

OREGON HIV PREVENTION
COMPREHENSIVE PLAN
2010 – 2014



IN PARTNERSHIP WITH
Oregon Department of Human Services
HIV Prevention Program

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Oregon HIV Prevention Comprehensive Plan: 2010 - 2014

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Oregon HIV Prevention Comprehensive Plan 2010 - 2014 Preface

The Oregon HIV Prevention Comprehensive Plan 2010-2014 represents a new beginning of strategic HIV Prevention Community Planning in Oregon. This plan was developed in alignment with the Centers for Disease Control and Prevention (CDC) guidance that all prevention services supported with its funds is evidence-based. As the HIV Prevention Program also receives funding from the State of Oregon, the Oregon HIV Prevention Statewide Planning Group (SPG) recognizes the state mandate to provide public information about HIV to all Oregonians.

The SPG

Oregon's HIV Prevention SPG is comprised of persons living with HIV, persons representing populations at risk of HIV infection in Oregon, public and private service providers and other interested individuals striving to understand how best to address the HIV prevention needs of Oregonians at risk for HIV infection and other blood-borne pathogens.

The mission of the SPG is to develop a comprehensive HIV/Hepatitis/STD prevention plan with DHS to ensure effective and efficient delivery of evidence-based prevention services that will result in a decrease in HIV, Viral Hepatitis, and STD transmission in the State of Oregon.

The goals of the SPG are to:

1. Follow the SPG Guiding Principles as follows:
 - Obtain community input
 - Integrate viral hepatitis and STD prevention
 - Plan across the continuum of HIV/Hepatitis/STD care
 - Develop a comprehensive plan that is useful and meaningful
 - Develop a plan that incorporates behavioral science data
 - Develop a plan that incorporates a state-wide focus
2. Identify priority HIV/Hepatitis/STD prevention needs by defined risk behavior populations and by specific strategies and interventions.

3. Implement and maintain an effective prevention planning process that ensures participation of its members and seeks to gain meaningful input from other Oregonians concerned about HIV/Hepatitis/STD prevention issues;
4. Maximize the effectiveness of prevention service through effective planning among persons infected and affected by HIV/Hepatitis/STD service providers and other concerned community members; and
5. Strengthen local and State-wide coordination in the fight against HIV/Hepatitis/STD diseases.

In 2008, there was a significant increase in new SPG members and an inherent need to review the purpose, policies and procedures of the group. As the SPG began clarifying its role, it became clear that to actively engage members in the development of a new comprehensive plan, structural changes were necessary. To better support the work of the SPG, five committees were created, Membership; Planning, Process, Monitoring and Evaluation; Community Services Assessment; Intervention and Executive. The work of these committees is described below.

- Membership committee is responsible for recruiting new members in alignment with parity, inclusion and representation (PIR) goals and orienting new members on SPG policies and procedures.
- Planning, Process, Monitoring and Evaluation committee (PPME) provide support to the planning infrastructure for writing the Comprehensive Plan. PPME is charged with overseeing the process of developing the plan to ensure that it incorporates and addresses the needs and priorities that have been developed.
- Community Services Assessment (CSA) committee is charged with providing SPG members with the information needed to prioritize populations and to make recommendations for future community needs assessments. The committee is also responsible for conducting an inventory of HIV/STD related resources and analyzing gaps in services. In addition, the CSA committee writes the community services assessment, priority population recommendations and resource inventory sections of the Comprehensive Plan.
- The Intervention committee's charge is to review HIV prevention interventions and activities on their ability to prevent new HIV

- infections and to make recommendations for which HIV prevention intervention activities should be recommended for Oregon.
- The Executive committee consists of the State and Community Co-Chairs and the Chairs of each of the above committees. This committee is responsible for ensuring that the work / activities of the SPG are in alignment with the stated mission and goals.

This plan represents the renewed efforts of the SPG to develop a comprehensive statewide HIV, Viral Hepatitis and STD Prevention Plan to decrease HIV, Viral Hepatitis and STD transmissions in the State of Oregon. This plan was designed to be used as a tool for the DHS HIV Prevention Program, local health authorities and community based organizations in Oregon delivering HIV intervention strategies to the populations most at risk for these infections in their communities. The initial focus of this plan is HIV Prevention, as the plan is updated each year, evidenced based practices and updated information will be incorporated to reflect a complete picture of the HIV, Viral Hepatitis and STD prevention needs in Oregon.

SPG meetings are open to the public. If you are interested in attending a meeting, becoming a member of the group, have any questions about this document, or need this document in an alternative format, please contact the Oregon Department of Human Services HIV Prevention Program at (971) 673-0153 or on the web at <https://www.oregon.gov/dhs/ph/hiv/spg/index.shtml> .

Parity, Inclusion and Representation (often referred to as PIR) are fundamental tenet for the success of any HIV prevention community planning group. Representation is defined as the act of serving as an official member reflecting the perspective of a specific community. Inclusion is defined as meaningful involvement of members in the process with an active voice in decision making. Parity is defined as the ability of members to equally participate and carry-out planning tasks/duties. To achieve parity, representatives are properly oriented and given skills to participate in the planning process and to have equal voice in voting and other decision-making activities.

It is the intention of the SPG to recruit and maintain members who are able to be meaningfully involved and participate equitably in the planning process and whom represent a diversity of ethnic/racial groups, state geography, and populations experiencing HIV disparities in Oregon.

Below is a table representing our current SPG member profile (in aggregate to maintain member confidentiality), our membership goals as related to PIR, and gaps in membership. These gaps are the basis for future SPG member recruitment.

Current / Goal Membership Parity, Representation, and Inclusion (PIR)

	Total Members	Goal	Goal Reached?
R1 (Counties with 100 or more living HIV cases)	13	19.2	No
R2 (Counties with 50 - 99 living HIV cases)	1	2.4	No
R3 (Counties with 10 - 49 living HIV cases)	3	1	Yes
R4 (Counties with less than 10 living HIV cases)	2	1	Yes

For more detailed information on specific counties, go to <http://www.oregon.gov/DHS/ph/hiv/data/index.shtml>

	Total Members	Goal	Goal Reached?
Asian / Pacific Islander	2	1	Yes
Alaska Native / American Indian	2	1	Yes
Black / African American	2	2	Yes
Hispanic	1	3	No

	Population represented	Goal	Goal Reached?
MSM (Men Who Have Sex With Men)	Yes	10	No
PWID (Persons Who Inject Drugs) or history of injecting	Yes	2	No
MSM / PWID	No	1	No
Heterosexual at Risk	No	2	No

**Oregon HIV Prevention
Comprehensive Plan
2010 - 2014**

I EPIDEMIOLOGIC PROFILE OF HIV/AIDS IN OREGON 2007 EXECUTIVE SUMMARY¹

HIV/AIDS remains an important public health problem in Oregon. According to data from the Oregon Public Health HIV/AIDS Reporting System (HARS) collected from 1981 through 2007 the number of newly diagnosed cases per year has not changed appreciably since 1997. However the total number of people living with HIV/AIDS continues to grow, presenting challenges for prevention and clinical services.

New HIV/AIDS diagnoses

The rate of new HIV/AIDS infections by year of earliest reported diagnosis reached a high of 19 cases per 100,000 people, a total of 547 cases in 1991. The following year, however, saw the beginning of a decline. By 1997 the rate had dropped to between 8 and 9 cases per 100,000 people, a rate that has persisted through 2007.

Oregon's decline in new diagnoses during the 1990s reflected similar trends throughout the United States. These declines probably resulted from a combination of factors, including earlier diagnosis, behavior changes, reduction in maternal-fetal transmission and reduced infectiousness of HIV-infected people taking antiretroviral therapy.

Survival for those infected with HIV also increased during the latter half of the period for which data have been summarized. Among the 3,229 HIV/AIDS cases diagnosed from 1981 through 1992, only 45% of patients survived at least five years. Yet 81% of the 3,529 diagnosed during 1993–2002 survived at least five years. Some increases in survival may reflect more timely diagnosis, but much of the improvement can be attributed to more effective antiretroviral therapy.

Despite these gains, many Oregonians continue to be diagnosed with HIV infection at an advanced stage. Approximately 39% of the 1,486 cases diagnosed during 2003–2007 had AIDS at the time of their HIV-infection diagnosis, or their infection progressed to AIDS within 12 months.

¹ Epidemiologic Profile of HIV/AIDS in Oregon 2007, Oregon Department of Human Services – Public Health Division – HIV/AIDS Program, April 2009, (the most complete data available at this time) <http://www.oregon.gov/DHS/ph/hiv/data/docs/epi2007.pdf>

Delayed diagnosis was more common among older patients, Hispanics compared to whites, males who inject drugs or heterosexual risk compared to men who have sex with men (MSM), and rural relative to urban cases.

