



HIV Care Services

FY 2015
(3.1.2015 – 2.29.2016)

Annual Report

Multnomah County Health Department

Adolescent Health Promotion and STD/HIV/HCV Programs

September 2016

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HIV Care Services Annual Report EXECUTIVE SUMMARY

FY 2015

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 12.31.2014

5,250

TGA Grant Amount

$3,505,035

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 34% of award

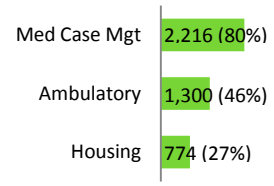
Number of Ryan White Part A clients served

2,844

Number of NEW Ryan White Part A clients

331

Top 3 Services utilized by the most number of clients



Percentage of RW clients medically engaged

78%*

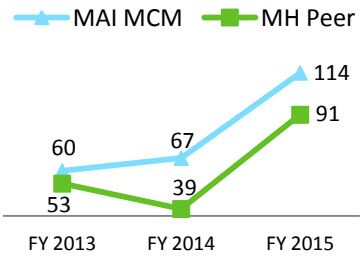
*Goal = 90%

Percentage of RW clients virally suppressed

87%*

*Goal = 80%

Sub-service categories with the largest increase in clients



Service Category with the highest percentage of medical engagement

Mental Health (89%)

The most commonly cited Part A unmet need

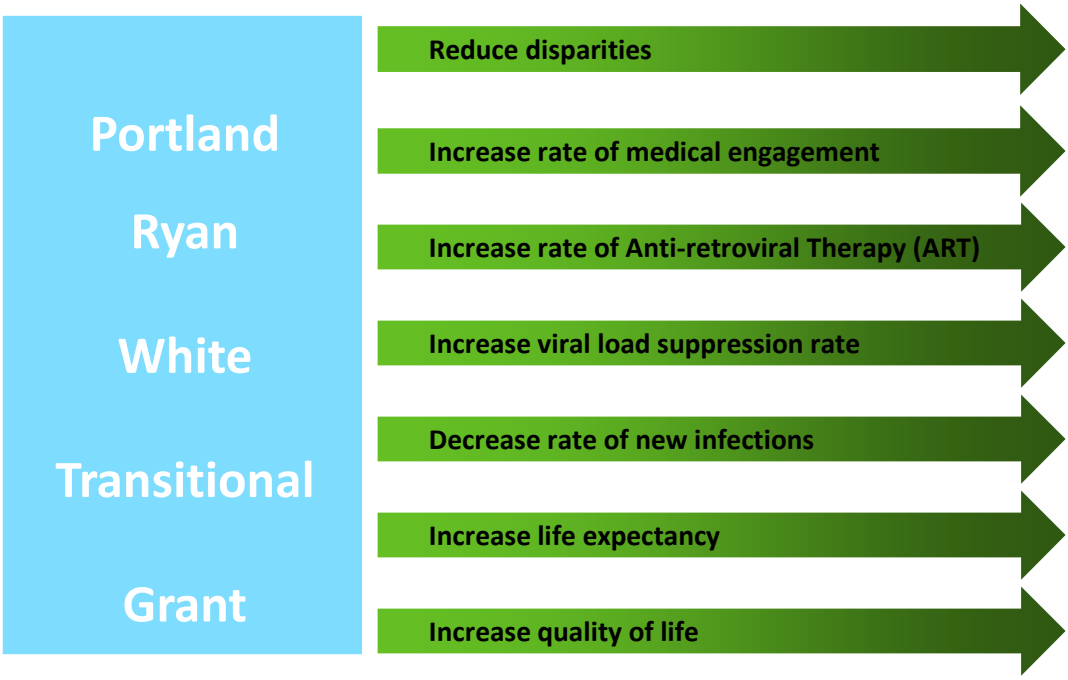
Dental Care (28%)*

*As reported by the OMMP for 2013-2014

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 service providers 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 2015 (March 1, 2015 to February 29, 2016).

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 over 500,000 people each year who do not have sufficient health care coverage or financial resources to cope with HIV.

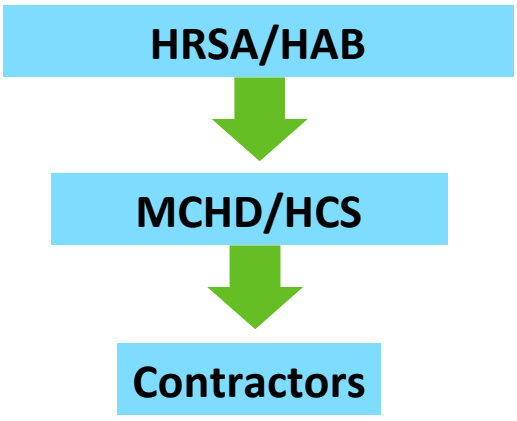
The Ryan White legislation created a number of programs, called Parts, to meet needs for different communities and populations affected by HIV/AIDS. The Portland metropolitan area is a recipient of a Part A Ryan White grant which provides emergency assistance to Eligible Metropolitan Areas (EMA) and 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 2015, there were a total of 52 Part A grantees across the country; 27 of these grantees including the Portland metropolitan area, were TGAs.

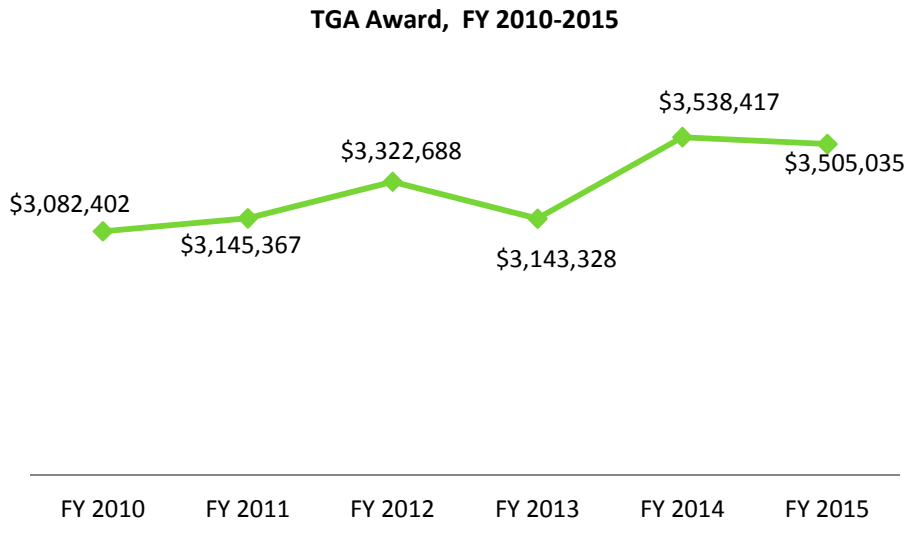
The Local System

For the past 21 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 2015, HCS received $3,505,035 in Part A service funds. While the pattern of TGA Part A funding has fluctuated over the past six years, three increases and two decrease, the general trend over this period of time can be characterized as an increase. During this time period there was a 14% increase in funding.

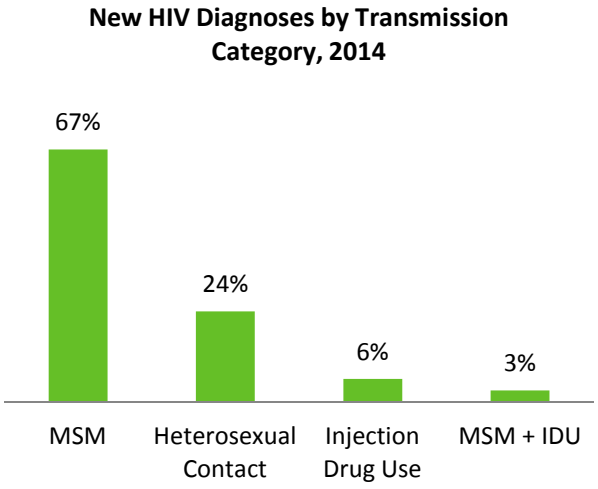


HIV Prevalence

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 2012. An estimated 156,300 (13%) are not aware of their HIV diagnosis. Despite concerted efforts toward reducing stigma, forging ahead with innovative prevention programs, and educating about the link between viral load suppression and transmission, approximately 44,073 individuals became newly infected with HIV in the US in 2014. The HIV new diagnosis rate across the county has declined by 19% from 2005-2014. Certain groups, including African Americans, Latinos and gay and bisexual men of all races/ethnicities, continue to be

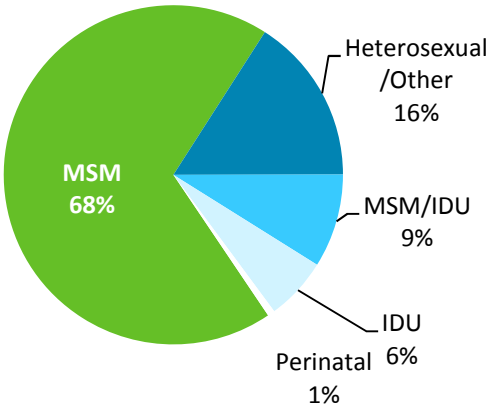


disproportionately affected by HIV. In the United States, it is estimated that 12,963 people living with HIV died in 2013. 6,955 deaths were attributed to HIV complications.

HIV in the Portland TGA

The number of persons living with HIV and AIDS (PLWHA) in the Portland TGA has continued to grow. As of 12/31/14, a total of 5,250 PLWHA resided in the TGA. This prevalence represents a 10.7% increase since 2013, and a 14.6% increase since 2012. These 5,250 HIV/AIDS cases are within a geographic area with a total population of 2,336,907. During 2012-2014, 203 new AIDS cases and 381 new HIV (non-AIDS) cases occurred. Twenty-six percent of PLWHA are persons of color, with Blacks/African Americans overrepresented and the proportion of Latinos continuing to grow. Sixty-nine percent of PLWHA are men who have sex with men (MSM), 6% are persons who inject drugs (IDU), 9% are MSM/IDU, 0.7% had pediatric/perinatal transmission, and 16% are associated with other modes of transmission, including heterosexual contact. Residence by county of PLWHA is as follows: 62% live in Multnomah, 15% in Washington, 12% in Clark, 8% in Clackamas, 2% in Yamhill, and 1% in Columbia. The majority of both HIV and AIDS cases are attributed to MSM transmission mode (72.2% and 65.6%, respectively). Injection drug use is associated with 4.7% of HIV cases and 7.3% of AIDS cases.

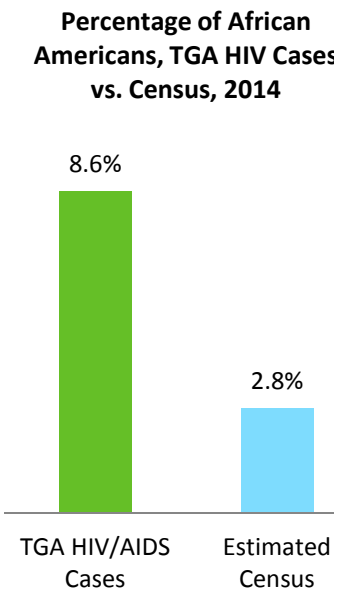
Percentage of TGA HIV/AIDS Cases by Risk Factor as of 12/31/2014

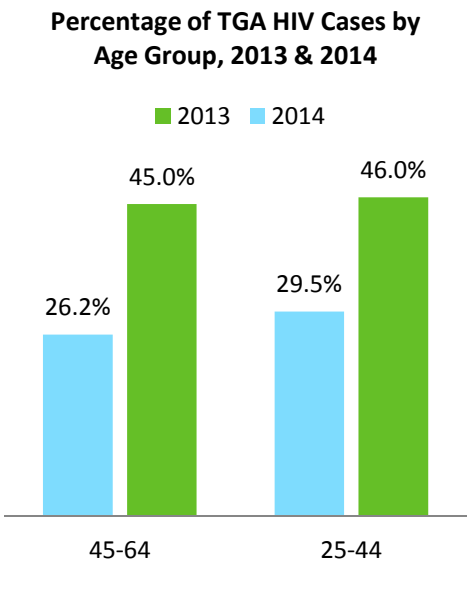


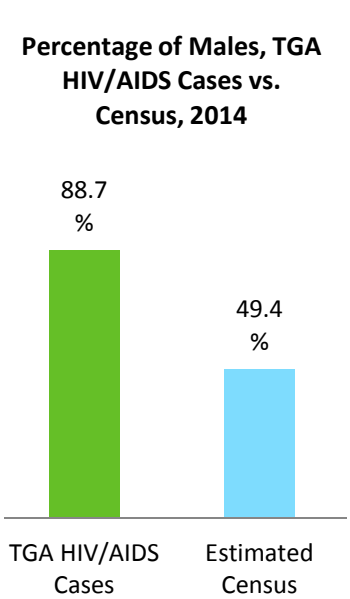
Disparities are differences in incidence, prevalence, mortality and burden of diseases that exist among specific populations. The comparison between those individuals who live in the TGA geographic area and those individuals who are living with HIV/AIDS in the TGA will provide a snapshot of which groups might be disproportionately affected by HIV/AIDS or bear the burden of the disease.

The calculated representation of each demographic group among total persons living with HIV (non-AIDS) (PLWH) and AIDS (PLWA) reveal a disproportionate impact of the disease among several populations. The majority of HIV and AIDS cases are among adults ages 45-64 years-old (45.0% of HIV cases and 64.1% of AIDS cases), while this age group makes up only 26.2% of the TGA's general population. Adults ages 25-44 are also disproportionately represented among HIV cases (46.0% compared to 29.5% of the general population) but not AIDS cases (27.0% of AIDS cases). Blacks/African Americans are dramatically overrepresented among HIV/AIDS cases: 8.6%

of HIV cases and 7.9% of AIDS cases but 2.8% of the general population. This disparity has been long-standing in the Portland TGA. Men make up 88.7% of HIV cases and 90.0% of AIDS cases despite comprising roughly half the population.







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 2015, the TGA funded a total of seven core services and three support services. Substance abuse treatment funding ended this year. Services were provided for the first quarter of the fiscal year. 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 2015 Ryan White Part A Allocations by Service Category

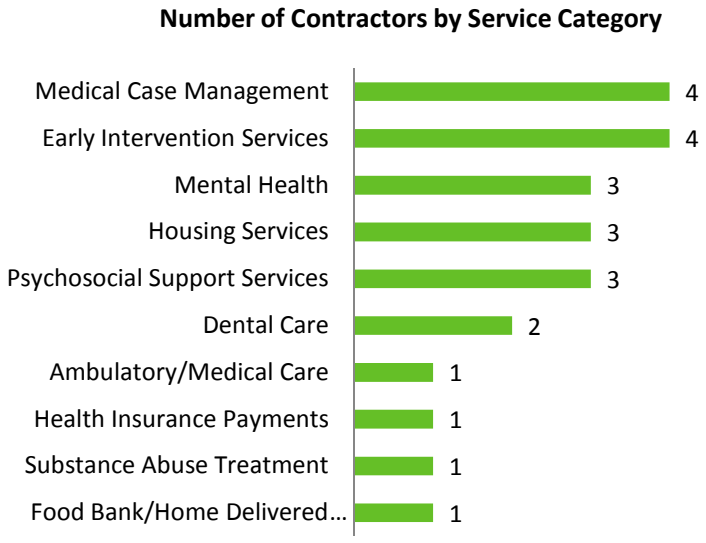
Service Category		Allocation Amount	% of Total Award
Core Medical Services	Ambulatory/Medical Care	$617,373	18%
	Health Insurance Payments	$24,000	1%
	Mental Health	$197,126	6%
	Dental Care	$390,848	11%
	Substance Abuse Treatment	$6,182	<1%
	Medical Case Management	$1,183,627	34%
	Early Intervention Services	$198,794	6%
Support Services	Housing Services	$547,506	16%
	Psychosocial Support Services	$294,920	8%
	Food Bank/Home Delivered	$44,658	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 2015, 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, seven 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 2015 there were a total of 2,844 clients who received at least one Ryan White Part A funded service. 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.

CW is set up to collect data through manual data entry (direct) from five 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.

Additionally, the Portland TGA is in the planning stage of creating a shared eligibility system using CW. Clients will only need to provide Ryan White Part A eligibility documentation one time with one provider every six months of service. Eligibility documents will be uploaded into CW for all Ryan White providers to access. Implementation of shared eligibility is set to begin August 2016.

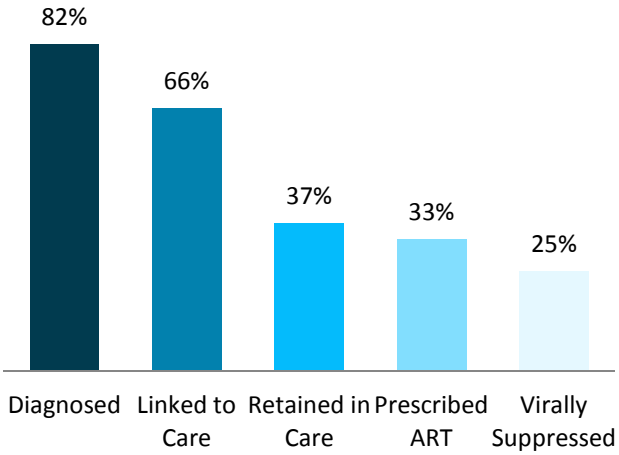
HIV Care Cascade

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.

