and can interfere with health behaviors such as avoiding risk behaviors and impairing the ability to cope with the stresses of daily life.

Part A funded mental health services include the provision of therapy by a licensed professional and peer mental health services provided by certified peer specialists. Peer specialists build relationships with clients based on their shared life experience living with HIV.

Mental Health Description
Mental health assessment and individual counseling on-site or at-home, couples or group counseling, and medication management for PLWH/A. Mental health services are delivered by mental health professionals (psychiatrists, psychiatric nurse practitioners, licensed social workers, or licensed professional counselors). Mental health peer wellness specialist support engagement and support for clients accessing professional mental health services.

During FY 2014, a total of 65 individuals received Mental Health services; this represents 2.2% of the total number of Part A clients served. Of these 65 clients, 28 received therapy services and 39 received peer support service hours. Over the past three years there was a 24% decrease in the number of clients served.

Mental Health Clients, FY 2012-2014



When comparing Part A clients who received Mental Health Care services with those who did not, Part A Mental Health clients were more likely to be:

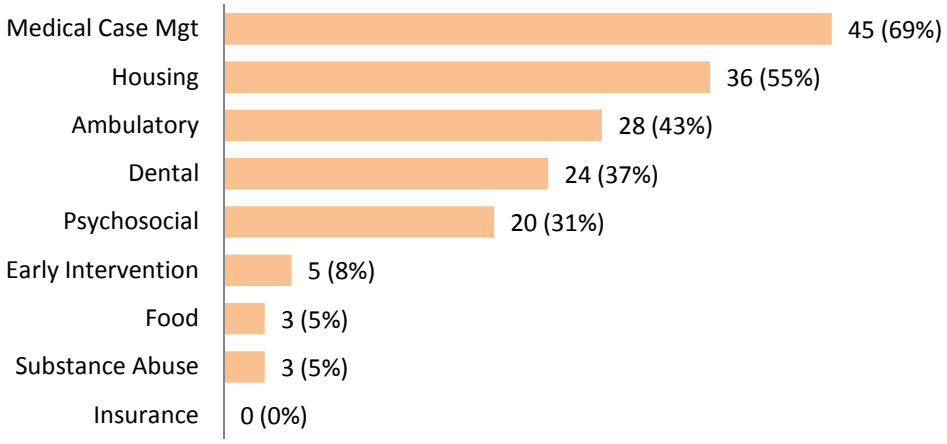
- Female or transgender
- Multnomah County residents
- Between the ages of 13-24 and 45-64
- Publically insured

We continue to hear from clients of the Peer Mentor program that they value the opportunity to access support from someone who shares their experience of being HIV+. The Peers have successfully supported clients in connecting to a variety of supports related to mental health and substance abuse treatment.

During FY 2014, 192 therapy hours were provided to 28 clients. Therefore the average number of hours provided to clients was 6.8 hours. A total of 602 peer hours were provided to 39 clients, for an average of 15.4 hours per client. The higher average time spent with a peer is due to the nature of the work, which is both intensive and time-consuming. The total number of mental health hours provided was 794, which is a 4% decrease from two years prior.

The decrease in clients served and services provided despite a 66% increase in funding for this service category across the past three years can be attributed to the building of programmatic infrastructure.

Number of Mental Health Clients by Service Category

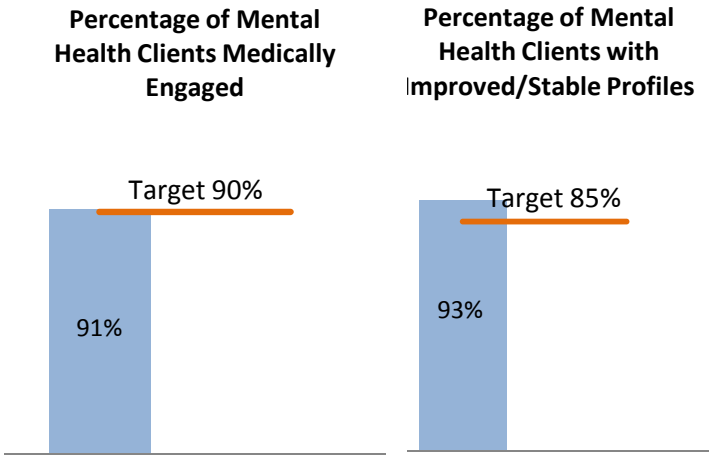


Around the mid-year point of the last fiscal year, one of the Part A contractors established a new Mental Health Peer Mentor program. Building a program from the ground up is a time consuming process and was a definite contributing factor in the lower than expected number of clients served and hours of service provided. Additionally, fewer clients need Ryan White to subsidize counseling since more people have access to Medicare or Medicaid covered counseling and treatment.

Of the 65 clients who received Mental Health Services, 57 or 88% also received at least one other Part A service. Over half of these Mental Health clients also received Medical Case Management (69%) and Housing (55%).

Outcomes

The medical engagement rate across all mental health clients (91%) is the only service category rate that exceeded the benchmark target of 90%. Central to the provision of mental health services, the second and last outcome measured for this service category revolves around improved or stable patient profiles. Again, the benchmark target for this outcome (85%) was exceeded (93%).

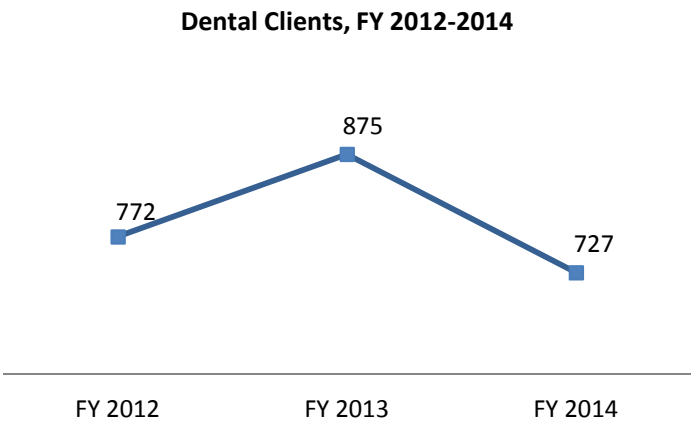


Dental Care

PLWH/A experience a high incidence of common oral health problems (e.g., dental decay/cavities, gingivitis) as well as other oral health problems directly related to HIV infection. HIV medication side effects can include dry mouth, which predisposes individuals to dental decay and other dental events. In addition, poor oral health can adversely affect quality of life.

Dental Care Part A funds were used to support a dental clinic which provides Oral Health services to the PLWH/A community as well as a broader base of clients. Funding was also used to support a reimbursement program, whereby clients receive dental care and submit receipts for reimbursement for non-covered oral health procedures.

Dental Care Description
Comprehensive dental care provided by practitioners who specialize in treating HIV positive patients. Services include diagnostic, preventative and restorative care, oral surgery and emergency care resulting from pain and infection. Crown and bridge procedures are also provided, with some limitations.



During FY 2014, a total of 727 clients received at least one Dental Care service from a Part A funded provider. This represents approximately one-quarter (24%) of all clients who received Part A services. Over the past three years, the

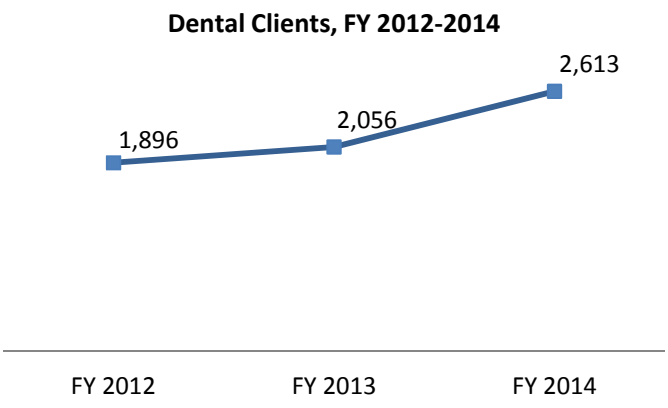
number of individuals who received Part A Dental services has fluctuated. When comparing the number of Dental Care clients in FY 2012 with clients who accessed Dental Care in FY 2014, there was a 6% decrease. This may be due to increased oral health coverage through Medicaid in both Washington and Oregon. In FY 2012, 27% of all Part A Clients received Dental Care from a Part A provider, a comparable percentage of Part A clients (24%) received Part A Dental services in FY 2014.

When comparing Part A clients who received Dental Care services with those who did not, Part A Dental Care clients were more likely to be:

- Male
- White
- Multnomah County residents
- 45 and older
- MSM as a reported risk factor
- Stably housed
- Not insured, publically insured or other insurance (i.e. VA, Tricare, military)
- Over 100% of the federal poverty level

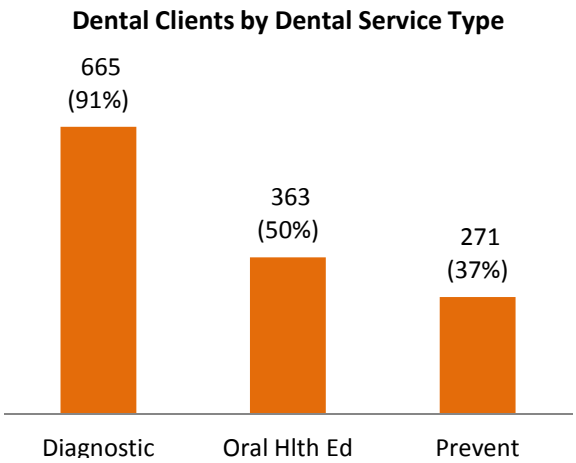
The dental clinic partners with clients to increase self-management of oral health care needs as part of a preventive dental program. The clinic does not discharge clients from the program in the belief that the partnership for prevention is best managed in an oral health home.

When the quantity of Dental Care measured in number of visits is considered, quite a different trend emerges. In FY 2012, Part A clients received a total of 1,896 dental visits, in FY 2014 this number increased to 2,613, which is a 38% increase in the number of dental services provided over the past three years.



Viewed together, the slight decrease in the number of clients served and the marked increase in the number of dental visits provided yields a higher rate of visits provided to dental clients over time. In FY 2012, a Dental Care client visited a dentist on average 2.5 times. In FY 2014, a total of 2,613 visits were provided to 727 Dental Care clients; an average of 3.6 visits per client.