Oregonians living with HIV/AIDS

From 1981 through the end of 2007, 8,252 Oregon residents diagnosed with HIV/AIDS infection were reported to the Oregon Public Health Division. Forty percent of those people had died by the end of 2007, leaving 4,922 people living with HIV/AIDS (PLWH/A). Beginning in 1997, the numbers of new diagnoses and deaths per year stabilized at approximately 300 new diagnoses and 100 deaths, meaning the number of PLWH/A in Oregon since then saw an annual increase of approximately 200 people.

Through 2007, compared with people living with AIDS (PLWA), people with HIV infection but not AIDS (PLWH) were more likely to be female and younger. This is consistent with modest recent increases in the proportion of women among those newly infected. No notable differences were observed between the numbers of PLWA and PLWH by race/ethnicity or risk.

Although it is home to only 19% of the state's population, 57% of PLWH/A in Oregon were living in Multnomah County at the end of 2007. PLWH/A in the Portland metropolitan area were more likely to be male and more likely to have acquired the infection via sex with men than PLWH/A in the remainder of the state where female cases and transmission via injection drug use were somewhat more prevalent. Other counties with 50 or more PLWH/A included Clackamas, Deschutes, Douglas, Jackson, Josephine, Lane, Linn, Marion and Washington. Post-diagnosis migration is likely to have affected the actual number of PLWH/A currently living in these areas.

Co-morbidity

From 2002–2007, the average annual reported rate of early syphilis among HIV/AIDS cases was 332 per 100,000. The average annual reported rate of gonorrhea among HIV/AIDS cases from 2002–2007 was 1,631 per 100,000. The average annual reported rate of Chlamydia among HIV/AIDS cases from 2002–2007 was 751 per 100,000. From 2002–2007, 32% of 266 reported male syphilis cases and 10% of 4,328 reported male gonorrhea cases occurred among people already infected with HIV.

In contrast to the increases of STDs among PLWH/A, Oregon has never observed a substantial number of cases of tuberculosis (TB) among those with HIV/AIDS. Of 1,945 TB cases in Oregon since 1993, only 82, or 4%, were known to have been co-infected with HIV.

Unmet need for medical care in Oregon

An important aspect of planning for HIV infection treatment and prevention is estimating the number of PLWH/A in Oregon who are aware of their infection, but not receiving medical care. For this reason, the Health Resources Services Administration (HRSA) requires all states and metropolitan areas that receive federal support for HIV/AIDS health care under Part A and Part B of the Ryan White CARE Act to annually estimate this population. People who receive regular high-quality medical care for HIV/AIDS typically visit their doctors three or more times a year and submit blood specimens for testing the quantity of HIV virus circulating in the blood (“viral load”) and immune function (such as “CD4 count”).

Seventy percent of 1,934 PLWH and 68% of 2,972 PLWA had at least one CD4 or viral load reported during 2007. Overall, 31% of 4,906 PLWH/A did not have any reported CD4 or viral load during 2007, suggesting approximately a third of PLWH/A do not receive regular medical care.

Oregon trends

- Since 1997, the rate of new HIV/AIDS diagnoses has remained 8 to 9 per 100,000 persons per year (300 new cases a year).
- The 2007 rate of new HIV/AIDS diagnoses among men was 8 times the rate among women (229 men and 31 women).
- The 2007 rate of new HIV/AIDS diagnoses among blacks was twice the rate among whites (12.4 vs. 6.2 per 100,000), but has averaged 4 times the rate of whites during 1998–2007 (33.3 vs. 7.6 per 100,000).
- The 2007 rate of new HIV/AIDS diagnoses among Hispanics was 1.6 times the rate among whites (11.6 vs. 6.2 per 100,000).
- The 2007 rate of HIV/AIDS diagnoses was highest among males aged 35–39 years (30 cases per 100,000) and among females 30–34 years (5 cases per 100,000).
- The most commonly reported risk of HIV/AIDS in 2007 among men was sex with other men (70% of 229 new diagnoses).
- The most commonly reported risk of HIV/AIDS in 2007 among women was heterosexual sex (61% of 31 new diagnoses).

II Community Services Assessment

CDC describes the Community Services Assessment (CSA) as a description of the prevention needs of populations at risk for HIV infection, the prevention / activities implemented to address these needs (regardless of funding source) and service gaps. The CSA is comprised of:

- Needs assessment - A process for obtaining and analyzing information to determine the current status and service needs of a defined population or geographic area.
- Resource Inventory – Current HIV Prevention and related resources and activities in the project area, regardless of the funding source. A comprehensive resource inventory includes information regarding HIV prevention activities within the project area and other education and prevention activities that are likely to contribute to HIV risk reduction.
- Gap analysis – a description of the unmet HIV Prevention needs defined in the epidemiologic profile. The unmet needs are identified by a comparison of the needs assessment and resource inventory

In the first year of this comprehensive plan due to time constraints the CSA committee's work focused more on the needs assessment component and the development of an outline for planning activities to produce a comprehensive resource inventory and gaps analysis which will be included in future updates.

A. Needs Assessments

The Community Services Assessment Committee (CSA) reviewed local assessments with goals of increasing its understanding of the needs of local population and sub-population groups at risk for HIV/AIDS and to identify gaps in knowledge, resources and services for these groups. Population assessments for People Living with HIV/AIDS (PLWH/A); Men who have sex with men (MSM); Methamphetamine (Meth) Injectors; Communities of Color; Women and Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) Youth were reviewed. Assessments related to priority populations are summarized below. Please review Appendix B for additional assessments that may relate to populations being served in your local jurisdictions.

People Living with HIV/AIDS (PLWH/A)

General Information about PLWH/A in Oregon:

- At the end of 2007, there was an estimated 6,558 PLWH/A in Oregon; 4,922 reported cases and 1,641 estimated cases (people not yet diagnosed and/or those not reported).
- Service delivery is divided geographically into the Portland Transitional Grant Area (TGA) which includes Clackamas, Columbia, Multnomah, Washington and Yamhill counties) and the balance of state (remaining 31 counties) stretching to the California, Idaho and Nevada borders.
- Most PLWH/A live in the TGA.
- Counties with 50 or more PLWH/A include Deschutes, Douglas, Jackson, Josephine, Lane, Linn and Marion.
- Approximately 90% of PLWH/A receiving Ryan White Care funded services live within 25 miles of I-5.

Oregon Medical Practices that Provide HIV Care, 2008 Snapshot

Attempted to answer three key questions:

1. How many medical practices in Oregon provide HIV care and treatment and where are they located?
2. What do medical facilities in Oregon look like in terms of practice affiliation/type, size and type of services offered?
3. What type of services do HIV medical care facilities in Oregon provide?

Summary of Key Findings:

- A small proportion of Oregon medical facilities that participate in HIV reporting (n=44, 15%) actually treat or manage HIV disease.
- Of these, 28 offer care and treatment of HIV disease of all severities without need for consultation and might be considered specialists; 8 co-manage care in conjunction with a specialist; and 8 only provide care up to a threshold and then refer to a specialist.
- Facility size is related to level of care provided (i.e. large practices of 50 or more PLWH are Tier 1 while practices with 10 or fewer PLWH are Tier 3).

- About half of all HIV medical facilities in Oregon served fewer than 15 PLWHA within the first four months of 2007.
- Most of the 44 facilities providing HIV medical care in Oregon were located along the N/S 1-5 corridor west of the Cascades, which is where a majority of the PLWH/A reside.
- 81% of facilities are located in three regions (19 or 43% in TGA), Central-East (9 or 20%, and Southern Oregon (8 or 18%).
- Disproportionate distribution of patients relative to both HIV care providers and care facilities across regions; in some regions, the supply of care facilities and providers may not be well matched to service demand.
- Portland TGA has 77% of patients and 43% of facilities (46% of Tier 1 and 41% of providers).
- Central-East region has 2% of estimated patients and 20% of HIV care facilities (21% Tier 1 and 33% of HIV care providers).
- Eastern Oregon and the N. and S. Coastal areas, there are few PLWH/A and no Tier 1 facility at all (meaning folks must travel great distances to access HIV specialty care).
- 33% of facilities have some type of psychosocial support person (social worker, case manager, educator) co-located at the same site as the medical provider.
- 33% of facilities offer additional medical support (i.e. treatment adherence, risk reduction counseling, or on-site pharmacy).
- Few offer dental, mental health, and drug and alcohol services within their facility.

Out of Care Project (2007)

Project Purpose:

- Explore whether PLWH/A identified as having unmet needs for health services (no CD4 and/or viral load (VL) tests in past 12 months) are in fact out of care.
- Explore whether PLWH/A are experiencing unmet medical care needs besides regular lab testing.
- Fill in the gaps in our current knowledge of out-of-care PLWH/A in Oregon.
- Explore reasons for not getting CD4 and viral load tests performed annually.

- Examine the trajectory of medical care for people who left or were dropped from the CAREAssist (ADAP) program.