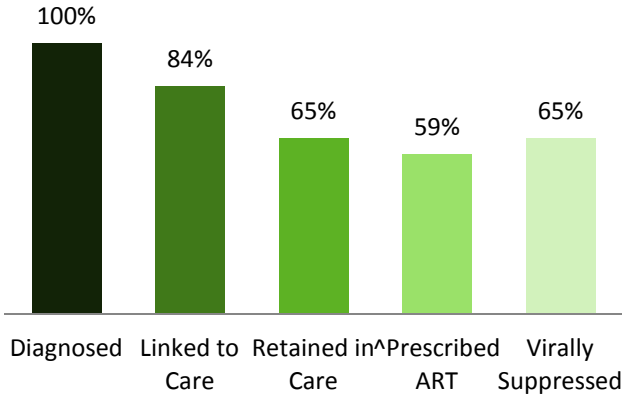
By closely examining these separate steps, policymakers and service providers can pinpoint where gaps may exist in connecting individuals living with HIV to sustained, quality care. If service providers keep track of when patients most commonly drop out, and what populations commonly do so, it can help 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 12/31/14



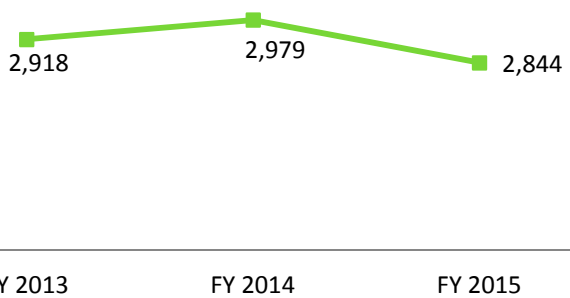
^ *Surveillance data do not record use of ART. This percentage was extrapolated from MMP sites 2009-2013.*

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 2,844 clients received at least one Part A service during FY 2015. The number of clients served by the Part A system over the past three years has fluctuated very little, with a slight 3% decrease of clients served over this time period.

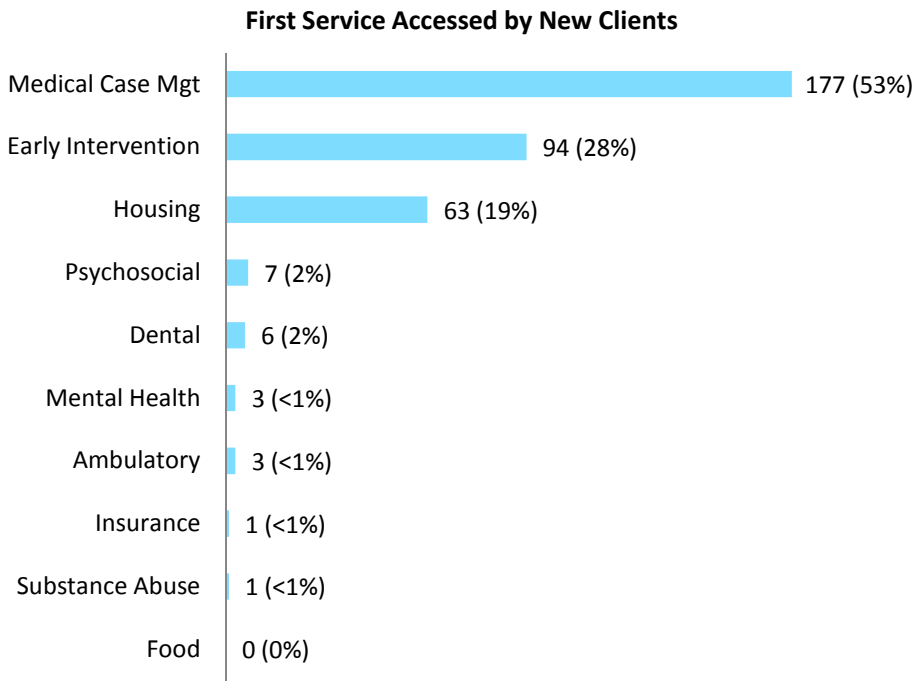
Number of Part A Clients, 2013-2015



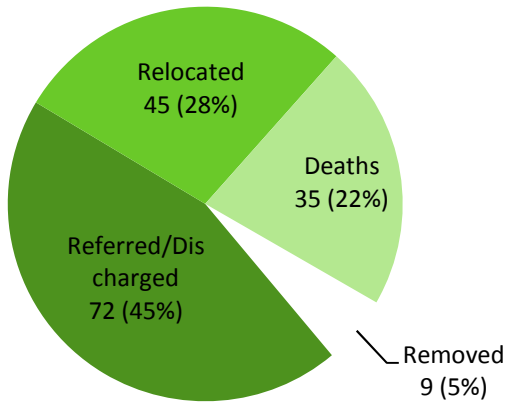
This fluctuation is due to clients moving in and out of the Part A system of care. The net increase in clients served over the past three years does very little to quantify or describe *who* is exiting and entering. The analysis that follows will provide insight into those who are new clients to the system as well as

those who have exited. Qualitative data that might help us understand *why* individuals are coming and going in and out of the system, is beyond the scope of this report.

During FY 2015, there were a total of 331 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 12% of the total number of clients (N=2,844) who received services during this time frame. For approximately half (53%) 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 28% 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.



Existing clients also exited the system over the course of the year. During FY 2015, a total of 161 clients exited the Part A service system (those clients who have either had a date of death or a date of case closed in the data system); 34 (22%) of the exited clients died during the year. An additional 5% were removed due to violation of agency rules. 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.



Demographic characteristics are important indicators of the types of clients served. These characteristics can help identify where there is need within the community and allows us to 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 12/31/2014. 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 5,250 individuals who are living with HIV/AIDS in the TGA, 54% or 2,844 are Part A clients. Rates of Part A service usage varies across demographic groups.

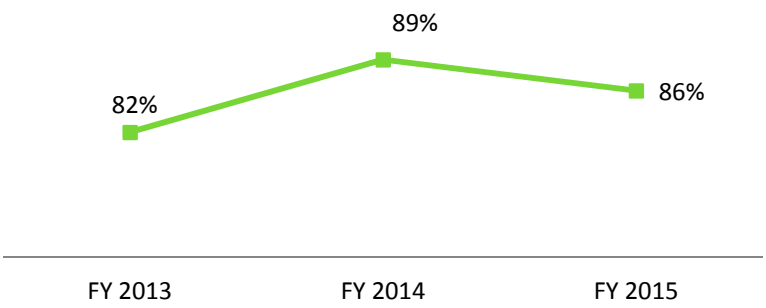
The proportion of overall cases versus the proportion of Part A clients for each demographic category will show how representative the clients are with respect to the epidemic. For example, 8.2% of all cases were individuals who self-identified as African American; this result is comparable with the proportion of African American clients who received Part A services (10%). 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 2015 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.

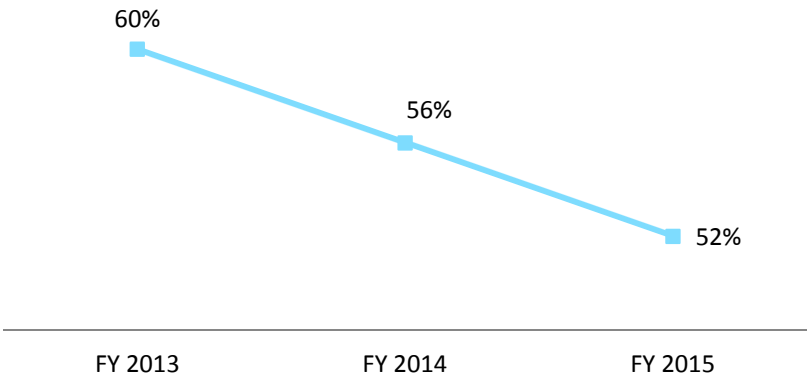
Often housing stability, income and insurance status are determinants of health outcomes. In the absence of stable housing, sufficient income and insurance, maintaining, improving and addressing a major health issue becomes infinitely more challenging. For this reason, we are particularly interested 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 2013-2015



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 individuals, 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 2015, over half of all Part A clients (52%) had an annual household income at or below 100% of the Federal Poverty Level.

Percentage of Clients at or Below the 100% of the FPL, FY 2013-2015



Clients who report no health insurance have fluctuated over the past three years. During the past contract year, 11%, or 327 clients reported no health insurance at the end of FY 2015. 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, non-White clients were more likely to have an income equal to or below 100% of the FPL compared to White clients. In FY 2015, 100% of the FPL for a one person household was $11,770; for a two person household it was $15,930.

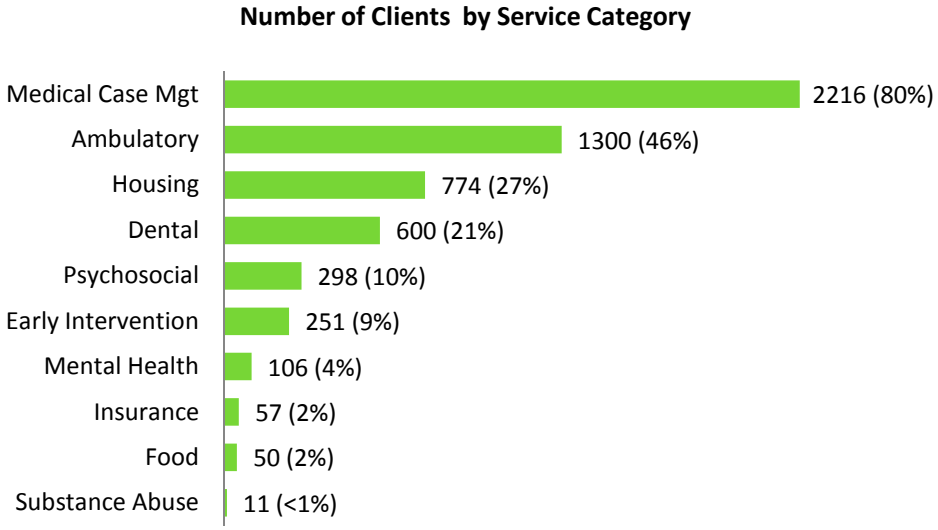
Demographic Group	Unstable housing	Income ≤100% FPL	No Insurance
Gender			
Male	-	-	-
Female	-	✓	-
Transgender	-	-	-
Race			
White	-	-	-
Non-White	-	✓	-
County of Residence			
Multnomah County	-	✓	-
Outside Multnomah County	-	-	-
Age			
≤12		-	-
13-24	✓	-	-
25-44	✓	✓	-
45>	-	-	-
Risk Group			
MSM	-	-	-
Non-MSM	-	✓	-
Income			
≤100%	✓	n/a	-
101-200%	-	n/a	-
≥201%	-	n/a	-
Housing Status			
Stable/Permanent	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 were 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 2015 a total of 2,844 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 below. 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.



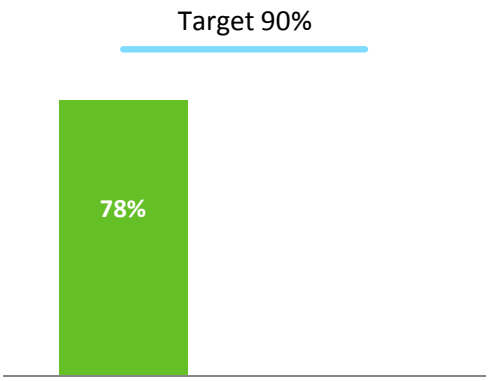
The following sections include, by service category, a profile of clients who have accessed HIV care services, their medical outcomes as well as service-specific outcomes. An outcome is a change that is expected to take place as a result of involvement or participation. In this instance, an outcome is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

TGA Medical Engagement and Viral Load 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 and maintained or improved health status 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.

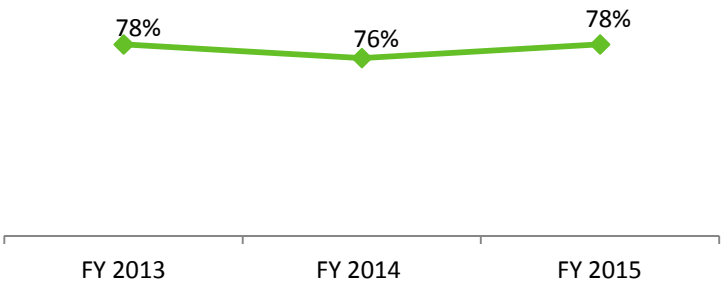
Percentage of Part A Clients Medically Engaged



During FY 2015 a total of 1,645 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, 1,283 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 2015 was 78%, below the TGA benchmark of a 90% rate of engagement.

For FY 2015, an engagement percentage of 90% would translate into 1,481 clients with a medical service in the second half of the year, which is a 198 increase from the actual number of clients engaged (1,283). The 90% benchmark target is one established by the TGA four 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. A comparison across the past three years shows that Medical Engagement is relatively stable.

Percentage of Clients That Are Medically Engaged FY 2013 - 2015



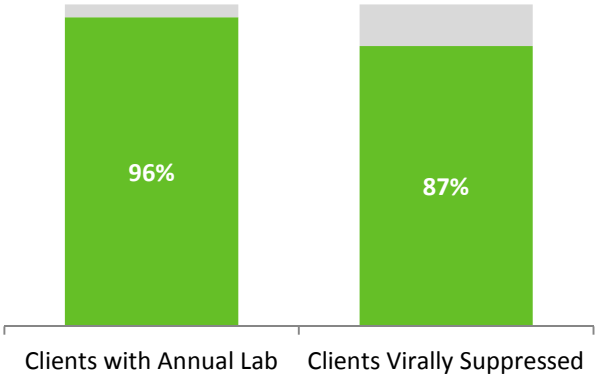
In an effort to understand why this rate for the Portland TGA is lower than the benchmark, there has been discussion around the need or lack of need for clients who are virally suppressed to visit a medical provider more than once a year. Engagement in medical care

cannot be diminished, as it often vital toward the goal of achieving and maintaining viral suppression. In 2016, HCS has gained access to client-level viral load data and additional analysis around the health outcomes of clients was performed.

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 less than 200 copies is the definition of viral suppression. The following analysis will attempt to shed light on the following questions: 1) How many clients are having their viral load measured annually? 2) What is the viral suppression rate of clients? 3) Are certain clients less likely to be virally suppressed? 4) What is the viral suppression rate of those clients medically engaged?

During CY 2015, a total of 2,605 Part A clients were included in the measurement of clients who may have received an annual viral load lab test, due to the fact that these clients were able to be matched between two data systems, CAREWare and ORPHEUS (the Oregon Public Health Epidemiology User System), or viral load lab results were directly reported in CAREWare. Of these clients, 96% had a viral load test in the past 15 months.* Of the clients who had a viral load test result (n=2,501 clients), 87% of clients were virally suppressed at their last lab test.

Part A Clients with Annual Lab and Virally Suppressed



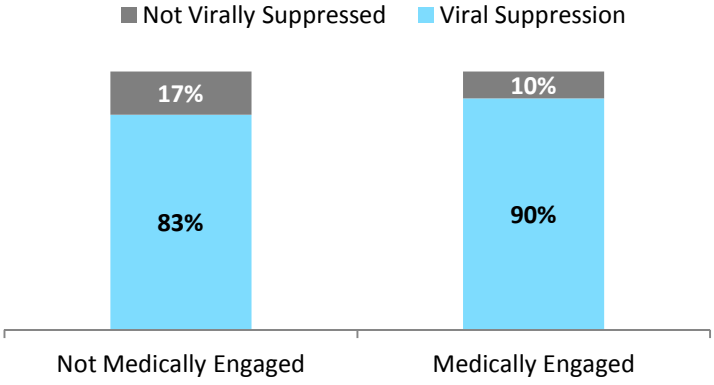
When comparing Part A virally suppressed clients with those who were *not* suppressed, Part A clients *not* suppressed were more likely to be:

- Unstably or temporarily housed
- Below 100% of the federal poverty level

No demographic differences were found when comparing Part A clients who had a viral load lab test and those who did not have a test.

Both medical engagement and viral suppression data were available for 1,581 Part A clients. When examining if clients who

Medically Engagement Clients by Viral Suppression*



**A 15 month timeframe was used to pull baseline viral load data to ensure viral load tests could be examined for Part A clients receiving services only in the beginning of CY 2015.*

were medically engaged were virally suppressed, 90% were also virally suppressed; of the clients not engaged, 83% 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 and virally suppressed with those who were not, the latter clients were more likely to be:

- Unstably or temporarily housed
- Below 100% of the federal poverty level

We have examined the combined analysis of Part A client medical engagement, viral load and annual viral load testing to determine the extent to which the Ryan White system of care in the Portland TGA is supporting Part A client health outcomes. While the majority of clients are in contact with the medical care system as demonstrated by the percent receiving annual viral load testing (96%) and have favorable health outcomes (87% of clients virally suppressed), client maintenance in medical care remains below target (78% versus 90%). As clients who are medically engaged are more likely to be virally suppressed (90% versus 83%), increasing the number of clients who are engaged in medical care remains a salient goal for the Portland TGA.

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).

Over the past three years there has been a non-linear trend in the number of clients who received Part A Medical Care. From FY 2013 to FY 2015 there was a 14% decrease, from 1,536 clients served in FY 2013 to 1,300 served in FY 2015. This non-linear trend is markedly similar to the trend also displayed in Ryan White medical care funding. Over the same period of time (FY 2013-2015), Ryan White allocations for this service category

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.

Medical Care Clients, FY 2013-2015

FY 2013 FY 2014 FY2015

decreased by a similar percentage; 13%. While there is not always a positive correlation between an increase in funding and an increase in clients served, this pattern over the past 3 years might suggest that a decrease in funding might be directly impacting the number of clients served by medical care funded by the Ryan White program.

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
- Publicly insured
- Under 100% of the federal poverty level
- Non-White

Similar to the trend in Medical Care clients and Ryan White medical care allocations, medical care visits have also followed a similar non-linear trend during the past three years; visits have decreased by 13%. During FY 2015, a total of 1,300 clients received a total of 6,430 medical care visits; a Medical Care client received an average of 4.9 visits during the past year. In FY 2014 this average was 5.1 and in FY 2013 this average was 4.8. 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.