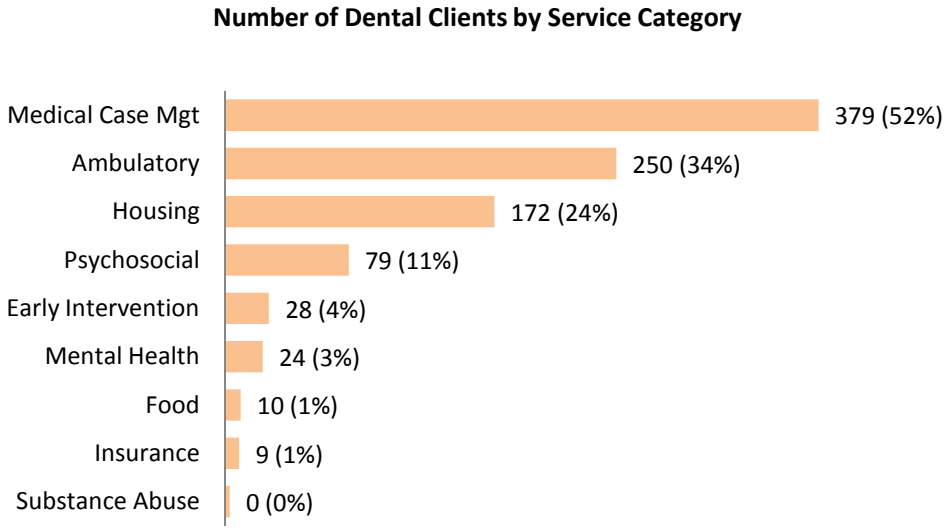
A total of 15 general categories of Dental Care are allowable by Part A funds. The top three most utilized dental care services were Diagnostic Procedure, Oral Health Education/Health Promotion and Preventive Procedure. 91% of all Dental clients received at least one Diagnostic Procedure, 50% received at least one Education service and 37% received at least one Preventive procedure. Note that the Preventive procedure service is one of several preventive services. For a full account of the number of clients who received any one of the preventive services, see the following outcomes section.



Clients who received a higher number of Dental Care visits were more likely to be:

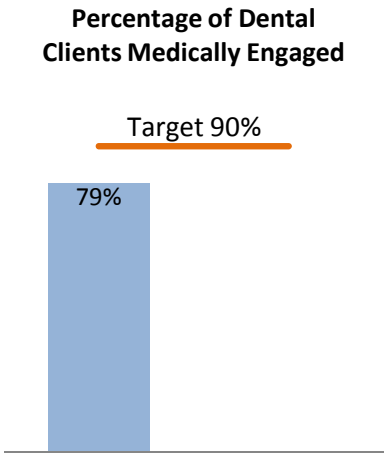
- Residents of Multnomah county
- Uninsured
- White
- MSM as a risk factor
- Between 101% and 200% of the federal poverty level
- Stably housed

Dental Care clients also received services from other providers within the Part A continuum of care. A total of 464 Dental Care clients (64%) received at least one other non-Dental Care service from a Part A provider. Over half (52%) of all Part A Dental Care clients received MCM services, 34% also received Medical Care and 24% also received Housing Services.



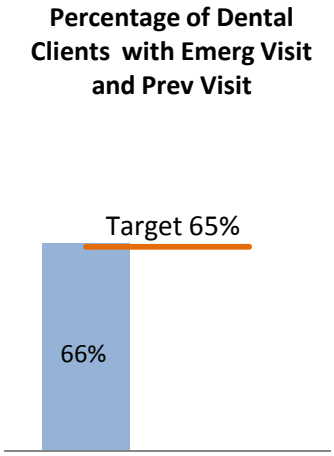
Outcomes

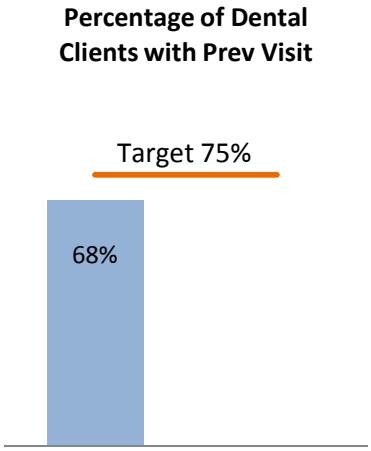
In addition to the provision of emergency dental care, there is also a programmatic focus on increasing preventive care. Preventive care allows for routine monitoring of oral health, which is more cost effective and ultimately leads to better oral health outcomes. Outcomes measured for Dental Care include: medical engagement, clients who received a preventive visit and clients who received an emergency visit in addition to a preventive visit.



Medical engagement for those clients who received Dental Care was slightly higher (79%), compared with the overall medical engagement outcome across the TGA (76%).

The two Dental Care service-specific outcomes both pertain to the provision of preventive visits. The first measures the percentage of Dental clients who received a preventive visit. The second measures the number of Dental clients who received an emergency dental visit who also received a preventive dental visit.





Substance Abuse Treatment

Substance abuse is associated with poor health outcomes for people living with HIV and can speed up the progression of the HIV disease. Drugs and alcohol can also impede the ability to plan, make good decisions and adhere to a medication regimen. Some individuals who experience substance abuse issues also encounter other issues such as unstable housing, loss of employment, involvement with the criminal justice system and mental health issues.

Substance Abuse Treatment Description
Assessment, individual and group counseling, as well as engagement coordination in outpatient treatment for clients in alcohol and drug-free housing.

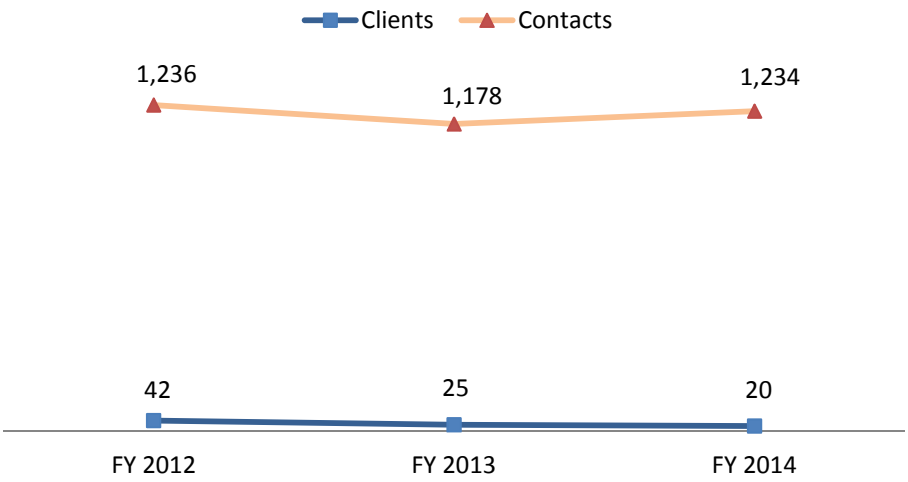
The Part A funded Substance Abuse Treatment program combines built-in support services designed to improve a client's chance of maintaining recovery, employment attainment and self-sufficiency.

A decreased gap in care happens when an individual that resides in the program is able to access trained, professional help when in crisis or in between [treatment] sessions with other care providers.

During FY 2014 a total of 20 clients received outpatient substance abuse treatment. This represents a 52% decrease from the number of clients who received services in this category during FY 2012.

Despite this 52% decrease in the number of Substance Abuse Treatment clients served, the number of client contacts remained almost the same; 1,236 contacts made in FY 2012 and 1,234 contacts made in FY 2014. In terms of the average number of client contacts per client, there was a marked increase from an average of 29 contacts per client in FY 2012 to an average of 62 during FY 2014.

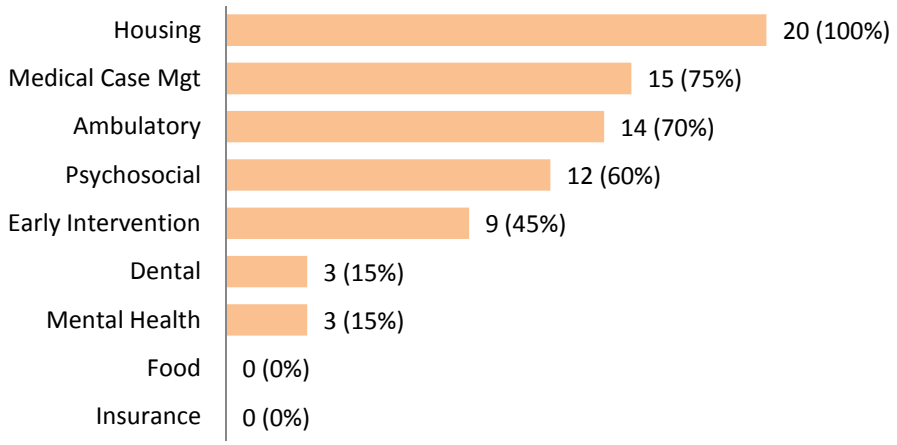
Number of Substance Abuse Clients and Contacts, FY 2012-2014



During this same timeframe expenditures for this service category have decreased by 31%, from $35,838 to $24,781. The contractor who provided this service ended their contract; in the next fiscal year substance abuse treatment will only be funded for the first three months of the contract year. Because the number of clients served in this service category was relatively small, tests of significance were not performed.

Clients engaged with Substance Abuse services were also housed in substance free units, thus, 100% of all Substance Abuse clients also received Housing Services. Over half of all Substance Abuse clients also received Medical Case Management, Ambulatory/Medical care, and Psychosocial Services within the Part A TGA.