Project Conclusions

Phase One - Provider Interviews:

- Oregon HIV service providers appeared to perform or recommend CD4 and VL tests every 3-6 months at a minimum for their clients.
- Provider-identified barriers to PLWH/A receiving the CD4 and VL tests as often as recommended include: untreated mental illness and substance abuse, lack of client finances, structural barriers such as lab hours and location, clients feeling healthy and the system failure commonly identified as “falling through the cracks.”
- Beliefs regarding professional role and responsibility around this issue varied according to provider type.

Phase Two - CARE Assist Client Follow-Up Interviews:

Persons interviewed were primarily stably housed, relatively well educated, employed PLWH/A. Of the 33 former Care Assist clients who completed the interview, 15% were uninsured. Two respondents (6%) met the definition of “out of care” in that they had not had a CD4 or viral load tests in the past 12 months. However, even patients who did not meet the “out of care” definition reported other unmet needs around HIV care:

- One in four respondents had gone 6 months or longer without seeing an HIV care provider.
- Eight (24%) reported a time in the last year when they needed to see a healthcare provider but could not because of cost.
- Nine (27%) reported skipping doses of HIV medications to save money.
- Just under half (45%) reported some level of medical debt.

While the loss of CARE Assist services did not result in negative health outcomes for all the former clients interviewed, one in five believed that losing CARE Assist caused their health to deteriorate.

The financial assistance from this program was important for these participants, a finding summarized by one former CARE Assist client who stated, *“I don’t get the HIV care I need now because I can’t afford it.”*

Phase Three: Out of Care Client Interviews:

- Over a third of the clients were unable to be reached and only one of the clients reached reported experiencing unmet medical needs consistent with this study's definition.
- Nearly all of the clients reached were supportive of the project, and a number of clients stated they feel unmet medical needs are an important issue for PLWH/A.
- Although information contained in the CAREAssist databases could be key to identifying Ryan White clients for evaluation projects in the future, using client contact and lab data from the databases was not an effective way to identify and locate clients with unmet medical needs. The lab data in both databases were incomplete or outdated.
- Recommend that program management consider investing resources in data cleaning with both databases.

Conclusion Summary:

- Results suggest that almost all current and former CARE Assist and Title II Case Management clients are getting their CD4 or viral load tests at least annually.
- These findings are consistent with those from the Ryan White Case Management Needs Assessment.
- Nevertheless, some of these same clients need assistance and support around medication, financial and insurance issues.

Men Who Have Sex with Men (MSM)

Community PROMISE (2007)

- Multnomah, Clackamas and Washington counties implemented this Diffusion of Evidence Based Interventions (DEBI) as “*The HookUp*”
- Lane County as *The Game*
- Initial assessment with agencies & gatekeepers
- In-depth interviews determined that men who have unprotected anal sex (UPAI) with other men of unknown or assumed serostatus were at highest risk
- In addition, the following sub-populations were identified as being at highest risk for HIV transmission:
 - Internet, bathhouse, adult/video store sex seekers of all races, ethnicities, and serostatus
 - PLWH

- African American/Black MSM (metro area only)

Interviews indicated that limited or no communication about serostatus and safer sex is a norm amongst men at highest risk for HIV transmission and that rather than actual communication with sex partners, assumptions are made that put partners at risk.

Additional assessments reviewed included:

- HIV Testing at Multnomah County Public Test Sites (2006)
- HIV, Hepatitis C and Syphilis Testing at Bar Outreach Events (July 1, 2005 – June 30, 2007)
- 2Snaps (2005) Rapid behavioral assessment of social, sexual, alcohol and drug use, MSM at PRIDE event in metro area
- HIV/STD testing
- Snapshot of Oregon (2004)
- Local Assessment of HIV Prevention in HIV Clinic Setting (2004)

Meth Injection Drug Use (PDX)

General information about persons who inject drugs (PWID) in Oregon:

- Injection drug use accounts for about 1 in 5 HIV infections and most HCV infections in Portland, OR.
- Methamphetamine abuse is especially prevalent in the West; injection is preferred mode of administration in Portland.
- Studies show increased sexual transmission risk among meth vs. heroin persons who inject drugs (PWID); evidence comparing injection risk is mixed.
- Syringe exchange programs (SEP) provide sterile injection equipment, safer sex supplies, referrals to prevention/treatment services, and brief counseling/motivational interviewing. Some PWID receive clean needles through other PWID via a “secondary exchange” process.
- PWID who receive needles through secondary exchange may be at higher risk of HIV, HCV, STD, and other health issues than PWID that interact with public health staff at SEP.

Services:

- Multnomah County has provided syringe exchange services for over 12 years; In fiscal year ‘08, the program had over 5000 client

encounters and exchanged 600,000 syringes (20% increase over last year).

Meth PWID Peers and HIV Prevention Multnomah County Health Department Project Description

- 2 year grant from National Institute on Drug Abuse (*Grant # 1 R21 DA23399-01*) to recruit and train meth injectors as peer educators, and evaluate the peer-delivered HIV prevention intervention.
- First year focus on formative evaluation; second year includes implementation of peer education intervention among meth injectors and their secondary exchange networks.

Formative Evaluation:

- Goals to assess the feasibility of recruiting & retaining meth injectors for participation in evaluation activities; understand reasons PWID do and do not use SEP; and understand the risk and risk reduction behaviors of meth injectors related to both sexual and injection behavior, as well as the context and contributing factors for each.

Activities conducted:

- 4 focus groups with 27 meth injectors; two groups of PWID that exchange needles for others and two groups of PWID who receive needles from other PWID (Jan-Feb 2008).
- 10 key informant interviews with meth injectors (April and May 2008).
- Incentives and written, informed consent

Results:

- Feasibility:
- PWID were eager to participate.
- Focus group recruitment ended early because groups were full. 56% of PWID participated in focus groups. 10 of 14 PWID selected for key informant interviews completed interview; 4 were lost to follow up. None refused.
- Reasons PWID Do and Do Not Use SEP:

- PWID exchange needles at SEP because they value their personal health, safety, and comfort; SEP is free; and they lack viable alternatives for needle acquisition and disposal.
- Barriers to using SEP include fear of the police; being “too high,” “lazy,” or living in the moment; lack of information about or access to SEP; and secretiveness or denial about injecting.
- Most participants reported regular engagement with SEP—either as an exchanger or a recipient of secondary exchange—and these roles were more fluid than initially hypothesized.

B. Resource Inventory

The SPG Community Services Assessment Committee reviewed the information and systems currently available for identifying and recording existing HIV prevention resources around the state.

Current sources of resource information and limitations:

- Stakeholder Map: In 2008-09, the state HIV prevention program began developing a ‘stakeholder’ map which includes programs/services (i.e. OHROCS, CTRS, outreach) by county which are directly funded by the state program. This map does not reflect program/services funded by sources other than the State HIV Program.
- County Health Department Eco- Maps: During 2008-09 site visits to some county health departments, state staff were able to collect information about local community based organizations, AIDS service organizations, health care providers, support groups, corrections programs, pharmacies, etc.
- Oregon HIV/STD Hotline: In 2008, the state HIV/STD hotline website and database was upgraded. Information contained in the current database is actively being updated to reflect current/existing resources.

While this information is helpful, the SPG recognizes our need to expand how we inventory resources and define the kind of information we need to collect to gain the best perspective on HIV prevention related services/programs in Oregon.

There are currently twenty one local health departments in counties that averaged at least one new diagnosed HIV infection over the prior three years are funded by the DHS HIV Prevention Program to conduct HIV counseling, testing, and referral services. Additionally, 14 of these local health departments are funded to provide recruitment and behavioral and/or structural HIV prevention services to populations with the highest incidence of HIV infection (specifically, men who have sex with men and persons who inject drugs). Statewide services are available for comprehensive risk counseling services, a hybrid of case management and prevention counseling, that is available to persons living with HIV who have complex HIV prevention needs, and their partners. Persons newly diagnosed with HIV infection may obtain support in disclosing their status to former sex and/or drug-using partners through partner counseling and referral services, which are provided statewide. Finally, public information services are available through the state-supported Oregon AIDS/STD Hotline; and brochures (reviewed and approved for distribution through a Program Review Panel) are available to local health departments and community-based organizations through the HIV Prevention Program.

In addition to services provided by local health departments, other state agencies provide some HIV prevention services or establish policy regarding the delivery of HIV prevention information, including the Oregon Department of Education, Oregon Department of Corrections, Oregon Youth Authority, and the Oregon Department of Human Services Addictions and Mental Health Division, Family Planning, and other programs.