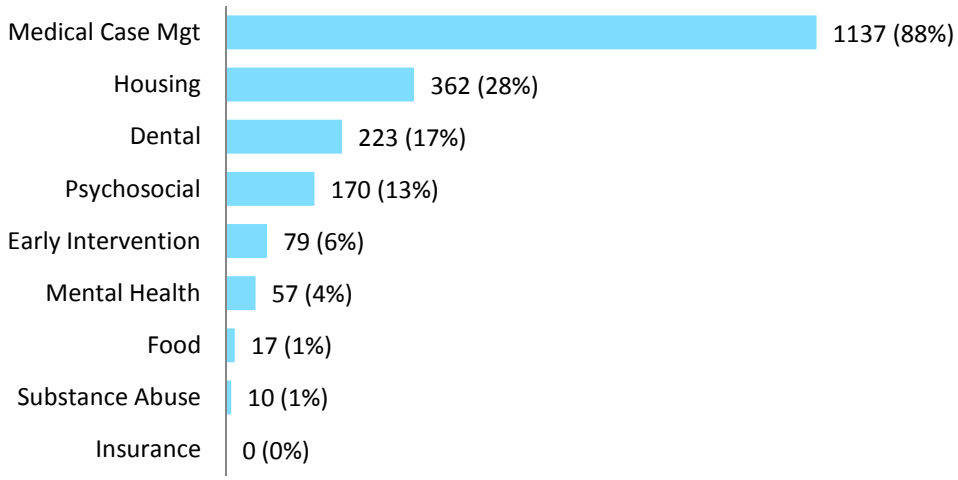
Many of our patients are long term survivors. The medical teams address individual needs and issues as they arise. We hope our services and new programs will help this population and others to manage stress, decrease isolation, and positively impact their engagement in HIV care.

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

- Residents of Multnomah County
- Non-MSM as a reported risk factor
- Under 100% of the federal poverty level

Most clients who received Part A Medical Care (88%) also received Medical Case Management (MCM). The only Part A medical contractor also receives medical case management funds. It is therefore apparent why this percentage of client overlap between the two services is high. Approximately one-fourth (28%) of Medical Care clients also received Housing Services and 17% also received Dental Services. Lastly, a total of 1,179 (91%) of Part A Medical Care clients also received at least one other Part A service.

Number of Medical Care Clients by Service Category

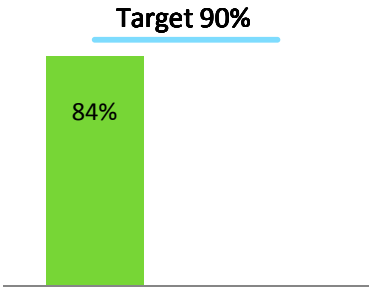


Outcomes

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 84%; out of 1,300 medical care clients, 1,036 received at least one medical care visit within the first six months of FY 2015 and were thus counted in the denominator. Of the clients in the denominator (n=1,036), 868 also received a medical care visit within the last six months of FY 2015 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 (1,300 medical clients, 1,036 counted in the calculation; which leaves 264 clients).

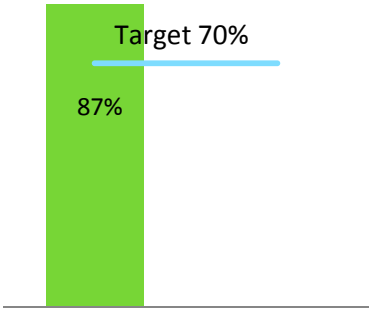
Percentage of Medical Care Clients Medically Engaged



Engagement in medical care is important as it is often vital toward the goal of achieving and maintaining viral suppression. Both the percentage of clients engaged in medical care and the percentage of clients whose last viral load lab was below 200 copies (<200 copies = viral suppression) were similar; 84% medically

engaged and 87% virally suppressed. Both of these percentages are an indication that medical engagement and viral suppression are inter-related; high medical engagement might yield a high percentage of those virally suppressed. It is also a testament to the evidence that Ryan White funded medical care clients are not only engaged but are showing very positive health outcomes which are not only important to the quality of life of the people being served but is also vital to reducing the transmission rate in our community.

Percentage of Medical Care Clients with VL Suppression



Viral suppression is an outcome that 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, 87% of all clients who had a recorded viral load lab were virally suppressed. The rate of viral suppression has stayed relatively consistent across the last three years; in FY 2013 the rate was 85% as it was in FY 2014 as well.

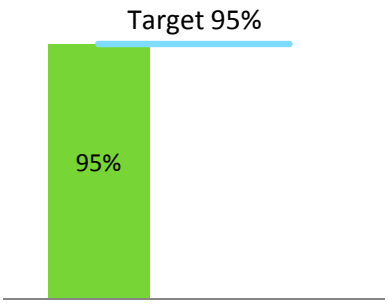
When comparing Part A Medical Care virally suppressed clients with those who were *not* suppressed, Part A Medical Care clients *not* suppressed were more likely to be:

- Multnomah county residents
- Unstably housed
- Between the ages of 25 and 44
- 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.

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 95% for all clients who receive Part A medical care. Syphilis screening rates have been in the 90th percentile during the past four years; a testament to the systemic processes in place to assure clients are screened.

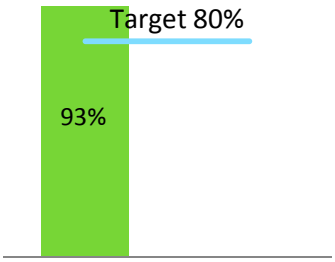
Percentage of Medical Care Clients with a Syphilis Screen



Tuberculosis cases have been declining since 1992. Most recent national co-infection rates with HIV were 8.6. Despite a decrease in reported TB cases, the disease remains a serious threat,

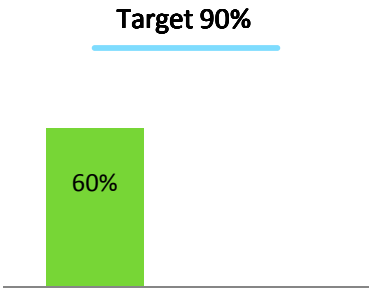
especially for people living with HIV/AIDS because TB infection and HIV infection can work together to make an individual very sick. Worldwide, TB is the leading cause of death among people living with HIV. Similar to the syphilis screening rate, Medical Care clients were also screened for TB at the 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. However, in October of 2015 the Opportunistic Infection Guidelines provided updated cervical cancer screening recommendations for women living with HIV. The guidelines call for a more measured approach which takes into consideration a woman's age, onset of sexual activity, results of previous Pap smears and other factors. Given this shift in guidelines, from one that recommended an annual cervical cancer screening for all female at birth clients to one that only recommends an annual screening under certain circumstances, the results of this outcome should be viewed as informational and not indicative of any sort of shortcoming. It is also worth noting that the rate of annual Pap smears has increased from 51% in FY 2014 to 60% in FY 2015, where a total of 86 our 144 female at birth clients had an Pap smear within the FY.

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 FY 2014, new systemic changes were reported, and the ACA continues to impact clients and services provided.

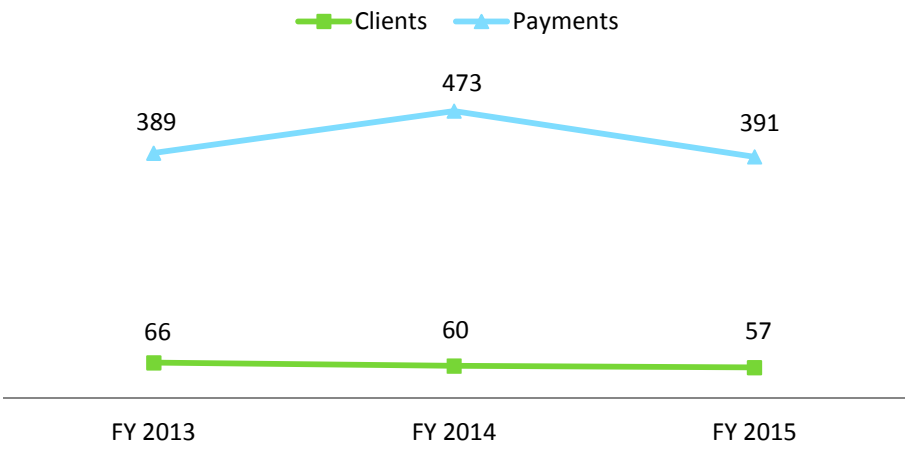
Health Insurance Description

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.

Case managers are able to meet clients in their home. Recently a new client was very ill, and the case manager was able to go to his home and enroll him in insurance so he could access affordable HIV medications. Today the person is on meds and back to work.

During FY 2015, a total of 57 clients or 2% of the total number of Part A clients served received at least one Health Insurance service. The number of Health Insurance clients has decreased by 14% from FY 2013 to FY 2015. Although the number of clients has decreased, the number of Health insurance payments, from FY 2013 to FY 2015 has fluctuated by less than 1%.

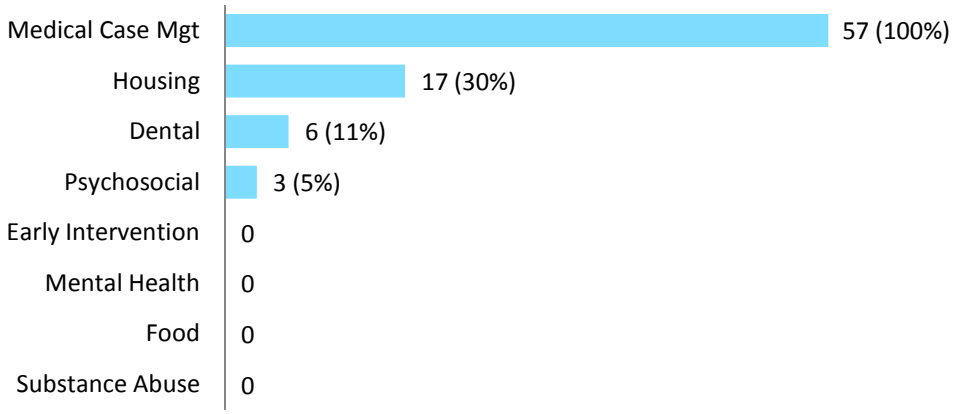
Number of Health Insurance Clients and Payments, FY 2013-2015



These Health insurance payments can be broken down into two general categories: co-payments and deductibles. Approximately 386 payments, or 99% were made toward co-pays and <1% deductibles. During the past 3 years, Health insurance co-payments have not only represented the majority of payments made, but have stayed relatively stable in number, whereas the number of deductible payments has decreased.

Allocations for this service category have decreased by 28% from FY 2013 to FY 2015. With a decrease which is disproportionate when compared to the decrease in number of payments over the same time period, this would suggest that providing fewer deductible Health insurance payments (perhaps due to the change in the health coverage landscape where deductible coverage is no longer a need) allows the program to provide a sustainable group of clients access to health insurance co-payments.

Number of Health Insurance Clients by Service Category

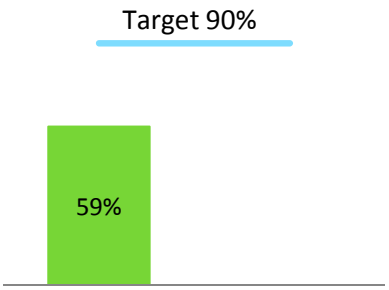


All clients who received Health Insurance payments also received Medical Case Management services, which is the only instance in which all clients who received a particular service also received an additional Part A service. A total of 30% of clients who received Health Insurance payments also received Housing services and 11% received Dental services.

Outcomes

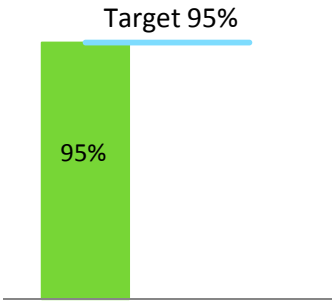
Outcomes measured for this service category include: medical engagement and lapse in insurance coverage.

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 78%. The low medical engagement rate was likely impacted by incomplete data provided by the contractor providing this service. To what extent this low rate can be attributed to poor data quality, is unknown at the writing of this report.

Percentage of Health Insruance Clients with No Lapse in Coverage



Out of 57 clients, 54 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.

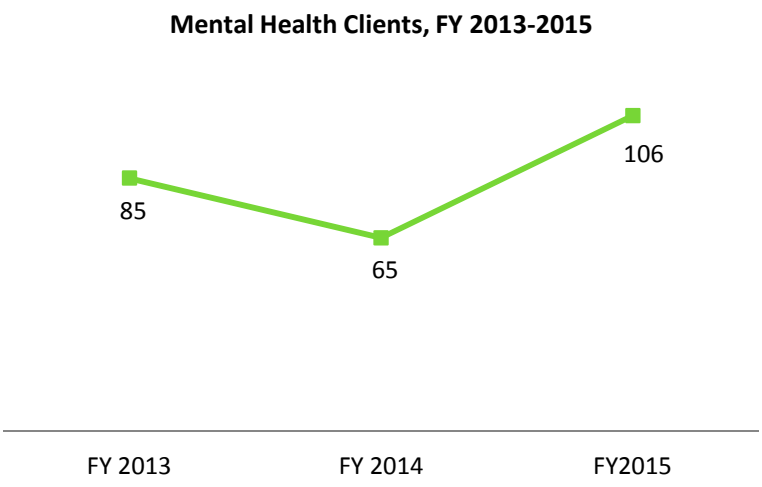
Mental Health

Mental health issues are very common amongst all Americans, not just those living with HIV. In 2014, there were an estimated 43.6 million adults aged 18 or older in the United States with any mental illness in the past year. This number represented 18.1% of all U.S. adults.

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.

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 specialists support engagement and support for clients accessing professional mental health services.

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.



During FY 2015, a total of 106 individuals received Mental Health services; this represents 3.7% of the total number of Part A clients served. Of these 106 clients, 15 received therapy services and 91 received peer support services. Over the past three years, as the Mental Health Peer program has been further developed and enhanced there existed a drop in FY 2014 in the number of clients served. Since then the Peer program has made tremendous strides toward serving the need for MH peers in the community.

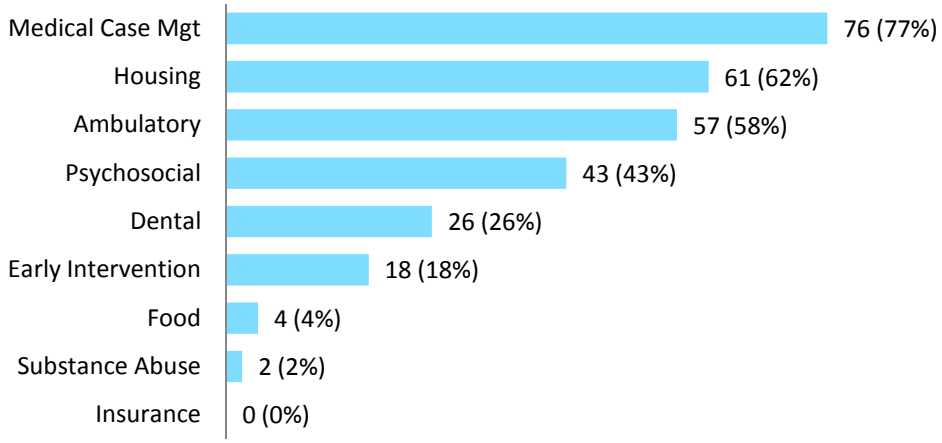
When comparing Part A clients who received Mental Health Care services with those who did not, Part A Mental Health clients were more likely to be:

- Transgender
- Multnomah County residents
- Under 100% of the federal poverty level
- Publicly insured
- Unstably housed

During FY 2015, 52 therapy hours were provided to 15 clients. Therefore the average number of hours provided to clients was 3.5 hours. A total of 1,578 peer hours were provided to 91 clients, for an average of 17.3 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. In terms of the trends over time, in FY 2014 the number of mental health therapy clients was 28, in FY 2015 the number served was about half of that number. Despite this decrease in mental health therapy clients, due to the changing landscape of insurance coverage for mental health therapy, the mental health peer program has experienced a tremendous increase in participation. A total of 91 clients received peer services, compared with 39 in FY 2014.

Peers have begun to play an increasing role to coordinate and consolidate care for PLWH, particularly those with dual diagnoses. Offering holistic, person-centered wrap-around care, our peers often function as a bridge between mental health and addictions programs.

Number of Mental Health Clients by Service Category

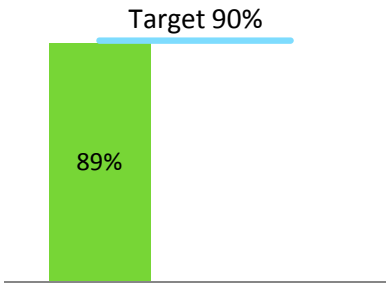


Of the 106 clients who received Mental Health Services, 93 or 88% also received at least one other Part A service. Over three-fourths of these Mental Health clients also received Medical Case Management (77%).

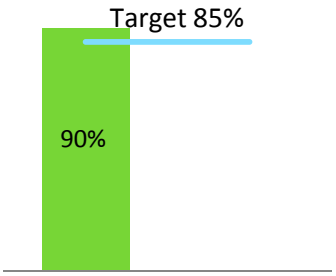
Outcomes

The medical engagement rate across all mental health clients (89%) is the highest rate across all service categories. 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. The benchmark target for this outcome (85%) was exceeded (90%).