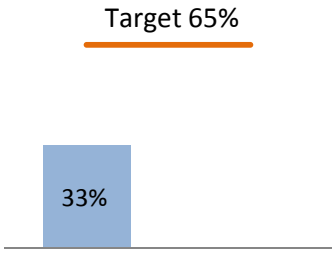
Number of Substance Abuse Clients by Service Category



Outcomes

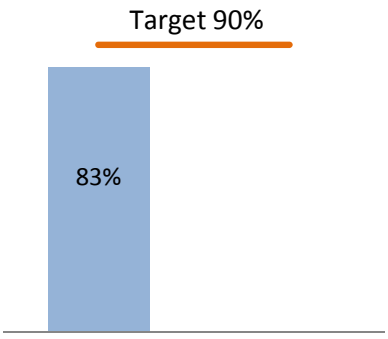
Substance abuse treatment programs have traditionally reported on the successful completion of substance abuse treatment. For this outcome, the creation of a benchmark target is difficult due to the program offered and the epidemic. The Part A funded program is an outpatient program and includes any type of substance abuse. Treatment completion rates for each year of the program's existence are very dependent on the clients who enroll. The program completion rate for FY 2014 was 33%, well short of the 65% benchmark target, but nevertheless an improvement over the 28% completion rate in the year prior.

Percentage of Substance Abuse Clients who Completed Treatment



The medical engagement outcome for Substance Abuse Treatment clients (83% engaged) was well above the TGA overall rate (76%), but again falling short of the benchmark target of 90%.

Percentage of Substance Abuse Clients Medically Engaged



Medical Case Management (MCM)

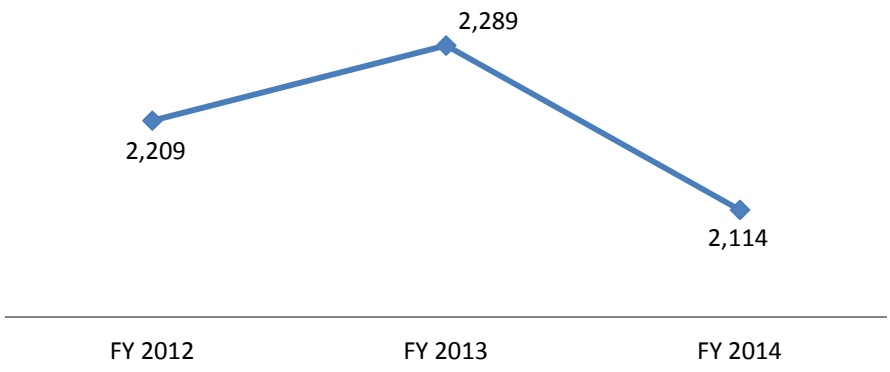
Designed to help connect clients with needed resources in the community, Medical Case Management (MCM) has a particular focus on retaining clients in medical care and achieving positive health outcomes for clients living in the TGA.

The MCM service category also includes clients who receive Minority AIDS Initiative (MAI) MCM, which is a subset of MCM that provides targeted services for communities of color. Communities of color have been disproportionately affected by HIV/AIDS since the earliest years of the epidemic. A closer examination of MAI clients and MAI-funded MCM will follow in a later portion of this section.

MCM Description
Assessment, coordination of services and linkages to services inside and outside the Ryan White system of care. All medical case management clients receive primary medical case management services which include treatment adherence assessment, health insurance maintenance, and coordinating timely access to appropriate levels of medical and supportive services, through ongoing client assessment.

During FY 2014, approximately three-quarters (71%) of all Part A clients received at least one Part A funded Medical Case Management Service. MCM was the service category utilized by the highest number of Part A clients (2,114). Over the past three years, the number of individuals who received Part A MCM services has fluctuated minimally. In FY 2012, 76% of all Part A clients received MCM contrasted with 71% in FY 2014. The decrease in percentage of clients who utilize MCM services during the past three years was 4% (175 clients).

Medical Case Mgt Clients, FY 2012-2014

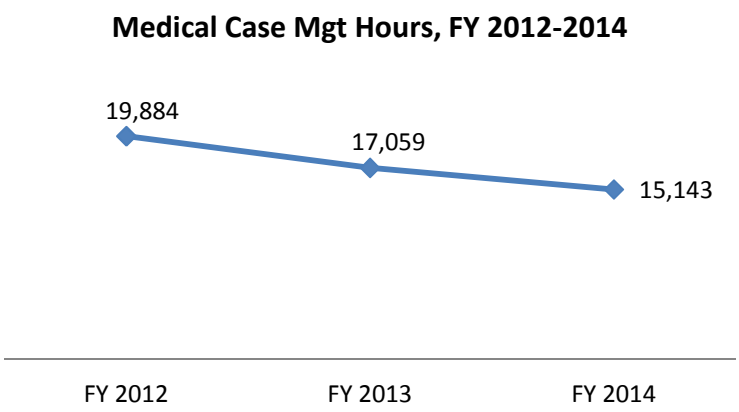


When comparing Part A clients who received Medical Case Management services with those who did not, Part A Medical Case Management clients were more likely to be:

- African American or Hispanic
- Between the ages of 25 and 44
- Living outside of Multnomah County

MCMs continued to prepare and began serving clients for ACA enrollment activities. This included all MCMs attending two trainings to understand the new healthcare exchange. MCM/Eligibility staff increased with the addition of 3 new staff which meant staff time was dedicated to panel management (redistribution of clients amongst staff), on boarding new team members with the goal of enhancing the ability to manage patient loads, which are increasing.

MCM services are quantified by the amount of time staff records working with or on behalf of a client. A total of 15,143 MCM hours were provided to 2,114 clients over FY 2014. The range of time spent with an individual client ranged between 15 minutes and 120 hours. On average, a Part A MCM client received approximately seven hours of MCM services during the year.



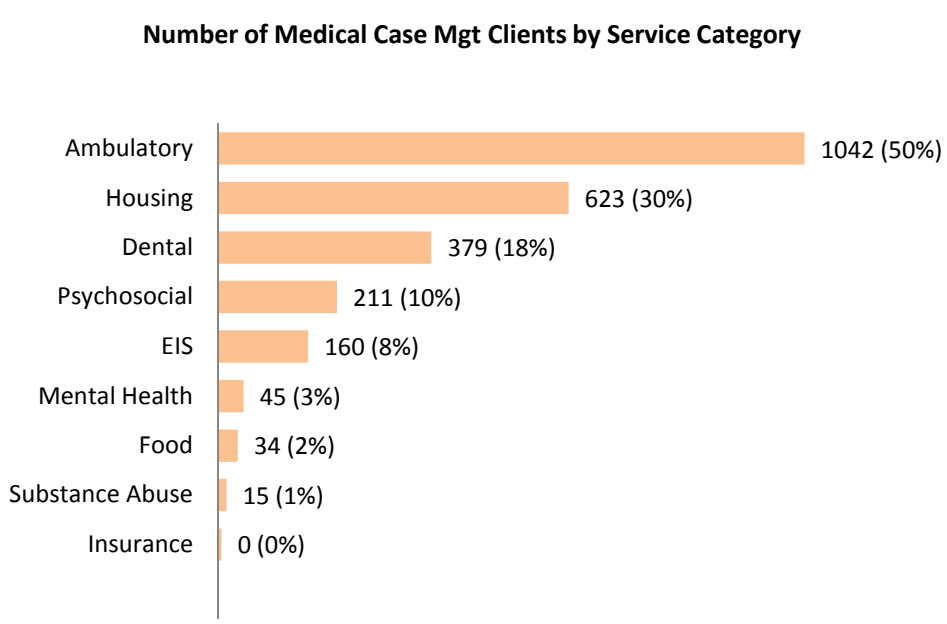
The total number of MCM hours delivered during FY 2014 represents a decrease in the number of hours delivered over the past three years. The percentage decrease in hours over this time frame was 24%, outpacing the percentage decrease (4%) in clients over the same time period. During FY 2014, the average was seven hours and 10 minutes; in FY 2012 the average was nine hours, a non-negligible difference. This percentage outpace suggest that on average clients are receiving less case management services compared with years previous. A potential explanation of this trend involve the need for almost all clients to see a staff person for health insurance enrollment, thus leaving less time for in-depth medical case management services.

Staffing changes during the fiscal year may have impacted service delivery. With the adoption of a new data system in 2013, the way services were entered or imported has changed. The impact of this change is difficult to decipher. Next year, HCS will have the ability to more accurately describe three year trends.

Clients who received a higher number of Medical Case Management visits were more likely to be:

- Female
- Non-White
- Non-MSM as a risk factor
- Under 100% of the federal poverty level

Many MCM clients also received other services from the Part A continuum. In fact, 70% of all MCM clients received at least one other non-MCM Part A service during this time frame. Half of all MCM clients also received Medical Care from a Part A contractor. This overlap of clients who received both MCM and Medical Care represents the clients who received services from the only Part A funded medical contractor in the TGA. This contractor provides both Medical Case Management and medical care.



A total of 623 MCM clients (30%) also received Housing Services which points to the demand for housing financial assistance within the TGA and also speaks to the coordination of services between contractors.

Minority AIDS Initiative

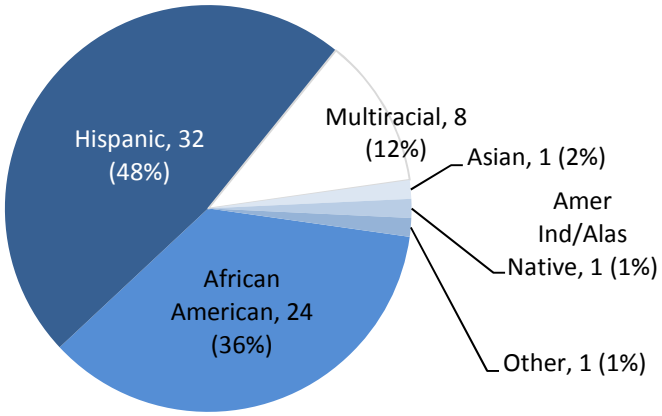
As stated earlier, Minority AIDS Initiative MAI MCM service provision was included in the account of clients and MCM services provided. What follows is a brief account of these MAI MCM clients and services extracted and separated from the overall analysis of MCM to better understand how MAI funding was used during FY 2014.

A new family from an African country arrived to the Portland area. The MAI case manager spent time with the entire family, including children, one of whom is disabled. The case manager took the family to get food, clothing, food stamps, connected them with a Part A housing provider, advocated with the school for the child's needs and attended an appointment with the mother and child to have the child assessed at a local children's hospital.

A total of 67 clients received MAI MCM services during FY 2014; this represents 3% of the total number of clients who received MCM services. These services were targeted toward African American, Latino, immigrants and refugee populations living with HIV/AIDS.

