

**Ryan White Part B Program
HIV Care & Treatment Program**

COMPREHENSIVE PLAN

(Includes the Statewide Coordinated Statement of Need)

State of Oregon



**Oregon Department of Human Services
Public Health Division
February 1, 2009**

**The Oregon Department of Human Services Public Health Division
HIV/STD/TB Program gratefully thanks and wishes to acknowledge the
work of the following Oregon HIV Care Coalition subcommittees in
developing this document:**

STATEWIDE COORDINATED STATEMENT OF NEED WORK GROUP

OREGON HIV/AIDS CASE MANAGEMENT TASK FORCE

STATEWIDE HIV SERVICES QUALITY MANAGEMENT TASK FORCE

CAREASSIST ADVISORY COMMITTEE

NEEDS ASSESSMENT COMMUNITY CONSULTATION GROUP

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INTRODUCTION

Oregon's Comprehensive HIV Planning Process

The Oregon HIV Client Services incorporates four distinct planning processes, with four written documents, into a statewide HIV care and treatment comprehensive planning process that produces the Comprehensive Plan document. These four planning processes were formally developed into one contiguous planning process:

- ❑ The Statewide Coordinated Statement of Need developed by the SCSN Work Group,
- ❑ A Strategic Plan with Goals and Objectives developed by the Oregon HIV Care Coalition (OHCC),
- ❑ An HIV Services Implementation Plan that is developed by HIV Care and Treatment staff in March/April of each year, and
- ❑ The Quality Management Plan reviewed by the Quality Management Task Force.

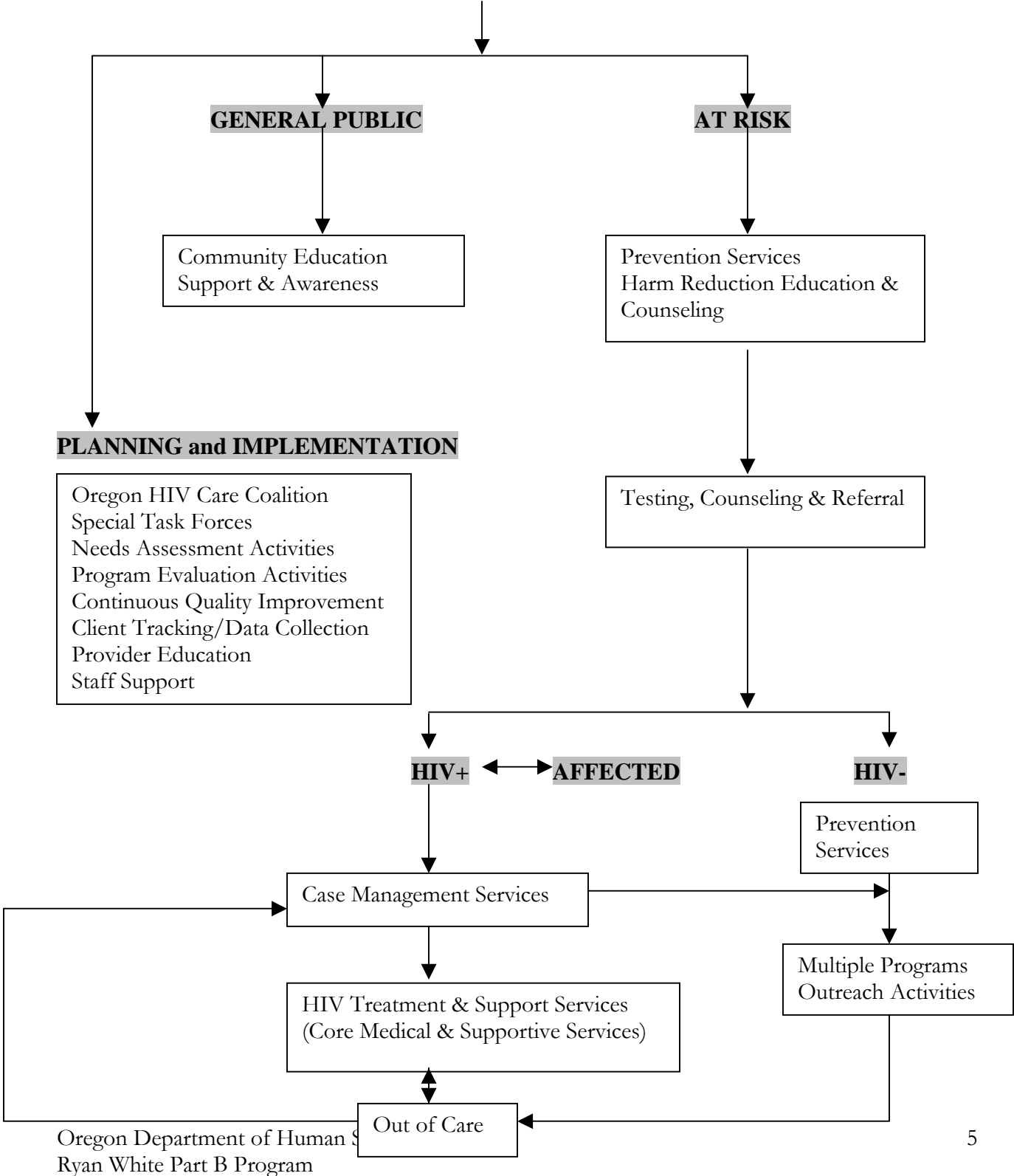
Throughout the year, OHCC members participate on various Task Forces and Committees and review data from numerous data sources that provide information on assessment of client and provider needs, client satisfaction, client service utilization, special needs studies and outcomes.

All of these components of a planning process are necessary to answer four core comprehensive planning questions:

- *Where are we now?* (The Statewide Coordinated Statement of Need [SCSN])
- *Where do we want to be?* (System Goals)
- *How will we get there?* (The Strategic Plan)
- *How will we know when we've accomplished our goals?* (Annual OHCC review of needs assessment, client satisfaction, special needs studies and outcomes data and Quality Management Plan Report)

Where Are We Now?

OREGON HIV CONTINUUM OF CARE



The proceeding diagram represents the HIV Continuum of Care in Oregon, as described by the Oregon HIV Care Coalition (OHCC) in its planning process. HIV impacts all Oregonians, and community education, HIV support and awareness are issues impacting the general public in Oregon. Oregonians at risk for HIV infection are targeted for HIV Prevention Services and Harm Reduction Education and Counseling Services. Additionally, persons at risk for HIV are encouraged to access HIV Testing, Counseling and Referral services available throughout the state. Oregonians who test negative for HIV continue to receive HIV Prevention Services. Oregonians who test positive for HIV are directed into the HIV care and treatment programs available in the state.

There are four Ryan White Parts providing HIV care and treatment services in Oregon: Ryan White Part A, Ryan White Part B, Ryan White Part C and Part F. HIV service delivery in the six county Part A Transitional Grant Area, known as the Portland TGA, (Columbia, Washington, Clackamas, Multnomah, Yamhill Counties and Clark County in the state of Washington) is administered by Multnomah County Health Department. A local HIV Planning Council sets service priorities and allocates Part A resources to the TGA.

Ryan White Part C funds the HIV Clinic located in Portland, also administered by Multnomah County. There are also a small amount of Ryan White Program funds from Part F at the Russell Street Dental Clinic in Portland and the Oregon AIDS Education and Training (AETC) Center, also funded by the Ryan White Program, provides training to physicians throughout the state.

Outside of the Portland TGA, local county public health departments and community-based organizations provide the Oregon Part B Continuum of Care services. This includes HIV Counseling, Testing and Referral (CTR), and HIV Medical Case Management. This creates an important link between public HIV testing and HIV care and treatment. All HIV clients outside of the Portland TGA area are encouraged to have an HIV Medical Case Manager and clients enrolled in the HUD/HOPWA-funded Oregon Housing Opportunities in Partnership (OHOP) program (also administered by the Part B Grantee) are required to also be enrolled in Part B funded case management. The HIV Medical Case Management providers also provide access to supportive services that include medical transportation, medical nutrition, emergency financial assistance, mental health treatment, substance abuse recovery, and oral health services.

HIV Alliance, a community based organization in Eugene, Oregon, is the largest provider of HIV Medical Case Management services outside of the Portland TGA. They are also a Part F Grantee and administer a 15 county Oral Health SPNS grant that provides oral health to persons living with HIV/AIDS (PLWH/A) through the Clock Tower Dental Clinic (Clock Tower). Clock Tower authorizes all oral health expenditures for all clients in their service area in collaboration with the Ryan White Part B program. Clock Tower services increase the oral health services (and resources) available for clients in the rest of the Balance of State (outside of the Portland TGA.)

The Ryan White Part B program (Oregon Department of Human Services [DHS], HIV Care and Treatment Program) convenes the Oregon HIV Care Coalition (OHCC) which is a statewide HIV services planning body composed of 25 members including people living with HIV/AIDS, representatives from state and county government agencies, HIV service providers, and

community leaders and meets twice a year. The members of OHCC sit on various committees, task forces and work groups that meet regularly throughout the year and produce the planning and advisory activities central to the delivery of HIV/AIDS in Oregon. The activities of these advisory groups are reported to OHCC at the General Membership Meetings. The groups under the OHCC “umbrella” are: The CAREAssist (AIDS Drug Assistance Program) Advisory Committee, the HIV Case Management Task Force, the HIV Housing Task Force, the Quality Management Task Force, the Needs Assessment Community Consultation Work Group and the PLWH/A Committee.

Core Services

HIV Medical and HIV Psychosocial Case Management services are provided at the local level through eighteen (18) subcontracted public health departments and community based organizations. (Oregon Part B requires all HIV Medical Case Managers to be registered nurses and requires all active clients in case management to receive a minimum of an annual Nurse Assessment.) There are no income eligibility requirements to access an HIV case management program funded under Part B. The Ryan White Part B-funded case management system is the primary resource for assisting clients to access medical care outside of the Portland TGA. All Ryan White Part B case managers will, on the first visit, assess the client’s eligibility to participate in any and all systems of medical care. Persons at or below 100% of the FPL who also have a disability status verified by SSA are referred to the Oregon Health Plan (Medicaid). Military veterans are referred to the Veteran’s Administration (VA) Health System for care though these clients have the choice of receiving medical care outside of the VA system and may sign up for services through CAREAssist.

Persons ineligible for other programs and with income up to 350% of the FPL are eligible to receive benefits from the state-managed AIDS Drug Assistance Program (CAREAssist). CAREAssist provides direct access to medications on the approved formulary, supports costs of co-pays and deductibles, and/or purchases insurance that will cover medication and care costs. Those not eligible for the Oregon Health Plan (OHP) are directed to the Oregon High Risk Insurance Pool (OMIP). Through OMIP, CAREAssist is able to purchase insurance with pharmacy benefits. Nearly 100% of all PLWH/A enrolled in the Ryan White Part B program are fully insured, including clients who are undocumented. Clients must use care systems for which they are eligible. Ryan White is the payer of last resort for services.

CAREAssist provides HIV-specific medications from its formulary to clients who are in a “pre-existing condition” exclusionary phase under insurance programs or are ineligible for prescription drug coverage. Additionally, CAREAssist funds are used to purchase insurance for persons who are covered under COBRA insurance support, have personal policies, or are eligible for the high risk Oregon Medical Insurance Pool. Co-pay and deductibles support is available to clients who are receiving direct support for insurance premium payments and for those requesting assistance with co-pay and deductible expenses only. CAREAssist staff assist Ryan White case managers and other case management services in advising the client on appropriate and required participation in a variety of health care delivery systems.

Ryan White Part B funds managed locally by the county health departments and community based organizations can only be used to purchase supportive services when a client has not been

qualified for other coverage or where there is an immediate emergency need to access care and treatment. Clients who meet income eligibility requirements of 250% (or less) of the FPL are eligible to receive Ryan White Title Part B funded support services through their local HIV case management program.

Substance abuse counseling & treatment, mental health services, home health care and oral health services are funded through an HIV Care & Treatment administered program that allows local HIV case managers to determine eligibility for the service and who will provide the service at the local level with HIV Care & Treatment then paying for the services centrally. This move to centralized core services was recommended by OHCC as a way to ensure equal access to these important services for clients throughout the state.

Support Services

Support services directly facilitate an HIV-positive person's ability to access health care and therapy and are approved, purchased and coordinated at the local level by HIV case managers. Included are housing services, medical transportation services, medical nutrition services, and emergency financial assistance. Support services are provided when they are of an urgent nature and they contribute to the long-term goal of retention in care and treatment.

Transportation to medical care and other core services is an identified need for all PLWH/A in Oregon. When the services are not available, or the client is ineligible, Ryan White funds are used to secure access. All clients receiving these services through a Ryan White provider system must have a primary care provider identified in their case management record.

Statewide Coordinated Statement of Need

Language in Section 2617 (b) (6) of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) requires grantees to develop a Statewide Coordinated Statement of Need (SCSN). The SCSN planning process provides a collaborative mechanism to identify and address significant care and treatment issues related to the needs of people living with HIV and AIDS (PLWH/A), and to maximize coordination, integration, and effective linkages across all Ryan White Program Parts.

Oregon's 2008 Statement of Need is organized into the following sections:

- *Developing Oregon's Statewide Coordinated Statement of Need*—a description of participants and the collaborative process we used;
- *Overview of HIV/AIDS in Oregon*—a description of the latest trends in HIV epidemiology statewide and a discussion of emerging service populations and populations with special needs;
- *Unmet Need in Oregon*—an estimation of the number of PLWH/A in Oregon who are aware of their infection, but not receiving medical care, and information about people who receive their HIV diagnosis late in the course of their disease;
- *Oregon's HIV Continuum of Care*—a description of services currently provided to PLWH/A statewide, as well as a discussion of service needs and gaps identified by PLWH/A and providers;
- *Cross-Cutting Service Goals and Issues*—important service issues identified by the SCSN workgroup and our shared goals related to those issues;
- *Appendices*—the appendices include additional data, such as a full list of SCSN workgroup participants, a list of data sources used to create this document, an inventory of funding sources and available resources, and notes from the workgroup meeting in October 2008.