Percentage of Mental Health Clients Medically Engaged



Percentage of Mental Health Clients with Improved/Stable Profiles



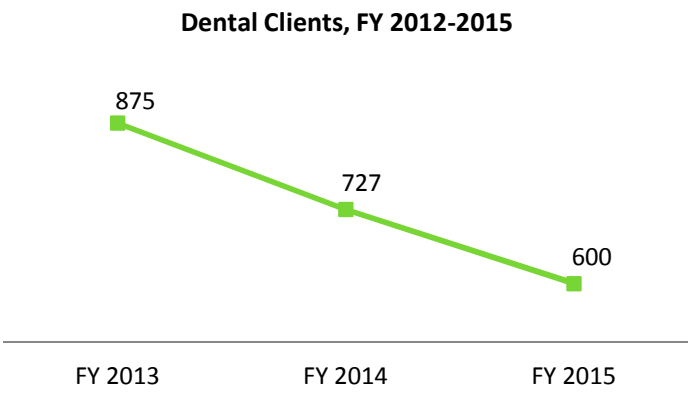
Dental Care

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 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.

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.

During FY 2015, a total of 600 clients received at least one Dental Care service from a Part A funded provider. This represents approximately one-fifth (21%) of all clients who received Part A services. Over the past three years, the number of individuals who received Part A Dental services has decreased. When comparing the number of Dental Care clients in FY 2014 with clients who accessed Dental Care in FY 2015, there was a 21% decrease. This may be due to increased oral health coverage through Medicaid in both Washington and Oregon. In FY 2013, 30% of all Part A Clients received Dental Care from a Part A provider, which suggests both the number and proportion of clients receiving dental care has decreased.



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:

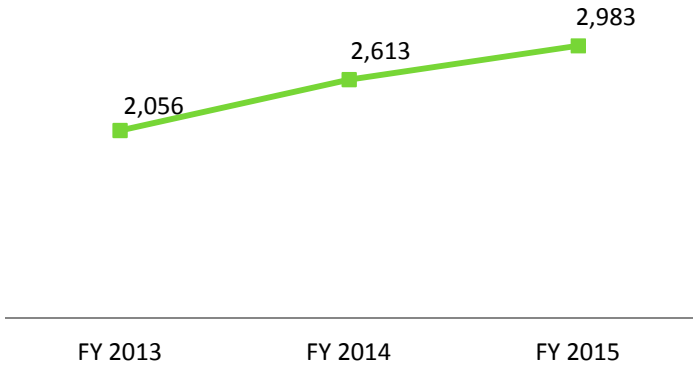
- Male
- White
- Multnomah County residents
- 45 and older
- MSM as a reported risk factor
- Stably housed
- Not insured, publicly insured or other insurance (i.e. VA, Tricare, military)
- Over 100% of the federal poverty level

The ACA and additional ADAP coverage for Part A patients has allowed Part A programs to continue basic dental services as well as services beyond the scope of Medicaid such as more periodic preventative appointments, advanced periodontal maintenance, prosthetic, endodontic, and surgical procedures.

When the quantity of Dental Care measured in number of visits is considered, quite a different trend emerges. In FY 2013, Part A clients received a total of 2,056 dental visits, in FY 2015 this number increased to 2,983, which is a 45% increase in the number of dental services provided over the past three years.

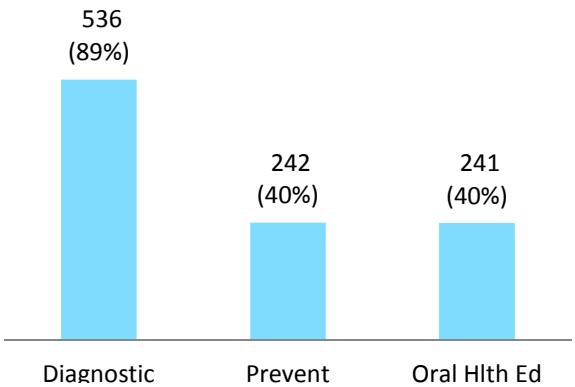
Viewed together, the decrease in the number of clients served and the marked increase in the number of dental visits provided yields a higher rate of visits provided to dental clients over time. In FY 2013, a Dental Care client visited a dentist on average 2.3 times. In FY 2014, a total of 2,983 visits were provided to 600 Dental Care clients; an average of 5 visits per client.

Dental Visits, FY 2013-2015



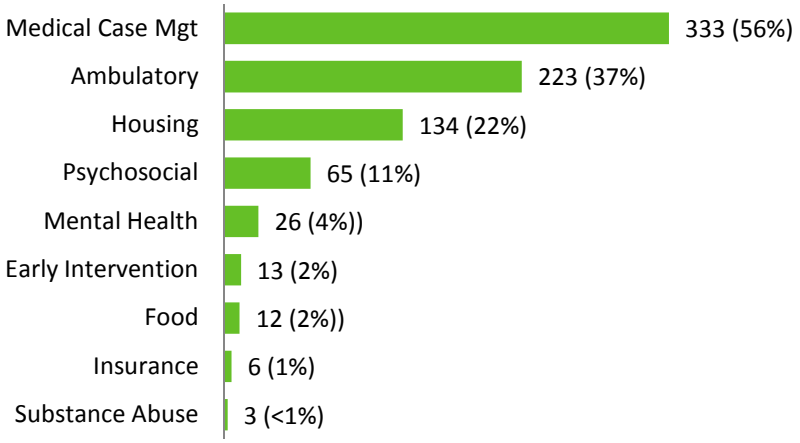
A total of 15 general categories of Dental Care are allowable by Part A funds. The top three most utilized dental care services were Diagnostic Procedure, Preventive Procedure and Oral Health Education/Health Promotion. 89% of all Dental clients received at least one Diagnostic Procedure, 40% received at least one Preventive Procedure and 45% received at least one Education service. 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.

Dental Clients by Dental Service Type



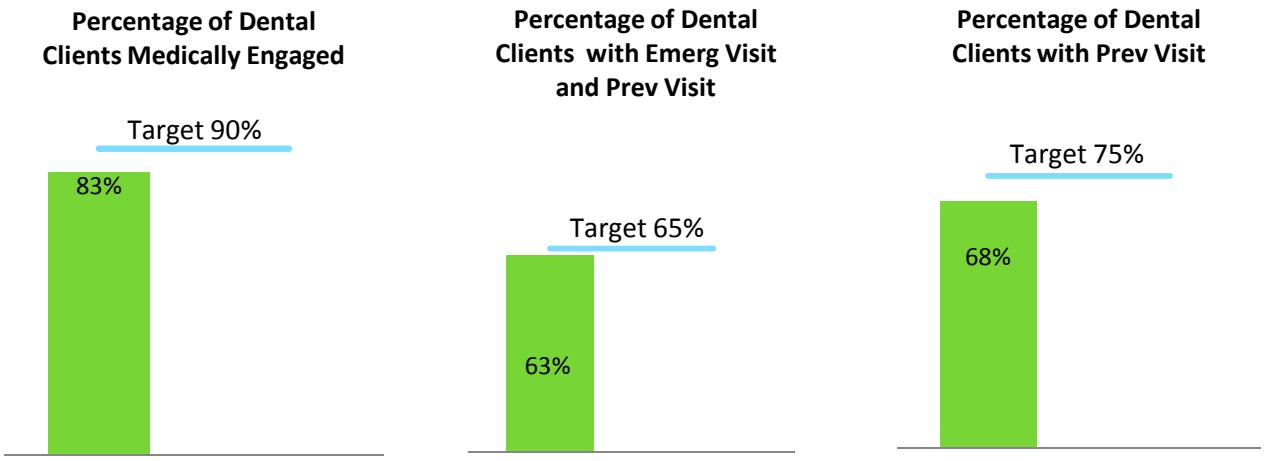
Dental Care clients also received services from other providers within the Part A continuum of care. A total of 464 Dental Care clients (64%) received at least one other non-Dental Care service from a Part A provider. Over half (56%) of all Part A Dental Care clients received MCM services, 37% also received Medical Care and 22% also received Housing Services. Lastly, of the 600 individuals who received Dental Care services, 397 (66%) also received at least 1 additional Part A funded service.

Number of Dental Clients by Service Category



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 (83%), compared with the overall medical engagement outcome across the TGA (78%).

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

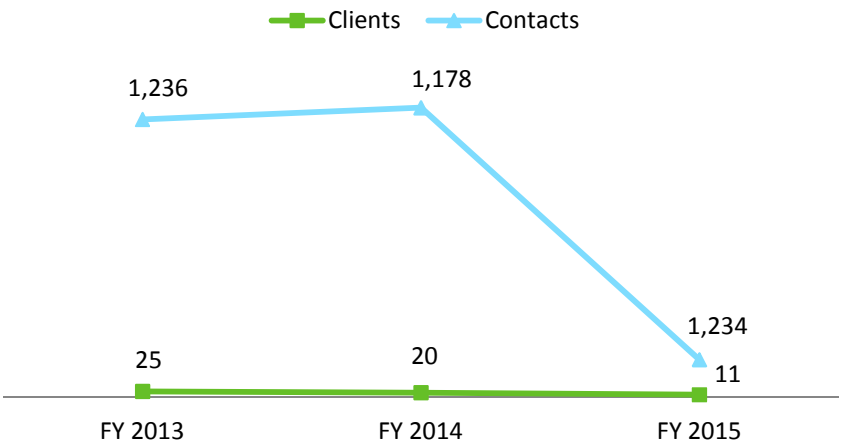
Substance abuse is associated with poor health outcomes for people living with HIV and can speed up the progression of the HIV disease. Drugs and alcohol can also impede the ability to plan, make good decisions and adhere to a medication regimen. Some individuals who experience substance abuse issues 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 provided services during the first quarter of the fiscal year. The sole substance abuse subcontractor ended their contract. Funding this fiscal year was primarily to transition clients to other substance abuse programs and close out the program.

During FY 2015 a total of 11 clients received outpatient substance abuse treatment. The number of clients and contacts represent three months of services only. Because the number of clients served in this service category was relatively small, tests of significance were not performed.

Number of Substance Abuse Clients and Contacts, FY 2013-2015

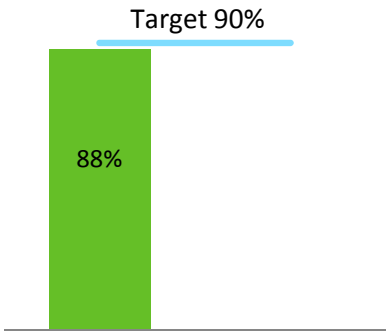


Clients engaged with Substance Abuse services were also housed in substance free units, thus, 100% of all Substance Abuse clients also received Housing Services. As sited in the Housing Services section, all clients were transitioned to another housing provider and were able to remain in substance free housing. No one was displaced as a result of the transition.

Outcomes

Substance abuse treatment programs have traditionally reported on the successful completion of substance abuse treatment. Because funding was primarily to close out the program, this outcome was not monitored.

Percentage of Substance Abuse Clients Medically Engaged



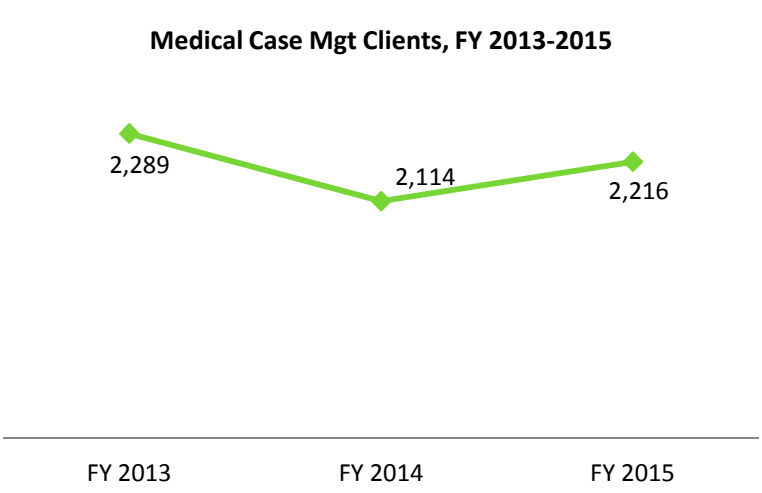
The medical engagement outcome for Substance Abuse Treatment clients (88% engaged) was well above the TGA overall rate (78%), but again falling short of the benchmark target of 90%.

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 2015, approximately three-quarters (74%) 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 2013, 78% of all Part A clients received MCM contrasted with 74% in FY 2014. The decrease in percentage of clients who utilize MCM services during the past three years was 3%.

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:

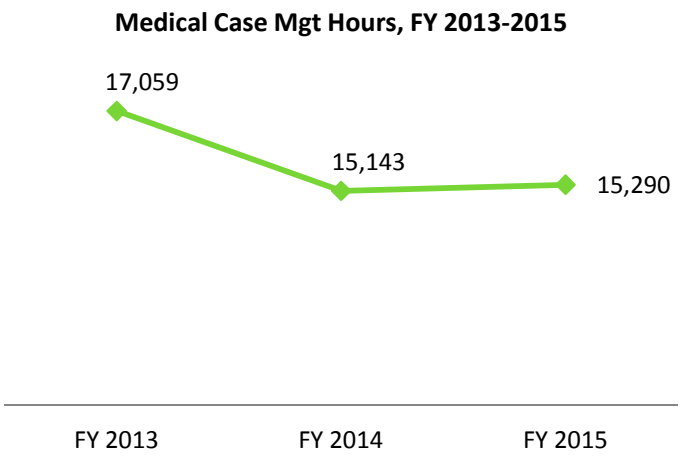
- Non-White
- Between the ages of 25 and 44
- Living outside of Multnomah County

MAI clients face daily challenges that make it hard to balance managing their health and daily needs. One of the major barriers that MAI navigators deal with is the lack of resources for clients. As advocates, they work to help clients meet these basic needs and often times find themselves going above and beyond to do so.

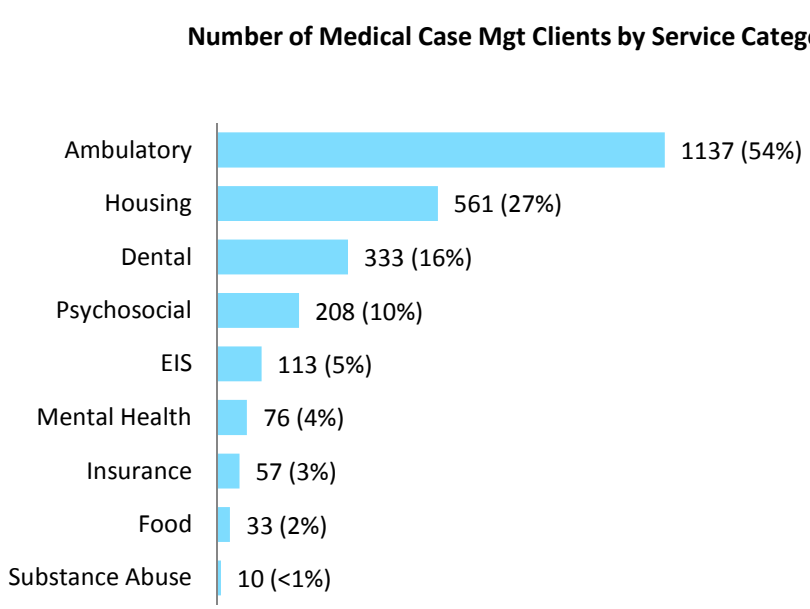
- Stably housed
- Private insurance

MCM services are quantified by the amount of time staff records working with or on behalf of a client. A total of 15,290 MCM hours were provided to 2,216 clients over FY 2015. The range of time spent with an individual client ranged between 15 minutes and 174 hours. On average, a Part A MCM client received approximately six hours of MCM services during the year.

The total number of MCM hours delivered during FY 2015 represents a decrease in the number of hours delivered over the past three years. The percentage decrease in hours over this time frame was 10%, outpacing the percentage decrease (3%) in clients over the same time period. During FY 2015, the average was six hours and 54 minutes; in FY 2013 the average was seven hours and 27 minutes, a negligible difference. This percentage outpace suggests that on average clients are receiving less case management services compared with years previous. A potential explanation of this trend involves 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.



Many MCM clients also received other services from the Part A continuum. In fact, 74% 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 561 MCM clients (27%) also received Housing Services which points to the demand for housing services within the TGA and also speaks to the coordination of services between contractors.

Minority AIDS Initiative

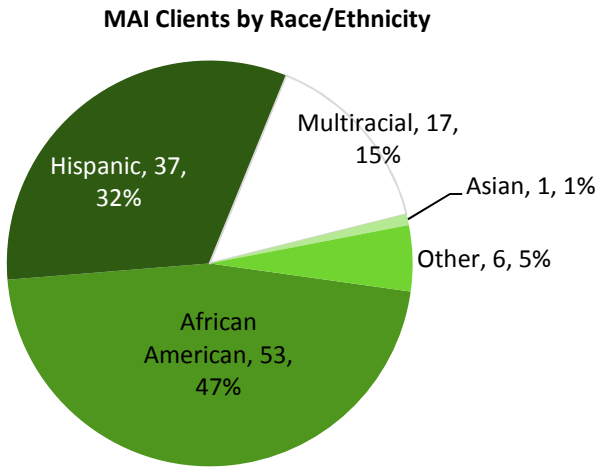
As stated earlier, Minority AIDS Initiative MAI MCM service provision was included in the account of clients and MCM services provided. What follows is a brief account of these MAI MCM clients and services extracted and separated from the overall analysis of MCM to better understand how MAI funding was used during FY 2015.

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 114 clients received MAI MCM services during FY 2015; this represents 5% 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.

Although, a small proportion of MCM clients receive MAI-specific services, the number of MAI clients has grown by 90% over the past 3 years; the largest growth over all service categories. In FY 2013 60 MAI clients were served, in FY 2014 that number rose to 67 and then in FY 2015 that number grew further to 114.