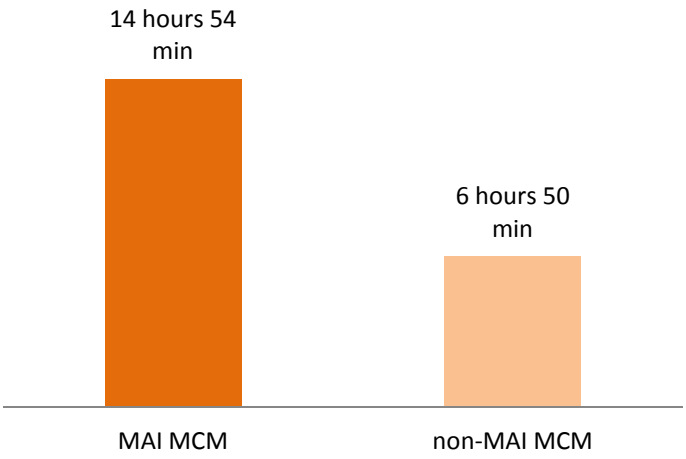
Almost half of the clients who received MAI MCM were Latino/Hispanic (48%), 7% of all Latino/Hispanic Part A clients received MAI MCM services.

MAI Clients by Race/Ethnicity



Sixty-seven MAI MCM clients received a total of 996 hours and 15 minutes of MAI MCM services. The average number of hours a MAI Medical Case Manager spends with a client is approximately 15 hours. As reported earlier in this section, the average number of hours a Medical Case Manager spends with a client was seven hours. This average decreases slightly with the removal of MAI MCM hours from the calculation from seven hours to six hours and 50 minutes. This comparison provides a lucid picture of the time intensive nature of MAI MCM.

Average Number of Hours Spent with Clients

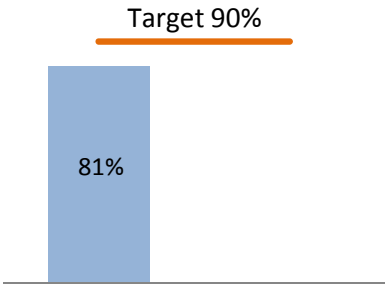


Outcomes

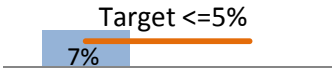
Outcomes measured for the MCM category include: medical engagement and lost to follow up. The definition of 'engagement in medical care' can be found in a prior section located on page 15.

Medical engagement for those clients who received MCM was higher (81%) compared with the overall medical engagement outcome across the TGA (76%). This finding is not surprising since most clients at the Part A funded Ambulatory/Medical Care provider also receive MCM as part of the medical home model. Therefore, the expectation that the percentage of medical engagement for this service category would be higher than the TGA-wide medical engagement percentage is valid.

Percentage of Medical Case Mgt Clients Medically Engaged



Percentage of Medical Case Mgt Clients Lost to Follow Up



The importance of retaining clients who need MCM, engaged in MCM cannot be overstated. Although, some clients might begin their journey in MCM and later decide the service is no longer needed, other clients receive MCM services but then drop out and might need assistance re-engaging. The TGA's target for MCM clients who are lost to follow-up has been established at less than 5%. During FY 2014, 7% of MCM clients were lost to follow-up.

Early Intervention Services (EIS)

Great emphasis has been placed on linking individuals with medical care immediately upon diagnosis, using support service to keep individuals in care over time and identify individuals living with HIV who know their HIV status but are not receiving HIV medical care.

Early Intervention Services Description
Counseling to individuals with respect to HIV/AIDS, testing, and referrals to medical care, mental health and substance abuse treatment services, as appropriate, to newly diagnosed individuals and persons and to people who are out of care, including clients transitioning from correctional facilities.

Early intervention services (EIS) in the Portland TGA are defined as support provided to clients who are not in care through planning, linkage, monitoring and advocacy. Service providers collaborate with prevention and disease investigation services to identify people who are living with HIV but unaware of their status, or who are not receiving HIV medical care. Services are intended to fill gaps in services for low-income individuals who are

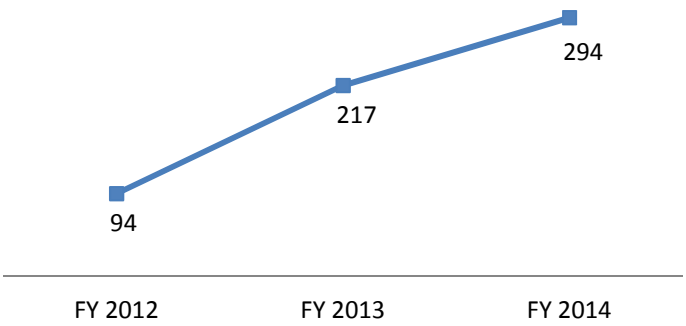
living with HIV/AIDS disease.

The newest addition to the array of EIS services available includes voluntary HIV testing offered during the booking process at the local jail in Multnomah County. During FY 2014, a total of 819 HIV tests were offered and 377 HIV tests were conducted by a Community Health Worker who is based in the jail 20 hours a week. No preliminary positive tests were discovered.

Since connecting with EIS staff, the client has accessed and followed through with medical care and substance abuse treatment and has gotten into a recovery-based transitional housing program. He now works on his recovery and has entered into an employment training program to open up more economic opportunities

Linkage to care EIS services were provided to a total of 294 clients during FY 2014. This number represents a very large percentage increase of clients served over the past three years. In FY 2012 a total of 94 clients were served, three years later that number has increased by 214%. This dramatic increase can be partially attributed to a 14% increase in funding allocation for this service category, but most of the increase can likely be explained by a programmatic surge to find clients not engaged in medical care, the addition of one contractor to the provision of EIS services and a contractor who exceeded their client served goal by 232%. Only two service categories experienced an increase in clients over the past three years: Early Intervention and Housing.

Early Intervention Clients, FY 2012-2014



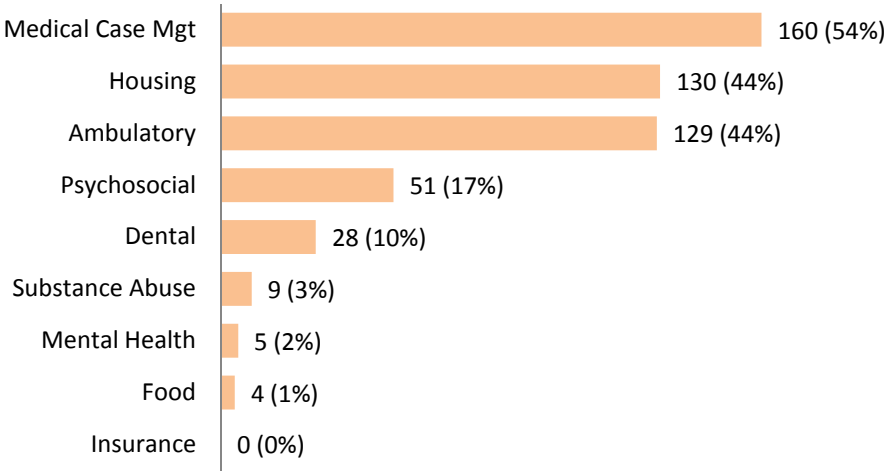
When comparing Part A clients who received Early Intervention services with those who did not, Part A Early Intervention clients (not including people tested for HIV in jail) were more likely to be:

- Multnomah County residents
- 44 years or younger
- Under 100% of the federal poverty level
- Unstably housing

In fiscal years prior to FY 2014, EIS services were measured by the number of encounters. This past year is the first time EIS services across all contractors (excluding the HIV testing program) are measured in units of hours. Therefore, a comparison over time cannot be executed until future years of data are collected. A total of 1,377 EIS service hours were provided to 294 clients. An EIS client received an average of four hours and 40 minutes of EIS services.

At some point during the fiscal year, more than half of all EIS clients (68%) also received other Part A services. Clients are generally connected with EIS services because they need assistance connecting with care. The fact that 44% received Medical Care and 54% received Medical Case Management is an indicator for program success.

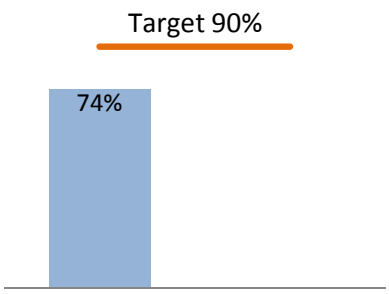
Number of Early Intervention Clients by Service Category



Outcomes

EIS services are designed to provide services to those clients who have fallen out of care. Therefore, measuring an EIS client's medical engagement is not salient, because a low engagement rate is expected; otherwise, a client would not be receiving EIS services. For this service category only, a better measurement of program performance is engagement in medical care within 90 days of program start. For this service category 74% of EIS clients were engaged in medical care within 90 days. Anecdotally, contractors report that clients who did not achieve this goal of engaging in medical care are typically individuals who have fallen out of care and not individuals newly diagnosed.

Percentage of Early Intervention Clients Medically Engaged in 90 days



Housing Services

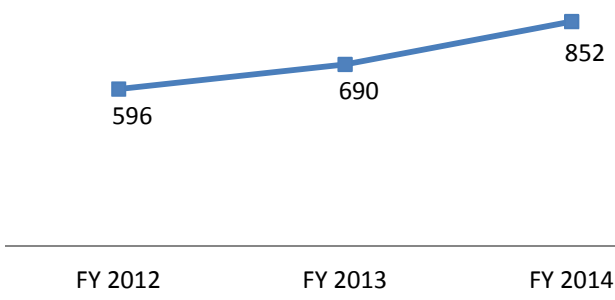
Stable housing allows persons living with HIV/AIDS to access comprehensive healthcare and adhere to complex HIV/AIDS drug therapies. Throughout many communities, persons living with HIV/AIDS risk losing their housing due to compounding factors, such as increased medical costs, limited incomes or reduced ability to keep working due to related illnesses.

Unlike most of the other Part A services, a steady growth of clients have received Housing Services over the past three years. During FY 2014, a total of 852 clients received Part A Housing Services, an increase of 43% since FY 2012. During the FY 2014, the total number of housing clients represented 29% of all Part A clients served in the TGA compared to 20% in FY 2012.