Developing Oregon's Statewide Coordinated Statement of Need

The Oregon Department of Human Services (DHS) HIV Care and Treatment Program (the Part B grantee) was responsible for convening partners across the Ryan White continuum of care, facilitating the development/update of the SCSN, and submitting the SCSN to the Health Resources and Services Administration (HRSA). The SCSN workgroup included representatives of all Ryan White grantees, PLWH/A, members of federally-recognized Indian tribes, and public agency representatives. A full list of workgroup members is available in Appendix A.

For the 2008 update, the Part B grantee proposed a streamlined process that required less travel time for workgroup members, but still allowed for maximum participation. The Part B grantee designated Program Design & Evaluation Services (PDES), a public health research and evaluation group affiliated with both the Oregon Department of Human Services and the Multnomah County Health Department, to facilitate the process. In July and August 2008, PDES engaged in face-to-face or telephone meetings with each of the grantees to identify and discuss key data sources. PDES integrated cross-program data into a draft document that was shared

with all workgroup members by mail or email, as well as reviewed during a presentation in early October 2008. Therefore, all workgroup members were well-schooled about statewide data related to the HIV continuum of care by the time the full SCSN workgroup convened in late October to identify broad goals and cross-cutting issues. Input from this full-day meeting was integrated into the document, which was then approved by the full group before being submitted to HRSA in January 2009 (Table 1).

Table 1: Key Deadlines, Tasks, and Participants in SCSN Process

Deadline	Task	Responsible Party/Participants
July/Aug 2008	Meet with partners across RWCA care continuum to discuss data	PDES & all RWCA partners
Aug/Sept 2008	Collate data sources into summary document.	PDES
Oct 7, 2008	Distribute draft document to Workgroup members for feedback	PDES and all RWCA partners
Oct 14, 2008	Present data to SCSN Workgroup at 2-hour forum and solicit feedback	PDES and all RWCA partners
Oct 2008	Integrate partner feedback in preparation for goal-setting meeting	PDES
Oct 21, 2008	Convene all-day meeting to identify broad goals and cross-cutting issues	PDES and full SCSN workgroup
Nov 2008	Integrate SCSN Workgroup discussion outcomes into SCSN document	PDES
Nov/Dec 2008	Final revisions/buy-in from full group on SCSN document	PDES and full SCSN workgroup
Jan 2009	Submit final SCSN to HRSA	Part B grantee

Overview of HIV/AIDS in Oregon

Data presented in this “Overview” section are drawn from the 2006 Epidemiological Profile (HIV/STD/TB Programs, 2008a).

HIV/AIDS Prevalence in Oregon

Understanding the epidemiology of HIV/AIDS in Oregon is a key component of health services planning. By the end of 2006, there were 4,727 living PLWH/A known to Oregon’s HIV/AIDS Reporting System (HARS). An additional 2,276 Oregonians are estimated to be infected with HIV/AIDS, but either not diagnosed or not yet reported, yielding a total estimate of 7,003 PLWH/A in Oregon.

Of the 4,727 living cases reported at the end of 2006, 88% were men and 56% were aged 35-49 years. Among men living with HIV disease, 70% reported their transmission risk as sex with men (MSM), 10% as MSM with injection drug use (MSM/IDU), and 9% as IDU alone. Among

women, combined heterosexual (59%) and presumed heterosexual (8%) transmission accounted for 67% of prevalent cases, with 25% of women reporting IDU transmission risk.

Service delivery in Oregon is divided geographically into the Portland Transitional Grant Area (TGA), which includes five counties that comprise or surround the Portland metropolitan area (Clackamas, Columbia, Multnomah, Washington and Yamhill)ⁱ, and the Balance of State, which includes the remaining 31 Oregon counties stretching to the California, Idaho, and Nevada borders. Key facts about the distribution of PLWH/A in Oregon include:

- Most PLWH/A (73%) lived in the Portland TGA at time of diagnosis.
- Fifty eight percent of cases lived in one county: Multnomah. Multnomah County is over-represented in the epidemic, as only 1 in 5 Oregonians live in Multnomah County compared to about 3 in 5 PLWH/A. At the end of 2006, prevalence of HIV disease in Multnomah County was 404 cases/100,000 residents: almost four times higher than the county with the next highest rate, Marion, which had 102 cases/100,000 residents.
- Balance of State counties with 50 or more PLWH/A include the following seven counties: Deschutes, Douglas, Jackson, Josephine, Lane, Linn, and Marion.
- Although Oregon is a large, primarily rural state, approximately 90% of PLWH/A receiving Ryan White Program-funded services lived within 25 miles of Interstate 5 at time of diagnosis.

A higher proportion of metropolitan cases were male (90% vs. 81%), and metropolitan male PLWH/A were more likely to report MSM as a transmission risk than males living in the Balance of State (75% vs. 57%).

Female PLWH/A in the Balance of State were more likely to report IDU transmission risk (29% vs. 22%) than female PLWH/A in the metropolitan area.

HIV Incidence in Oregon

Since 1997, the rate of new HIV/AIDS diagnoses has remained stable at about 300 new cases per year (approximately 8.5/100,000/year), while the number of deaths has held steady at about 100 per year, resulting in a net increase of about 200 cases per year. Some groups of people are disproportionately represented among new diagnoses. Rates of new diagnoses in 2006 were:

- 8 times higher among men than women
- 2.5 times higher among blacks than whites (but the rate among blacks has averaged almost 5 times higher from 1997-2006)
- 1.7 times higher among Hispanics than non-Hispanics
- Highest among persons age 30-39 years (18 cases/100,000).

ⁱ The TGA includes a sixth county: Clark County in Vancouver, Washington. Information on Clark County cases is not included in the Oregon SCSN.

The most commonly reported HIV transmission route among new male cases was sex with other men (MSM, 68% of new diagnoses); among women, the most commonly reported transmission route was heterosexual sex (76% of new diagnoses). Injection drug risk (IDU) accounted for just under 1 in 5 new diagnoses: 18% of new diagnoses among men (13% MSM/IDU and 5% IDU only) and 17% among women.

Seventeen percent of new diagnoses in 2006 were among foreign-born persons. Of foreign-born cases, 76% were born in Latin America.

Among cases newly diagnosed with HIV during 2002-2005, 39% had HIV disease that had already progressed to AIDS at or within 12 months of initial diagnosis. Some people were disproportionately likely to have a “late” HIV diagnosis. From 2002-2006, the relative risk of receiving an AIDS diagnosis within 12 months of initial HIV diagnosis increased with increasing age (RR: 1.23 for age 50 and older, 95% CI: 1.06-1.43) and was higher among Hispanics than non-Hispanic whites (RR: 1.3, 95% CI: 1.11-1.52). Compared to MSM, early AIDS diagnosis was also higher among IDU (RR: 1.44, 95% CI: 1.17-1.78), people with male heterosexual transmission (RR: 1.42, 95% CI: 1.06-1.9), and presumed male heterosexual transmission (RR: 1.8, 95% CI: 1.53-2.12).

Co-morbidities

Reported cases of chlamydia, gonorrhea, and syphilis among people with previously reported HIV infection in Oregon (> 1 month prior to STD diagnosis) have risen steeply since 1999. During 2006, PLWH/A accounted for 17% of all syphilis cases (31% of all male syphilis cases) and 8% of all gonorrhea cases (10% of all male gonorrhea cases).

Co-infection with hepatitis B and/or hepatitis C is of concern for health services planning, but hepatitis C did not become reportable in Oregon until 2005, so data are limited and should be considered a minimum estimate. Of all living and dead HIV/AIDS cases reported to Oregon HARS as of the end of 2006, 6% were co-infected with hepatitis B and/or C. Higher proportions of hepatitis co-infection were found among women and people with an IDU risk.

Oregon has never observed a substantial number of TB/HIV co-infections. Only four percent of confirmed TB cases in Oregon from 1993-2006 were co-infected with HIV (76/1,853). Ninety three percent of co-occurring HIV/TB cases were male and 43% were foreign-born.

A comparison of HARS and Oregon’s cancer registry found 423 HIV/AIDS cases who reported at least one cancer. This comparison included all HIV/AIDS cases in HARS (1981-2006) and all records in the Oregon State Cancer Registry (1996-2005). The most frequently reported cancers among PLWH/A were non-Hodgkin’s lymphoma (n=133, 31% of all matched records), Kaposi’s sarcoma (n=98, 23%), and cancers of the anus/rectum (n=48, 11%). Cancer diagnoses occurred subsequent to HIV diagnosis in about two-thirds of the matched records (n=232); for about one-third (n=98), the two diagnoses occurred with a year of each other.

Case Fatality

Age-adjusted case fatality rates were similar among men and women (1.82/100 person-years for men vs. 1.42/100 person-years for women). Likewise, there were no statistical differences by

race/ethnicity in age-adjusted HIV/AIDS case fatality statewide. These data suggest that among people aware of their status, treatment outcomes do not differ substantially by age, race/ethnicity, or gender.

However, from 2001-2005, the Native American population in Multnomah County had the highest HIV mortality rates of any group in the county (15.9/100,000 vs. 4.9/100,000 for non-Hispanic whites), and this disproportionate rate has been cited by county officials as “a health disparity that requires intervention” (Bhat, 2008).

Unmet Need for Medical Care in Oregon

Unmet Need Estimate

HRSA requires all states and metropolitan areas that receive federal support for HIV/AIDS health care under the Ryan White CARE and Treatment Act to estimate annually the number of PLWH/A who are aware of their HIV infection, but not receiving medical care. Laboratory results for CD4 and viral loads are used as a proxy for medical care for the purpose of calculating these estimates.

During calendar year 2006, an estimate 37% of PLWH and 29% of PLWA did not have a CD4 or viral load test done, indicating an unmet need for medical care (Table 2). The probability of having at least one CD4 or viral load test done in 2006 declined with age. However, there was no difference among those with and without records of a CD4 or viral load test in 2006 by sex, race/ethnicity, or stated mode of transmission.

Table 2: Estimate of Unmet Need, Oregon, 2006*

Estimate of PLWA during 2006	2,911
Estimate of PLWH during 2006	2,221
Estimated number of PLWA who received primary medical care during 2006	2,056 (71%)
Estimated number of PLWH who received primary medical care during 2006	1,390 (63%)
Estimated number of PLWH/A who received primary medical services	3,446 (67%)

*Estimates based on adjusted data from HARS and TRIO (lab database)

Some groups of PLWH/A living in the Balance of State were more likely to have an unmet medical need than PLWH/A in the Portland metropolitan area; differences were noted among women (23% metro vs. 33% non-metro), Hispanics (30% metro vs. 43% non-metro), and among MSM/IDU (27% metro vs. 39% non-metro).

Late Diagnoses with HIV

Late diagnosis data provide another indication of which PLWH/A are not receiving appropriate medical care. Individuals considered to have “late diagnoses” are those who are reported to HARS with an AIDS diagnosis within 12 months or less of initial diagnosis with HIV. HIV

disease had already progressed to AIDS in 39% of people newly diagnosed during 2002 to 2005. It is unclear whether these individuals were aware of or suspected their HIV status prior to diagnosis, and more information is needed about why they were not diagnosed until their condition progressed. As discussed earlier, older PLWH/A (age 50 or older), Hispanics, IDU, and men with heterosexual/presumed heterosexual transmission had significantly higher relative risks of receiving an AIDS diagnosis within 12 months of initial HIV diagnosis. Approximately 1% of PLWH/A die within the first 12 months following their HIV diagnosis.

Oregon's HIV Continuum of Care

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 directs state and local grantees to spend at least 75% of grant funding on core medical services, defined by HRSA as: outpatient and ambulatory health services, health insurance premium assistance, pharmaceutical assistance, oral health care, substance abuse outpatient services, medical nutritional therapy, home health care and hospice services, mental health services, early intervention services, and medical case management, including treatment adherence services. The remaining 25% of funding may be spent on a wide range of supportive services, defined as “services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS” (US Department of Health & Human Services, 2007). Important supportive services provided in Oregon include housing, medical transportation, psychosocial support, and food and nutritional assistance.

The “HIV Continuum of Care” section details some of the key core medical and supportive services provided across the HIV continuum of care in Oregon, and documents identified needs of PLWH/A related to the specific service area. Data in this section are drawn from a wide range of sources, which are cited briefly in the text and listed in full in Appendix B. In addition, a list of available resources is provided in Appendix C.

Challenges in the HIV Service Environment

The dire economy has dramatically impacted clients seeking HIV services in Oregon. Like others with limited resources, HIV clients are negatively affected by the rising costs of food, fuel, and housing. HIV service providers report increased anxiety among their patients; clients report difficulty competing for scarce resources within the larger service sector. The SCSN workgroup members identified numerous examples within the larger economy that impact HIV clients, including the tightening of the rental housing market (which allows landlords to be choosier about potential tenants and require higher deposits); the increase in fees at the Oregon Community Warehouse (which previously assisted families with household items for free, but now charges a \$35 usage fee/family), and fewer resources available through mainstream services (e.g. community food distribution programs).

The public health infrastructure is also severely challenged by the economic crisis. Multnomah County Health Department reported a 10-15% cut in county general funds for the next year, and a 4% cut effective immediately. The Oregon Department of Human Services is operating with a large deficit this biennium, with consequent cuts in services or personnel expected. Local health departments around the state are impacted by decreases in state and local general funds, as well as the sunset of timber revenues that once shored up public services. Community-based agencies are reporting a decrease in private donations and grant dollars that decrease their ability to provide the same level of services that clients have received in past years.

HIV clients in Oregon have always depended on a continuum of services that extend beyond RWCA-funded services, and use RWCA as a payer of last resort. However, the options available to them beyond RWCA are shrinking. For this reason, descriptions of services available in the

HIV continuum of care are generally limited to RWCA or other specifically HIV-related services.

Outpatient Medical Care in Oregon

The full range of primary care services are provided to PLWH/A through a combination of public and private health systems and community-based agencies. Individuals with private or public insurance access primary care through their designated health care providers.