The amount of funding that local health departments receive from the DHS HIV Prevention Program to provide HIV prevention services is determined by a funding formula that is negotiated with and approved through the Conference of Local Health Officials (CLHO), a group representing the interests of local public health. The table below summarizes HIV prevention funding that was awarded to local health departments (and/or their contractors) for FY 2010 to deliver HIV prevention services. In addition to the following amounts, agencies may opt to spend up to 10% of direct expenses towards indirect costs. Although not all local health departments budget funds for indirect services, most do. In FY 2009, local health departments (and/or their subcontractors) committed \$2,032,964 of their state HIV prevention awards toward direct program costs, and \$152,748 toward indirect costs. Additionally, local health departments and/or their

subcontractors leveraged services with an additional \$860,559 in local or other support.

FY 2010 DHS HIV PREVENTION PROGRAM FUNDED ACTIVITIES					
COUNTY / REGION	INTERVENTION / ACTIVITY	HIV PREVENTION PROGRAM FUNDING	OTHER FUNDING	RISK POPULATION	CONDUCTED BY
Statewide	Comprehensive Risk Counseling Services	\$110,000		PLWH/A and their partners	Partnership Project
Statewide	Oregon AIDS/STD Hotline	\$75,000		At-risk and general population	Cascade AIDS Project (CAP)
Statewide	HIV DIS			PLWH/A and their partners	State STD staff and Multnomah County STD Clinic
Benton / Linn	HIV Counseling, Testing and Referral Services (CTRS)	\$6,884	\$8,421	MSM, PWID, Partners of PLWH	Local Health Department (LHD)
	Outreach to CTRS	\$13,768	\$16,840	MSM, Partners of PLWH	LHD
	Oregon Harm Reduction Outreach & Care Services (OHROCS)	\$13,768	\$16,840	PWID	LHD
Clackamas	HIV Counseling, Testing and Referral Services	\$53,891		MSM, PWID, Partners of PLWH	LHD
	Outreach to CTRS	\$52,768		MSM, Partners of PLWH	LHD
	OHROCS	\$4,614		PWID	LHD
Clatsop	HIV Counseling, Testing and Referral Services	\$3,011		MSM, PWID, Partners of PLWH	LHD
	Outreach to CTRS	\$4,332		MSM, Partners of PLWH	LHD
Columbia	HIV Counseling, Testing and Referral Services	\$6,608		MSM, PWID, Partners of PLWH	LHD
Coos	HIV Counseling, Testing and Referral Services	\$3,242		MSM, PWID, Partners of PLWH	LHD
	Outreach to CTRS	\$7,566		MSM, Partners of PLWH	LHD
Deschutes	HIV Counseling, Testing and Referral Services	\$20,832	\$25,000	MSM, PWID, Partners of PLWH	LHD

FY 2010 DHS HIV PREVENTION PROGRAM FUNDED ACTIVITIES					
COUNTY / REGION	INTERVENTION / ACTIVITY	HIV PREVENTION PROGRAM FUNDING	OTHER FUNDING	RISK POPULATION	CONDUCTED BY
	Outreach to CTRS		\$5,000	MSM, PWID, Partners of PLWH	LHD
	OHROCS	\$8,000	22,000	PWID	LHD
Douglas	HIV Counseling, Testing and Referral Services	\$12,552	\$59,700	MSM, PWID, Partners of PLWH	LHD / Harm Reduction Center of Southern Oregon (HRC)
	Outreach to CTRS	\$15,250	\$2,041	MSM, Partners of PLWH	LHD / HRC
	OHROCS	\$7,614	\$3,000	PWID	HRC
Hood River	HIV Counseling, Testing and Referral Services	\$7,868		MSM, PWID, Partners of PLWH	LHD
Jackson	HIV Counseling, Testing and Referral Services	\$25,454	\$3,000	MSM, PWID, Partners of PLWH	LHD & LaClinica del Valle
	Outreach to CTRS	\$15,273		MSM, Partners of PLWH	LHD
	OHROCS	\$8,340		PWID	LHD
Josephine	HIV Counseling, Testing and Referral Services	\$7,128	\$3,000	MSM, PWID, Partners of PLWH	LHD / HRC
	Outreach to CTRS	\$9,062	\$2,500	MSM, Partners of PLWH	LHD / HRC
	OHROCS	\$4,520	\$8,033	PWID	HRC
Lane	HIV Counseling, Testing and Referral Services	\$81,485	\$16,323	MSM, PWID, Partners of PLWH	LHD HIV Alliance
	Outreach to CTRS	\$25,000	\$3,100	MSM, Partners of PLWH	LHD HIV Alliance
	OHROCS	\$20,000	\$5,000	PWID	HIV Alliance
Lincoln	HIV Counseling, Testing and Referral Services	\$9,031		MSM, PWID, Partners of PLWH	
	Outreach to CTRS	\$1,590	\$6,338	MSM, Partners of PLWH	LHD
Malheur	HIV Counseling, Testing and Referral Services	\$9,162		MSM, Partners of PLWH	LHD
Marion	HIV Counseling, Testing and Referral Services	\$76,354		MSM, PWID, Partners of PLWH	LHD
	Outreach to CTRS/	\$37,589		MSM, Partners	LHD

FY 2010 DHS HIV PREVENTION PROGRAM FUNDED ACTIVITIES					
COUNTY / REGION	INTERVENTION / ACTIVITY	HIV PREVENTION PROGRAM FUNDING	OTHER FUNDING	RISK POPULATION	CONDUCTED BY
	Venue based Outreach to CTRS/ Social Networks Strategy (SNS)			of PLWH	
	OHROCS	\$3,524		PWID	LHD
Multnomah	HIV Counseling, Testing and Referral Services	\$401,312	\$94,375	MSM, PWID, MSM/PWID, Partners of PLWH At risk GP	LHD
	Community Promise	\$277,954	\$25,739	MSM	
	Outreach to CTRS	\$86,760	\$17,159	MSM	CAP
	Outreach to CTRS/ SNS	\$34,140			
	OHROCS	\$211,353	\$301,050	PWID	LHD/ Outside In
	HIV DIS				
Polk	HIV Counseling, Testing and Referral Services	\$9,361		MSM, Partners of PLWH	LHD
Umatilla	HIV Counseling, Testing and Referral Services	\$13,608		MSM, PWID, Partners of PLWH	LHD
	Outreach to CTRS	\$4,134		MSM, Partners of PLWH	LHD
Wasco	HIV Counseling, Testing and Referral Services	\$9,221		Partners of PLWH	LHD
Washington	HIV Counseling, Testing and Referral Services	\$109,857	\$119,077	MSM, PWID, MSM/PWID Partners of PLWH	LHD
	Outreach to CTRS	\$10,000		MSM, PWID, Partners of PLWH	LHD
	Mpowerment Chicos Latinos	\$70,000		MSM	CAP
Yamhill	HIV Counseling, Testing and Referral Services	\$6,874	\$20,059	MSM, PWID, Partners of PLWH	LHD
	Outreach to CTRS	\$7,808		MSM, Partners of PLWH	LHD
Total		\$1,828,462	783,595		

Overview of Known Community-Based Organizations Providing HIV Prevention Services

Area Served	Organization Name	General Services Provided
Benton/Linn Counties	Valley AIDS Information Network	Provides support services to people with HIV and community education. Speakers Bureau, HIV+ Support Groups, information tables at public events, and website www.valleyaidsinfo.org . <i>(Does not receive funding from state or local health department, but does receive brochures used to promote public understanding.)</i>
Coos/Curry/Douglas/Josephine counties	Harm Reduction Center of Southern Oregon	Outreach, counseling and testing services, other HIV prevention services, and support services for persons living with HIV. <i>(HRC has contracts with each of the counties it serves for the delivery of HIV counseling and testing and other HIV prevention services.)</i>
Lane	HIV Alliance	Outreach, counseling and testing services, other HIV prevention services, and support services for persons living with HIV (and their families). <i>(HIV Alliance has a contract with Lane County Public Health for HIV Counseling and Testing, Community PROMISE, and OHROCS.)</i>
Lincoln/Tillamook	Coastal AIDS Network (CAN)	Outreach to susceptible populations, HIV prevention activities, education, a newsletter and public events designed to reach at-risk groups. <i>(CAN has a contract with Lincoln County Health Department to conduct outreach into county-provided HIV counseling and testing.)</i>
Marion	HIV AIDS Awareness Project (HAAP)	Peer-driven HIV prevention in the Oregon State Penitentiary. Serves as resource to other Correctional facilities. <i>(HAPP receives in-kind governance support through state HIV Prevention staff participation on Board of Directors of Program.)</i>
Multnomah	African American AIDS Awareness Action Alliance (A6)	The African American AIDS Awareness Action Alliance (A6) is a coalition of several community based organizations, Multnomah County Health Department and community members who have partnered collectively for over seven

Overview of Known Community-Based Organizations Providing HIV Prevention Services