Housing Description

Emergency and transitional housing assistance to PLWH/A and their families. Eviction prevention, information and referrals and housing case work enable clients to access and remain in transitional and permanent housing. Alcohol/drug-free housing is also provided for PLWH/A while enrolled in outpatient substance abuse treatment.

Housing Clients, FY 2012-2014



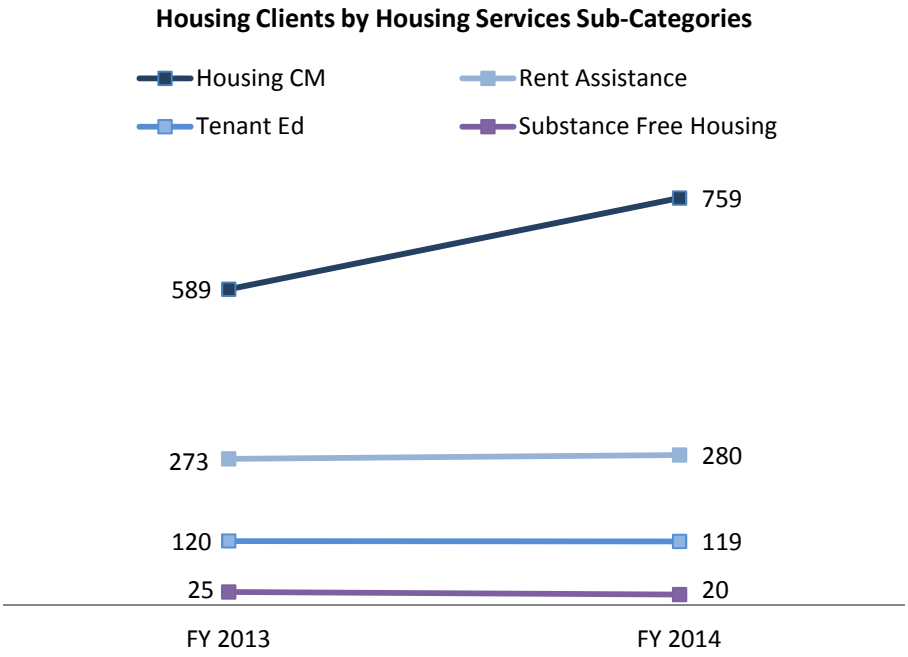
When comparing Part A clients who received Housing Services with those who did not, Part A Housing clients were more likely to be:

- Multnomah County residents
- Non-white
- Between ages of 25 and 44
- Non-MSM
- Temporary or unstably housed
- Publically insured
- Under 100% of the federal poverty level

A client receiving housing case management was living outside for 18 months and is now housed in a 1 bedroom apartment. This client made dramatic behavioral changes from the last time he was housed and subsequently lost his housing.

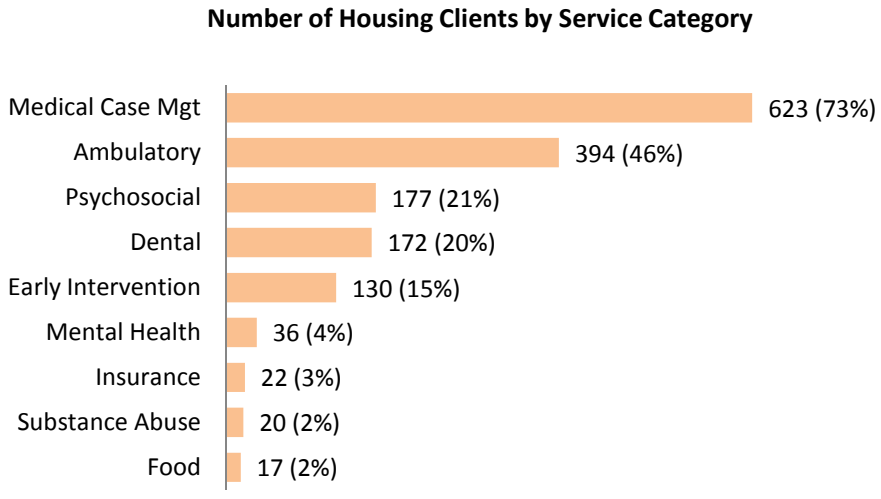
Housing clients received a variety of housing services during FY 2014. These services can be divided into four housing sub-categories. The majority of housing clients received housing case management, which is designed to help a client navigate the housing market, develop a plan to reduce barriers and support a client's effort to secure short-term, long-term or emergency rental assistance. A total of 759 clients received housing case management, which represents 89% of all housing clients. The second category of housing services is the provision of rental assistance in the form of eviction prevention, rental payment assistance or medical motel vouchers. One-third (33%) of housing clients received at least one

form of housing financial assistance. Clients seeking housing services also had the opportunity to participate in a tenant education course, with the goal of helping to reduce housing barriers and acquiring knowledge about tenant rights and responsibilities. Housing clients who participated in a tenant education workshop series represented 14% of the total number of housing clients served. Finally, a small portion of housing clients (2%) were provided with alcohol and drug free housing based on qualifying factors.



When these four housing sub-categories are examined over the past two years (sub-category data was unavailable in FY 2012), it becomes apparent that the increase of housing clients served can be attributed to an increase of clients who are receiving housing case management services. The other three housing sub-categories (rent assistance, tenant education and substance free housing) showed a minimal fluctuation in number of clients served.

Coupled with the 43% increase in Housing Services clients over the past three years, the number of housing case management hours also increased. In FY 2012, clients received a total of 1,652 hours of Housing Case Management services. During FY 2014, clients received a total of 3,386 hours, a 105% increase from two years prior. This increase in hours of housing case management delivered represents the largest percentage increase across all service categories. This service



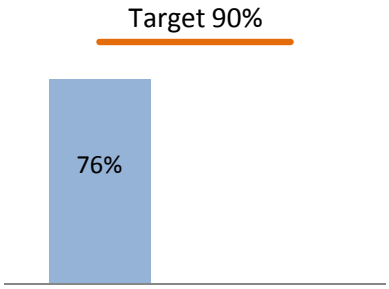
category is the only category out of the 10 funded Part A categories to exhibit both an increase in clients and an increase in services delivered.

A total of 730 out of 852 or 85% of all Housing clients also receive services from other Part A providers. This is the highest percentage across all service categories and points to the fact that Housing clients are in need of and utilize a wide range of Part A funded services in the TGA continuum. The most prevalent service Housing clients access was Medical Case Management, followed by Medical and Psychosocial and Dental.

Outcomes

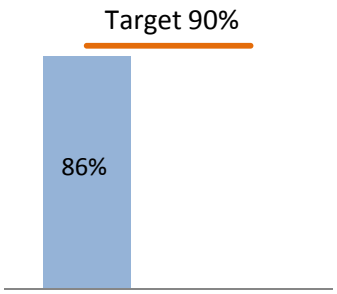
Housing is a support service that helps clients stay in medical care, adhere to a medication regimen, and contributes to viral suppression. For clients who receive housing support, medical engagement as well as housing status after program exit is assessed.

Percentage of Housing Clients Medically Engaged



Medical engagement for Housing clients was the same (76%) compared with the overall medical engagement outcome for the TGA (76%). Both medical engagement rates are well below the benchmark target of 90%. However, as examined in the TGA Medical Outcome section of this report (see page 15), clients who are not medically engaged were more likely to be unstably housed.

Percentage of Housing Clients Maintain Stable Housing



Housing services are provided to help clients establish stable housing. Housing stability is measured after six months of last housing service for clients who received rental assistance. 86% of all rental payment assistance housing clients reported stable housing six months after last service. This outcome represents an increase from FY 2013, where the percentage for this outcome was 82%.

Psychosocial Support Services

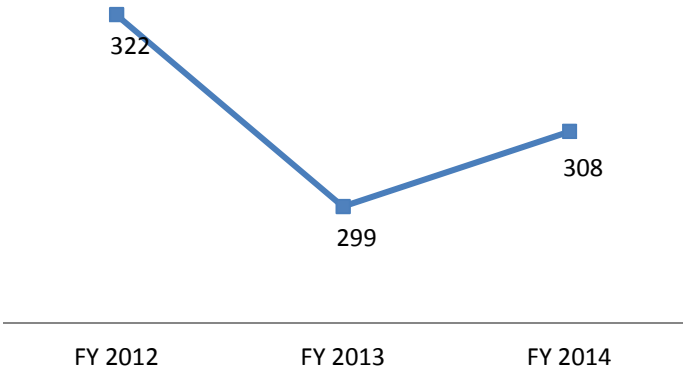
Psychosocial Support Services addresses the ongoing psychological and societal issues of HIV infected individuals, their partners, families and caregivers. Counseling and social support can enhance quality of life, assist people in making informed decision, cope better with the disease and more effectively deal with discrimination. Finally, on-going counseling can be critical in enhancing adherence to treatment regimens.

Psychosocial Description

Emotional, social and practical support to clients through day drop-in centers, congregate meals and peer support. Psychosocial services are targeted for women, youth and children and historically underserved populations – clients who are homeless, clients with multiple diagnoses, and racial and ethnic minorities.

During FY 2014, a total of 308 individuals received psychosocial services from a Part A contractor. This represents 10.3% of the overall number of clients who received Part A services. The number of clients served over the past three years has fluctuated. Over this time frame there was a small decrease in Psychosocial clients; a 4% decrease from 322 to 308.