A 2007/2008 assessment of outpatient medical facilities in Oregon (HIV/STD/TB Programs, 2008b) showed that 44 medical practices have at least one provider who orders HIV viral load or CD4 count tests and/or prescribes antiretroviral therapy (ART) for the purpose of making decisions about treating or managing a patient's HIV diseaseⁱⁱ. Most facilities (n=28) provide treatment of HIV disease of all severities and degrees without a need for additional formal consultation with another HIV specialist (Tier 1 level care). Eight facilities each provide HIV care in consultation with a HIV specialist (Tier 2 level care) and HIV care up to a practice-specific threshold of severity ("until it gets too bad," Tier 3 level care), and then refer to a specialist.

What Do Medical Facilities Providing HIV Care in Oregon Look Like?

Facility size varies greatly in terms of number of clinicians and patients, and is related to level of HIV care provided. All of the large practices (≥ 50 patients) provide Tier 1 HIV care, while small practices (≤ 10 patients) provide care across the full range of care levels. All facilities providing Tier 3 care) are small practices with 10 or fewer patients. About half of all HIV medical facilities in Oregon served 15 or fewer PLWH/A within the first four months of 2007.

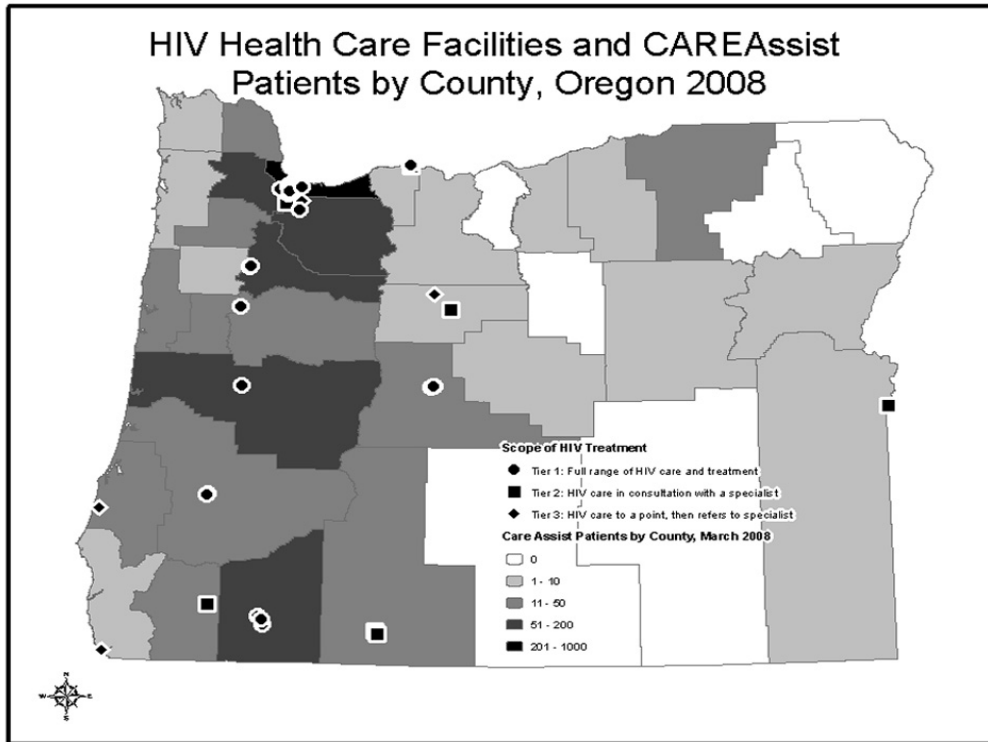
Of the 44 HIV medical care facilities, most (69%) are private sector practices; the remaining 31 percent are a combination of public and community-based entities. One-third of the facilities—particularly facilities that serve higher numbers of PLWH/A—have some type of social support provider (e.g., health educator, social worker, case manager) co-located with their HIV medical care providers. In addition, about one third of the facilities offer additional medical support services like treatment adherence help, risk reduction counseling, or an on-site pharmacy. Very few offer important ancillary services like dental health, mental health, or substance abuse care within their facility.

Location of Facilities Providing HIV Medical Care in Oregon

Figure 1 displays a map of Oregon with the location of the 44 HIV medical care practices (subdivided by tiers) and the estimated number of PLWH/A by county. We used service data from the CAREAssist Program (Oregon's AIDS Drug Assistance Program) as of March 2008, in order to reflect the projected need for HIV medical care in Oregon. For HIV health services planning, CAREAssist data may provide a better proxy for HIV prevalence because they are more current than surveillance data, which are based on residence at initial HIV diagnosis and case reporting.

ⁱⁱ 44 of 301 (15%) potential medical facilities identified through Oregon's HIV/AIDS Reporting System (HARS), HIV Laboratory Reporting System (TRIP) and data sources related to the Medical Monitoring Project.

Figure 1: Map of Facilities that Provide HIV Medical Care



As the map illustrates, most of the facilities providing HIV medical care are located along the North/South I-5 corridor, which is also where a majority of PLWH/A reside. However, the map also shows several areas where PLWH/A might be underserved in regards to HIV care. There are no Tier 1 facilities in the Eastern, North Coast and South Coast regions, which means patients must travel (sometimes great distances) to access HIV specialty care.

Based on counties where facilities are located and the distribution of PLWH/A, we categorized the state into seven regions: Portland TGA, Central-East, Central-West, Eastern, North Coast, Southern, and South Coast. Table 3 shows the number of facilities by tier in each of the regions.

Table 3: HIV Care Facilities by Region, Number and Tier

Region	Counties	Tier 1	Tier 2	Tier 3	Total HIV Facilities
Portland TGA	Clackamas, Columbia, Multnomah, Washington, Yamhill	13 (68%)	2 (11%)	4 (21%)	19
Central-East	Crook, Deschutes*, Hood River, Jefferson, Sherman, Wasco	6 (67%)	2 (22%)	1 (11%)	9
Central-West	Benton, Lane*, Linn*, Marion*, Polk	4 (100%)	0 (0%)	0 (0%)	4
Eastern	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler	0 (0%)	1 (100%)	0 (0%)	1
North Coast	Clatsop, Lincoln, Tillamook	0 (0%)	0 (0%)	0 (0%)	0
Southern	Douglas*, Klamath, Jackson*, Josephine*	5 (63%)	3 (38%)	0 (0%)	8
South Coast	Coos, Curry	0 (0%)	0 (0%)	3 (100%)	3
Total	Oregon	28	8	8	44

*Balance of State county with ≥ 50 PLWH/A.
Percentages may not add to 100 because of rounding

Are Medical Care Facilities in Oregon Accessible to PLWH/A?

Eighty-one percent of the facilities are located within three regions: the Portland TGA (n=19, 43%), Central-East (n=9, 20%), and Southern Oregon (n=8, 18%) (Table 4).

Table 4: Regional Summary of Number of Total and Tier 1 Facilities That Provide HIV Care, Number of HIV Care Providers, and Estimated Patient Load

Region	Total # of Facilities	Total # of Tier 1 Facilities	Total # of HIV Providers	Total 4 Month Estimated Patient Load*
Portland TGA	19 (43%)	13 (46%)	41 (41%)	2,476 (77%)
Central-East	9 (20%)	6 (21%)	33 (33%)	76 (2%)
Central-West	4 (9%)	4 (14%)	5 (5%)	423 (13%)
Eastern	1 (2%)	0 (0%)	3 (3%)	4 (<1%)
North Coast	0 (0%)	0 (0%)	0 (0%)	NA*
Southern	8 (18%)	5 (18%)	9 (9%)	226 (7%)
South Coast	3 (7%)	0 (0%)	8 (8%)	8 (<1%)
Total	44 (99%)*	28 (99%)	99 (99%)	3,213 (100%)

*41% of the facilities estimated their 4 month HIV estimated patient load (HIV EPL); the remainder gave an exact count.

*There are no HIV care facilities in the North Coast region; therefore, we do not have a HIV EPL.

*Percentages do not sum to 100 because of rounding.

According to facility estimates, just over three-thousand patients (n=3,213) received HIV care at one of the 44 HIV care facilities between January 1, 2007 and April 30, 2007 (4 month estimated patient load [EPL]). HIV EPL should be interpreted with caution because: 1) numbers are based on a 4-month period, not total patient estimate over a full year and 2) in many cases, numbers are based on facility estimates rather than an exact count.

However, the estimates of HIV EPL are instructive. HIV EPL approximate the regional distribution of both RWCA service data and HIV surveillance data, with the vast majority of patients seen in three regions (the Portland TGA, Central-West and Southern). All of these data suggest a disproportionate distribution of patients relative to both HIV care providers and HIV care facilities across regions. This indicates that, in some regions, the supply of HIV care facilities and providers may not be well matched to service demand.

For example, the Portland TGA has 77 percent of estimated patients, but only 43 percent of the facilities, 46 percent of Tier 1 facilities, and 41 percent of HIV providers. Conversely, the Central-East region, with only 2 percent of estimated patients, is home to 20 percent of HIV care facilities, 21 percent of Tier 1 facilities, and a full third (33%) of care providers.

Other regions display different patterns. The Central-West region, a relatively small geographic area with the second largest concentration of PLWH/A (13% according to HIV EPL), has a similarly concentrated HIV care system, with five HIV care providers working from four Tier 1

facilities. The HIV care system in the larger Southern region is more diffuse, with eight facilities (18% of total) serving seven percent of the HIV EPL.

Finally, some areas of Oregon are clearly underserved with regards to HIV medical care: patients in the Eastern, North Coast, and South Coast areas do not have a Tier 1 facility in their region at all, meaning they must travel great distances to access HIV specialty care. However, there are very few patients in these areas.

The Ryan White Part C Clinic: Multnomah County HIV Health Services Center

The Multnomah County HIV Health Services Center (HHSC) in Portland is the only Part C clinic in Oregon. This clinic provides the full range of primary care services, supported by multiple funding streams. Part A and Part C funds work together to bridge gaps in access to medical care for uninsured clients and to offer services not covered by other resources, including an on-site pharmacist. Multnomah County's HHSC has been the AIDS Education & Training Center's (AETC) clinical training site for a five state region since 1999, providing preceptorships for physicians, nurses and pharmacists. Part A and AETC collaborate on training opportunities for primary care and support services providers in the TGA, most recently focused on implementation of the chronic care model.

The Role of Part C Clinics in Neighboring States

Because of the lack of medical providers in the large geographic area east of the Cascade Mountains, some PLWH/A in Eastern Oregon travel across state lines to seek HIV medical care. Providers in Idaho and Washington estimate that 16 PLWH/A in Eastern Oregon receive care from the Part C clinic in Boise, Idaho and 30 receive "minimum to extensive medical case management" for HIV at the Part C clinic in Walla Walla, Washington because those facilities are closer and easier to access than medical care facilities in Oregon (personal communications with Alfredo Hernandez and Alison Millar, September 2008).

Overall Needs and Gaps in Medical Care: Consumer Needs Assessment and "Out of Care" Program Evaluation Data

Results of the 2005 Consumer Needs Assessment (Pickle, 2006) indicate that RWCA clients generally have good access to medical care and HIV medications, but are heavily dependent on public systems (Medicaid/Oregon Health Plan, Medicare, and Oregon's Medical Insurance Pool). Compared to Portland-area PLWH/A, PLWH/A in the Balance of State reported a higher service gap for outpatient medical care (28% BOS vs. 18% TGA).

Almost all participants (97%) reported having had at least one CD4 or viral load lab test in the past 12 months. However, African Americans were more likely than White non-Hispanics to report no lab tests in the past year, and those with no lab tests were also likely to be more recently diagnosed with HIV.

The Out of Care Project, conducted in 2007 (Greene, 2007), further examined whether people living with HIV/AIDS (PLWH/A) were receiving CD4 and viral load testing at least annually. Data were collected from interviews with HIV healthcare providers, HIV service providers, former CAREAssist (Oregon ADAP) clients, and current CAREAssist or Ryan White Part B Case Management clients. HIV care service providers and former CAREAssist clients offered insight into numerous structural and systemic factors that might be associated with PLWH/A not

receiving CD4 and viral load tests annually. However, results from this project showed that nearly all current and former CAREAssist and Part B Case Management clients were getting their CD4 or viral load tests at least annually. On the other hand, many of these clients said they need assistance and support around medication, financial and insurance issues, in order to maintain regular CD4 and viral load testing.

Health Insurance

The State of Oregon has a unique ability to provide health insurance for virtually every person living with HIV/AIDS in Oregon through the CAREAssist Program (Oregon's ADAP). The Oregon HIV Care and Treatment Program (Part B Grantee) uses Ryan White funding to pay health insurance premiums and co-pays for eligible PLWH/A who are not insured through Oregon Health Plan (OHP). By ensuring payment of premiums and providing uninterrupted coverage for these clients, the program leverages the Oregon Medical Insurance Pool (OMIP) to ensure universal coverage for even high-risk clients. OMIP coverage is available to Oregon residents with qualifying medical conditions including HIV/AIDS that would otherwise restrict their individual health insurance coverage through private insurers (Ending Homelessness Advisory Council, 2006).

In 2007, CAREAssist served 1,928 unduplicated clients statewide. Examined against Oregon surveillance data, CAREAssist appears to serve a disproportionate number of Hispanic PLWH/A (10% prevalence vs. 16% CAREAssist enrollment). However, there do not appear to be significant differences in enrollment by gender, age, or race.

Ninety percent (90%) of enrolled clients in CAREAssist received at least one drug and ninety six percent (96%) received a service paid for by insurance. Seventy one percent of clients enrolled in CAREAssist live in the TGA and represent 72% of the program costs. The only CAREAssist service that costs less for TGA clients is Medical Appointment and Medical Equipment Co-Pays (71% of clients accessing these services were in the TGA representing 66% of the program cost vs. 29% of BOS clients accessing services, representing 34% of the program cost.).

CAREAssist currently has a 99% retention rate, with a 98% 6-month re-certification rate. One of the programs developed to reduce barriers to accessing primary medical care is the Bridge Program, which pays for outpatient ambulatory medical services (including labs and prescriptions) during the period of time it takes to get the client enrolled, or to get through the period of exclusion for a pre-existing condition, in either OMIP or OHP. In 2007, 68% of clients who received a Bridge service successfully transitioned to full CAREAssist enrollment. The 32% who did not transition to CAREAssist may or may not represent a service gap (CAREAssist program data, 2008).