Area Served	Organization Name	General Services Provided
Multnomah, Clackamas and Washington counties	Unity Project of Oregon / Brother to Brother (B2B)	<p>years to increase awareness about the impact of the HIV/AIDS disparity among the Portland African American community. Through innovative initiatives, targeted education, providing resources, erasing stigma, changing community norms, and HIV testing we seek to engage and empower community members.</p> <p>Social, spiritual, civic and health care networks to improve the quality of life Black/African-American, bisexual, gay, lesbian, same-gender loving, and transgender people, family and friends through advocacy, arts, education, and social change.</p>
Multnomah, Clackamas and Washington counties	Cascade AIDS Project (CAP)	<p>Client services, HIV prevention activities, public relations, housing and support for the infected community. CAP also conducts statewide advocacy and policy work. <i>(CAP receives funding to reach Latino gay/bi men through Mpowerment under a contract from Washington County. Additionally, CAP receives funding directly from CDC to conduct rapid testing in non-clinical settings, conduct the Healthy Relationship intervention for persons living with HIV, and to conduct an outcome monitoring project of Healthy Relationships.)</i></p>
Multnomah and Clackamas counties	Outside In	<p>Serves homeless street youth in the Portland metro area. Offers needle exchange, street outreach, medical services and educational support to youth. <i>(Outside In receives funding to conduct HIV testing at needle exchange sites and to conduct rapid testing under a subcontract from CAP.)</i></p>

Overview of Known Community-Based Organizations Providing HIV Prevention Services

Area Served	Organization Name	General Services Provided
Clackamas, Columbia, Multnomah and Washington counties	Partnership Project	Provides case management for persons living with HIV/AIDS and comprehensive risk counseling services for HIV-positive persons and partners with complex HIV prevention needs. (<i>Partnership Project receives funding for in-person and telephone-based comprehensive risk counseling services throughout the state.</i>)
Umatilla and Morrow counties	Umatilla Morrow Alternatives	Advocacy for under served minority populations. HIV/AIDS support groups, Hepatitis C support groups. Provides speakers for community events and schools of people living with HIV/AIDS, Hep C and GLBT to increase awareness and education and leadership development

In summary, while this information is helpful, the SPG recognizes our need to expand how we inventory resources and define, more specifically, the information we need to collect to gain the best perspective on HIV prevention related services/programs in Oregon.

Future Resource Inventory Activities:

To develop a more comprehensive picture of resources we plan to use the current sources of information (described above) and the following future sources of information to accurately inventory resources in place (see Appendix B for a complete list of resources/services identified as importance to include in future editions of the resource inventory activities). We will identify gaps in services when we have comprehensive information and determine how to use existing and planned resources to further meet the needs of the target communities.

- **County Network Agency Forms: HIV Prevention Program** contractors are in the process of completing network agency forms as part of the 2009-2010 planning data collection effort. These forms include basic information on agencies within the contractor's referral network.
- **HIV/Hep C Resource Guides (English and Spanish):** These guides are available in print and electronically include a range of comprehensive HIV care services as well as Hepatitis resources. Service information reflects mental health, substance use/abuse, housing, medical,

- insurance, education, prevention, and a host of other allied support services. This guide only includes counties within the Ryan White Transitional Grant Area.
- Spanish HIV/Hep C Resource Guide: This guide is available in print and electronically and includes a range of comprehensive HIV care services as well as Hepatitis resources for Spanish speakers. Service information reflects mental health, substance use/abuse, housing, medical, insurance, education, prevention, and a host of other allied support services. This guide only includes counties within the Ryan White Transitional Grant Area.
 - Other metro resource lists include but are not limited to: Multnomah and East County Community Resource List, Gay/Bi/Trans Men's Resource List, Sexual Health 4 Men Coalition (SH4MC) Resource Inventory, and the online and print Rose City Resource Guide.

Furthermore, the SPG outlined what a comprehensive HIV prevention system of care would include and identified the importance of tracking/identifying the existence or lack of the following resources and services by county in the future: HIV testing; Outreach into testing; STI screening and treatment; Partner Counseling and Referral Services; Syringe exchange/disposal programs; HIV/STD Community Education; Hep A and B vaccines; Hepatitis C Testing; HIV Care and Treatment; HIV Care Case Management; HIV Prevention Case Management; Medical care; Hospitals/ERs; Indian Health Services; Faith-based services; Pharmacies; Mental health programs; A&D treatment or support programs; Dental care; Low income housing and homeless shelters; Youth programs and services; Support Services/Groups; Sex worker services; Domestic violence services; and Lesbian/Gay/Bisexual/Trans and Queer programs/services.

Tracking these resources will include identifying which are public and private resources, who is eligible and prioritized, how services are accessible (language, disability, hours), and methods used for service provision (i.e. technologies used, frequency of services).

Resource information will be verified with line staff (tester, outreach workers, case managers), clients and SPG members from local communities. This information will then be used to assist us in determining what services are in place and to assess where service gaps exist.

C. Gaps Analysis

A Gaps Analysis describes the unmet HIV prevention needs within the high-risk populations defined in the epidemiologic profile. Unmet needs are identified by comparing needs assessments and the resource inventory. Due to time constraints of this first phase of planning we have not yet gathered all of the resource information needed to develop a gaps analysis. Over the course of the next planning year the SPG plans to begin this process and will include this in the 2011 update.

III PRIORITY POPULATIONS

The process used by the CSA committee to prioritize populations most at risk for HIV included a systematic review of the local HIV epidemiology and trends (HIV counseling and testing data, enhanced HIV/AIDS Reporting System); a review of health disparities; and a review of the literature on HIV prevention for high risk populations.

Five criteria were established for prioritizing populations to be targeted with HIV prevention interventions. These five criteria are:

- Incidence (average annual number of Oregon cases from 2003-2007)
- Prevalence (Oregon cases thought to be living as of 12-31-07)
- Late diagnosis (Oregon cases with AIDS within 12 months of first diagnosis)
- Other health disparities (mortality and case fatality, foreign birth, HIV by region, and unmet medical need)
- Literature Review (community needs assessments)

Criteria were selected after review of other state HIV prevention planning processes. These criteria were specifically based on the Washington State HIV Strategic and Operational Plan. Committee members reviewed Oregon data on incidence, prevalence, late diagnosis and other health disparities. The Department of Health and Human Services' Healthy People 2010 specifies that the term health disparities designate "differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation" (see Appendix C). Committee members reviewed and summarized existing local and regional needs assessments.²

² Assessments and source data include: a) Oregon Medical Practices that Provide HIV Care: 2008 Snapshot. Portland, OR: HIV/STD/TB Programs, Oregon Department of Human Services, Public Health Division; April 2008. b) Out of Care Study Summary of Study Design and Findings. Kari Greene, Julie Maher and Linda Drach. May 15, 2007. c) Community PROMISE Community Identification Methods and Findings: A Report from the Tri-County Community PROMISE Workgroup (Drach L, Anderson-Nathe B, Smith C). 2007. d) Drach L, Holbert T. HIV Testing at Multnomah County Public Test Sites, 2006, e) Drach L, Holbert T. HIV, Hepatitis C, and Syphilis Testing at Bar Outreach Events Program Data from MCHD HIV & Hepatitis C Community Prevention Targeted Testing Programs f) Snapshot of Oregon: Understanding HIV Risk Among Oregon's MSM. 2004. g) Local Assessment of HIV Prevention in Clinic Settings. Multnomah County Health Department, 2005. h) Early Learning from a Peer Education Model Designed to Reduce HIV Risk among Methamphetamine-Injecting (Drach L, Rumptz M, Guernsey Camargo J, Pranian K, Maher J, Casciato C, Stark M. MCHD/OPHD, PDES and MCHD HIV/HCV Community Programs) i) AIDS Detected Late in Latinos by Rebecca Kimitch. San Gabriel Valley Tribune - November 14, 2008. j) Unmet HIV Prevention Needs of Communities of Color (Oregon, 1998) k) Voices of Oregon Women at Risk for HIV (Oregon, 1999) l) National Network for Youth. <http://www.nn4youth.org/hivstd.aspx> m) National Coalition for the Homeless at <http://www.nationalhomeless.org/publications/facts/HIV.pdf> n) National Gay and Lesbian Task Force Policy Institute, National Coalition for the Homeless. An Epidemic of Homelessness. 2006. o) Bao, W.N., Whitbeck, Hoyt. Journal of Health and Social Behavior. Abuse, Support, and Depression among Homeless and Runaway Adolescents. 2000. p) Berger, C. What becomes of the at-risk gay youths? The Gay & Lesbian Review Worldwide, pppp.24-25. 2005. q) Dewey, C. The Struggles of Homeless Trans Youth. Windy City Times, 2007. r) Cochran, B, Stewart, A. et al. Challenges Faced by Homeless Sexual Minorities: Comparison of Gay,

Populations listed below were prioritized by HIV status, gender, behavioral risk, race, and age when appropriate.