Psychosocial Clients, FY 2012-2014



When comparing Part A clients who received Psychosocial services with those who did not, Part A Psychosocial clients were more likely to be

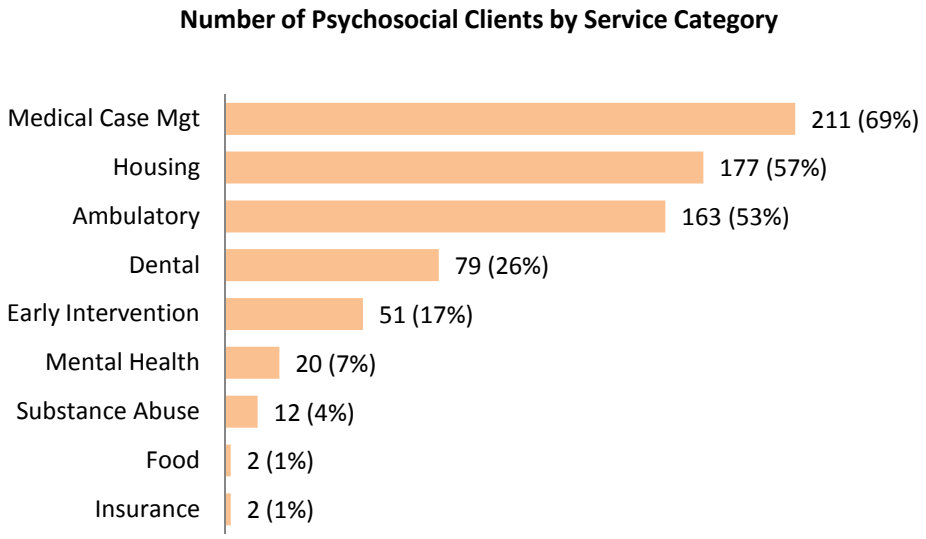
- Female
- Multnomah County residents
- Non-white
- Non-MSM
- Publically insured
- Under 12 years old
- Under 100% of the federal poverty level
- Unstably housed

The client-led peer support group discusses such things as navigating services, relationships, living in recovery, fighting depression, etc. Not only have the individuals facilitating the meeting gained invaluable group facilitation skills, a number of the group members are now serving as informal community peer mentors

As outlined in the psychosocial service description, these services are targeted toward women, youth, and historically underserved populations of people. Therefore, the results displayed above can be viewed as confirmation that targeted service provision is working well. Specifically, clients who were

female, non-White, and under 12 years old were more likely to receive psychosocial services compared with Part A client who did not receive psychosocial services. .

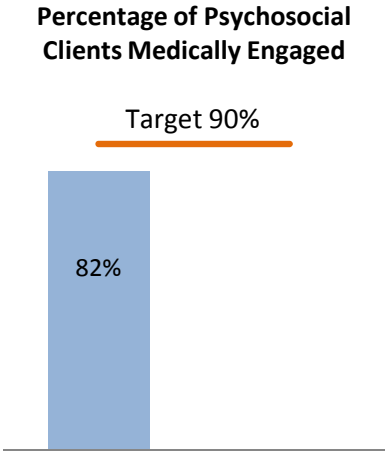
Three general types of Psychosocial Support Services were provided: women's group services, center visits, and center meals. During the past three years, women group contacts have decreased by a small percentage (3%). Center contacts have increased by 3% and center meals have increased by 10%. These increases in services and clients also follow a similar trend in allocations for this service category. Across the same time frame, the psychosocial service category funding has increased 8%.



Most Psychosocial clients (83%) received other Part A services. The majority of Psychosocial clients received Medical Case Management, Medical Care and Housing Services.

Outcomes

Medical engagement rate for this service category (82%) is higher than the TGA medical engagement rate of 76%. Medical engagement was the only outcome measured for this service category.

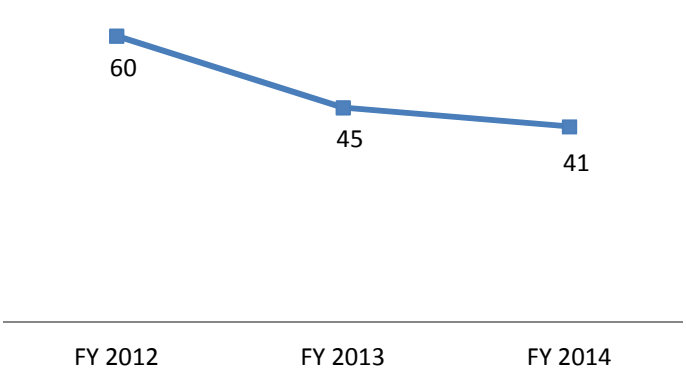


Food/Home-delivered Meals

Proper nutrition and sustenance is important for all people. Individuals living with HIV who experience proper nutrition have an increased quality of life, a strengthened immune system, and a reduction in HIV medication side effects. During FY 2014, seven nutritious meals were delivered weekly throughout the six-county Portland metro area to people in need. Program participation hinges on a specified medical need for home delivered meals and a referral into the program by a case manager.

Food Description
This service provides medically necessary home-delivered meals and nutritional supplements.

Food Clients, FY 2012-2014



During FY 2014, a total of 41 clients received at least one home-delivered meal or supplement. This represents 1.4% of all clients who received Part A services. Over the past three years there was a 31% decrease in the number of clients served.

When comparing Part A clients who received Food services with those who did not, Part A Food clients were more likely to be

- Multnomah County residents
- Older than 45 years
- Publically insured

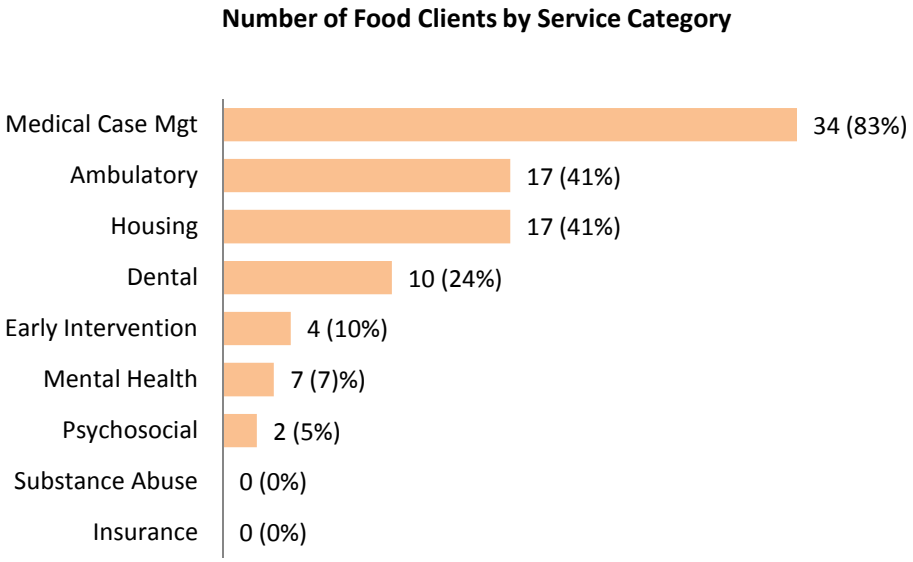
Additional funding increased the food options provided. This not only increases the quality of food available, it increases the variety. Providing people the opportunity to make choices such as this, even if small, contributes to increased sense of dignity and self-determination-very important when combating social isolation, stigma and discouragement.

Clients received a total of 7,237 home delivered meals and supplements for an average of 176.5 meals and/or supplements during this time frame per client. The number of meals and supplements provided represented a 25% decrease from the number of meals and supplements provided in FY 2012 This downward trend for both clients served and meals/supplements provided follows a similar trend of a decrease in the allocation for this service category. Over the past three years there has been a 22% reduction in funding all the while, costs have increased in both food and transportation.

Clients who received a higher number of Food services were more likely to be:

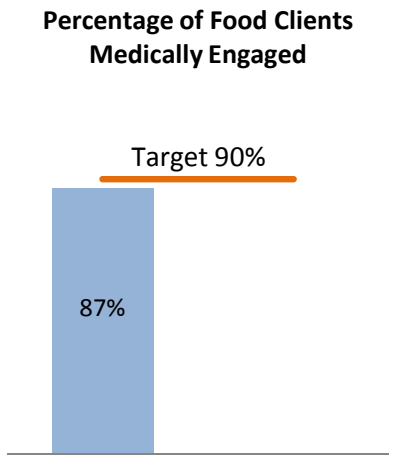
- Multnomah County residents

An overwhelming number of clients who received food also received other Part A services. Out of the 41 clients who received Food Services, 38 or 93%, also received other Part A services. Because a client's enrollment in the home delivered meals programs is dependent upon a case manager referral, it is not surprising that 83% of these Food clients also received Medical Case Management services. Food clients also received Medical Care and Housing Services at a rate of 41%. For Food clients, this points to the tight co-mingling of both Food and Medical Case Management services. This finding supports the strong referral system that exists between Food and Medical Case management.



Outcomes

Clients who received Food Services have the second highest rate of medical engagement across all service categories. During FY 2014, clients who received food services had a medical engagement rate of 87%. This rate has been high over the past three years, 92% in FY 2012, 88% in FY 2013 and 87% in FY 2014. This high rate, compared to the average TGA medical engagement rate of 73% is likely due to the program's qualifying parameters. Clients who receive home-delivered meals must be based on a medical necessity, and therefore all clients who receive such services will also likely be receiving regular medical care. Medical engagement was the only outcome measured for this service category.



Priority Populations

The Affordable Care Act offers that a health disparity exists for a population when "there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population." To address disparities requires focusing on disproportionately affected communities and populations. For the Portland TGA, those priority populations are women (25 and older), infants (<2 years of age), children (2-12 years of age), youth (13-24 years of age), adults (55 and over) and people of color. These priority populations have been defined in part by national trends in overall disparity rates nationwide, but also based on what is observed here in the Portland TGA.

Women, Infant, Children and Youth (WICY)

As the grant recipient of Part A funding from HRSA, HCS is responsible for insuring a proportional amount of grant funding is provided to services for women, infants, children and youth living with HIV. The Portland TGA has met this fiscal requirement. What follows is an examination of WICY clients compared with the epidemic and Part A service utilization.

	Cases (N=4741)		RW Clients (N=2938)	
	#	%	#	%
Women	511	11%	350	12%
Infants	0	0%	1	<1%
Children	0	0%	2	<1%
Youth	103	3%	97	3%

A comparison of HIV prevalence demographic data (cases as of 12/31/13) with Ryan White Part A client demographic data shows that the PLWH/A clients served in the Part A system are representative of the TGA epidemic. The time frame for each data set (cases and RW clients) is different, which explains why we might expect to see zero cases for one WICY category (as there were no cases for infants as of 12/31/13) and >0 clients for the same category (for RW clients we are looking for clients who received services between 3/1/14 and 2/28/15).