The CAREAssist Program last surveyed all clients in November 2006 to assess client satisfaction and quality of medical care. More than 90% of CAREAssist clients rated their medical care as good or excellent. A majority of clients (93%) rated the quality of the CAREAssist Program as excellent or good. Suggested program changes included decreasing paperwork, adjusting the income eligibility requirements, and making small adjustments to several aspects of customer

service. The program has implemented policy changes based on feedback from the survey (Holbert, 2007).

In 2005, nearly all Ryan White HIV case management clients that were surveyed (97%) reported having some kind of health care coverage at the time of the survey. However, one in four (25%) reported experiencing a gap in health coverage in the 12 months preceding the survey, indicating that a significant proportion of PLWH/A—even those engaged in the Ryan White system—may be at risk of treatment interruption and falling out of medical care. The proportion of RWCA case management clients that reported receiving help from CAREAssist increased from 43% in 2002 to 68% in 2005, according to consumer needs assessments conducted in both years (Pickle, 2006).

Prescription Drug Assistance

CAREAssist ensures that PLWH/A have access to antiretrovirals by paying for health insurance premiums. In addition, CAREAssist's drug formulary covers the costs of many other prescription drugs that PLWH/A may need, and for which their health plans do not pay. CAREAssist's drug formulary include a wide range of medicines PLWH/A may need to maintain their health and quality of life, including pain medicines and, as of July 2008, smoking cessation drugs. In fiscal year 2008, 90% of CAREAssist clients received financial assistance with at least one drug from the CAREAssist program (CAREAssist, 2008).

In 2005, almost 3 of 4 HIV case management clients (71%) said they needed help buying prescriptions; 26% of those said they did not get the help they needed. Compared to Portland-area PLWH/A, PLWH/A in the Balance of State reported higher service gaps for help buying prescriptions (33% BOS vs. 21% TGA) (Pickle, 2006).

Medical Case Management

Medical case management consists of assessment, coordination of services and linkages to services inside and outside the Ryan White system of care. All clients have access to medical case management services that include treatment adherence assessment and coordinating timely access to appropriate levels of medical and supportive services, through ongoing client assessment and care plan development. Statewide, Medical Case Management is performed by teams of nurses, social workers, and other professionals.

In the TGA, specialty case management services are also offered in conjunction with primary case management services; this includes nursing case management, intensive case management for high acuity Latino and African and African American clients, and services for clients living in transitional housing units to ensure they are able to maintain housing, thereby impacting their ability to maintain medical care and medication adherence (McLaughlin, 2008).

In fiscal year 2007/8, 1,497 unduplicated clients received medical case management in the TGA, averaging 8.8 hours per client per year. For the last two years, case management client load has increased, while average number of encounters per client has decreased. Over one third of case management clients (38%) required intensive case management (acuity score 29+), a decrease

since FY 05-06 (55%). Female clients, clients of color, and clients with IDU as primary risk factor had higher acuity scores. This year, 22 groups/workshops, such as HIV 101, were offered by case management providers; 44 clients attended the Positive Self-Management Program (PSMP) in Portland.

In 2007, 883 unduplicated clients in the Balance of State received at least one case management service, averaging 16.5 hours per client in direct case management services. This represents 65% of persons living with HIV/AIDS in the service area as reported by the HARS database. Case management is delivered through three major models: 12 provider sites are RN only local public health departments (25% of clients averaging 14 hours per client), 3 provider sites are multi-disciplinary community based organizations (38% of clients averaging 21 hours per client) and 3 provider sites are multi-disciplinary local public health departments (37% of clients averaging 14 hours per client). The average case management caseload across the BOS system is 49 clients/1 FTE, represented across all acuity levels (an increase from 42 clients/1 FTE in 2005). About 3 in 4 clients (77%) actively enrolled in case management received, at a minimum, an annual RN Assessment & Nursing Care Plan (Part B program data, 2008).

Oral Health Care

Comprehensive dental care is 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.

In the TGA, Oregon Health and Science University (OHSU) participates in the Part F Dental Reimbursement program at their community-based Russell Street Dental Clinic. This program provides partial payment for unreimbursed costs of HIV care provided by the clinic. OHSU also has a Dental Community Partnership Grant that funds HIV clinical rotations for dental students, expanding access to services for PLWH/A. OHSU coordinates outreach for the grant with the two largest Part A primary care and support services providers, Multnomah County Health Department and Cascade AIDS Project. Part A contributes oral health care funding to help fill the gap in resources for the majority of PLWH/A without dental insurance.

In FY 2007/08, 619 TGA clients received a total of 2,885 dental care visits from Part A-funded dental providers. Racial/ethnic minorities (24%), youth (2%), clients 50+ years of age (35%), and TGA clients from outside Multnomah County (26%) were served in equal or greater proportion to their representation in the epidemic; women were served in lower proportion (8%). Nearly two thirds of clients (63%) had at least one preventive visit in FY 2007/2008. The average Part A cost per client per year decreased in FY 2007/08 (\$443) from FY 2005/06 (\$597). Part F provides some reimbursement, but there was a lower reimbursement rate from Part F for uncompensated dental services than in previous years (McLaughlin, 2008).

In the Balance of State, PLWH/A can receive dental services through a network of private dental providers funded through Part B funds. In CY 2007, 109 BOS clients received 205 dental care visits at an average cost of \$1,088 per client from Part B-funded dental providers. In addition, BOS clients in 14 counties have access to dental clinic services provided through a \$2 million

SPNS grant awarded to HIV Alliance in Eugene in 2006. The Oregon Rural Alliance of Dental Leadership (ORAL) is a partnership between HIV Alliance, Lane Community College Dental Program, and the Community Health Centers of Lane County. Services are delivered through a number of regional satellite clinics in addition to the Clock Tower Clinic in Eugene, which serves a majority of clients in the program. ORAL also provides van service or reimburses transportation costs (paid for by Part B) to all clinics. Since April 2007, ORAL served clients in 14 counties: Benton (7 clients), Coos (14 clients), Crook (2 clients), Curry (1 client), Deschutes (15 clients), Douglas (14 clients), Jackson (24 clients), Josephine (8 clients), Klamath/Lake (3 clients), Lane (109 clients), Linn (17 clients), Marion (7 clients) and Polk (4 clients) for a total of 225 clients served and 360 referred. Nineteen (19%) percent of ORAL clients are women; six (6%) percent of ORAL clients are Black/African American and eight (8%) Hispanic/Latino (Part B, 2008).

Data from the Medical Monitoring Project (MMP), conducted in 2006/2007, indicated that 29% of HIV medical clients statewide need assistance finding dental services. There was a significant difference in need by region, with 25% of TGA clients needing help compared to 40% of BOS clients ($p=.02$). Of clients who needed assistance finding dental services, 70% of clients received the help they needed (76% TGA vs. 62% BOS, $p=.22$, NS). One in five respondents (20%) said they needed dental care in the past year, but were unable to obtain it (18% TGA vs. 24% BOS, $p=.032$, NS).

Just over half of respondents (54%) report having dental insurance (53% TGA vs. 57% BOS, $p=.61$, NS), and 72% have a usual dentist or clinic that they go to for dental care (75% TGA vs. 66% BOS, $p=.16$, NS). Nearly two thirds (64%) reported seeing a dentist in the past year (Table 5) (MMP unpublished data, 2008).

Table 5: Clients' Last Dental Visit, Statewide, Portland TGA and Balance of State

Last Visit	Oregon	Portland TGA	Balance of State	p value
Less than 6 months ago	45%	49%	35%	p= .15
6 months to 1 year ago	20%	16%	28%	
> 1 year and up to 2 years ago	9%	8%	11%	
> 2 years and up to 5 years ago	15%	16%	12%	
More than 5 years ago	12%	12%	14%	

Substance Abuse Treatment

Ryan White-funded substance abuse treatment services include assessment, individual and group counseling, as well as engagement and coordination in outpatient treatment for clients in alcohol and drug-free housing. In the TGA, recruitment into mental health and substance abuse treatment services by peer mentors is also funded through a joint mental health and substance abuse funding effort.

In fiscal year 2007/8, a total of 43 TGA clients received outpatient substance abuse treatment. The average number of hours of treatment per client increased in FY 07-08 (20.5 hours) from FY 06-07 (13 hours). Racial/ethnic minorities comprised 33% of all clients, women 7%, and clients

over 50 years of age 19%. Almost two thirds of clients (61%) were unstably housed, a higher percentage than Part A clients not receiving these services. Approximately two out of three clients (64%) had successfully completed treatment at service termination. A variety of strategies are being used to engage clients, such as:

- a harm reduction group which combined HIV prevention with treatment for intravenous drug using clients at risk of relapse,
- support to clients in A&D free housing to help engage clients in medical care and provide tailored help for those newly recovering,
- a peer mentor engagement program to connect clients with mental health and/or substance abuse treatment services.

Providers reported that insurance or other public funding for services covered most clients in need of outpatient substance abuse treatment, resulting in a low number of clients being served with Part A funds. The average Part A, FY 2007/2008 cost for treatment services per client per year was \$813. One provider discontinued their contract in FY 08-09 (McLaughlin, 2008).

Part B Substance Abuse Outpatient Treatment services are available through the Statewide Managed Services Program (SMS), with all clients in the BOS having equal access to the services. Three (3) clients received 17 units of service (encounters with a provider/agency) for a total cost of \$2,559. Substance Abuse Treatment services have a per client service cap of \$5,000. This service is underutilized, which may indicate that a service access barrier exists (Part B, 2008).

There are no definitive data related to the prevalence of substance abuse among PLWH/A in Oregon. One study conducted among Medicaid-insured PLWH/A in 2002 found that 30% had been treated for a substance abuse issue over a two-year period (1999-2000); 20% had been treated for both substance abuse and mental health issues (PDES, 2002).

In 2008, 64% of PLWH/A participating in the MMP reported current alcohol use, 35% reported recreational marijuana use, and 61% reported current cigarette smoking. These MMP data in this area should be used as a very broad indicator, as they do not distinguish between substance use and abuse. Four percent of MMP participants reported being admitted to an inpatient substance abuse treatment facility in the preceding 12 months (MMP, 2008).

Case managers and other service professionals working with PLWH/A report multiple client-level and system-level barriers to getting HIV positive clients enrolled in substance abuse treatment services. These include a client's lack of treatment readiness, lack of insurance, mismatches between treatment modalities and clients' needs, lack of education about HIV in the mainstream behavioral health care system, and limited availability of behavioral health providers with an HIV focus, especially within certain geographic areas (Van't Hof, 2008).

Mental Health Services

Ryan White-funded mental health services include assessment and on-site or at-home counseling (individual/couple/family), group counseling, crisis intervention, 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).

Recruitment into mental health and substance abuse treatment services by peer mentors is also funded through a joint mental health and substance abuse treatment project in the TGA.

In FY 2007/08, 167 TGA clients received Part A-funded mental health services. This included over 1,400 hours of mental assessment, counseling, medication management, and/or group therapy, as well as 122 encounters with peer mentors. Clients received close to 300 fewer hours of therapy in FY 07-08 compared to FY 06-07. Mental health parity legislation related to coverage for mental health services by insurance plans resulted in less reliance on Part A funds to fill service gaps. The percentage of clients with stable or improved functioning by the end of the year, as indicated by the OQ-45, a scientifically reliable measurement tool for tracking psychotherapy and behavioral treatment progress, increased from 82% in FY 06-07 to 91% in FY 07-08. Many mental health clients also have co-occurring substance abuse issues. Part A-funded mental health providers serve dual diagnosis clients through partnerships with drug and alcohol treatment services; the largest mental health provider has substance abuse treatment on site. Finally, 55 clients received peer mentor services, in which staff in recovery connects clients with mental health and/or substance abuse treatment services and provide support to continue their engagement in care. Almost two thirds of clients in this program (61%) successfully engaged in treatment. The Part A cost for mental health services averaged \$733 per client in FY 2007/2008 (McLaughlin, 2008).

In FY 2007/08, 22 clients received Part B-funded mental health services (146 encounters at a per client cost of \$1,409) (Part B, 2008). As with substance abuse issues, there are no definitive data related to the prevalence of mental health issues among PLWH/A in Oregon. One study conducted among Medicaid-insured PLWH/A in 2002 found that 46% had been treated for a mental health issue, including depression, over a two year period (1999-2000); 20% had been treated for both substance abuse and mental health issues (PDES, 2002).

Thirty seven percent of PLWH/A participating in the MMP reported a need for mental health counseling in the preceding 12 months; of those, 83% said they received the needed services. However, MMP participants only include PLWH/A engaged in medical care: a group that may have less difficulty accessing care. About 3% reported being admitted to an inpatient mental health facility in the past 12 months.

The 2005 Consumer Needs Assessment (Pickle, 2006) showed that PLWH/A with mental health needs were significantly more likely to need ongoing help with housing (50% vs. 31%, $p < .001$). One in five Needs Assessment respondents reported ongoing needs for both housing help and mental health counseling. Predictably, homelessness was also significantly associated with mental health needs: 56% of recently homeless PLWH reported mental health needs compared to 35% of housed PLWH ($p < .001$). Of the 39% of total respondents who reported a need for mental health counseling, more than half reported that they did not receive the needed counseling.

As with substance abuse services, case managers and other service professionals working with PLWH/A report multiple client-level and system-level barriers to getting HIV positive clients enrolled in mainstream mental health services. These include a client's lack of treatment readiness, lack of insurance, mismatches between treatment modalities and clients' needs, lack of education about HIV in the mainstream behavioral health care system, and limited availability of

behavioral health providers with an HIV focus, especially within certain geographic areas (Van't Hof, 2008).

Early Intervention Services

Early intervention services (EIS) focus on newly diagnosed individuals and persons who have fallen out of care. Programs provide counseling and referrals to medical care. Referrals to mental health and substance abuse treatment services are also provided, as appropriate. EIS is currently available in the TGA only.