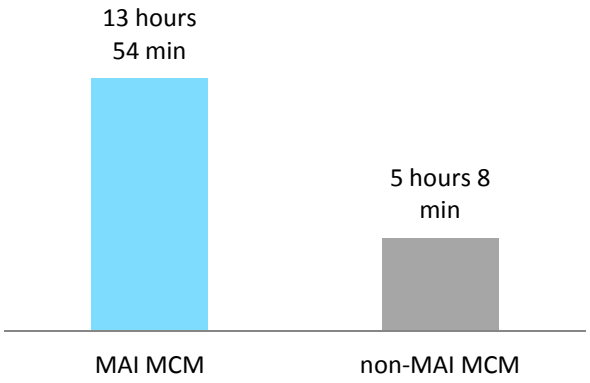
Almost one-third of the clients who received MAI MCM were Latino/Hispanic (32%) and almost one-half of the clients were African American (47%). This demographic breakdown across the two largest racial/ethnic categories has changed since last year. In FY 2014 Latino/Hispanic MAI MCM clients represented a larger percentage of clients (48%) and African American MAI MCM clients represented a smaller percentage of clients (36%). This points to an increase in the percentage



and number of African American MAI clients served and a slight increase in the number of Latino/Hispanic clients served. The number of African American clients served in FY 2014 was 24, this number more than doubled to 53 clients in FY 2015. The number of Latino/Hispanic clients served in FY 2014 was 32, this number rose slightly to 37 clients in FY 2015.

One hundred and fourteen MAI MCM clients received a total of 1,583 hours of MAI MCM services. The average number of hours a MAI Medical Case Manager spends with a client is approximately 14 hours. As reported earlier in this section, the average number of hours a Medical Case Manager spends with a client was seven and a half hours. This average decreases slightly with the removal of MAI MCM hours from the calculation from seven and a half hours to five hours and 8 minutes. This comparison provides a lucid picture of the time intensive nature of MAI MCM.

Average Number of Hours Spent with Clients

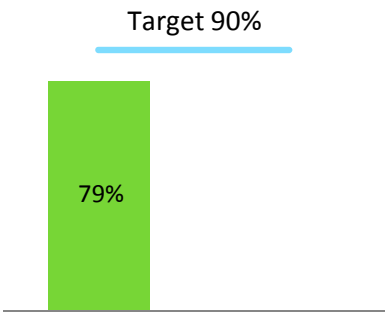


Outcomes

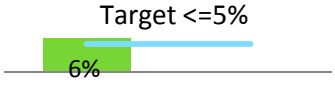
Outcomes measured for the MCM category include: medical engagement and lost to follow up. The definition of 'engagement in medical care' can be found in a prior section located on page 15.

Medical engagement for those clients who received MCM was slightly higher (79%) compared with the overall medical engagement outcome across the TGA (78%). 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 2015, 6% 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 services 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
Assistance linking 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.

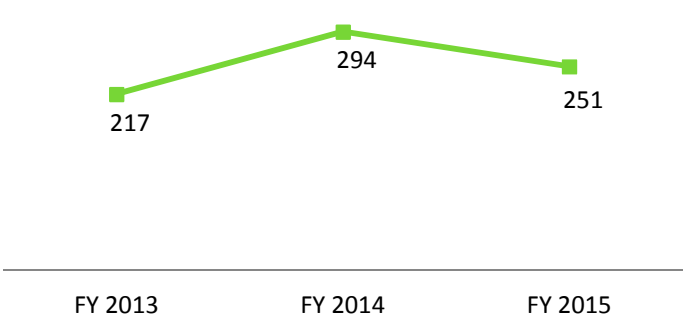
Early intervention services (EIS) in the Portland TGA are defined as support provided to clients who are not in care through planning, linkage, monitoring and advocacy. Service providers collaborate with prevention and disease investigation services to identify people who are living with HIV but unaware 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 beginning in FY 2014. During FY 2015, a total of 1,566 HIV tests were offered and 661 HIV tests were conducted by a Community Health Worker who is based in the jail. No preliminary positive tests were discovered. After a 2 year pilot period (FY2014 and FY 2015) no positive tests were yielded and therefore it was decided that Ryan White Part A funds would no longer be used to support this program.

EIS staff strengthened relationships with the state prison's HIV services and release counselors. EIS staff can work towards housing and medical care planning often up to six months prior to an individual being released from prison. The goal is to support people in their transition process in hopes of stabilizing their engagement in medical care once back in the community.

Linkage to care EIS services were provided to a total of 251 clients during FY 2015. This number has fluctuated over the past three years. In FY 2014, there was 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 clients served goal by 232%.

Early Intervention Clients, FY 2013-2015



When comparing Part A clients who received Early Intervention services with those who did not,

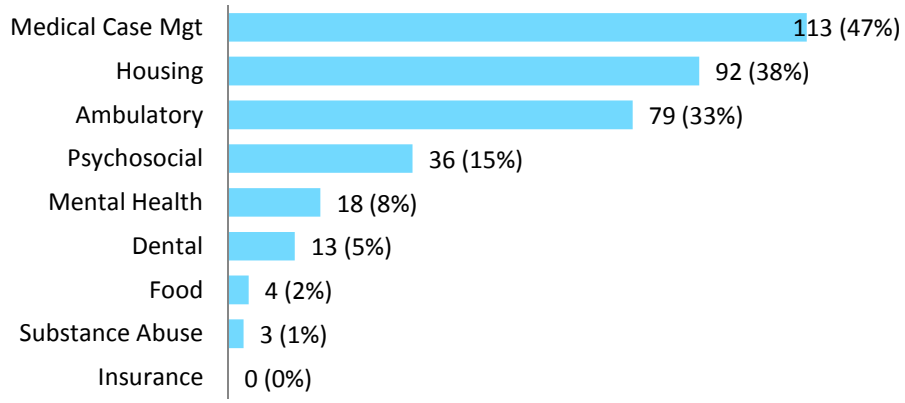
Part A Early Intervention clients (not including people tested for HIV in jail) were more likely to be:

- Multnomah County residents
- Between the ages of 13 and 44 years
- Male
- Men who have sex with men
- Not insured
- 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. FY 2014 was the first time EIS services across all contractors (excluding the HIV testing program) were measured in units of hours. Therefore, a comparison over a three year time span cannot be executed until future years of data are collected. In FY 2014 a total of 1,377 EIS service hours were provided to 312 clients. An EIS client received an average of four hours and 40 minutes of EIS services. In FY 2015 a total of 1,083 EIS service hours were provided to 251 clients. The average number of EIS service hours was almost the same compared with FY 2014, the average number of hours in FY 2015 was four hours and 18 minutes.

At some point during the fiscal year, more than half of all EIS clients (54%) 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.

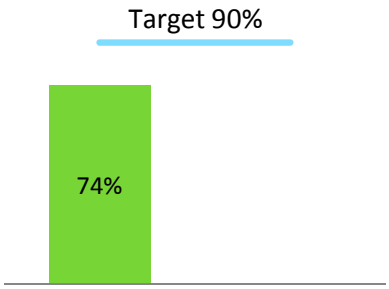
Number of Early Intervention Clients by Service Category



Outcomes

EIS services are also 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

Percentage of Early Intervention Clients Medically Engaged in 90 days



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.

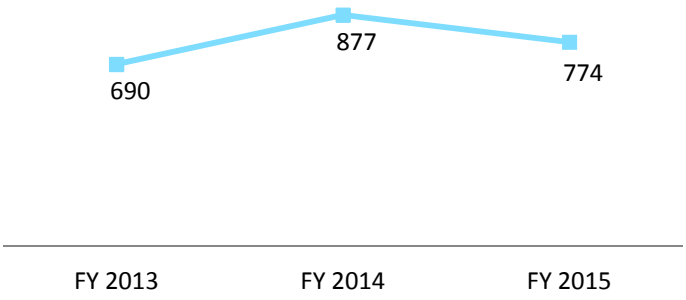
Housing Services

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.

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 options are also available.

Unlike many of the other Part A services, a steady growth of clients have received Housing Services over the past three years. During FY 2015, a total of 774 clients received Part A Housing Services. This total number of clients represents 27% of all clients who received Part A services during this time frame; third only to ambulatory care and medical case management.

Housing Clients, FY 2013-2015



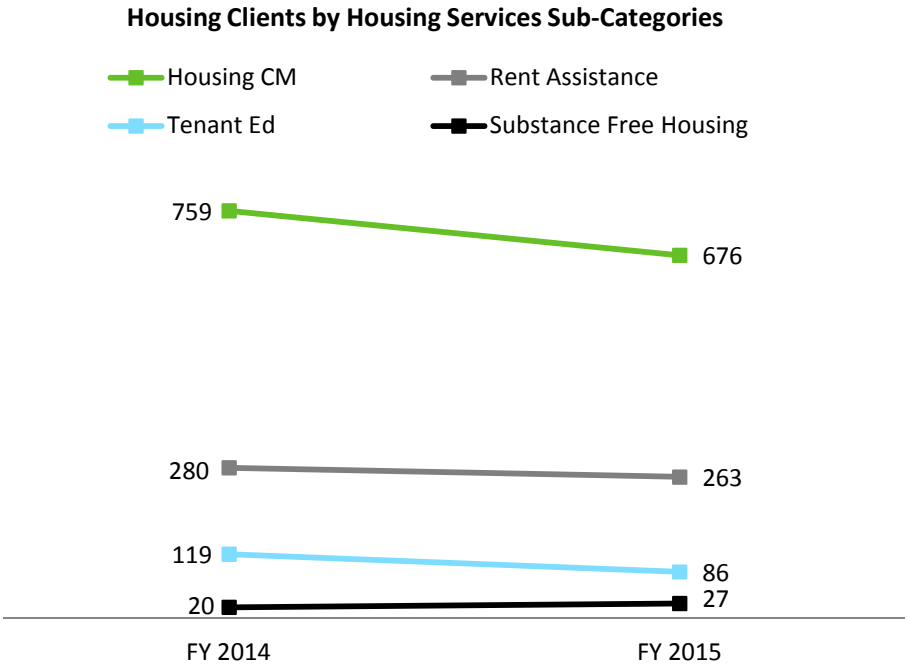
When comparing Part A clients who received Housing Services with those who did not, Part A Housing clients were more likely to be:

- Multnomah County residents
- Non-white
- Between ages of 25 and 44

- Non-MSM
- Temporary or unstably housed
- Publicly insured
- Under 100% of the federal poverty level

Rent assistance and case management support [has been provided] since May of 2015. Since that time this client was able to increase his income through employment and, during this reporting period, his wife was also able to find employment. With both of them working they now have sufficient income to cover their full rent and no longer need financial assistance from CAP.

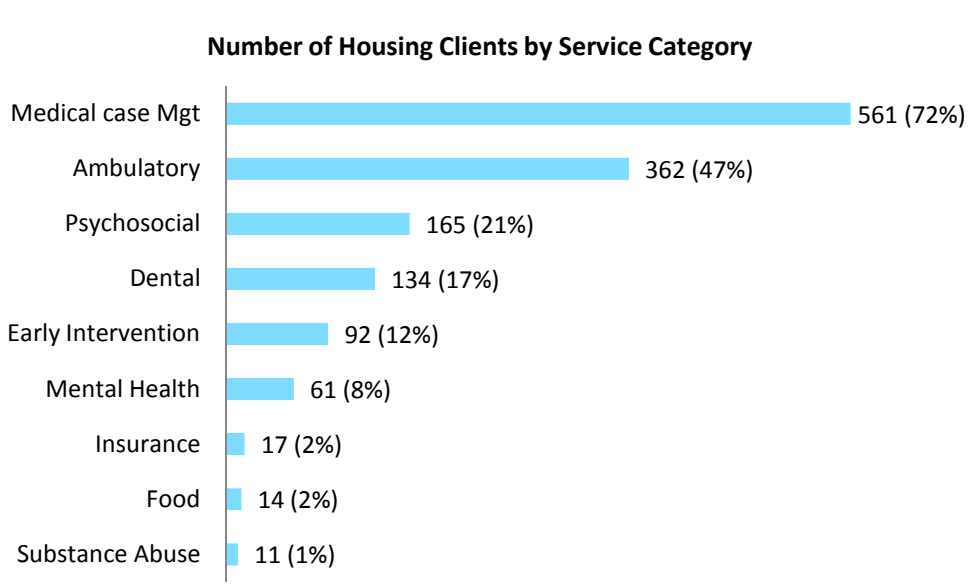
Housing clients received a variety of housing services during FY 2015. These services can be divided into four housing sub-categories. The majority of housing clients received housing case management, which is designed to help a client navigate the housing market, develop a plan to reduce barriers and support a client's effort to secure short-term, long-term or emergency rental assistance. A total of 676 clients received housing case management, which represents 87% 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 (34%) 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 11% of the total number of housing clients served. Finally, a small portion of housing clients (3%) were provided with alcohol and drug free housing based on qualifying factors.



Between 2012-2014, there was a 43% increase in number of clients served and 105% increase in service hours. The increase in housing services was primarily within the housing case management sub category. However, in 2015, the number of clients decreased by 103 clients, but the number of service hours increased by 1,260 (137%). This decrease in clients and increase in hours suggests staff are spending more time with individual clients. Fewer clients served does not seem to be based on the need for housing as housing is regularly cited as an

unmet need. Multnomah County and the City of Portland have declared a housing state of emergency. Housing service providers express challenges such as not having access to affordable units, increased rents, and few options for people with multiple housing barriers such as criminal histories, past evictions, or poor credit.

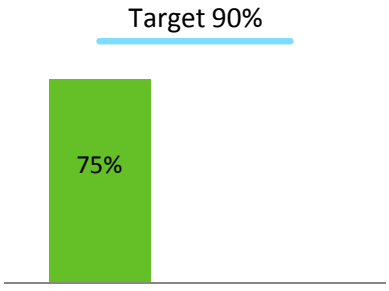
A total of 643 out of 774 or 83% of all Housing clients also receive services from other Part A providers. This is the highest percentage across all service categories and points to the fact that Housing clients are in need of and utilize a wide range of Part A funded services in the TGA continuum. The most prevalent service Housing clients accessed was Medical Case Management, followed by Medical, Psychosocial and Dental.



Outcomes

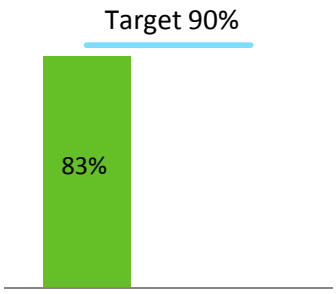
Housing is a support service that helps clients stay in medical care, adhere to a medication regimen, and contributes to viral suppression. For clients who receive housing support, medical engagement as well as housing status after program exit is assessed.

Percentage of Housing Clients Medically Engaged



Medical engagement for Housing clients was slightly lower (75%) compared with the overall medical engagement outcome for the TGA (78%). 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 or virally suppressed 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. 83% of all rental payment assistance housing clients reported stable housing six months after last service. This outcome represents a decrease from FY 2015, where the percentage for this outcome was 86%.

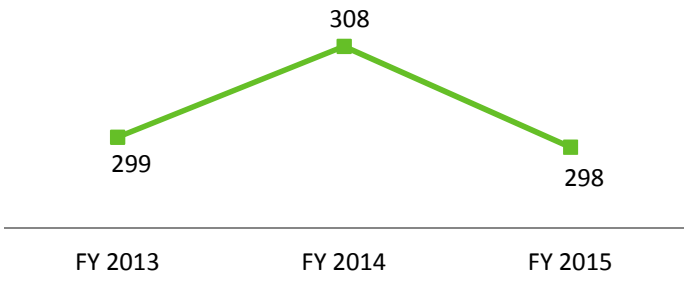
Psychosocial Support Services

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 and historically underserved populations – clients who are homeless, clients with multiple diagnoses, and racial and ethnic minorities.

During FY 2014, a total of 298 individuals received psychosocial services from a Part A contractor. This represents 10.5% of the overall number of clients who received Part A services.

Psychosocial Clients, FY 2013-2015



The number of clients served over the past three years has slightly fluctuated. Over this time frame there was a small decrease in Psychosocial clients; a 3% decrease from 308 to 298.

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

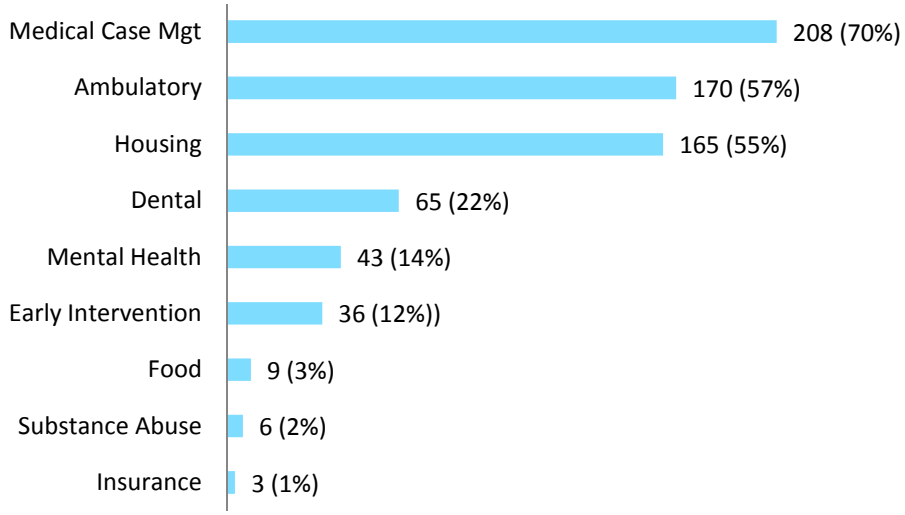
- Female
- Multnomah County residents
- Non-white
- Non-MSM
- Publicly insured
- Under 12 years old
- Under 100% of the federal poverty level

Over the past 3 years, we have worked to make sure our [psychosocial] programming is qualitatively sounds and based firmly on the needs of the client.