Recommendation Summary

Priority populations were defined as Intervention Populations or populations warranting HIV prevention interventions resources, and Populations of Concern, populations warranting quantitative and qualitative assessments.

Intervention Populations

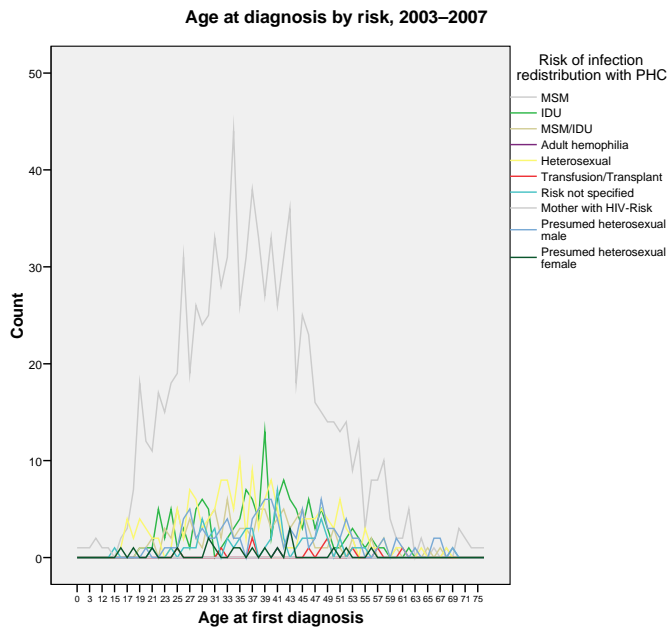
In accordance with the CDC Community Planning Guidance, the CSA committee prioritized the top populations for which HIV prevention services could have the greatest impact to reduce new infections.

The prioritized populations, excluding those living with HIV, represent 73% of all reported cases of HIV in Oregon.

The prioritized intervention populations are ranked as follows:

1. Persons living with HIV/AIDS
2. Men who have sex with men (MSM) whose HIV status is unknown or was negative at last test, and
3. Persons who inject drugs (PWID) whose HIV status is unknown or was negative at last test

Lesbian, Bisexual, and Transgender Homeless Adolescents With Their Heterosexual Counterparts. *American Journal of Public Health*. May 2002, Vol 92, No. 5. s) Ward, Ann A. Mental Health and HIV Risk Behaviors Among Homeless Youth. Graduate School of Social Work, PSU. 2003 Dissertation.



Persons Living with HIV/AIDS (PLWH/A)

PLWH/A require HIV prevention priority setting and intervention resources to reduce further transmission of HIV/AIDS in non-infected communities. PLWHA include those in and not in HIV medical care. In Oregon, groups most likely to be without medical care were Hispanics and African-Americans, compared to whites; older persons; male PWID; MSM/PWID; and heterosexuals (compared to MSM).

PLWH/A are mostly white, due to population size; however, Latinos/Hispanics and Black/African-Americans are overrepresented.

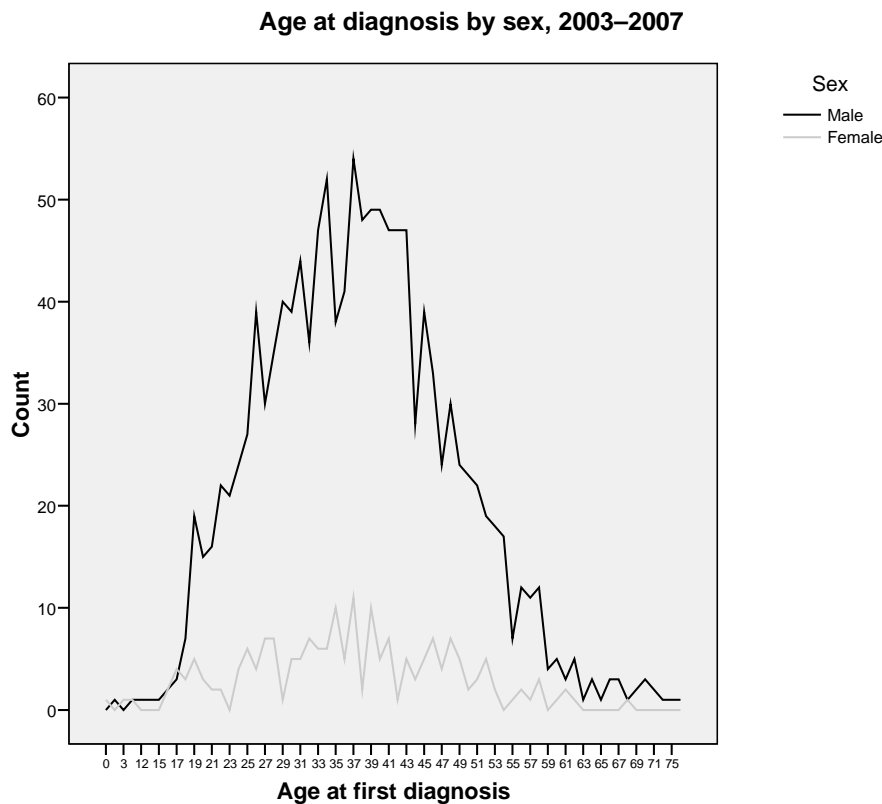
HIV-positive MSM are the primary priority subpopulation of PLWH/A to be reached with HIV prevention intervention, followed by HIV-positive PWID. Other PLWH who engage in unprotected vaginal/anal sex with persons of unknown, assumed or HIV serodiscordant status are also prioritized. Interventions selected need to address varying behavioral risks (i.e. sexual versus drug using transmission risk) as well as cultural factors.

MSM with Unknown or Negative HIV Status

Per the most current epidemiologic profile for the State of Oregon, 21% of PLWH/A are unaware of their HIV status; demographics are the same as for those who know their status. As such, the targeted population includes MSM regardless of self-identified sexual orientation or identities that do not know their HIV status or had an HIV negative result at last test.

These are men who have sex with other men and may also have sex with women and/or transgender folks. Among these MSM, white MSM are ranked highest, followed by MSM who also inject drugs (MSM/PWID), Hispanic MSM, and Black/African-American MSM. Interventions selected need to address varying behavioral risks (i.e. sexual versus drug using transmission risk) as well as socio-cultural factors (i.e. racial/ethnic; gay/non-gay identified).

MSM prioritized for intervention are those 13 years of age and older engaging in unprotected anal intercourse with persons of unknown, assumed, or serodiscordant HIV status. MSM seeking sex via internet, adult book/video stores, bathhouses and within substance using sexual networks.*



Age at diagnosis by sex and risk, shown above suggest that most persons were diagnosed with HIV/AIDS between 24-49 years of age. This suggests HIV prevention interventions should target persons starting 10 years earlier.

PWID with Unknown or Negative HIV Status

Per the most current epidemiologic profile for the State of Oregon, 21% of PLWH/A are unaware of their HIV status; evidence indicates demographics are the same as for those who know status. As such, the final targeted intervention population includes PWIDs who do not know their HIV status or had an HIV negative result at last test. For this population, all genders are priorities for intervention. Interventions selected need to address varying behavioral risks (i.e. drug use alone versus drug use and sexual transmission risks), gender groups, social and cultural factors.

INTERVENTION POPULATIONS								
Populations to be targeted with HIV prevention funded interventions								
RANK	POPULATION	SUBPOPULATIONS <i>Ranked within larger population</i>	Reported # living with HIV to 12/31/07	% of total # of HIV+ persons	Average annual # of newly dx cases 2003-07	Pop. Size estimate	Estimated prev. of reported cases	Average # & % of late dx 2003-07
1.	Person Living with HIV/AIDS— <u>Status Known In & Out of Care</u>	a. HIV+ MSM* b. HIV+ IDU c. Other PLWH who engage in unprotected vaginal/anal sex with persons of unknown, assumed or HIV serodiscordant status.	4922 ³	100%	299	3,649,637*	0.1%	117/299 (39%)
2.	MSM 13+ HIV Status Unknown or Negative At Last Test	All MSM* 13+	3050	62%	179	75,182	4.1%	62/179 (35%)
		a. White	2617	53%	146	64,110	4.1%	50/146 (34%)
		b. MSM/IDU	403	8.2%	20	-	-	7/20 (35%)
		c. Hispanic	258	5%	22	7,802	3.3%	7/22 (32%)
		d. Black and African-American	115	2%	5	1,545	7.4%	1/5 (20%)
3.	IDU of Unknown or Negative HIV Status 13+	a. White- all genders b. All genders- not white	530 ⁴	11%	27	45,648	1.2%	11/27 (41%)

POPULATIONS OF CONCERN

Populations of concern were identified based on insufficient data, overrepresentation in HIV cases, and/or higher reported risk activity for HIV/STD acquisition and transmission according to epidemiological data and community assessments.