The EIS program in the TGA began in July 2007 and has focused on PLWH/A who are out of care and the newly diagnosed, many of whom come into care later in their disease progression with a variety of cofactors including mental health and substance abuse issues. EIS staff provided a total of 479 contacts to 64 clients in FY 07-08. This averages 7 contacts per client per year. The majority of these clients had been diagnosed with HIV over one year prior to receiving EIS (n=39), while 25 clients needing services had been newly diagnosed in the past year. Of the 64 clients, 29 clients needed assistance engaging in medical care, 4 clients needed assistance engaging in mental health or substance abuse treatment, and 31 clients needed assistance in engaging in both kinds of services. Emphasis is placed on finding clients who are out of medical care (McLaughlin, 2008).

Housing

This service category includes emergency and transitional housing assistance to PLWH/A and their families. Eviction prevention, information and referral, education, and housing case management enable clients to access and remain in transitional and permanent housing. Alcohol/drug-free housing is also provided for PLWH/A while enrolled in outpatient substance abuse treatment.

There are three Housing Opportunities for Persons with AIDS (HOPWA) grantees in Oregon: the State of Oregon (which has both formula and competitive grants), the City of Portland (formula), and Our House of Portland (competitive). Between these three sources, housing services are provided throughout the state of Oregon.

Housing services in the TGA include permanent alcohol and drug-free housing; housing with supportive services for clients with mental illness; permanent subsidized housing for homeless PLWH/A; housing for homeless women through the *Safety off the Street* program; emergency housing for youth; and transitional housing for formerly incarcerated clients.

Our House of Portland, a community provider, delivers a continuum of services covered by public and private resources for advanced stage PLWH/A. Services include 24-hour specialized nursing and end of life care, assisted living in adult care homes, and a neighborhood housing and care program that combines stable housing with integrated in-home medical, occupational therapy, and social work services.

BOS clients receive services through the HOPWA-funded Oregon Housing Opportunities in Partnership (OHOP) Program and through Part B supportive services funds. OHOP provides a continuum of housing services for low-income people living with HIV/AIDS through several distinct services delivered by four regional HOPWA housing coordinators:

- Comprehensive housing needs assessments and housing planning;
- Referral to community-based emergency housing and other housing resources, including Ryan White Program-funded emergency housing assistance;
- Direct provision of:
 - assistance with eligible move-in deposits and fees
 - tenant based rental assistance through monthly rental and utility subsidy payments
 - short-term rent, mortgage, or utility assistance to prevent homelessness by helping individuals at risk of losing their existing housing maintain that housing
 - Low Income Energy Assistance Program (LIEAP) winter heating assistance through limited utility and heating fuel assistance payments
 - transitional services and tenant based rental assistance for individuals returning to the community following incarceration through the Oregon Statewide Supportive Community Reentry (OSSCR) project
 - tenant-based rental assistance and supportive behavioral health care for Oregonians living with HIV and a co-occurring mental illness through the Oregon Housing and Behavioral Health Initiative (OHBHI).

In a 2007 evaluation, nine out of ten PLWH/A enrolled in OHOP reported living situations that met the HUD definition of stable housing (e.g. rental housing). Eight in ten clients (81%) said they were satisfied with their current housing situation and 84% said that it had improved since they began participating in the OHOP program. Ninety one percent of respondents rated the quality of OHOP services as good or excellent, and 83% thought that having a Housing Coordinator had made it easier for them to access better housing. Responses to open-ended questions echoed a high level of satisfaction and provided examples that emphasized increased levels of safety and security and decreased levels of stress (Drach, 2008).

Furthermore, local case management evaluation data indicate that PLWH with mental health problems are often unable to enter existing housing programs without additional, specialized case management support. Case managers report evictions due to behavioral problems (e.g. schizophrenic clients disturbing neighbors by repeatedly yelling at voices), which lead to destructive cycles of homelessness and disengagement with medical care. Data also indicated that a client's ability to stay adherent to HIV medicines was inextricably linked to both housing stability and mental health treatment, for those who needed it (Drach, 2007). Though community mental health systems exist throughout Oregon, these systems lack the resources to provide care to clients other than the most acutely ill. Few, if any, of these systems combine behavioral health services in home-based settings with affordable housing assistance and housing retention services, and none directly link those services with ongoing HIV care. Housing and supportive case management provided through the HOPWA/SPNS-funded OHBHI grant helps support clients with HIV, mental health problems, and ongoing housing needs.

The Part B program also subsidizes housing needs that OHOP does not meet. In CY 2007, 161 clients received 562 housing-related payments at an average per client cost of \$508 (Part B, 2008).

The 2005 Consumer Needs Assessment (Pickle, 2006) revealed a high level of unmet need for housing, even among clients who were receiving support through HIV case management. One in four (26%) reported unstable housing situations in the past 12 months, defined as living in places not meant for housing (like a car, abandoned building or outside), staying in an emergency shelter, living in transitional housing or a treatment facility, being in jail or prison, or staying temporarily with friends or family. Fifteen percent had been homeless in the past year. Two in five case management clients reported a need for emergency assistance with rent or utilities. Although unmet need remains high, the gap in getting ongoing help with housing appears to have decreased since the 2002 survey (52% in 2002 vs. 38% in 2005).

PLWH/A living in the TGA consistently report greater housing needs than those in the Balance of State. According to the 2005 Consumer Needs Assessment (Pickle, 2006), PLWH/A living in the Portland metropolitan area were more likely to have experienced unstable housing in the past year (31%) than those living in other parts of the state (19%). A full 40% of TGA clients reported they needed help with housing, while 27% faced a service gap in rent and utility assistance. More recently, the 2007/2008 MMP data show that 11% of PLWH/A in medical care statewide were homeless in the year preceding the survey, including 13% from the TGA and 4% in the Balance of State (p=.04).

Part A service utilization data show that 20% of clients receiving Part A funded services in 2007 were non-permanently housed. The Part A program provided housing services to a total of 485 clients in FY 2007/2008. Part A funds continue to support a mix of both direct housing assistance (156 clients in FY 07/08) and support services (357 in FY 07/08), which are used to leverage housing from other funding sources. Thirty substance abuse treatment clients also lived in Part A-funded alcohol and drug-free housing while enrolled in outpatient treatment. Women (18%) and racial/ethnic minorities (35%) were served in equal or greater proportion than their representation in the TGA epidemic. Eighty three percent of ERA clients and 87% of client receiving rental subsidies were still stably housed six months post-assistance.

Participants in community forums conducted in the TGA identified the lack of quality, stable housing as a barrier to receiving HIV medical care. Participants also found there to be long waiting lists for housing, and strict eligibility requirements that excluded individuals who may need housing the most, such as people with mental illness, substance abuse and incarceration histories (McLaughlin, 2008).

The OHOP program currently maintains a wait list of approximately 50 eligible clients, and the primary provider of HOPWA-funded services in the TGA has waitlisted or turned away more than 50 clients in the last year.

Food and Nutrition

This service category includes food vouchers/grocery gift cards, nutritional supplements and counseling, medically necessary home-delivered meals and group meals at a multi-service center.

In FY 2007/08, 54 TGA clients received 9,064 home-delivered meals and 209 clients accessed 7,456 congregate meals at a multi-service center, a decrease from FY 06-07.

The home-delivered meal program has restructured to adjust to more stringent client requirements around medical necessity for this service, and both programs had less Part A funding this year. As a result of reduced funding, the home delivered meals program now delivers a week's worth of frozen meals to clients once a week; however, the program is able to ensure that each client in the program has a microwave to heat the meals. The average Part A cost per home-delivered meal was \$5.21 in FY 2006/2007 (McLaughlin, 2008).

Esther's Pantry, located in the Portland metropolitan area, is the only food bank in Oregon specifically serving PLWH/A. It was founded in 1985 "to provide financially challenged individuals living with HIV/AIDS access to food and personal care items," and serves approximately 200 PLWH/A each month. Esther's Pantry is currently administered by Our House of Portland. The Pantry is unique in that it has always maintained a policy of allowing clients to select the food they want from well-stocked shelves, rather than handing out pre-packaged food boxes, which is a standard procedure at most emergency food programs. However, Esther's Pantry does not receive any Ryan White funding, only serves the Portland metropolitan area, and has had to limit services over the years due to budget constraints. The Tod's Corner program provides clothing, household goods, pet food, cleaning and personal care items. (Our House of Portland, 2008).

Part B provided Medical Nutrition Therapy to 222 clients (1,000 units) at an average cost of \$96 per client in CY 2007; units in this category includes nutritional supplements recommended by a primary care provider, nutritional counseling provided by a licensed registered dietician and food cards/vouchers. Food cards/vouchers represent 68% of the services accessed in this service category. A Nutritional Assessment, identification of nutritional needs and goals, and development of a written Nutritional Plan by a Medical Case Manager (an RN) are required to access food cards/vouchers under this service category. Two hundred and twelve (212) clients also accessed food cards/vouchers who did not require a nutritional assessment through another service category (Emergency Financial Assistance/EFA—866 food cards/vouchers) for an average cost of \$116 per client. Medical Nutrition Therapy has an annual cap of \$1,300 and EFA has an annual category cap of \$500 (Part B, 2008).

In 2007, HIV case management clients in the Part B service area were asked about their food needs as part of the annual client satisfaction survey; 57% (n=220/388) said they had needed financial help getting food or groceries in the past 12 months. The percentage needing help with food and groceries in 2007 was higher than the 49% identified in the 2005 Needs Assessment survey. The most common source of financial help for food came from food stamps, accessed by

47% of respondents. Other common sources of help were food banks/food pantries (27%), friends and family (25%), and grocery vouchers from case managers (23%) (Drach, 2007b).

In 2005, almost half of HIV case management clients (49%) said they needed help with food, groceries, or prepared meals in the preceding year. Of those who needed help, 58% said they had not been able to get their needs met using existing resources (Pickle, 2006). The 2005 Needs Assessment revealed that food-related needs and gaps were high among PLWH/A, but did not provide information about the context of or causes for food-related needs, nor about barriers to and strategies for getting needs met. A cross-sectional assessment conducted in 2007 gathered these additional data for Part B clients.

Focus groups identified a number of themes surrounding food-related needs and gaps. First, as supported by the scientific literature, PLWH/A have unique nutritional needs that extend beyond health promotion and disease prevention. Nutritional problems caused by HAART, including nutritional deficiencies, malabsorption, elevated cholesterol, and lipodystrophy are common, as are digestive problems such as nausea, vomiting, acid reflux, and diarrhea. Identified barriers to eating for optimal health included lack of transportation, lack of appetite, depression, and fatigue, but the most commonly cited barrier was lack of income. Although participants shop at discount stores, buy in bulk and pool resources, in order to stretch limited resources, they are often still short at the end of the month and some buy food on credit cards—a necessary stopgap, but an unsustainable long-term strategy.

Although many communities in Oregon are served by food banks, food distribution programs through churches, and congregate meal programs, PLWH/A found these resources only marginally helpful at best. Although most had used these programs, they cited multiple barriers including lack of access, long waits, concerns about food safety and the types of food offered, and feelings of stigma and discomfort related to competing for scarce resources with other individuals and groups in need (Drach, 2007b).

Medical Transportation

This service includes assistance with transportation to and from medical appointments, using the most cost-efficient means available for the client's locale.

Coordination of medical transportation for TGA clients is provided through medical case management. Case managers determine client needs and link them to the most appropriate resources, which are usually transportation resources outside of the RWCA-funded system. Most TGA clients live in Portland or the areas immediately surrounding it, and most Part A-funded services are also located in this area. Tri-Met provides an extensive public transportation system, including buses and light rail in Clackamas, Multnomah and Washington Counties. Case managers can provide gas vouchers or bus/rail tickets for those who use public transportation and can reimburse other types of transportation (taxi, gas cards, other medical transport) for clients unable to use public transportation.

Most Balance of State clients have fewer public transportation options and greater medical transportation needs. In CY 2007, Part B provided Medical Transportation services to 311 clients

(2,329 units, including gas cards/vouchers, bus passes, taxi fare, or other special transportation payments) at an average per client cost of \$92 (Part B, 2008).

Almost half of HIV case management clients in 2005 (45%) reported a need for help with transportation to and from medical appointments (Pickle, 2006). Fewer clients participating in the 2006/2007 MMP reported needing help with medical transportation (24%, including 22% TGA vs. 28% BOS, $p=.29$, NS). However, the MMP only sampled clients who had recently been in medical care (MMP, 2008).

MMP data indicate that about two thirds of PLWH/A statewide travel 30 minutes or less to access HIV medical care, but these proportions vary significantly between the TGA and BOS (70% TGA vs. 48% BOS). Thirty percent of PLWH/A in the Balance of State have one-way travel times to HIV medical care that exceed 90 minutes (Table 6) (MMP, 2008).

Table 6: One-way travel times to access HIV care

One way travel to HIV care (time):	TGA	BOS	Oregon	< 0.001
Less than 15 Minutes	18.4	18.3	18.4	
15-30 Minutes	51.5	30.4	45.1	
31-60 Minutes	21.5	7.8	17.3	
61-90 Minutes	6.8	13.1	8.7	
91-120 Minutes	0.6	14.5	4.8	
More than 2 hours	1.2	15.9	5.7	

The largest proportion of PLWH/A said they drive themselves to HIV-related medical appointments (48%), but like distances traveled, mode of transportation varied significantly between the TGA and BOS (Table 7). For example, 77% of BOS respondents use their own or someone else's private vehicle to access medical care compared to only 44% of TGA clients. Because of shorter distances and more transportation options, TGA clients were far more likely than BOS clients to use public transportation (44% vs. 8%) or to walk (10% vs. 2%) to medical appointments. Fifteen percent of PLWH/A statewide said it was either somewhat or very difficult for them to get to HIV medical appointments (12% TGA vs. 23% BOS, $p=.12$, NS).

Table 7: Mode of travel to access HIV care

Mode of travel to HIV care:	TGA	BOS	Oregon	<0.001
Drive Myself	40%	67%	48%	
Driven by Others	3%	11%	5%	
Taxi/Hire Driver	0	3%	1%	
Bus/Train	44%	8%	33%	

Walk	10%	2%	7%
Other	4%	10%	6%

Psychosocial Support Services

Psychosocial support services offer stability for a marginalized population; this leads to more consistent participation in HIV care and treatment services.