- Unstably housed

As outlined in the psychosocial service description, these services are targeted toward women and historically underserved populations of people. In previous years, psychosocial services were also targeted towards youth and family support, but funding ended due to a shift in leveraged Ryan White Part D funding. 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.

Four general types of Psychosocial Support Services were provided: women's group services, peer support, center visits, and center meals. During the past three years, women group contacts have steadily decreased. Program staff contribute this to people being forced to live further outside of the Portland city center and transportation to and from groups is a challenge both for cost and commute time. More women receive individual support from program staff or peers either via phone conversations or home visits. Center contacts and center meals have decreased by 12% and women's group contacts have decreased by 21% although service category funding was increased by 5%.

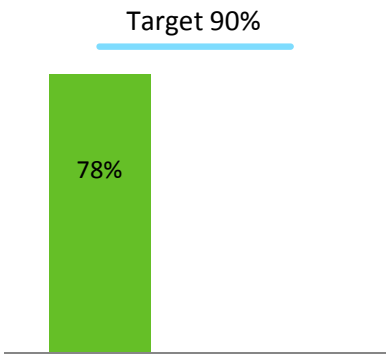


Most Psychosocial clients 247 (83%) received other Part A services. The majority of Psychosocial clients received Medical Case Management, Medical Care and Housing Services.

Outcomes

Medical engagement rate for this service category (78%) is the same as the overall TGA medical engagement rate. Medical engagement was the only outcome measured for this service category.

Percentage of Psychosocial Clients Medically Engaged



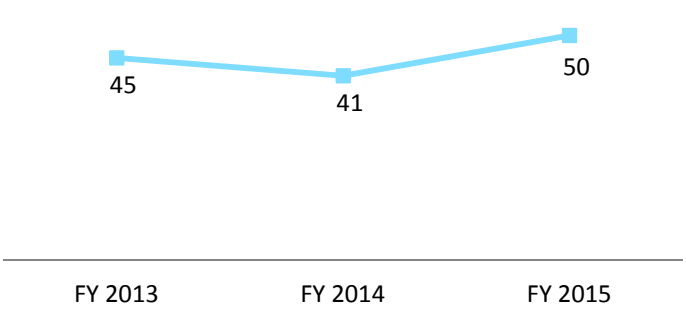
Food/Home-delivered Meals

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. 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.

During FY 2015, a total of 50 clients received at least one home-delivered meal or supplement. This represents 1.8% of all clients who received Part A services. After a three year downward trend of number of clients served, there was a 22% increase this year.

Food Clients, FY 2013-2015



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

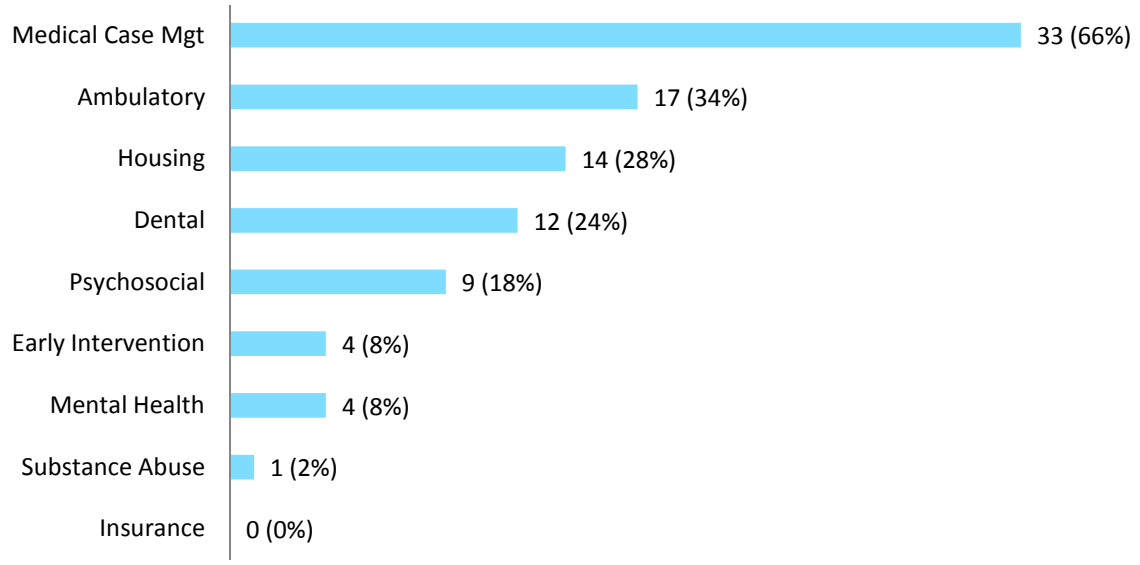
- Multnomah County residents
- Older than 45 years
- Publicly insured
- White
- Under 100% FPL

Increased capacity for formal (cooking classes and nutritional workshops) and informal (conversations over breakfast or lunch) discussion of client nutritional needs, and encouraging clients to think critically about food options as it relates to their other medical needs.

Clients received a total of 11,700 home delivered meals and supplements for an average of 234 meals and/or supplements during this time frame per client. An additional 4,463 meals and supplements were provided this year. In part this was due to a increase in funds and outreach. Compared to past years, more referrals came from people that only had a short term need such as post surgery recover.

An overwhelming number of clients who received food also received other Part A services. Out of the 50 clients who received Food Services, 44 or 88%, also received other Part A services. The percentage of clients that are enrolled in both medical case management services and food services went from 83% in FY14-15 to 66% in FY15-16. A client's enrollment in the home delivered meals program is dependent upon a case manager or medical provider referral. The decrease of medical case management service enrollment is lower than expected. This could also be a result of clients receiving case management outside of the Part A system, but data to support this is not available.

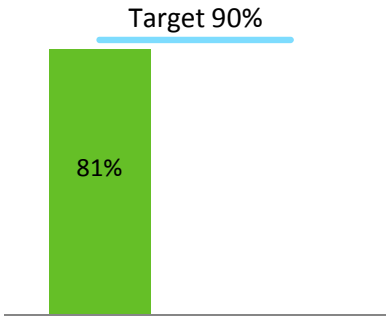
Number of Food Clients by Service Category



Outcomes

During FY 2015, clients who received food services had a medical engagement rate of 81%, which is slightly higher than the TGA rate of 78%. This rate has been higher than the TGA rate for the past four years. This high rate 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.

Percentage of Food Clients Medically Engaged



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 ensuring 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=5,250)		RW Clients (N=2,811)	
	#	%	#	%
Women	554	11%	346	12%
Infants	10	.2%	3	.1%
Children				
Youth	105	2%	76	3%

A comparison of HIV prevalence demographic data (cases as of 12/31/14) 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, but because neither the

epidemic or clients served change drastically from year to year a comparison across two different time frames is not particularly problematic.

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 (80%), Medical Care (47%) and Housing (31%). 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 men, women were more likely to access Insurance, EIS and Psychosocial services and less likely to access Dental services.

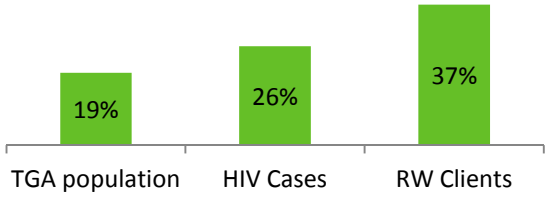
Youth who accessed Part A services also followed a similar pattern as women; 72% of youth accessed MCM services, 49% accessed Medical care and, different from women, 26% accessed EIS services. This finding, points to the fact that youth are accessing EIS at a higher rate (26%) compared with all Part A clients (5%).

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 2014 a disproportionate 44% of all new HIV diagnoses in the United States were African American. At the end of 2012, an estimated number of 496,500 African Americans were living with HIV, representing 41% of all Americans living with the virus.

Percentage of Non-White Individuals



In the Portland TGA, census data shows that at the end of 2010, 19% of the population was non-White, as of 12/31/14 26% of the HIV/AIDS cases were non-White and during FY 2015, 37% 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 client percentages shows that non-White Part A clients are over-represented when compared with the local epidemic.

A total of 1,056 clients of color were served during FY 2015. Of these clients, the top three most utilized services were MCM services (81%), Medical Care services (49%) and Housing Services (31%). These were the same top three most utilized services for all Part A clients. Statistical tests of significance shows the following patterns:

Clients of color were *more* likely to access the following Part A services:

- Medical
- Medical Case Management
- Housing
- Psychosocial

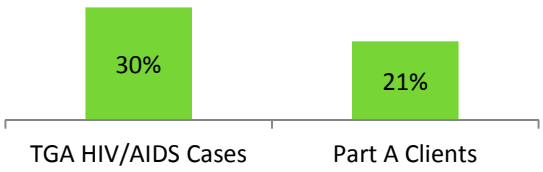
Clients of color were *less* likely to access the following Part A services:

- Dental
- Food

55+ Adults 55 and Older

In 2013, people aged 55 and older accounted for more than one-quarter (26% or 319,900) of the estimated 1.2 million people living with diagnosed or undiagnosed HIV infection in the United States. 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.

Percentage of 55+ Clients, TGA HIV/AIDS Cases vs. Part A Clients



A total of 599 adults 55 and older received Part A services during the previous fiscal year. Of these clients, well over half (64%) received Medical Case Management Services, 33% received Dental Care and 33% received Medical Care. The rate of Dental Care utilization is higher (33%) than the rate of 21% 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.

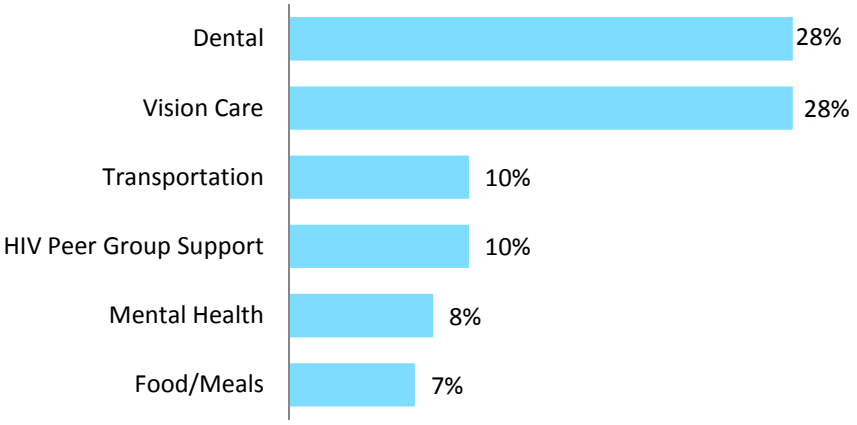
Unmet Need

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 2013 to 2014, where 375 TGA residents participated. For this data set, unmet needs data revealed almost one-fourth (28%) of MMP participants reported an unmet need of Dental Care.

Percentage of MMP Participants by Unmet Need, 2013-2014



Since 2012, concerted efforts have been made in the Portland TGA to recruit and engage new clients into dental care based on the information that clients did not know about available services. Beginning March 2013 HCS launched a poster campaign to increase awareness of Ryan White dental resources in the TGA. Additionally, Oregon's ADAP program now offers dental insurance for ADAP/CAREAssist clients. These more recent MMP data reveal that while 28% of those who reported an unmet need said the reason was financial, 25% reported a psychological barrier to dental care.

Additional services reported as having a high unmet need include vision care, mental health care, transportation, peer support and meal/food services. Ryan White funding cannot be used to provide vision care unless the vision problem is directly caused by HIV disease. Medical case managers help clients access other sources of vision care but assistance is quite limited.

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 2015: Fiscal Year 2015 (March 1, 2015 – February 29, 2016)

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 2015 (N=2,844)

Demographic Group	Number	%
HIV Status		
HIV-positive (not AIDS)	**1634**	**58**
HIV-positive (AIDS status unknown)	**60**	**2**
CDC defined AIDS	**1117**	**39**
HIV-negative (affected)	**27**	**1**
Missing	**6**	
Gender		
Male	**2443**	**86**
Female	**371**	**13**
Transgender	**30**	**1**
Missing	***0***	
Race		
White	**1779**	**63**
Hispanic/Latino	**458**	**16**
Black/African American	**269**	**10**
Multi-racial	**229**	**8**
Asian	**60**	**2**
Amer Indian/Alaska Nat	**24**	**1**
Native Haw/Pac Islander	**13**	**1**
Other	**3**	**<1**
Missing	***9***	
County of Residence		
Multnomah	**1864**	**67**
Clark (WA)	**305**	**11**
Washington	**345**	**12**
Clackamas	**153**	**6**
Other	**89**	**3**
Yamhill	**27**	**1**
Columbia	**15**	**1**
Missing	***46***	
WICY Population		
Women (>=25)	**352**	**78**
Infants (<2)	**3**	**1**
Children (2-12)	**16**	**4**
Youth (13-24)	**81**	**18**
Missing	**0**	

Demographic Group	Number	%
Age		
≤24	**105**	**4%**
25-44	**1197**	**42**
45-54	**943**	**33%**
55-64	**492**	**17**
>65	**107**	**4%**
Missing	**0**	
Risk Factors		
Men who have sex w/men	**1695**	**63**
Heterosexual Contact	**438**	**16**
MSM-IDU	**287**	**11**
IDU	**206**	**8**
Blood/Product Transfusion	**20**	**1**
Other Reason Not Listed	**14**	**1**
Perinatal	**14**	**1**
Hemophilia/Coagulation	**1**	**<1**
Missing	***169***	
Income		
≤100%	**1395**	**52**
101-200%	**835**	**31**
≥201%	**467**	**17**
Missing	***147***	
Housing Status		
Stable	**2053**	**86**
Temporary	**170**	**7**
Unstable	**155**	**7**
Institution	**4**	**<1**
Non-Permanently Housed	**4**	**<1**
Missing	**458**	
Health Insurance		
Public	**645**	**23**
Medicare	**674**	**24**
Medicaid	**1067**	**39**
VA, Tricare, other military	**39**	**1**
No Insurance	**327**	**12**
Other	**15**	**<1**
Missing	***77***	

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

	HIV Cases As of 12/31/2014 (N=5,250)		Part A Clients FY 2015 (N=2,844)	
Demographic Group	**Number**	**%**	**Number**	**%**
Gender				
Male	4,696	89%	2443	86%
Female	554	11%	371	13%
Transgender	--	--	30	1%
Race				
White	3883	74%	1779	63%
Hispanic/Latino	652	12%	458	16%
Black/African American	432	8%	269	10%
Multi-racial	108	2%	229	8%
Asian/Pacific Islander	121	2%	73	3%
Amer Indian/Alaska Native	48	1%	24	1%
Other	--	--	3	<1%
County of Residence				
Multnomah	3,245	62%	1864	67%
Clark (WA)	643	12%	305	11%
Washington	797	15%	345	12%
Clackamas	424	8%	153	6%
Other	--	--	89	3%
Yamhill	85	2%	27	1%
Columbia	56	1%	15	1%
Age				
0-12	10	<1%	19	1%
13-24	105	2%	86	3%
25-44	1,844	35%	1197	42%
45-64	2,936	56%	1435	51%
65+	355	7%	107	4%

Appendix D: 2015 Client Satisfaction Survey Results

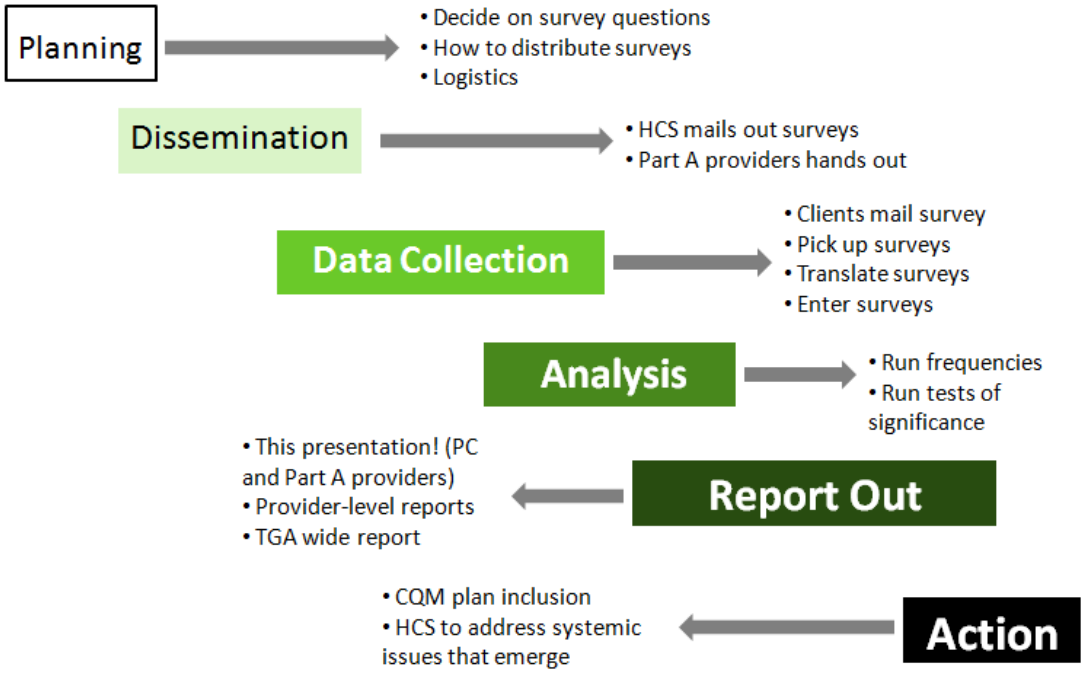
The HIV Care Services program manages the Ryan White Part A federal grant which addresses the unmet health needs of low-income persons living with HIV disease in the Portland metropolitan area. The federal grant-defined Portland metropolitan area consists of five counties in Oregon (Clackamas, Columbia, Multnomah, Washington, and Yamhill) and one in Washington (Clark). Through contracts with eleven organizations, including community-based non-profits, local health departments, and medical centers, client's access primary health care and support services which increase retention in care, improve health outcomes and ultimately increase the quality of life for those living with HIV and reduce the transmission of HIV. As part of their administrative responsibilities, HCS has conducted an annual client satisfaction survey; alternating every year between surveying medical case management (MCM) agencies and non-medical case management agencies. Starting with the 2015 client satisfaction survey (the results of which are presented in this report), it was decided that HCS would alter their previous plan to survey all agencies every other year and instead proceed forward with surveying *all* Part A agencies every other year; this reduces the burden incurred for both HCS and those agencies who provide both MCM and non-MCM services.