Populations warranting quantitative and qualitative monitoring are ranked as follows and described below:

1. HIV+ Males of Undisclosed Risk, 13+ years of age
2. Female sex partners of MSM
3. Sex Partners of PWID
4. Non-MSM and non-PWID persons over 50 year of age
5. Transgender Persons, 13+
6. American Indians and Alaska Natives 13 years and older

HIV+ Males of Undisclosed Risk

According to 2003-2007 Oregon HIV/AIDS cases, a significant portion of persons who test positive for HIV in Oregon did not report risk factors. Twelve percent of males diagnosed 2003–2007 in Oregon did not have an identified risk. These men are mostly white but Hispanics and Blacks are over-represented. 65% of those with late diagnosis are among males with undisclosed/unreported.

Literature continues to suggest that persons with unknown, unreported or undisclosed risk often reflect those with reported risk. As such, we believe a large proportion of these men are part of sexual and social networks of MSM and PWID.

Female sex partners of MSM

Female sex partners of MSM are part of MSM sexual networks where HIV prevalence is increased.

Sex Partners of PWID

Sex partner of PWID are part of injection drug using networks where HIV prevalence is increased.

Non-MSM and non-PWID persons over 50 year of age

There are 1,503⁵ reported persons living with HIV (to 12.31.07) who are 50 years of age or over, representing 31% of the total number of PLWHA. The

average annual number of newly diagnosed cases between 2003-07 for this population group is 41, based on a population size estimated at 1,147, 562. While the estimated prevalence is 0.1%, 54% (109/202) of persons 50 years of age and older were diagnosed late (i.e., diagnosed with AIDS or progressed to AIDS within 12 months).

Transgender Persons 13+

Transgender persons are at increased risk for HIV for a variety of reasons including, but not limited to being sexual and drug use partners of persons with high prevalence of infection; high reported rate of sexual risk taking, alcohol and drug abuse, homelessness, and systemic barriers to medical care and related services (i.e. housing, mental health).

American Indians and Alaska Natives 13 years and older

Native American/Indian community members are at increased risk for HIV due to high reported rate of sexual risk taking, alcohol and drug abuse, homelessness, and systemic barriers to medical care and related services (i.e. housing, mental health).

Native American/Indian communities represent a small actual number of persons living with HIV but are a group overrepresented in data.

IV INTERVENTIONS

The Intervention committee is charged with reviewing HIV prevention interventions and activities on their ability to prevent new HIV infections and to make recommendations for which HIV prevention intervention activities should be recommended for Oregon. To that end the committee designed a process to achieve this goal through the following activities:

1. Establishing a system to evaluate and rank HIV prevention interventions and activities based on sound criteria
2. Developing a prioritized list of recommended HIV prevention interventions and activities for each priority population as outlined by the SPG
3. Addressing issues of cost effectiveness and how it relates to HIV prevention intervention and activities
4. Developing guiding principles for HIV prevention intervention and activity selection

For the purpose of this section of the comprehensive plan, the committee included the following in the category of HIV prevention intervention activities: DEBIs (Diffusion of Evidenced-based Interventions), best evidenced interventions, promising interventions, and HIV prevention strategies. All of these interventions and activities are promoted by the Centers for Disease Control and Prevention (CDC) and are considered eligible for implementation with CDC funds whether passed through the State or through direct funding opportunities. For the most part the committee decided not to examine structural or non CDC promoted intervention activities (except for needle exchange), but plans on addressing these for Oregon's comprehensive plan updates.

The committee established a ranked prioritization of intervention activities for each priority population (included in Appendix D) and recommends that agencies or local health department's use in a similar process on the ranked interventions included in this plan to select the best intervention activity for their area. An additional component of intervention selection includes addressing some universal recommendations created by the Intervention committee in addition to the overall guiding principles established by the SPG.

Universal Recommendations:

The SPG Intervention committee recommends that local communities use the guidelines listed below to determine which evidenced-based intervention will most likely be effective for a given priority population.

- 1. Use local epidemiological data:** Use of local data allows prevention providers to identify those priority populations at greatest risk in their community. This allows providers the opportunity to focus limited resources on prevention strategies for those at highest risk.
- 2. Consider your capacity:** There is a wide range in the level and type of resources needed to implement interventions identified in this plan. Local prevention providers must be realistic in identifying their capacity when deciding which intervention will be most successful in their area. Interventions are only effective when their core elements are followed and implemented as recommended.
- 3. Consider your cultural competency:** For HIV/AIDS prevention and treatment to succeed, the special needs and life contexts of those who are marginalized because of race, ethnicity, socioeconomic status (SES), sexual orientation, age, or gender must be sensitively addressed. Cultural competence must be demonstrated not only by intervention programs and staff, but also by surveillance staff, researchers (and their investigations), as well as by those delivering prevention services, care, and treatment programs to those who are HIV-infected. [National Prevention Information Network (NPIN)].
- 4. Consider your local political will:** Prevention providers should be aware of their local political climate. This includes the politics of their organization, organizations they currently partner with, governmental agencies, school boards, and other funding sources. There are many highly effective prevention interventions that can be very controversial in certain political climates. If you determine that an intervention will be most effective in your community and is also an intervention that may raise opposition, it is very important to have a plan in place to address that opposition. An example of this could include needle exchange or distributing condoms in prisons or schools.

5. **Consider expertise and competence available:** In addition to determining capacity in terms of funding, space, and other programmatic resources, prevention providers must clearly define the expertise needed to implement a given intervention and honestly assess their capacity to provide this level of competence. Evidenced-based interventions have been evaluated based on a specific level of provider expertise and competence. Effectiveness is compromised if these are not available.
6. **Remember – this is in addition to SPG guiding principles:** Local prevention providers should check their intervention selection process against the overall SPG Prevention Guiding Principles listed on page ii of this plan. This will help ensure that those at highest risk within your local community are the focus of the planned prevention activities.

If a non-CDC recommended intervention is selected for use, the local health department/CBO will need to validate that the intervention is based on solid evidence and identify the process by which the intervention was selected as most effective for their community for State HIV prevention pass-through funding to be approved.

Prioritized Interventions

The interventions ranked by the SPG Intervention committee as most effective for the prioritized populations are listed below. All interventions listed are recommended by the CDC as effective evidenced-based interventions. Specific information on a given intervention can be found on CDC's website: <http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm> . The CDC is continually updating the compendium and folks should review it online and review any newly added interventions. For the purpose of Oregon's comprehensive plan, any listed intervention on the CDC's effective interventions website should be considered for implementation in Oregon.

- A. **Prioritized list for Persons Living with HIV/AIDS (PLWHA)**
 - Popular Opinion Leader (POL)
 - Options/Opciones Project
 - Safe in the City
 - Comprehensive Risk Reduction Counseling Services (CRCS) - formerly PCM (Prevention Case Management)

- Healthy Relationships (HR)
- Healthy Living Project (HLP)
- Partner Counseling and Referral Services (PCRS) also referred to as Partner Services
- Real AIDS Prevention Program
- Willow
- Community PROMISE
- Social Networking Services
- Counseling and Testing Services
- Partnership for Health
- Holistic Health Recovery Program
- Positive Choice: Interactive Video Doctor
- Many Men, Many Voices
- Mpowerment
- Voices/Voces
- Together Learning Choices (TLC)
- SUMMIT Enhanced peer led
- Living in the Face of Trauma

Prioritized list for Men who have Sex with Men (MSM):

- RESPECT – brief
- Popular Opinion Leader (POL)
- D-Up: Defend Yourself
- Many Men, Many Voices
- Social Networking Strategy
- Healthy Relationships (HR)
- START
- Mpowerment
- Together Learning Choices (TLC)
- Comprehensive Risk Reduction Counseling Services (CRCS) - formerly PCM (Prevention Case Management)
- Respect
- Counseling and Testing Services
- Be Proud! Be Responsible!
- Cuidate!
- Partner Counseling and Referral Services (PCRS) also referred to as Partner Services
- Safe in the City
- Personalized Cognitive Risk-Reduction Counseling
- Voices/Voces

- Street Smart
- Community PROMISE
- Healthy Living Project (HLP)
- "light"
- Real AIDS Prevention Program
- Partnership for Health
- SHIELD
- Positive Choice: Interactive Video Doctor
- Living in the Face of Trauma

Prioritized list for Persons Who Inject Drugs (PWID)/Injection Drug Users (IDU)

- RESPECT – brief
- Popular Opinion Leader (POL)
- Syringe Exchange
- D-Up: Defend Yourself
- Sniffer
- Street Smart
- STRIVE – Study to Reduce Intravenous Exposures
- Social Networking Strategy
- START
- Safe in the City
- Community PROMISE
- Healthy Living Project (HLP)
- Comprehensive Risk Reduction Counseling Services (CRCS) - formerly PCM (Prevention Case Management)
- Counseling and Testing Services
- Partner Counseling and Referral Services (PCRS) also referred to as Partner Services
- BRAINE
- Safety Counts
- SHIELD
- Holistic Health Recovery Program
- Options/Opciones Project
- Responsible, Empowered, Aware, Living Men (REAL Men)
- Positive Choice: Interactive Video Doctor
- Drug Users Intervention Trial (DUIIT)
- Clear (In person)
- MIP