In the TGA, a drop-in day center serves PLWH/A who have difficulty dealing with activities of daily living, many of whom have substance abuse and mental health issues and are homeless or living in temporary housing. The center provides regular supportive activities, meals, peer support, and a place for clients to meet with social service providers. In FY 2007/2008, 231 clients made 6,585 visits to the multi-service center. Another center provides services for women and their families, including child-care while women participate in support groups and other center activities; in FY 2007/2008, 75 clients made 708 visits.

FY 2007/2008 service data showed that a higher percentage of clients receiving support services were female (19.9%), persons of color (34.5%), poor (80% <100% FLP) and non-permanently housed (39.5) than those receiving core services only. The Part A cost for psychosocial support services averaged \$355 per client (McLaughlin, 2008).

Emerging Service Populations with Special Needs

The SCSN Workgroup identified seven populations that may have special service needs and/or are a growing part of the local HIV/AIDS epidemic. These include PLWH/A who are: age 50 and older; foreign-born; women; dually diagnosed with mental health and substance abuse issues; formerly incarcerated; unstably housed; and/or males with a heterosexual transmission risk.

PLWH/A Aged 50 Years or Older

The number of PLWH/A age 50 and older in the U.S. has increased 77% from 2001 to 2005, and now comprise a quarter of all cases nationally. In Oregon, 27% of PLWH/A are aged 50 and older, including 21% of PLWH and 31% of PLWA. (In addition, 45% of PLWA and 34% of PLWH are aged 40-49, representing the next wave of older PLWH/A.)

Population increases within this age category are due to both the success of antiretroviral medications in treating HIV/AIDS and increases in the number of persons aged 50 and older being diagnosed with HIV/AIDS for the first time; about 1 in 6 PLWH/A diagnosed in 2006 (15%) were aged 50 or older.

PLWH/A aged 50 and older face several unique challenges within their care. Many older people living with HIV face serious co-morbid medical conditions, including cardiovascular disease, diabetes, certain cancers, osteoporosis, and depression, which further complicates medical care and compromises quality of life. PLWH/A that have been living with HIV/AIDS for long periods

of time may begin to lose their motivation to continue to follow drug treatment regimes, especially when these regimes come with negative side effects. Newly infected patients within this population are often diagnosed late: men and women diagnosed at aged 50 and older were 1.23 times more likely than 30-49 year olds to have AIDS within 12 months of their initial diagnosis. This population also has higher rates of infection with drug resistant strains of the virus. In general, PLWH/A aged 50 and older are more socially isolated and report higher rates of depression and loneliness, poverty, housing concerns, and poor nutrition. These issues are compounded by frequent losses of important social networks, as partners and friends die of AIDS and aging-related illnesses.

Gaps in care that are unique to this patient population include social support groups targeted to their needs; increased outreach, testing, and prevention services to decrease the rates of incidence within this population and bring infected people into care as soon as possible; increased coordination with aging and disabilities services; and increased access to specialists for treatment of conditions associated with aging. Additional needs of PLWH/A aged 50 and older include case management, mental health services, housing assistance, transportation and grocery assistance.

Foreign-Born PLWH/A

In 2006, 17% of newly diagnosed HIV infections in Oregon were foreign-born. Blacks accounted for 16% of foreign-born cases diagnosed during 2006, compared to only 2% of non-foreign born cases. Fifty four percent of all blacks, 69% of Hispanics, and 1% of whites newly diagnosed with HIV during 2006 were born outside of the U.S. Foreign-born blacks with HIV diagnosed in 2006 were born in 5 different countries, while a majority of HIV+ foreign-born Hispanics (94%) were born in Mexico. A higher proportion of foreign-born cases are female (22% foreign-born vs. 8% US-born). Within foreign-born cases, African-born cases were more than three times as likely to be female than those from Latin America (46% vs. 11%).

Many foreign-born PLWH/A reside in the Portland TGA. In June 2005, the Office of Refugee Resettlement ranked Multnomah County sixth nationally in terms of concentration of refugees compared with the area's general population and the five-year new arrival rate. Between 1/1/2003 and 12/31/2006, 25 HIV+ refugees were officially resettled to Oregon from overseas, and an additional 99 foreign-born individuals were diagnosed within the TGA. Since 2003, more than 50% of all newly diagnosed HIV/AIDS cases among Blacks and Hispanics in the TGA were foreign-born, and as of 12/31/06 approximately 42% of racial/ethnic minority PLWH/A were foreign born.

Foreign-born PLWH/A face a number of unique challenges that create substantial barriers to accessing and remaining in care. One of the largest barriers is language. Oregon providers do not have the resources to offer their services in the native languages of all of their clients; this service gap is particularly acute outside of urban areas. This challenge has increased dramatically over the past ten years as new waves of immigrants and refugees have arrived. Language barriers are compounded when clients refuse translation services for fear of being identified as HIV+ within their community. Cultural issues and health literacy levels present another unique challenge to accessing care. Health education messages, patient instructions, and service delivery methods must be tailored to be culturally competent and effective. Finally, immigrants and

refugees face many of the same challenges that other PLWH/A populations face, including poverty and lack of health insurance.

The barriers that immigrants and refugees face result in gaps in service, including translation/interpretation services, culturally competent education materials and services, access to outpatient medical and oral health care, case management and social supports, resources for prescription and over the counter medicines, and assistance with transportation, housing, food, and other basic needs.

Women

As of December 31, 2006, women comprised 12% of PLWH/A statewide, including 10% of PLWH/A in the Portland TGA and 19% in the Balance of State. Oregonians living with HIV are more likely to be female compared to those living with AIDS. Among female PLWH/A statewide, the primary method of transmission is heterosexual contact, accounting for 67% of new diagnoses, followed by IDU, accounting for 29% of newly diagnosed cases. However, female PLWH/A outside of the Portland metropolitan area were more likely to report IDU as the presumed transmission mode (29% vs. 22%).

The age-adjusted annual risk of death for female PLWH/A is 11 times higher than for Oregon women overall. Women need accessible primary care providers who have specialized knowledge of HIV and women's health, as well as coordinated access to specialists for treatment of HIV related illnesses and common co-morbidities such as mental disorders and co-infection with hepatitis or STD. The higher proportion of female PLWH/A with current or past history of IDU requires access to substance abuse treatment services, and may indicate greater levels of poverty and/or social isolation. Case management services are particularly important for this population to help coordinate care and keep clients engaged. Women need to receive HIV prevention and early intervention messages in conjunction with their HIV care, and in places where they congregate. All services for female PLWH/A must be gender and culturally appropriate, and childcare should be available to clients while they are receiving other services.

According to *We're Listening: 2002 Survey for People Living with HIV and AIDS in Oregon* (Dowler, 2003), gaps and access to primary care are significant issues for female PLWH/A because they are less likely to have health insurance, have higher poverty rates, and are likely to forego their own health care needs in favor of children and other family members for whom they provide care. This study also reported proportionately higher needs by women for psychosocial support services, referral services, emergency financial assistance, outpatient substance abuse treatment, and child care. *We're Listening* also indicates that women were more likely to need emergency rent/utilities and housing assistance. Barriers to addressing these issues were most often related to system capacity issues such as wait times and lack of knowledge about services.

The 2007 Part B HIV case management client satisfaction survey indicated that female PLWH/A are significantly less satisfied with the overall quality of case management services than male PLWH/A. However, there were no differences in satisfaction for seven specific aspects of case management services (e.g. respect, privacy, access), suggesting that female clients may have service needs that are different from male clients and that are not being addressed by the current HIV case management system.

Dual Diagnosis of Mental Illness and Substance Abuse

No surveillance data are available on co-occurring HIV disease, substance abuse and mental health disorders. However, national studies have identified a much higher HIV prevalence among people with serious mental illnesses, such as schizophrenia and affective disorders, than among the general Medicaid population. An analysis of Medicaid claims data in Oregon estimated that up to 46% of PLWH/A were treated for mental health conditions, including depression, up to 30% have substance abuse issues, and up to 20% are affected by both. The 2002 Consumer Needs Assessment (*We Listened*) found slightly higher numbers using a self-reported measure, with 77% of surveyed PLWH/A in Oregon reporting a mental health issue in the last 12 months, 32% reporting substance use issues in the last 12 months, and 25% reporting both. Injection drug use was the presumed transmission risk in about 20% of prevalent male and 25% of prevalent female HIV cases.

Mental illness and substance abuse are common to all gender, race/ethnicity, age, and risk populations. Data show that mental illness among PLWH/A in the TGA increased from 40% of the population in 2005 to 56% of the population in 2006. The percentage of PLWH/A in the TGA with a dual diagnosis of mental illness and substance abuse has increased from 21% in 2005 to 25% in 2006, but these numbers understate the prevalence of substance use and abuse by PLWH/A with a mental illness, as substance use and abuse is not always diagnosed. An analysis of 2006 service utilization data for mental health services and substance abuse services shows that women, minority populations other than Hispanics, persons aged 20-44, and persons infected with HIV/AIDS through heterosexual transmission have higher rates of mental health service utilization rates, and black, Hispanic, and persons aged 20-44 have higher rates of substance abuse treatment services.

PLWH/A with mental illness and/or substance abuse diagnosis face multiple challenges to initiating, engaging and remaining in care. For example, male PLWH/A with IDU transmission risk have a higher relative risk of late diagnosis with HIV (e.g. progression to AIDS within 12 months of initial diagnosis) compared to those without IDU history. Furthermore, PLWH/A with mental illness and substance abuse are more likely to experience unemployment, homelessness, and poverty than the general population. For example, 2005 Needs Assessment data show that PLWH/A with mental health needs were significantly more likely to need ongoing help with housing (50% vs. 31%, $p < .001$).

One in five 2005 Needs Assessment respondents reported ongoing needs for both housing help and mental health counseling. Predictably, homelessness was also significantly associated with mental health needs: 56% of recently homeless PLWH reported mental health needs compared to 35% of housed PLWH ($p < .001$). Of the 39% of total respondents who reported a need for mental health counseling more than half reported that they did not receive the needed counseling. This population also faces gaps in medical care, case management services, client advocacy services, culturally competent mental health services, substance abuse treatment services, including out-patient and residential care, and basic needs like food, housing, and transportation. Finally, PLWH/A with mental health and substance abuse issues also have higher rates of incarceration than other PLWH/A, with each episode of incarceration having the potential to interrupt their treatment for HIV disease.

People within this population require primary treatment by specialists who understand the dynamics of both illnesses, and who are prepared to deal with their potential effects, particularly those related to drug interactions that may create a higher mortality risk when combined with certain antiretroviral medications. Mental illness and substance abuse can adversely affect the ability of PLWH/A to follow scheduled medical treatment and to adhere to HIV drug treatment regimes. High levels of case monitoring and service coordination are required to reduce the interference of psychiatric disorders, medications, and illegal drugs with HIV medical treatment. These services, particularly mental health services, must be designed and delivered in a manner that is culturally appropriate for ethnic and sexual minority populations. As both mental illness and substance abuse are chronic conditions, access to appropriate services must be assured for extended periods of time, and treatment must be adjusted to varying levels of acuity over time. Mental health and substance abuse treatment services must be able to be accessed quickly in the case of an emergency, and must be coordinated with primary HIV care. However, mental health and substance abuse providers do not have a systematic way of knowing the HIV status of their clients, so unless clients disclose their own status, treatment in relation to HIV-specific issues is difficult.

Formerly Incarcerated PLWH/A

The formerly incarcerated population is another group that is disproportionately impacted by HIV/AIDS. Reports from State and County correctional systems support national statistics that illustrate this disproportionate impact. The Oregon Department of Corrections reports that 58 inmates self-identified as HIV+ during 2007, and estimates that 1.2-1.8% of their incarcerated population is infected with HIV, up to four times the number of those who self-identified. An analysis of population data for the State of Oregon shows that approximately 3.67/1,000 of the general population are incarcerated compared to 13.85/1,000 for PLWH/A.

In 2007, Multnomah County, the largest county in the TGA, had 710,025 residents and 24,447 unduplicated bookings in its corrections systems (3.4% of the total population). The Corrections Health unit of the Multnomah County Health Department reports treating 152 clients for HIV/AIDS within the County jail system during 2007. Additionally, the HIV Health Services Center, the largest HIV primary care provider in the state, reports that in 2007, 6-9% of its patient population had a history of recent incarceration, and Cascade AIDS Project, one of the largest HIV service organizations in the TGA, reports that of the 890 clients it served in 2007, 29% reported a recent criminal history. Of those, 25% reported lack of insurance and 40% reported no income in a 2006 survey. In addition, PLWH/A with criminal histories were almost three times as likely to report active or past substance abuse (85% vs. 29%) and about twice as likely to report mental health issues (60% vs. 32%), compared to clients without criminal histories.

Statewide, 14% of the MMP (non-incarcerated) sample was in jail, prison, or detention in past 12 months. Fourteen additional MMP participants were interviewed in prison.

PLWH/A with histories of incarceration often face several co-morbidities, including poverty, substance abuse, and mental illness. They also face many unique challenges in accessing and remaining engaged in medical care and support services. Ex-offenders have particular difficulty securing employment and stable housing due to the stigma attached to being an ex-convict,

landlord policies prohibiting criminal backgrounds, poor or nonexistent credit, rental and employment histories, and lack of funds for deposits and rent. Lack of health insurance is also a substantial challenge to accessing care. When entering the jail system, inmates are taken off of public insurance programs, and upon release must go through a re-application process that can take over six months. Even with insurance, lack of resources for co-payments results in barriers to care. Many former inmates also struggle with active mental health and/or substance abuse issues and have limited family and community support systems in place.

Unstably Housed PLWH/A

Homelessness is a major risk factor for HIV, and HIV is a major risk factor for homelessness. The prevalence of HIV/AIDS is three to nine times higher among persons who are homeless or unstably housed compared with persons with stable and adequate housing, depending upon the population and geographic area studied. Furthermore, up to 60 percent of all persons living with HIV/AIDS report a lifetime experience of homelessness or housing instability (Aidala 2005, Culhane 2001).