Consumer feedback in the form of client satisfaction surveys provides a structured method of obtaining client insight around service provision is of interest to multiple parties (contractors, consumers, HIV Services Planning Council, HCS, community members, etc.). Measuring client satisfaction is important for the following reasons:

- Strengthens communication between clients and agencies
- Enables agencies to assess the strengths and weaknesses of their programs from the clients' perspective
- Creates baseline data against which to measure changes in clients' satisfaction over time
- Provides a focal point for quality improvement efforts

The client satisfaction data gathered was analyzed at the Part A agency level as well at the TGA level. Results produced by agency were presented to all 7 participating agencies during a Quality Improvement meeting whereby HCS and agency staff collaboratively reviewed program outcome and client satisfaction data to guide the development of annual quality goals. Each of the 7 agencies also received a written summary of the client satisfaction survey results for their agency. TGA-wide client satisfaction survey results were presented to both the Part A agencies at the June 2016 quarterly contractor meeting and the May 2016 HIV Services Planning Council meeting. This report contains TGA-wide client satisfaction survey results.

The below graphic summarizes the overall process HCS created around this client satisfaction survey project:



Methodology

During the planning phase of this project, two versions of the survey were developed. A 17-question survey for those clients who received at least one Part A medical case management service during the FY 14-15 time frame (3/1/14 to 2/28/15) and a 16-question survey for those clients who received at least one Part A non-medical case management service (these services included the following: housing, mental health, psychosocial, food, dental, medical and insurance). Surveys were self-administered, anonymous, available in English and Spanish, and respondents did not receive an incentive for their participation.

HCS contracted with a total of 11 providers during FY 14-15. A total of 4 providers were excluded from participation in this project because 2 of the agencies provided Disease Intervention Services (DIS), not suited for a follow-up client satisfaction survey (HCS will be working with the DIS programs to develop a client feedback mechanism more suited to the work being done). One of the excluded entities provided HIV testing services in the jail, again not appropriate for this round of surveying and finally, the last provider excluded ended their contract with HCS during the beginning of the FY 14-15.

Surveys were distributed in early January 2016 and for those agencies that had a lower response rate at the end of the first 4-5 week collection phase, additional surveys were distributed in February 2016. Agencies used a variety of methods to distribute surveys, including: mailing them to clients, offering them to clients when they checked in for appointments, or leaving them in a common area at the agency. HCS also assisted some agencies with the mailing of the survey to clients. Respondents deposited their completed surveys in either a locked drop box at the agencies where they received them, or mailed them directly HCS, using a self-addressed, prepaid envelope. In order to keep the burden of survey distribution low for staff at participating agencies, refusals were not tracked.

Across these 7 participating Part A funded agencies, a total of 2,955 unduplicated clients were served in FY 14-15. HCS received a total of 630 completed surveys. The estimated response rate was 21%; but is considered an estimate because the number of completed surveys do not

equal the number of clients served in FY14-15, because if a client received services from multiple agencies they would have received multiple surveys.

Five percent (n=29) of surveys were completed in Spanish.

Data were analyzed using IBM SPSS Statistics 22. We compared participants in subgroup analysis, using the chi-square statistic for categorical variables and the two sample t test for age as a continuous variable.

In these sub-analyses, response categories were collapsed for some variables due to small numbers, including: gender, race, age, and county of residence. The sub-group sections describe those variables which produced p values less than 0.05 only. Results included in this report are univariate or bivariate only, and were not adjusted for confounding factors.

Because the methodology for this project included all clients a longitudinal analysis of how satisfaction patterns have changed over time can only be executed for those questions pertaining to MCM.

RESULTS

Demographics

The demographic characteristics (age, gender, race/ethnicity, county of residence, HIV/AIDS diagnosis year) of those who completed a client satisfaction survey are important for the following reasons:

- Determine if the survey sample was representative of the clients who received Part A services.
- Understand more about the group of individuals who answered the survey.
- Measure if there were any significant difference around demographics as it pertains to satisfaction with services provided.

Participants who graciously took the time to complete a client satisfaction survey were mostly, Male, White and living in Multnomah County. Future recruitment of client participants will also include the use of technology, which might draw in a younger sample of individuals in an effort to acquire a more representative sample of participants. Table 1 below displays the demographic characteristics of client participants.

Table 1: Demographic Characteristics of Part A Survey Participants (N=630)

	#	%		#	%
Age			**Gender**		
Mean	51.2		Male	526	88%
Median	52		Female	90	12%
Range	21-79		Transgender	5	<1%
Missing	*32*		*Missing*	*14*	
Age (by group)			**County of residence**		
Under 20	0	0%	Multnomah	425	70%
20-29	30	5%	Clark	53	9%
30-39	65	11%	Washington	62	10%
40-49	139	23%	Clackamas	34	6%
50-59	221	37%	Yamhill	3	<1%
60-69	122	20%	Columbia	7	1%
70+	21	4%	Other	25	4%
Missing	*32*		*Missing*	*21*	
Race/ethnicity *(check all that apply)*			**HIV/AIDS Diagnosis Yr**		
White	417	68%	1985-1989	70	12%
Hispanic/Latino	69	11%	1990-1994	97	17%
Black/Af-American/African	60	10%	1995-1999	104	18%
Asian	11	2%	2000-2004	91	16%
American Indian/Alaska Native	8	1%	2005+	201	36%
Native Hawaiian/Pac Islander	3	<1%	*Missing*	*67*	
Other	14	2%			
Multiracial	35	6%			
Missing	*13*				

Although not a traditional demographic, this year it was decided to add a survey question around HIV/AIDS diagnosis year. Approximately one-third (36%) of client participants had an HIV/AIDS diagnosis in the year 2005 or later.

The survey sample, when compared with the demographics of those who accessed Part A services, was mostly similar. Survey participants were on average older and a slightly greater percentage of survey participants were Male, White and residents of Multnomah County. See the below table for a side by side demographic comparison of the survey participants and Part A clients.

Table 2: Demographic Comparison of Survey Participants and all Ryan White Clients

Demographic characteristic	Survey sample	Ryan White Part A Clients*
Male	88%	86%
Average age (in years)	51.22	44.91
Person of color	32%	39%
Multnomah County resident	70%	67%

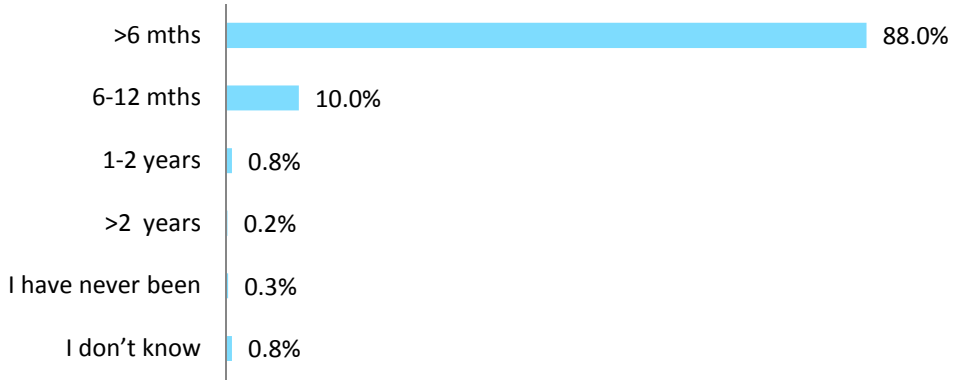
**Clients who received at least 1 Part A services during the 2015 fiscal year (3/1/15-2/29/16).*

Medical Care and Mental Health

Client participants were asked about their engagement in medical care as well as their mental health as a means to understand more about the survey participants, but also to understand if there is any correlation between medical engagement, mental health and satisfaction with services. Due to the lack of dispersion across response categories (most all participants were engaged in medical care) correlations could not be performed between medical engagement and client satisfaction.

Client participants were engaged in medical care at a very high rate, where approximately 9 out of 10 participants reported that they had visited their HIV primary care provider during the last 6 months.

Figure 1: Length of Time Since Last HIV Med Visit



Almost all of the participants reported that they are taking Antiretroviral therapy (ART) (98%) and have medical insurance (96%). We can therefore conclude that the client participants were highly engaged in medical care. See below table for a full account of a client's reported engagement in ART treatment and health insurance status.

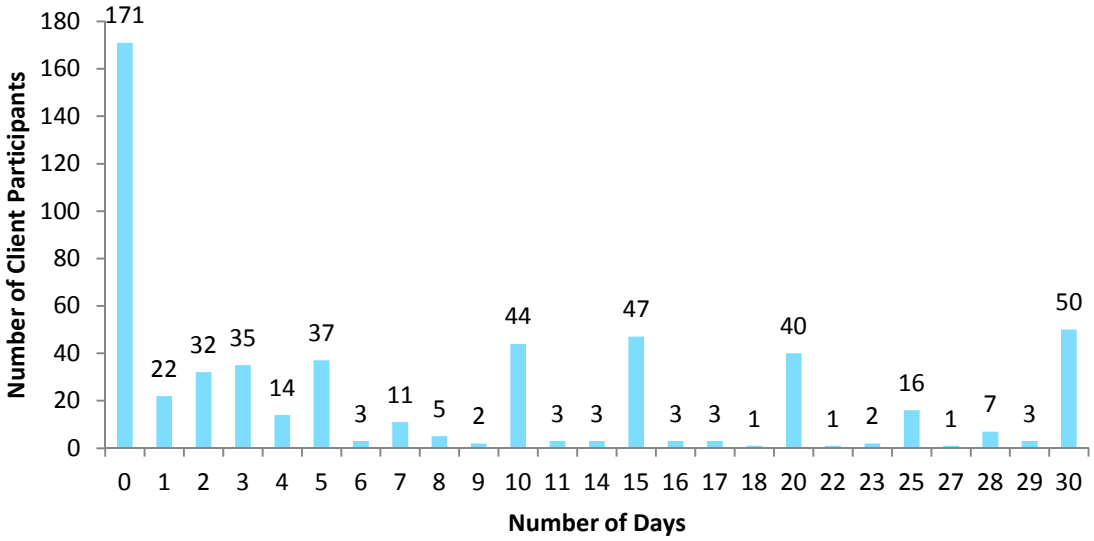
Table 3: ART and Medical Insurance

	n	%
On HAART		
Yes	586	98%
No	13	2%
Missing	*31*	
Medical insurance status		
Insured	571	96%
Not insured	27	5%
Missing	*32*	

In 2011, HCS began using two questions from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) survey to be more specific in the way mental health status is measured. A total of 557 of the 630 client participants answered these mental health questions. The average number of days that participants reported their mental health was not good was 9. The average number of days that participants reported their poor mental health kept them from doing usual activities was 6. To understand more about the distribution of MH responses, see the below scatter plots which show that there is quite a dispersion across the number of days client participants felt their MH was either not good or that their MH prevented them from engaging in routine activities. About one-third (30%) of client participants who answered this MH

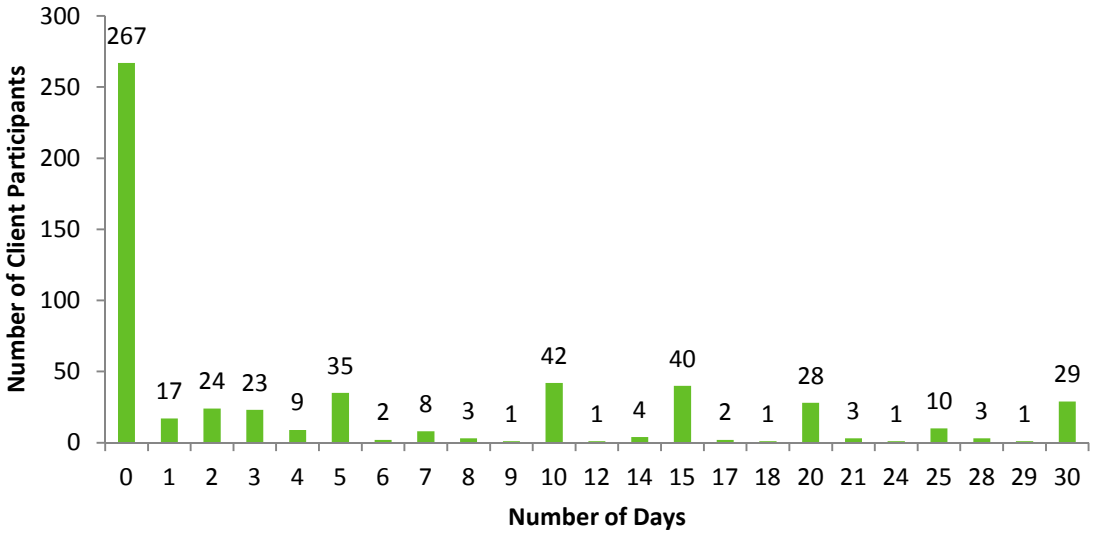
question reported that they experienced zero days where they felt their MH was not good. Another one-third (31%) of client participants reported that their MH was not good between 15-30 days out of the last 30 days.

Figure 2: Distribution of Days Client Participants Reporting MH was Not Good in Last 30 Days



An even greater percentage of client participants reported that their MH did not keep them from doing usual activities (such as work, recreation, or self care). At the other end of the spectrum, approximately one-fourth (21%) reported that they felt poor MH was keeping them from usual activities for half or more (15-30 days) of the last 30 days.

Figure 3: Distribution of Days Client Participants Reporting MH Prevented Routine Activities



Client Contact with Part A Agency

Clients were asked to report how often they were in contact with the agency/ies where they received Part A services. They were also asked to determine if this level of contact was satisfactory. Approximately one half (43%) of all client participants reported that they had contact with a Part A agency about twice a year. Most clients (84%) felt that the level of agency contact was "Just the right number of contacts".

Figure 4: Client Contact with Part A Agency

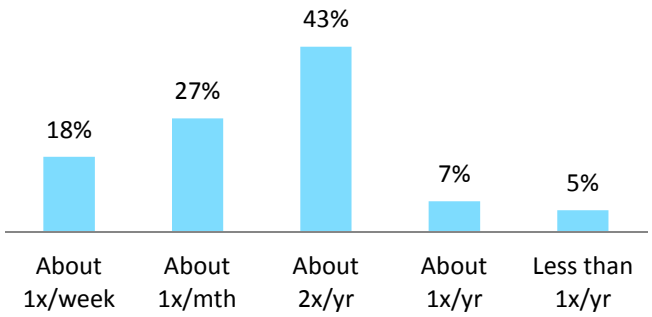
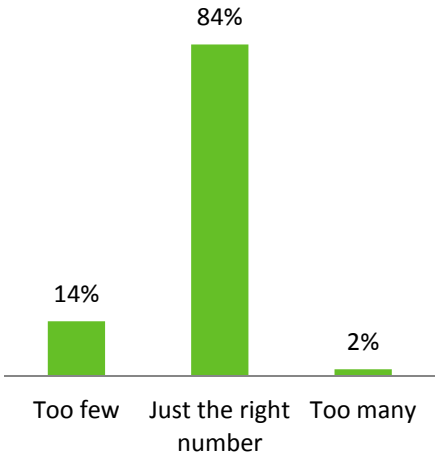
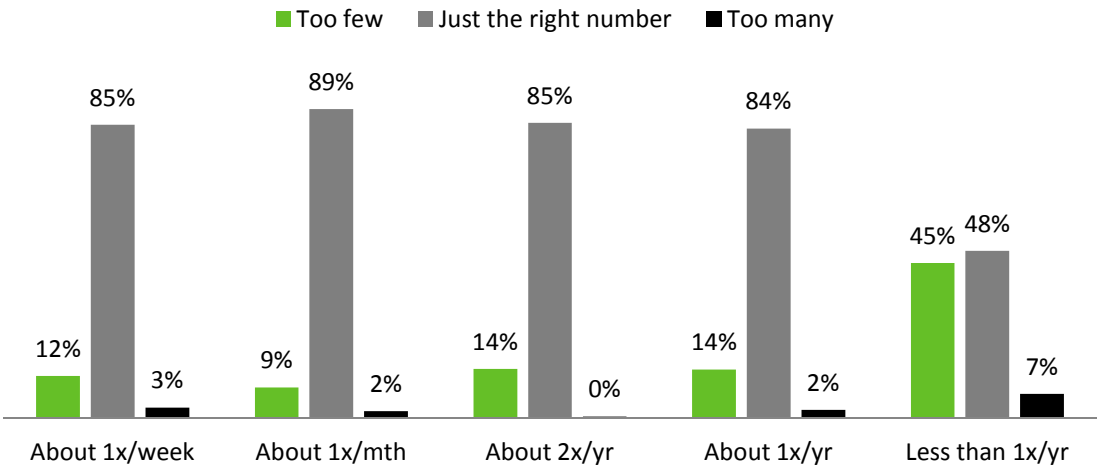


Figure 5: Client Evaluation of Contacts with Part A Agency



When the intersection of agency contact satisfaction and level of contact (see figure 6) was examined, clients who reported contact with a Part A agency between once a week and one year seemed to be generally satisfied with their contact frequency (84%-89% satisfaction rate). Those who reported having contact with a Part A agency "less than once a year" reported a much lower satisfaction rate (48%).