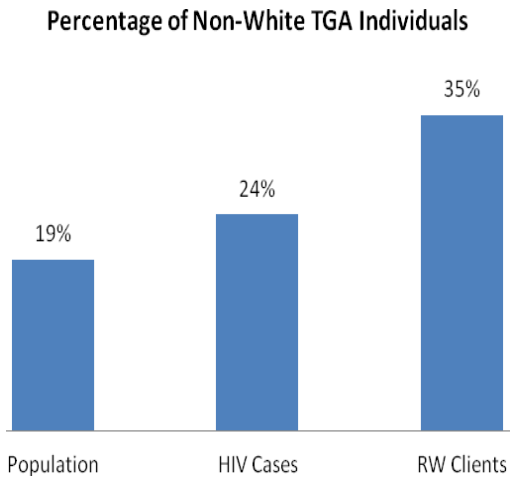
Women accessed a wide range of services spanning across the entire service category array. The services accessed by the most number of women were MCM (74%), Medical Care (46%) and Housing (34%). The same trend emerged when examining the service categories the most number of clients (regardless of gender) accessed, MCM, Medical and Housing were also the top three. In terms of the services women accessed at a higher rate compared with the other WICY categories, women were more likely to access Psychosocial, Mental Health and Part A services in general.

Youth who accessed Part A services also followed a similar pattern as women; 70% of youth accessed MCM services, 44% accessed Medical care and, different from women, 27% accessed EIS services. This finding, points to the fact that youth are accessing EIS at a higher rate (27%) compared with all Part A clients (10%). Finally, youth were more likely than women, infants and children to access EIS services; a reiteration that the rate of EIS usage was higher amongst youth.

A similar analysis for infants and children was not conducted due to the low number of Part A clients who fall into these demographic sub-groups.

People of Color

Historically, people of color have been disproportionately affected by HIV. At the national level, although African Americans comprised approximately 12% of the United States population, as of 2012 a disproportionate 47% of all HIV diagnoses were African American. In the Portland TGA, Census Data shows that at the end of 2010, 19% of the population was non-White, as of 12/31/13 24% of the HIV/AIDS cases were non-White and during FY 2014, 35% of all clients served were non-White. The comparison between the population and HIV cases percentages shows that non-White individuals are disproportionately affected by HIV. The comparison between the HIV cases and RW clients percentages shows that non-White Part A clients are over-represented when compared with the epidemic.

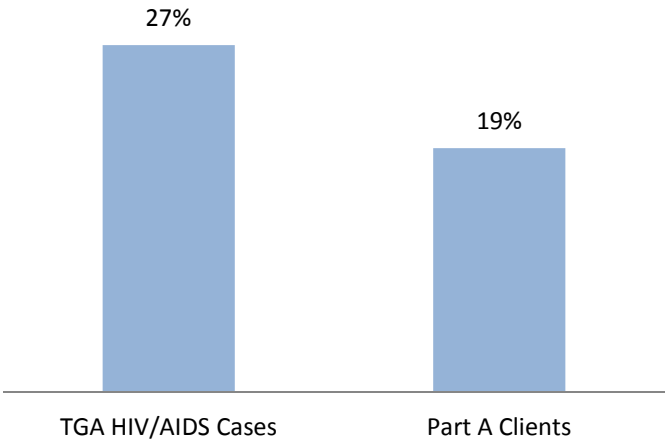


A total of 1,043 clients of color were served during FY 2014. Of these clients, the top three most utilized services were MCM services (78%), Medical Care services (47%) and Housing Services (34%). These were the same top three most utilized services for all Part A clients. Statistical tests of significance shows the following patterns:

- Hispanics were more likely to access Part A services
- African American and Hispanic clients were more likely to receive MCM services
- The average number of hours spent with a medical case manager is greater for clients of color
- Clients of color were more likely to receive housing services
- Clients of color were more likely to receive psychosocial services

55+ Adults 55 and Older

Persons 55 and older accounted for 26% of the estimated 1.2 million people living with HIV infection in the United States in 2011. Older Americans are more likely than younger American to be diagnosed with HIV infection late in the course of their disease, meaning a late start to treatment and possibly more damage to their immune system. Older people also face unique issues, including: less likely to discuss sexual habits and drug use with their doctors, older women are less likely to use a condom because they no longer worry about getting pregnant, and some may be less knowledgeable about HIV than younger people.



A total of 576 adults 55 and older received Part A services during the previous fiscal year. Of these clients, over half (59%) received Medical Case Management Services, 39% received Dental Care and 28% received Medical Care. The rate of Dental Care utilization is higher (39%) than the rate of 24% which is the rate at which all Part A clients utilize Dental Care.

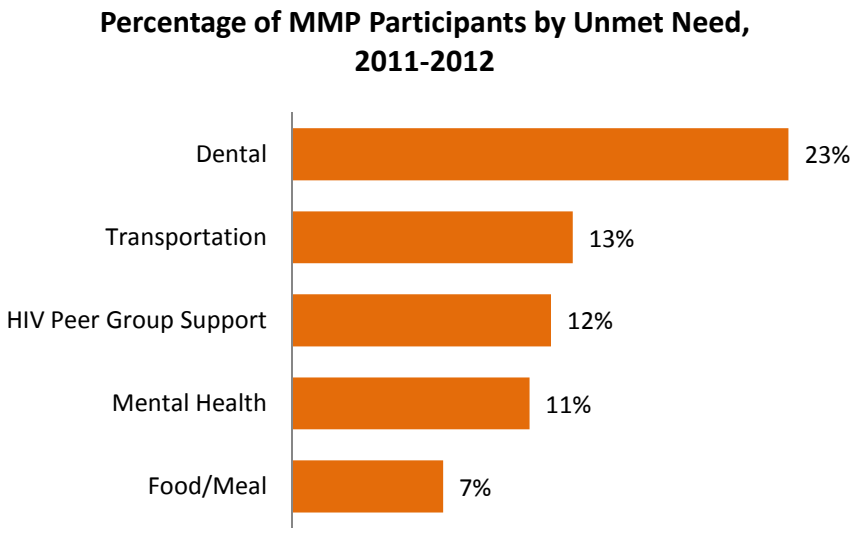
TGA population data is not available for this age grouping at the time of the writing of this report.

Unmet Need

The Medical Monitoring Project (MMP) is a surveillance system designed to learn more about the experiences and needs of people who are living with HIV. It is supported by several government agencies and conducted by state and local health departments along with the Centers for Disease Control and Prevention (CDC).

Administered by the Oregon Health Authority, Oregon's MMP is designed to address access/barriers to care, unmet needs, quality of treatment, co-morbidity, health behaviors and topics of local interest. The MMP collects data from interviews and medical records.

At the writing of this report, the most recent MMP data available was for a two year time span from 2011 to 2012, where 349 TGA residents participated. For this data set, unmet needs data revealed almost one-fourth (23%) of MMP participants reported an unmet need of Dental Care.



Since 2012, concerted efforts have been made in the Portland TGA to recruit and engage new clients into dental care. Beginning March 2013 HCS launched a poster campaign to increase of Ryan White dental resources in the TGA. Additionally, Oregon's ADAP program now offers dental insurance for ADAP/CAREAssist clients beginning in the 15-16 contract year.

HCS anticipates the acquisition of more recent unmet data summaries in order to measure the effectiveness of all efforts to raise awareness of dental resources within the Part A continuum of services.

Glossary of Terms

CAREWare: The client-level data system used by contractors in the Part A TGA.

Census data: An official count of a population. The US government conducts a census every 10 years, and calculates estimates for all other years in between.

EIS: Early Intervention Services

EMA: Eligible Metropolitan Area

FPL: Federal poverty level

FY 2014: Fiscal Year 2014 (March 1, 2014 – February 28, 2015)

HCS: HIV Care Services located, within the Multnomah County Health Department, is the Portland EMA Ryan White grant recipient.

HIV Prevalence: The number of people living with HIV at a given time, such as at the end of the year

HRSA: Health Resources Services Administration is the federal entity which administers the Ryan White federal dollars

IDU: Injection drug users

MAI: Minority AIDS Initiative

MCM: Medical Case Management

MSM: Men who have sex with men

Part A: Type of Ryan White grant which provides emergency assistance to geographic locations most severely affected by the HIV/AIDS epidemic.

PLWH/A: Persons living with HIV/AIDS

Portland TGA: Portland Transitional Grant Area consists of 6 counties; Clackamas, Columbia, Multnomah, Washington, and Yamhill Counties in Oregon and Clark County in Washington.

Viral Suppression: A viral status of 200 copies or less.

WICY: Women, Infant, Children and Youth

Appendix A: HRSA Service Categories

Core Medical Services

Core medical services are specified in the Ryan White HIV/AIDS Treatment Extension Act of 2009. They are a set of essential, direct health care services provided to Ryan White HIV/AIDS Program clients who are HIV positive or HIV indeterminate, with one exception. HIV-negative clients may receive HIV counseling and testing (HC&T) services under Early Intervention Services for Parts A and B

RWHAP-funded core medical services may not be provided anonymously.

Outpatient/ambulatory medical care includes the provision of professional diagnostic and therapeutic services directly to a client by a physician, physician assistant, clinical nurse specialist, nurse practitioner, or other health care professional certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

AIDS Drug Assistance Program (ADAP) is a State-administered program authorized under Part B of the Ryan White HIV/AIDS Program that provides FDA-approved medications to low-income individuals with HIV/AIDS disease who have limited or no coverage from private insurance, Medicaid, or Medicare. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments.

Local AIDS pharmaceutical assistance (APA, not ADAP) includes local pharmacy assistance programs implemented by Part A or Part B grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds or Part B base award funds. These organizations may or may not provide other services (e.g., outpatient/ambulatory medical care or case management) to the clients they serve through a RWHAP contract with their grantee.

Programs are considered APAs if they provide HIV/AIDS medications to clients and meet all of the following criteria:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;

- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are not APAs if they dispense medications in one of the following situations:

- As a result or component of a primary medical visit;
- On an emergency basis (defined as a single occurrence of short duration); or
- By giving vouchers to a client to procure medications.