Similar to other parts of the nation, housing for PLWH/A continues to be an area with high service needs and gaps in Oregon and Clark County, Washington. A consumer needs assessment conducted in 2005 with PLWH/A receiving case management services in Oregon revealed that one in four clients (26%) had experienced housing instability in the preceding year, including living in places not meant for housing (e.g. car, outside), staying in transitional housing, or doubling up with family and friends. PLWH/A living in the Portland metropolitan area were more likely to have experienced unstable housing in the past year (31%) than those living in other parts of the state (19%). Furthermore, although only 4% of surveyed clients were homeless at the time of the survey, 1 in 7 (15%) had been homeless in the past two years and 1 in 15 (6%) had been in a correctional facility in the past year.

Housing status has profound implications for persons living with HIV/AIDS. Data from multiple studies suggest that PLWH/A need stable housing in order to negotiate bureaucracies, file entitlement applications, keep appointments, and access social and medical services. Stable, adequate housing has become especially critical with the advent of highly active antiretroviral therapy (HAART) and its significant impact upon morbidity and mortality. Inadequate housing is associated with inadequate health care, putting the homeless and marginally housed at risk for poor health and clinical outcomes. Some physicians are reluctant to prescribe HAART to homeless PLWH/A, fearing inconsistent adherence with consequent drug resistance.

Research indicates that homeless PLWH/A are more likely than stably housed PLWH/A to report a wide range of negative health outcomes, including lower CD4 counts, less likelihood of undetectable viral loads, poorer self-reported HAART adherence, and less likelihood of current treatment with HAART.

Male PLWH/A with Heterosexual/Presumed Heterosexual Transmission Risk

In 2006, male PLWH/A with heterosexual transmission risk in Oregon were 1.5 times more likely than MSM to be diagnosed with AIDS at or within 12 months of their initial HIV diagnosis; males with presumed heterosexual risk were almost twice as likely to be diagnosed late. Early HIV diagnosis is crucial to an individual's long-term health, quality of life, and

positive treatment outcomes. New studies indicate that the ideal time for initiation of HAART is earlier in the course of infection than previously thought.

Male PLWH/A with heterosexual transmission risk comprise a small proportion of Oregon's epidemic and support services tailored to this group (such as support groups or peer-based services) are limited or nonexistent. These PLWH/A may face additional stigma and/or fear of status disclosure, which can impact their ability to engage and stay involved with HIV care and treatment services—as evidenced by their disproportionate likelihood of late HIV diagnosis. Male PLWH/A with heterosexual transmission risk may also have less knowledge of HIV overall, requiring culturally competent medical care and HIV prevention services.

Cross-Cutting Service Goals and Issues

Members of the SCSN 2008 Workgroup met for a full-day, in-person meeting on 10/21/08 to discuss cross-cutting themes in HIV care and treatment services, and to identify shared goals related to moving HIV care and treatment services forward over the next three years. The Part A Planning Council and the Oregon HIV Care Coalition (the Part B planning body) are responsible for developing measurable objectives for each of the broad goals identified here, and shaping them into action plans.

Outcomes of the SCSN Workgroup Meeting

The SCSN Workgroup identified a host of issues that were organized under the following four “themes” or points in the HIV care continuum:

- preventing new HIV infections,
- finding HIV+ people who need care and treatment services,
- engaging HIV+ people in care and treatment services, and
- retaining HIV+ people in care and treatment services.

Workgroup members acknowledged that there is overlap between these four areas, and that actions in one area often affect the others (e.g. engaging and retaining people in care can prevent new infections).

Service Needs Identified SCSN 2008 Workgroup

The group identified a need to build stronger links between HIV prevention and care services, in order to prevent new HIV infections and to link newly infected people into care earlier. According to the group, we need to focus on vulnerable populations in order to find HIV+ people who are out of care. We also need to test people in a larger variety of settings and develop effective systems for seamlessly triaging newly diagnosed individuals into care.

In addition, there is a need to build bridges to “mainstream” social services, in order to engage HIV+ people in care, and to provide a full spectrum of disease management services to HIV+ people as early as possible. Funding shortages coupled with increasing case loads make creation of a parallel HIV service system unfeasible, so there is a need to move clients between the RWCA system and other general social service programs and community services, such as Section 8. Referrals outside of the RWCA system can be tricky, however, and provide

opportunities for HIV+ clients to “fall through the cracks.” Facilitated referrals work better than simply giving clients a phone number; RWCA providers need to develop better systems for accessing a wide range of services for clients and ensuring a smooth transition for clients between programs and services.

Likewise, there is a need for more responsive services for HIV+ people, in order to keep them retained in care. The group said that integrated behavioral health services are needed, since both active substance abuse and untreated mental illness impede medical care. However, there are many barriers to accessing substance abuse and mental health services for HIV+ clients, including limited treatment modalities and insurance difficulties. Services tailored to older PLWH/A are also in ever greater demand, with the aging of the HIV+ population. Each part of the RWCA system is responsible for identifying and working to remove client barriers, wherever possible. Identified needs for system changes included coordinating intake forms, providing client-centered care, track appointments and making follow up phone calls to clients, soliciting provider input, and triaging clients to specialty and/or “mainstream” providers or disease management programs, where appropriate.

Finally, on a broader scale, the group identified a need for ongoing evaluation and assessment, in order to ensure that we are using our limited funds in the most efficient and beneficial manner. The group also advocated for identification of promising evidence-based models for delivering care and treatment services, without imposing a one-size-fits-all approach onto very different populations across the state. The group called for honest assessments of service capacity in different regions; rural areas face additional challenges related to resources and need creative approaches to service delivery. For the long-term, the group advocated for an upstream approach to service delivery, framing our goals broadly to address specific service needs, but to also address structural factors like poverty, racism, and homophobia, in our efforts to prevent and treat HIV disease in Oregon.

More details about the variety of issues discussed at the meeting can be found in the notes from the SCSN 2008 Workgroup Proceedings (Appendix D).

Resource Changes Affecting HIV Services

(Identified by the Oregon HIV Care Coalition at its December 2008 Comprehensive Planning Meeting.)

- Local County Public Health programs are severely impacted by the downturn in the economy and by changes in federal funding (such as the “Timber Funding.”) Many programs are being cut and some have threatened to close the agency completely. Because many of the local County Public Health Agencies are cutting back to only providing Core Public Health services, they are pulling out of the HIV case management program, forcing the Oregon HIV Care & Treatment Program to develop a new model to continue to provide services to clients within those communities. Multnomah County (the county with the largest population in the state) is reporting cuts of approximately 20% across all clinical services.

- Programs funded through the state General Fund are looking at a possible 20% budget cut. The Department of Human Services has a huge deficit in the current budget and all programs are experiencing increased scrutiny.
- Reduced revenues at local and state levels have resulted in service cuts for clients, with a 20% increase in case load vs. an average of 20% cut in services.
- Private community based organizations are reporting a 50% reduction in donations.
- Grant funds are being reduced as foundation portfolios are reduced and private donations are decreased.
- Reduction in HIV prevention funding has resulted in less testing happening statewide.
- The Oregon Health Plan (Medicaid) opened up 24,000 slots for the OHP Standard program (a waiver for clients based solely on income eligibility – no disability required) and 90,000 applied for the slots. OHP is looking at negotiating a provider tax to fund Medicaid. OHP currently provides very limited coverage and can't pay for facility costs, only provider fees.
- The Statewide Children's Health Insurance Program (SCHIP), federal funding for children, expires in February 2009.
- More PLWH/A are coming in worried about money and being homeless. More people are experiencing anxiety about these issues for the first time.
- There is increased competition for scarce resources for clients. Clients are experiencing housing instability, increased cost of transportation, and increased cost of heating.
- A decrease in food bank donations was reported. There is now a \$35/per family charge to use the Oregon Food Bank warehouse.
- The Ryan White Treatment Modernization Act of 2006 expires in September 2009. We are vulnerable.
- Political changes with President and Congress will impact the future of this program.

Broad Goals Defined by the SCSN 2008 Workgroup

The group identified the following broad goals within each of the four thematic areas:

1. Preventing New HIV Infections:
 - Develop stronger linkages between HIV care and treatment and HIV prevention
 - Develop and disseminate consistent messages around HIV testing and linkage to care & treatment that can be used in a variety of sites (e.g. private providers, hospitals, emergency rooms, correctional settings)
2. Finding HIV+ People Who Need Care and Treatment Services:
 - Gather data to better understand why people are out of care
 - Develop evidence-based systems to follow up on people who fall out of care
 - When looking for people who may be out of care, go beyond "emerging populations" and consider larger social determinants of disease transmission (e.g. poverty, marginalization)
3. Engaging HIV+ People in Care and Treatment Services:
 - Shore up early intervention services, particularly in the Balance of State
 - Identify and reduce system barriers (possibly via peer advocates/health navigators)

- Develop flexible models of care that better reflect client needs and do not attempt a “one size fits all” approach
4. Retaining HIV+ People in Care and Treatment Services:
- Develop client-centered approaches to care (relationship building between providers and clients, reminder phone calls, anniversary/incentives)
 - Implement and promote self-management programs and tools for clients further along disease management continuum
 - Develop strong linkages between systems (“warm hand off”) so clients don’t fall through the cracks
 - Engage in evaluation/assessment/continuous quality management to ensure that services are accomplishing intended goals.

Where Do We Need To Go?

Service System Goals

To understand how HIV care services are delivered in Oregon, a description of the Oregon Continuum of Care was provided that specifies and shows the linkages between a full range of client-centered, cost-effective services that unify the prevention and treatment of HIV and AIDS throughout the state. The following goals of the Oregon HIV Care and Treatment Program are reflected in the Continuum of Care:

Ryan White Part B Services are intended to:

- Ensure that all persons with HIV disease, and those affected by HIV disease, are served by a care system that provides a comprehensive continuum of primary care and supportive services that facilitate access to existing and emerging HIV/AIDS treatments.
- Ensure that women and children receive services funded by Ryan White Title II proportionate to their HIV/AIDS prevalence in the state.
- Ensure that racial/ethnic minorities will receive services proportionate to their representation as indicated in the prevalence data.
- Ensure that the needs of emerging populations are addressed and that services and outreach efforts are designed to encourage early intervention and participation in HIV medical care and therapy by these populations.
- Ensure that services will be provided to all PLWH/A generally in proportion to the HIV prevalence.
- Ensure and document the impact of services on improving access to quality care and treatment.

How Will We Get There?

Strategic Plan

Focus Area I: Prevent HIV Infection and Co-Infection in PLWH/A

Goal I.A: Develop program that targets partners of current consumers of HIV Care & Treatment Services.

- Objective I.A.1: Explore the feasibility in providing early intervention services to identify infected partners of Part B clients.
- Objective I.A.2: Coordinate with Early Intervention Programs in Part A and Part C to assure access to CAREAssist for newly identified HIV positive individuals.
- Objective I.A.3: Work with DIS and partner notification services to pursue collaborative opportunities.
- Objective I.A.4: Include partners in case management risk-reduction education opportunities.

Goal I.B: Develop training of risk reduction messages/education for key providers so everyone is giving the same message, over and over to clients and partners.

- Objective I.B.1: Collaborate with Prevention for Positives programs.
- Objective I.B.2: Encourage Orasure/rapid testing training with case management clients identifying themselves as IDU or other who may resist standard testing procedures (i.e. blood draws).

Goal I.C: Collaborate with HIV Prevention Programs.

- Objective I.C.1: Meet with the HIV Prevention Statewide Planning Group (SPG) to create a Joint Task Force to look at HIV prevention activities statewide and where the HIV Care & Treatment Program can put some resources and support activities.
- Objective I.C.2: Improve HIV Care & Treatment Program visibility by attending community events with HIV Prevention and providing education and outreach services.
- Objective I.C.3: Include/increase HIV care service information available through the HIV Hotline currently funded by HIV Prevention.
- Objective I.C.4: Include HIV Prevention staff in SCSN and HIV Care & Treatment Program Comprehensive Planning.
- Objective I.C.5: Include local County Health Departments that do not currently receive HIV Prevention funding in the HIV Prevention update emails.

Goal I.D: Develop targeted Outreach Strategies.

Objective I.D.1: Provide prevention/risk reduction messages to clients in CAREAssist.

Focus Area II: Finding PLWH/A Who Know They Are Positive and Not in Care

Goal II.A: Find out why PLWH/A who know they are positive are not in care.

Objective II.A.1: Develop an evaluation strategy with Program Design and Evaluation Services (PDES) to find out why these PLWH/A are not in care.

Objective II.A.2: Work with the HIV Prevention Statewide Planning Group to collaborate services for targeted populations.

Objective II.A.3: Connect with MMP and other programs conducting evaluation of targeted populations.

Goal II.B: Develop an Outreach Plan that includes the following strategies.

Objective II.B.1: Get information about care and treatment programs on internet/chat rooms and social networking sites.

Objective II.B.2: Work with HIV Prevention to include care and treatment service information in prevention related education materials.

Objective II.B.3: Explore the development of a peer advocate program.

Objective II.B.4: Distribute program information to hospital systems, federally funded clinics and private clinical offices, immigration offices and Indian Health Services.

Focus Area III: Engaging PLWH/A In Care

Goal III.A: Reduce barriers to entering care.

Objective III.A.1: Create a common Intake across as many HIV Programs (and Ryan White Parts) as is possible.

Objective III.A.2: Conduct a formal assessment of institutional barriers for clients and case managers to determine what they are and what might be done to reduce the barriers (for example: scheduling appointments during the week is difficult for low income working clients who can't get time off from work and need evening and weekend case management & medical appointments, simplify application process, cultural and language competency, etc.)

Objective III.A.3: Develop a pilot with collaboration with a few Mental Health counselors & Substance Abuse counselors or agencies in one region to develop strategies on how to assist clients to engage in HIV Care who have mental health and/or substance abuse problems that create a barrier to entry into HIV care.

Goal III.B: Educate PLWH/A not in care about the importance of being in care.

- Objective III.B.1: Market a positive message about HIV care services and the importance of being in care if you are HIV+ in the HIV prevention campaigns.
- Objective III.B.2: Develop a plan to market/educate around the message “It’s still important to get into HIV care” and the realities of HIV treatment today (fewer pills, fewer side effects, etc.)
- Objective III.B.3: Develop a plan to provide family education about HIV.