Figure 6: Intersection of Client Contact with Agency and Evaluation of Contact



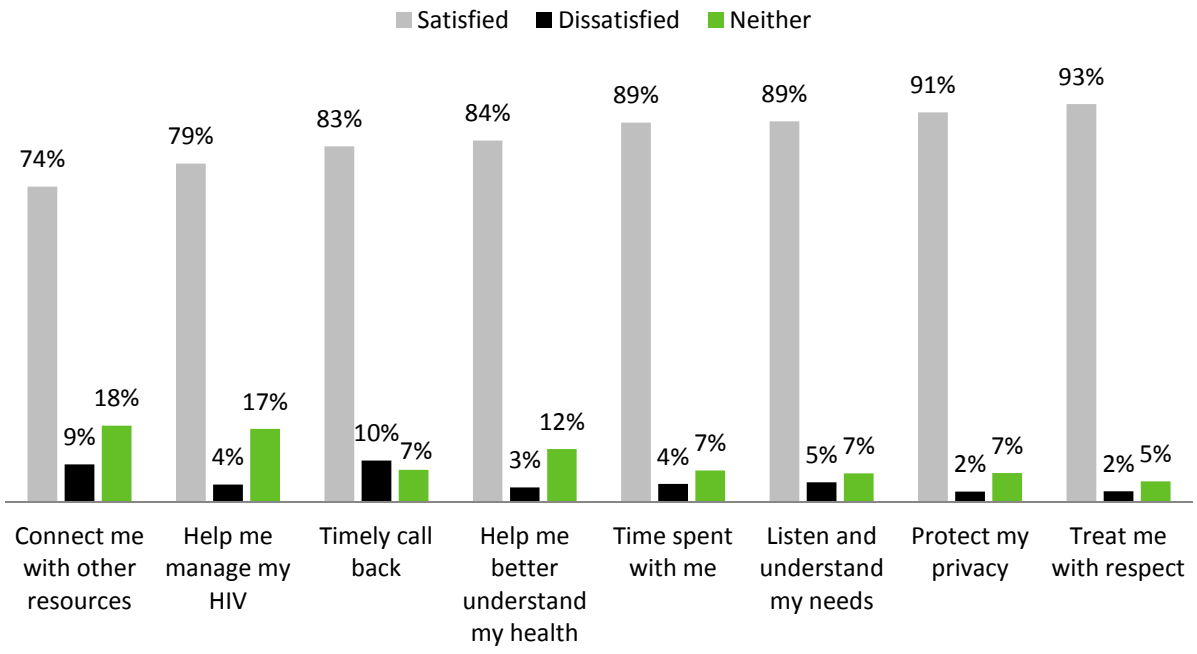
Client Satisfaction

Results of this survey suggest that agencies funded within the Portland TGA Ryan White Care system are doing well in providing health care and key support services for many people living with HIV/AIDS (PLWHA) in the Portland area.

In general, participants reported high rates of satisfaction with the Part A agency efforts along 8 dimensions. In Figure 6, responses were combined so that the grey column represents respondents who reported they were either "very satisfied" or "somewhat satisfied," and likewise for the dissatisfied responses.

The majority of participants responded positively (74%-93%) with respect to the eight satisfaction areas shown in Figure 7. For these questions, a range of 7-32 respondents did not answer. Missing responses were excluded from the percentages calculated from Figure 7 (i.e., the denominator for each item was less than the overall N=630).

Figure 7: Overall Client Satisfaction



Based on the results above, client participants were most satisfied with being treated with respect by agency staff (93%) and the level of agency privacy protection (91%). The highest rate of *dissatisfaction* was with 'timely call back' (10%) and 'connect me with other resources' (9%). The two categories of satisfaction which had the highest rate of clients who reported being neither satisfied nor dissatisfied was 'help me manage my HIV' (17%) and 'connect me with other resources' (18%).

In terms of satisfaction rate differences across demographic characteristics, clients who were non-White were more likely to be satisfied with the amount of time it took for agency staff to respond to questions or needs and the ability of agency staff to connect clients with other needed programs. Non-Multnomah county residents were more likely to be satisfied with the degree to which they were treated with respect by agency staff. The average age of client

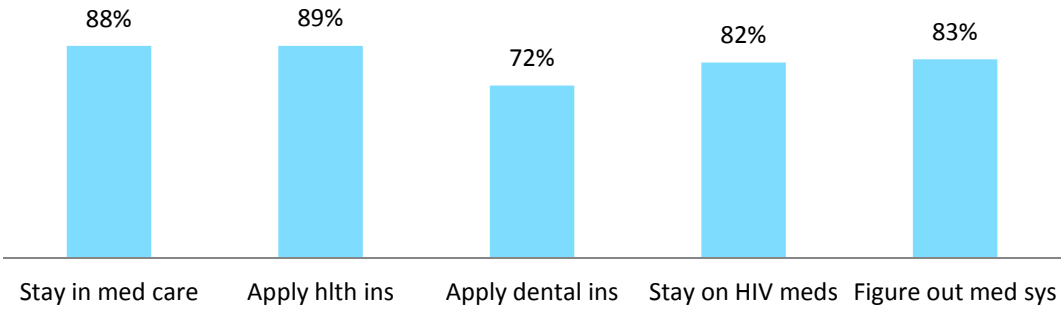
participants who were satisfied with protection of privacy was higher than those who were dissatisfied.

Case Management

In addition to being asked about overall satisfaction with Part A service agencies, a subset of clients who received medical case management (MCM) services (n=280) were asked specifically about how their medical case manager has helped. MCM includes 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. To evaluate how clients feel about the MCM they received, clients were asked to what extent their MCM helped with the following 5 aspects of this service: stay in medical care, apply for health insurance, apply for dental insurance, stay on HIV medications and Figure out the medical care system.

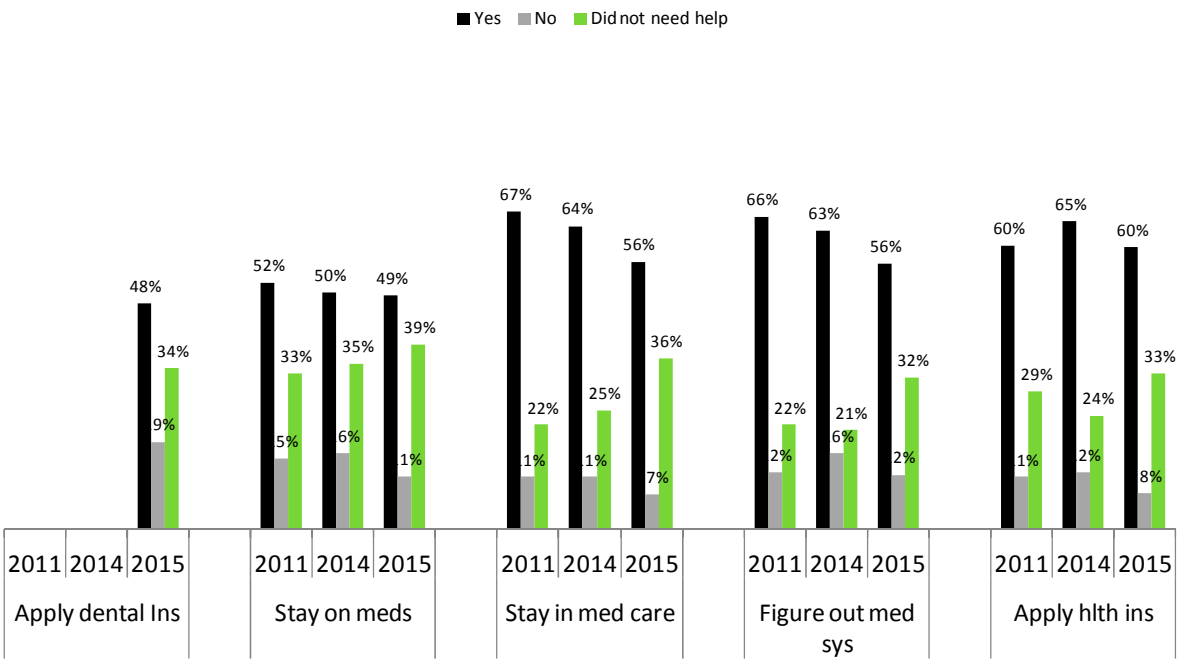
Overall, clients reported they were assisted with a wide range of MCM services (72%-89% assistance rate). Clients reported a very high assistance rate with both 'staying in medical care' (88%) and 'applying for health insurance' (89%); both core functions of the work that medical case managers perform. The lowest rate of assistance was for 'applying for dental insurance' where 72% of client participants reported receiving help with the application process. See figure 8 for complete results.

Figure 8: Aspects of Medical Case Management that Clients Have Received Help With



As mentioned in the methodology section of this report, how clients have reported being helped with aspects of MCM can be examined over time to determine if there were changes in client perception of this service. MCM clients were surveyed as part of this project in 2015, and were also surveyed in 2014 and 2013. With the exception of 'apply for dental insurance'; the other MCM questions stayed relatively the same across these three time periods, with just a few wording changes. These three time periods will be included in the longitudinal analysis that follows.

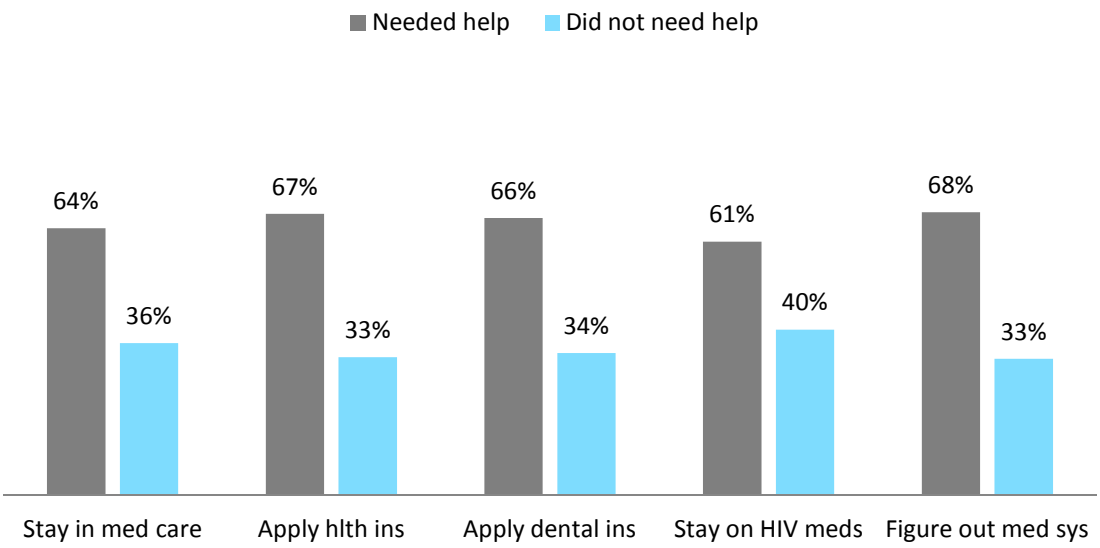
Figure 9: Percentage of Medical Case Management (MCM) Client Participants Who Reported Being Helped With the Following Aspects of MCM



An interesting inverse relationship emerged when MCM over time was examined (see figure 9). While there appears to be a decline in the percentage of client respondents who reported being helped by most of the above aspects of MCM, at the same time there was an increase in the percentage of clients who reported not needing help with many of the aspects above. For example, in 2011 67% of clients surveyed reported that their medical case manager helped them stay in medical care. Approximately four years later, in 2015, this percentage had decreased to 56%. However, for the same two time points (2011 and 2015) the percentage of clients who reported they did *not* need help from their medical case manager increased from 22% to 36%.

In addition to being asked if medical case managers helped them to stay in medical care, apply for health insurance, apply for dental insurance, stay on HIV meds and understand the medical care system, clients were also asked whether or not they felt they *needed* help with these different aspects of MCM. About one-third (33%-40%) of clients reported they did *not* need assistance with one or more of these aspects of MCM. Collectively, a total of 153 (55%) MCM client participants reported that they did not need help with all of the 5 aspects of MCM. Of these 153 clients, 44 clients reported that they did not need assistance with any of the MCM aspects.

Figure 10: Aspects of Medical Case Management Clients Needed vs. Did Not Need Help With



When examining if there were demographic difference across these 5 MCM aspects, the following was found:

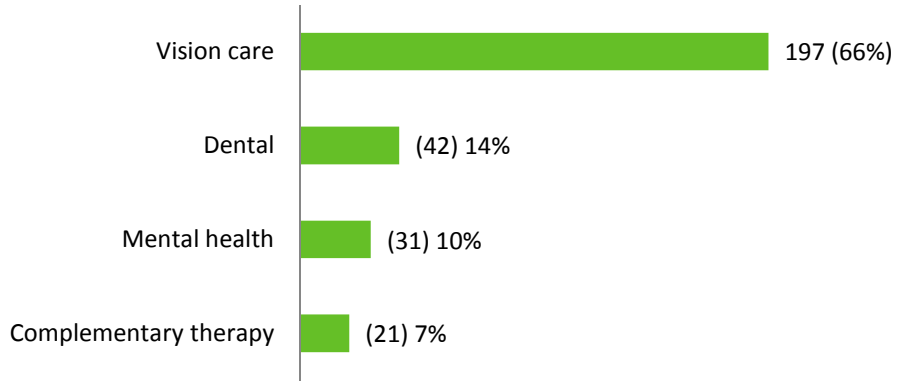
- Women were more likely than men to report needing help applying for dental care and figuring out the medical care system
- Non-White clients were more likely than White clients to report needing help staying in medical care, applying for dental insurance, staying on HIV meds and figuring out the medical care system
- Non-white clients were more likely than White clients to report receiving help with staying in medical care, applying for health insurance, staying on HIV meds and figuring out the medical care system.

Qualitative Results

Client participants were asked a total of 3 open-ended questions. The first question they were asked pertained to what a particular agency could do to improve services. The results of these agency-specific comments are available in the agency-specific summaries. The survey also contained a question soliciting ideas around services that might help improve quality of life. A total of 300 (47%) client participants took their time and wrote-in ideas, which are summarized in figure 11. Of those who provided ideas, 66% suggested that access to vision care would help to improve quality of life. It must be pointed out that the question, as written in the survey looked like this, which likely led to a bias toward client's listing "vision" in their response:

"Do you have ideas for services that would help improve your quality of life? (Vision care, etc.)"

Figure 11: Services That Would Help Improve Quality of Life

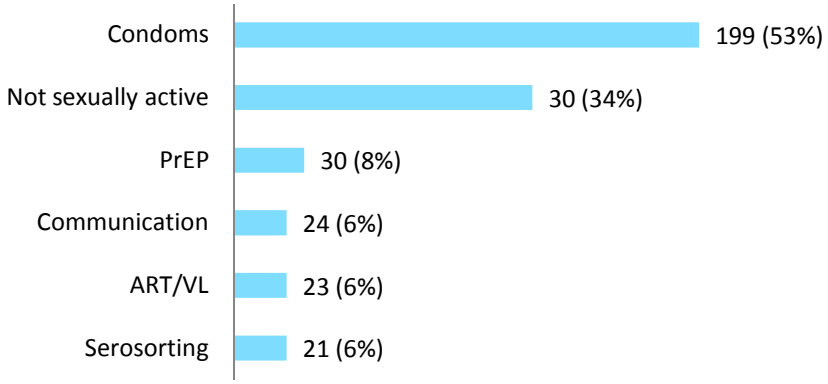


The question was written like this because HCS wanted to know about vision care in particular, but also wanted to leave the question open-ended for other ideas to be captured.

Clients were full of ideas around vision care needs, which included the provision of new prescription glasses, laser eye surgery and eye exam coverage. For dental care, clients commented that they would like more dental providers within the Part A system; they also had specific needs around dental equipment and procedures. Under the mental health umbrella, clients expressed wanting access to various types of mental health services (group, individual, family), an increased number of providers, and the establishment of a larger mental health network, which includes a more robust referral system. Finally complementary health, such as acupuncture, chiropractic care, massage were also put forth as ideas. The services displayed in figure 11 only represent those services where 20 or more clients coalesced around a particular idea. Services which were suggested but not represented in the above figure included: social activities, medical devices, housing, nutrition, group exercise, transportation, employment.

The final open-ended question pertains to HIV prevention efforts used by client participants. A total of 380 (60%) client participants provided their comments around this topic, many reported multiple strategies spanning across several of the categories listed below. About one-half (53%) of all survey participants reported use of condoms, while one-third (34%) reported not being sexually active.

Figure 12: HIV Prevention Efforts



Summary

This report presents a representative sample of Ryan White clients in the Portland area. Results were based on a survey of all clients who had received Part A services during FY 14-15. Comparisons across years could only be made for clients who received medical case management services. Most participants were on HIV medication (98%), insured (96%) and had seen their HIV primary care provided within the past 6 months (88%).

Most clients were satisfied with the number of contacts they have had with a Part A agency, however, 45% of those clients who reported only having contact with an agency less than once a year felt it was not enough contact.

In general, survey participants reported high rates of satisfaction (74%-93%). Clients were most satisfied with the way that have been treated with respect (93%) and protection of privacy (91%). Clients were more dissatisfied with being called back in a timely manner (10%) and connection with other resources (9%).

A subset of client participants (those who have received medical case management services) were also asked about the extent to which their medical case manager has helped them with certain aspects of this service. Over three time periods, 2011, 2014 and 2015 clients have reported receiving less help but have also reported not needing this help.

When asked which service would help to improve quality of life, 66% of those who responded to this question reported they would like vision care services. Finally, the most commonly reported HIV prevention effort was the use of condoms.