Local APAs are similar to AIDS Drug Assistance Programs (ADAPs) in that they provide medications for the treatment of HIV disease. However, local APAs are not paid for with Part B funds "earmarked" for ADAP.

Oral health care includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants.

Early intervention services (EIS) for Parts A and B include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.

Health insurance premium and cost-sharing assistance, also referred to as Health Insurance Program (HIP), is the provision of financial assistance for eligible individuals living with HIV to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Home health care is the provision of services in the home by licensed health care professionals, such as nurses, and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Home and community-based health services includes skilled health services furnished to the individual in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services.

Inpatient hospital services, nursing homes, and other long-term care facilities are not included as home and community-based health services.

Hospice services are end-of-life care provided to clients in the terminal stage of an illness. They include room, board, nursing care, counseling, physician services, and palliative therapeutics. Services may be provided in a residential setting, including a non-acute care

section of a hospital that has been designated and staffed to provide hospice services. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.

Mental health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Mental health services provided to HIV- affected clients should be reported as psychosocial support services.

Medical nutrition therapy, including nutritional supplements, is provided by a licensed, registered dietitian outside of an outpatient/ambulatory medical care visit. The provision of food may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician. Nutritional counseling services and nutritional supplements not provided by a licensed, registered dietician shall be considered a support service and be reported under psychosocial support services and food bank/home-delivered meals, respectively. Food not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician should also be considered a support service and is reported under food bank/home-delivered meals.

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the needs and personal support systems of the client and other key family members. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include:

(1) initial assessment of service needs;
(2) development of a comprehensive, individualized service plan;
(3) coordination of services required to implement the plan;
(4) client monitoring to assess the efficacy of the plan; and
(5) periodic reevaluation and adaptation of the plan, at least every 6 months, as necessary over the life of the client.

It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face meetings, telephone calls, and any other forms of communication.

Substance abuse services (outpatient) are medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel. They include limited support of acupuncture services to HIV-positive clients, provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists.

Support Services

Support services are a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS. Support services may be provided to HIV-positive and HIV- indeterminate clients as needed. Support services may also be provided to HIV-affected clients. However, the services provided to HIV-affected clients must always support a medical outcome for the HIV-positive client or HIV-indeterminate infant.

RWHAP-funded support services may not be provided anonymously. *NOTE: This includes outreach services.*

Case management services (non-medical) include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.

Child care services are care for the children of clients who are HIV positive while the clients are attending medical or other appointments, or RWHAP-related meetings, groups, or training. These do not include child care while the client is at work.

Pediatric developmental assessment and early intervention services are professional early interventions by physicians, developmental psychologists, educators, and others for the psychosocial and intellectual development of infants and children. They involve the assessment of an infant or child's developmental status and needs in relation to the education system, including early assessment of educational intervention services. They include comprehensive assessment, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-infected clients, and education/assistance to schools also should be reported in this category.

Only Part D programs are eligible to provide pediatric developmental assessment and early intervention services.

Emergency financial assistance is the provision of one-time or short-term payments to agencies or the establishment of voucher programs when other resources are not available to help with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), transportation, and medication. Part A and Part B programs must allocate, track, and report these funds under specific service categories, as described under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of Ryan White HIV/AIDS Program funds for

these purposes will be the payer of last resort, and for limited amounts, use and periods of time. Continuous provision of an allowable service to a client should be reported in the applicable service category.

Food bank/home-delivered meals involve the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies should also be included in this item. The provision of food or nutritional supplements by someone other than a registered dietician should be included in this item as well.

Food vouchers provided as an ongoing service to a client should be reported in this service category. Food vouchers provided on a one-time or intermittent basis should be reported in the Emergency financial assistance category.

Health education/risk reduction activities educate clients living with HIV about how HIV is transmitted and how to reduce the risk of transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

Health education/risk reduction services can only be delivered to individuals who are HIV positive. These services cannot be delivered anonymously. Client- level data must be reported for every individual that receives these services.

Housing services are short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that provides some type of medical or supportive services (such as residential substance abuse or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services but is essential for an individual or family to gain or maintain access to and compliance with HIV-related medical care and treatment.

Housing funds cannot be in the form of direct cash payments to recipients for services and cannot be used for mortgage payments. Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Therefore, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation. For more information, see the policy **"The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs"** at **http://hab.hrsa.gov/manageyourgrant/policiesletters.html**.

Legal services are services to individuals with respect to powers of attorney, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program.

Legal services to arrange for guardianship or adoption of children after the death of their primary caregiver should be reported as a permanency planning service.

Linguistic services include interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support the delivery of Ryan White–eligible services.

Medical transportation services are conveyance services provided, directly or through a voucher, to a client to enable him or her to access health care services.

Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding) so that they may become aware of, and may be enrolled in, care and treatment services. Outreach services do not include HIV counseling and testing or HIV prevention education. Broad activities such as providing "leaflets at a subway stop" or "a poster at a bus shelter" or "tabling at a health fair" would not meet the intent of the law. These services should target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort, targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, conducted at times and in places where there is a high probability of reaching individuals with HIV infection, and designed with quantified program reporting that will accommodate local effectiveness evaluation.

RWHAP-funded Outreach services cannot be delivered anonymously. Client-level data must be reported for every individual that receives this service.

Permanency planning includes services to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them. It includes the provision of social service counseling or legal counsel regarding (1) drafting of wills or delegating powers of attorney; and (2) preparation for custody options for legal dependents, including standby guardianship, joint custody, or adoption.

Psychosocial support services are support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Nutrition counseling services provided by a non-registered dietitian are reported in this service category.

Nutritional services and nutritional supplements provided by a licensed, registered dietician are considered a core medical service and should be reported as Medical nutrition therapy. The provision of food and/or nutritional supplements by someone other than a registered dietician should be reported in the Food bank/home-delivered meals service category.

Referral for health care/supportive services is the act of directing a client to a service in person or in writing, by telephone, or through another type of communication. These services are provided outside of an Outpatient/ambulatory medical care, Medical case management, or Non-medical case management service visit.

Referrals for health care/supportive services provided by outpatient/ambulatory medical care providers should be reported under the outpatient/ambulatory medical care service

category. Referrals for health care/supportive services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category—i.e., Medical case management or Non-medical case management.

Rehabilitation services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. These include physical and occupational therapy, speech pathology, and low-vision training.

Respite care is community or home-based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client living with HIV/AIDS.

Substance abuse services (residential) include treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term care). They include limited support of acupuncture services to HIV-positive clients, provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists.

Treatment adherence counseling includes counseling or special programs provided outside of a medical case management or outpatient/ambulatory medical care visit by non-medical personnel to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Treatment adherence counseling provided during an outpatient/ambulatory care service visit should be reported under the outpatient/ambulatory medical care service category. Likewise, treatment adherence counseling provided during a medical case management visit should be reported in the Medical case management service category.

Appendix B: Demographics of all Clients Served in FY 2014 (N=2,979)

Demographic Group	Number	%
HIV Status		
HIV-positive (not AIDS)	1581	53%
HIV-positive (AIDS status unknown)	154	5%
CDC defined AIDS	1203	40%
HIV-negative (affected)	27	<1%
Missing	14	
Gender		
Male	2562	86%
Female	384	13%
Transgender	30	1%
Missing	3	
Race		
White	1916	65%
Hispanic/Latino	460	15%
Black/African American	266	9%
Multi-racial	229	8%
Asian	54	2%
Amer Indian/Alaska Native	18	1%
Native Haw/Pacific Islander	16	<1%
Other	5	<1%
Missing	15	
County of Residence		
Multnomah	1985	67%
Clark (WA)	345	12%
Washington	328	11%
Clackamas	142	5%
Other	102	4%
Yamhill	27	1%
Columbia	15	<1%
Missing	35	
WICY Population		
Women (>=25)	357	75%
Infants (<2)	2	<1%
Children (2-12)	15	3%
Youth (13-24)	104	22%
Missing	0	

Demographic Group	Number	%
Age		
≤24	126	5%
25-44	1295	44%
45-54	982	33%
55-64	473	16%
>65	103	4%
Missing	1	
Risk Factors		
Men who have sex with men	1762	63%
Heterosexual Contact	439	16%
MSM-IDU	304	11%
IDU	220	8%
Blood/Product Transfusion	24	1%
Other Reason Not Listed	18	1%
Perinatal	14	<1%
Hemophilia/Coagulation	2	<1%
Missing	196	
Income		
≤100%	1565	56%
101-200%	868	31%
≥201%	366	13%
Missing	180	
Housing Status		
Stable	2284	89%
Unstable	150	6
Temporary	91	4
Institution	16	1
Non-Permanently Housed	15	<1
Missing	423	
No Insurance		
Public	1890	67%
Private	560	20%
No Insurance	323	11%
Other	67	2%
Missing	139	

Appendix C: HIV Cases and RW Part A Client Demographic Comparison

	HIV Cases As of 12/31/2013 (N=4,741)		Part A Clients FY 2014 (N=2,979)	
Demographic Group	**Number**	**%**	**Number**	**%**
Gender				
Male	4230	89%	2562	86%
Female	511	11%	384	13%
Transgender	--	--	30	1%
Race				
White	3596	76%	1916	65%
Hispanic/Latino	552	12%	460	15%
Black/African American	382	8%	266	9%
Multi-racial	56	1%	229	8%
Asian	99	2%	54	2%
Amer Indian/Alaska Native	41	<1%	18	1%
Native Haw/Pacific Islander	15	<1%	16	<1%
Other	--	--	5	<1%
County of Residence				
Multnomah	3283	63%	1985	67%
Clark (WA)	627	12%	345	12%
Washington	709	14%	328	11%
Clackamas	454	9%	142	5%
Other	--	--	102	4%
Yamhill	73	1%	27	1%
Columbia	39	<1%	15	<1%
Age				
0-12	--	--	2	<1%
13-19	18	<1%	11	<1%
20-24	85	2%	91	3%
25-29	241	5%	232	8%
30-34	338	7%	291	10%
35-39	445	9%	323	11%
40-44	661	14%	439	15%
45-49	806	17%	520	18%
50-54	848	18%	457	16%
55-59	595	13%	306	10%
60-64	403	9%	162	6%
65+	301	6%	103	4%