- Living in the Face of Trauma

Next Steps:

The process described above represents the first step in identifying and ranking evidence based interventions for the state of Oregon. The next steps for the SPG Intervention committee will be as follows:

1. **Research and rank interventions not currently listed in the CDC Compendium of Evidence Based Interventions.** Having completed the ranking of CDC recommended evidence-based interventions the Intervention committee will begin the process of identifying and ranking interventions available through other sources, both nationally



and internationally. These will be added to the list of recommended interventions as ranking is completed. This assessment will utilize the socio-ecological model as its base. The socio-ecological model of health promotion recognizes the relationship that exists

between the individual and their environment. While individuals are responsible for instituting and maintaining the lifestyle changes necessary to reduce risk and improve health, individual behavior is determined to a large extent by social environment, such as community norms and values, regulations, and policies. The most effective way to support healthy behaviors is to have a combination of efforts at all levels--individual, interpersonal, organizational, community, and public policy. The interventions recommended by the CDC and listed in this plan identify strategies which individuals and communities can use to change norms and behaviors that may lead to HIV/STD infection. In addition to researching, identifying and ranking other individual, interpersonal, and community level interventions, the SPG Intervention committee plans to research, identify, and rank interventions and efforts which address regulations and policies which affect the ability of an individual or community to support positive sexual health. This process will be updated annually in an effort to include new, innovative, effective interventions to the

menu of options available to intervention providers in the state of Oregon.

In addition to identifying existing effective interventions, the group will initiate a process to brainstorm and identify ideas for new interventions that will address prevention gaps in Oregon. Evidence-based interventions are not the end all of prevention nor can they possibly meet all the needs of local communities. In fact we think of these interventions as a part of a web of intervention/prevention activities and that while many communities and community members may be reached through them, there are those folks who are falling through the cracks. The committee is determined to look at where these gaps are and finding out what new and innovative programming may be needed to fill in these gaps.

Feedback will also be solicited on the criteria developed by this committee to rank interventions. As part of the continued plan for updating our SPG comprehensive plan, this committee recognizes the need to reevaluate interventions prioritized by looking at the criteria on which they were evaluated. It is our intent to continuously seek feedback on the criteria originally used and to update this as we move to future years in order to maintain its relevance.

- 2. Evaluate and collect feedback on the experiences of local health departments and community based organizations in implementing DEBIs and other CDC recommended evidence based interventions.** The realities of implementing evidenced based interventions and activities can vary depending on multiple factors including: geographic location, community dynamics, level of funding and resources, etc. The Intervention committee will create a process to both evaluate the effectiveness of local implementation efforts as well as collect feedback on the experience of implementing interventions. Feedback would include implementation challenges and successes as well as suggestions for how to support local efforts. In particular, we would like to address how agencies and health departments decide what is and is not working and when and how to switch their prevention efforts. We have included an article on this topic in the appendix as a resource. The committee hopes that this feedback will provide helpful information for organizations in the process of evaluating current interventions/activities as well as

identifying interventions/activities that might work in their area. A statewide list of individuals with experience and skills in intervention selection, adaptation, implementation and evaluation will be compiled from this assessment and will serve as a technical assistance and resource bank for other providers throughout the state.

3. **Create a step by step process which individual organizations and local health departments can use when researching, selecting, adapting, implementing and evaluating new interventions in their area.** The steps in this process will include:
 - a. Utilizing the socio-ecological model, develop a tool to assessment of current programs, interventions, activities, and collaborations/partnerships involved in providing prevention activities to the focus population/s. This process will help identify current strengths as well as gaps in services which a new intervention may address.
 - b. Development of criteria that can be used to assess suitability of interventions to the local circumstances. These will be modeled after the criteria used to rank interventions for the state prevention plan. Throughout this process the committee recognized that the process we went through to rank/prioritize the interventions was more useful than the actual prioritized list. The work done in the process and the dialogue that came out of it was the most useful aspect. To that end, we are hoping to create a step-by-step guide outlining our process for local communities to use when selecting their intervention activities. Ideally this will also be supplemented with some information on how to adapt and tailor these interventions for more effective impacts.
 - c. Work with the state to identify a process for assessing cost effectiveness of evidence based interventions. State staff has begun to review the literature and potential models in this area and will be a key partner in this effort. Identifying the cost effectiveness of prevention interventions is very complex. The SPG Intervention committee will try to determine a basic method that local communities can use to inform their intervention selection process. In this review, attention will be paid to the realities of limited funding (especially in more rural areas) and the financial costs of interventions.

V. COMPREHENSIVE PLAN NEXT STEPS

The first year of this plan represents the renewed efforts of the SPG to develop a comprehensive statewide HIV, Viral Hepatitis and STD Prevention Plan to decrease HIV, Viral Hepatitis and STD transmissions in the State of Oregon. While many important steps were taken to prioritize populations and identify and rank interventions to serve them, the SPG is evaluating the processes and structure used during the development of this plan to ensure that SPG adhered to its Guiding Principles and to identify needed adjustments. As presented earlier in this document each committee contributed to the development of this Comprehensive Plan and each committee has identified goals for the coming year. These include the following:

Membership committee- Will continue to recruit new members in alignment with parity inclusion and representation goals, orient new members on SPG goals and procedures and ensure attendance at full SPG meetings and assist co-chairs if needed with attendance at their meetings.

Intervention committee- Will focus its efforts on the following:

1. Research and rank interventions not currently listed in the CDC Compendium of Evidence Based Interventions.
2. Evaluate and collect feedback on the experiences of local health departments and community based-organizations in implementing DEBIs and other CDC recommended evidence-based interventions.
3. Evaluate and collect feedback on the experiences of local health departments and community based organizations in implementing DEBIs and other CDC recommended evidence based interventions.
4. Create a step by step process which individual organizations and local health departments can use when researching, selecting, adapting, implementing and evaluating new interventions in their area.

Community Services Assessment committee (CSA)-Due to the large workload of the CSA committee two additional committees will be formed to address resource inventory and epidemiologic profile needs. The CSA committee will continue to research and be familiar with the needs assessments that are happening in the community and utilize them for information needed for the SPG as appropriate. This committee will work closely with the Resource Inventory committee to develop the gap analysis.

Resource Inventory committee- This new committee will compile a list of HIV prevention related programs and activities taking place in Oregon, present resource inventory information to SPG to ensure members know the resources available in Oregon, work with the CSA Committee to develop the gap analysis and write the resource inventory section of the Comprehensive Plan.

Epi Profile committee- This is another new committee charged with reviewing HIV surveillance data and working with State surveillance staff to provide SPG with the information they need to prioritize populations.

Planning, Process, Monitoring and Evaluation committee -This committee was formed as an ad hoc committee as part of the evaluation process by the SPG Executive Committee. This committee was instrumental in setting the committee structure for the SPG and has met its goals for the initial development of the Comprehensive Plan. Several areas of this committees' work is duplicative to the responsibilities of the Executive Committee and the decision was made to disband this committee. The remaining functions of this committee will be folded into the responsibilities of the Executive committee.

The intent of each committee is to compliment each others' work and to support the writing and implementation of the Comprehensive Plan for the State of Oregon. Inherent in the adherence to the work of each committee, the Comprehensive Plan will be written in alignment with the Guiding Principles and thereby provide information around the need for HIV prevention and interventions that can impact the decrease in the HIV infection rate in the State of Oregon.

VI. Letter of Concurrence, Concurrence with Reservations, or Non-concurrence

The Oregon HIV Prevention Statewide Planning Group (SPG) met on September 23, 2009 and were provided a copy of the final Oregon HIV Prevention Comprehensive Plan, a draft version of the CDC Cooperative agreement application due to CDC on October 5, 2009 and the state HIV Prevention Budget Narrative for 2010.

Understanding that the application to CDC would be submitted by October 5, 2009, the SPG workgroup determined that there was not enough time to review documents, have interactive discussion and provide a letter to accompany the application by October 5, 2009.

The resulting plan is for the SPG to reconvene on February 10, 2010 with an agenda item to have a presentation regarding the application, have discussion, and anticipate the provision of a letter regarding the application to the state HIV Prevention office within two weeks of that meeting.

We will anticipate forwarding a letter of concurrence, concurrence with reservations or non-concurrence by February 26, 2010.

VII. Appendices

- A. Acronyms
- B. Summary of Needs Assessments & Resource Inventory Process
- C. Population Priority Setting
- D. Intervention Committee Process