Goal III.C: Develop a program that targets newly diagnosed and newly identified PLWH/A.

- Objective III.C.1: In the regional Care Coordination Pilot, develop policies/procedures and standards for intense Medical Case Management interventions for newly diagnosed and newly identified PLWH/A.
- Objective III.C.2: Develop and pilot a “First Response Team” that includes an assigned medical provider, Medical Case Manager, Care Coordinator and Peer Advocate.

Focus Area IV: Retaining PLWH/A In Care

Goal IV.A: Develop an outreach program that targets PLWH/A in medical care experiencing a change in care status.

- Objective IV.A.1: Develop marketing strategy to get message out: “If you lose your job, contact us immediately.”
- Objective IV.A.2: Collaborate with Bureau of Labor and Industry to get general information about HIV Care & Treatment services to PLWH/A who may use their services.
- Objective IV.A.3: Collaborate with other dislocated worker/work force programs.
- Objective IV.A.4: Collaborate with DHS to make information available about HIV Care & Treatment services at all these sites.

Goal IV.B: Develop a formal Retention Initiative that includes the following strategies:

- Objective IV.B.1: Develop a Peer Navigator program.
- Objective IV.B.2: Institute regular Case Conferencing between Nurse/Medical Case Managers and medical providers in Standards of Care. Work with Medical Case Managers to assist in developing relationships with medical providers to assist clients to stay in care.
- Objective IV.B.3: Institute formal letter to the client’s physician summarizing the findings from every Nurse Assessment & Reassessment in the Medical Case Management Standards of Care.

- Objective IV.B.4: CAREAssist will develop and implement a client orientation training for all newly enrolled clients including a training in Spanish.
- Objective IV.B.5: Targeted services for Hispanic clients in CAREAssist to include:
- Bi-cultural, bi-lingual staff person in CAREAssist will follow-up with all Hispanic clients who are due for recertification.
 - Pilot helping clients fill out their application via phone and mailing completed application to client for signature.
- Objective IV.B.6: Continue to expand the Client Self-Management Training program.
- Objective IV.B.7: Work with Medical Case Managers and Care Coordinators to develop policies/procedures and standards on intervening early with a client who is experiencing treatment disruption.

HOW WILL WE MONITOR OUR PROGRESS?

Quality Management Plan 2008-2009

Quality Statement

The Oregon HIV Care and Treatment Program is committed to developing and continually improving a quality continuum of HIV treatment and supportive services statewide that meets the identified needs of people living with HIV/AIDS (PLWH) and their families. The Quality Management (QM) Program supports this mission by gathering and reporting on the data and information needed to measure both program and service quality and then implementing improvement activities based upon the data analysis. The following domains for improvement guide the QM program implementation: (1) improving access to and retention in care, (2) integrating data and information systems, (3) optimizing the management of resources and (4) aligning jurisdictions and services across the entire continuum of care.

Quality Infrastructure

The HIV Care & Treatment program resides under the Office of Disease Prevention and Epidemiology (ODPE). ODPE works to prevent and control illness and death from injury, acute and communicable diseases, sexually transmitted diseases, and environmental and occupational illnesses. HIV Care & Treatment is housed with the STD, TB and HIV Prevention programs.

The Manager of HIV Care & Treatment oversees the Quality Management Program. The ongoing development and implementation of the QM Program is coordinated and directed by a contracted consultant. In addition to the Program Manager and the QM Consultant, the QM Team within HIV Care & Treatment includes the following staff:

- HIV Medical Case Management & Support Services Manager
- CAREWare Program Consultant
- OHOP (Housing program) Coordinator
- CAREAssist program staff
- CAREAssist data specialist from Data & Analysis

- HARS data specialist from Data & Analysis
- Data Analyst from Data & Analysis
- Program liaison from Program Design and Evaluation Services

This team is responsible for implementing the QM Plan, gathering and reporting the data from the various databases, evaluating program elements and reporting on the findings, developing and implementing the PDSA/improvement change activities and providing input and feedback to the overall QM Program.

Oregon HIV Services Quality Management Task Force

The Oregon HIV Services Quality Management Task Force was formed to centralize and coordinate quality management efforts across Ryan White contractors statewide. The Task Force is made up of representatives from Ryan White Program Part A, Part B and Part C administration, the AIDS Education and Training Center (AETC) and the Dental SPNS program; contractors with the Part A and Part B programs; Planning Council representatives; Oregon HIV Care Coalition representatives; and consumer representation from urban and rural areas. The Task Force meets quarterly and is responsible for reviewing the Quality Management plans for all three Ryan White Program Parts, for promoting collaboration, and for establishing shared measures and standards whenever possible.

Participation of & Communication with Stakeholders

Stakeholder	Type of Involvement	Communication
Clients	<ul style="list-style-type: none"> • Participate in OHCC and on QM Task Force; • Participate in surveys; • Give feedback to providers; • Review reports on-line. 	<ul style="list-style-type: none"> • Reports on QM Program outcomes at OHCC and QM Task Force; • Reports & survey results posted on web site.
Contractors	<ul style="list-style-type: none"> • Provide data on services provided; • Participate in QI processes such as Case Management Task Force; • Participate in OHCC; • Meet Standards of Service. 	<ul style="list-style-type: none"> • Statewide meetings and trainings; • Technical assistance via NetLink; • Summary report on the CM Chart Review they perform sent to them; • Reports at OHCC; • Reports & survey results posted on web site.
OHCC Members	<ul style="list-style-type: none"> • Provide input and advise; • Participate in discussions about data 	<ul style="list-style-type: none"> • Written & verbal reports at OHCC meetings; • Reports & survey results posted on web

	<ul style="list-style-type: none"> and information; • Make suggestions; • Review written reports. 	site.
Oregon HIV Services QM Task Force	<ul style="list-style-type: none"> • Provide input; • Shared knowledge and education about QM methodology & issues; • Networking and collaboration toward standardization statewide. 	<ul style="list-style-type: none"> • Reports at meetings. • Reports & survey results posted on each program's web sites.
HIV Care & Treatment staff	<ul style="list-style-type: none"> • Provide data. • Provide analysis of data. • Provide suggestions on improvement. • Implement improvement activities. • Review program reports. • Assist in writing grant applications – the QM components. 	<ul style="list-style-type: none"> • Staff meetings. • Reports. • Participation at OHCC and the QM Task Force.
Program Design & Evaluation Services	<ul style="list-style-type: none"> • Provide evaluation skills. • Evaluate program components. • Develop reports on findings. • Report to OHCC & QM Task Force. 	<ul style="list-style-type: none"> • Staff meetings. • Reports. • Participation at OHCC and the QM Task Force.

Program Goals for 2008-2009

Domain #1: Improving access to and retention in care

Goal 1.1: Continue to measure the retention rate in CAREAssist (pending status, re-certification, and termination) and test improvement changes to improve retention.

Goal 1.2: Investigate why all clients served in the CAREAssist Bridge program do not successfully transition into CAREAssist and develop an improvement strategy based on findings.

Goal 1.3: Design data collection mechanism to measure length of time between receipt of application to CAREAssist and client notification of status.

Goal 1.4: Investigate data showing length of time between testing HIV positive and first lab. Develop and test a strategy to improve data.

Goal 1.5: Develop outcomes and indicators for the regional Care Coordination Center pilot.

Goal 1.6: Develop measures and data collection methodology for Medical Case Management focus of interventions on newly HIV diagnosed clients.

Goal 1.7: Develop new CAREAssist application and re-certification form. Create on-line versions.

Domain #2: Integrating data and information systems

Goal 2.1: Continue to refine data query with Oregon Medical Insurance Pool to assist in obtaining the HAB required Group 1 clinical measures.

Goal 2.2: Finalize plan to collect data on the five HAB required Group 1 clinical measures.

Goal 2.3: At least annually, have HARS run the number of labs clients received and the values of the labs for both the CAREAssist active client list and the CAREWare active client list.

Domain #3: Optimizing the management of resources

Goal 3.1: Develop measures and data collection requirements for the HAB required Care Plan indicator for Medical Case Management.

Goal 3.2: Develop outcomes and measurement criteria for referral process in the HIV Medical case management program.

Goal 3.3: Develop QI plan with benchmark measures for new regional Care Coordination Center Pilot.

Domain #4: Aligning jurisdictions and services across the entire continuum of care

Goal 4.1: Develop a plan to collect data for the new HAB required-clinical measures.

Goal 4.2: Continue to participate on the Oregon HIV Services Quality Management Task Force, sharing QM plans and assessment system-wide outcome measures evaluating client engagement in medical care.

Goal 4.3: Continue to collect and report statewide aggregate client information from HARS (lab information, HIV or AIDS status at diagnosis, progression from HIV to AIDS and number of people who die within 12 months of HIV diagnosis.)

Implementation Plan: Data Collection Activities

1. CAREWare 4.1 is installed in all Part-B funded provider locations and is generating real-time, unduplicated data reported via a secure central server.		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Case Management services utilization	Reported & reviewed in March of each year.	Program manager/CAREWare consultant
Support Services utilization data	Reported & reviewed in March of each year.	Program manager/CAREWare consultant
Health outcomes data	Reported & reviewed in March of each year.	Program manager/CAREWare consultant
Quality Assurance data	Reported & reviewed in March of each year.	Program manager/CAREWare consultant

2. CAREAssist data base		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Health outcomes data	Quarterly reports	D&A – CAREAssist staff
Quality assurance data	Quarterly reports	D&A – CAREAssist staff
Quality Improvement data	Quarterly reports	D&A – CAREAssist staff

3. HIV/AIDS Reporting Systems (HARS) data base (surveillance data)		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
HIV & AIDS status of CAREAssist clients	Quarterly reports	D&A – Surveillance staff
HIV & AIDS status of CAREWare clients	Quarterly reports	D&A – Surveillance staff
Number of labs / year for all PLWH/A in state	Quarterly reports	D&A – Surveillance staff
Number of labs / year for CAREAssist clients	Quarterly reports	D&A – Surveillance staff
Number of labs / year for CAREWare clients	Quarterly reports	D&A – Surveillance staff
Lab values for all PLWH/A in state	Quarterly reports	D&A – Surveillance staff
Lab values for CAREAssist clients	Annually in March of each year	D&A – Surveillance staff
Lab values for CAREWare clients	Annually in March of each year	D&A – Surveillance staff

4. Provider site visit & client file review		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Compliance with HIV Case Management Standards	5 sites/year (final report in June of each year)	Program Manager & consultant
CAREWare data quality	5 sites/year (final report in June of each year)	Program Manager & consultant
Evaluate accuracy of locally managed client file review	5 sites /year (final report in June of each year)	Program Manager & consultant

5. Contractors (providers) perform an internal chart review and CARE Ware data audit, following a proscribed protocol.		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Compliance with HIV Case Management Standards	Annually – report is due at end of October each year. (Summary Report for state in December.)	Each provider site QM consultant
CAREWare data quality	Annually – report is due at end of October each year. (Summary Report for state in December.)	Each provider site QM consultant

6. Contractors (providers) submit: (1) annual plans which report on compliance with program requirements, (2) quarterly service utilization and financial reports, and (3) quarterly program narrative reports.		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Annual plans	Annually	Each provider site
Service utilization and financial report	Quarterly	Each provider site
Program narrative report	Quarterly	Each provider site

7. Client Satisfaction Surveys		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
Case Management Program Client Satisfaction	Bi-Annually	Program Design & Evaluation Services (PDES)
CAREAssist Client Satisfaction	Annually	Program Design & Evaluation Services (PDES)

8. Special evaluation projects		
<i>Data Reported</i>	<i>Time Line</i>	<i>Source</i>
HIV Case Management acuity scale evaluation	Completed in April 2007	Program Design & Evaluation Services (PDES)
HIV Case Management key informant survey	Completed in April 2007	Program Design & Evaluation Services (PDES)

Client Satisfaction with Case Management Services: Ryan White Part B Service Area	Completed December 2007	Program Design & Evaluation Services (PDES)
“Alive and Healthy”, CAREAssist Client Satisfaction Survey	Completed April 2007	Program Design & Evaluation Services (PDES)
Out of Care Study (CAREAssist clients)	Completed May 2007	Program Design & Evaluation Services (PDES)
Eating Right When Money’s Tight: Evaluating the Need for Food & Nutritional Assistance Among RW Part B Case Management Clients	Completed December 2007	Program Design & Evaluation Services (PDES)
Oregon Medical Practices that Provide HIV Care: 2008 Snapshot	Completed April 2008	Program Design & Evaluation Services (PDES)

Implementation Plan: Performance Measures

Client Level Health Outcomes

Outcomes	Indicators	Data Elements	Data Sources & Methods
Disease progression among Ryan White clients is slowed or prevented over time.	<ol style="list-style-type: none"> 1. Improved or maintained CD4 counts and viral loads as measured over a six month period of time. 2. Increased percentage of aggregate clients in overall Acuity Levels #1 and 2, over a twelve-month period of time. 	<ol style="list-style-type: none"> 1. Test results needed to calculate changes in CD4 counts & viral loads for individual clients annually. 2. Case manager reported acuity level results for individual clients every twelve months. 	<ol style="list-style-type: none"> 1. Sources: <i>CARE Ware & HARS</i> Reported by case Managers 2. Sources: <i>CM Chart Review & CARE Ware</i>. Reported by case managers.
Proportion of clients accessing primary health care services increases over time.	Change in the number of clients with reported “primary source of medical care” and primary care provider.	Number and percent of clients with “no primary source of medical care” and no primary care provider in record and the number and percent of	Source: <i>CARE Ware & CM Chart Review</i> . Reported by case managers.

		HIV-positive clients with record of “primary source of medical care” and primary care provider.	
Proportion of clients who have health insurance increases over time.	Change in the number of clients with reported “primary source of insurance” and health insurance.	Number and percent of clients with “no primary source of insurance” and no health insurance in record and the number and percent of HIV-positive clients with record of “primary source of insurance” and health insurance.	Source: <i>CARE Ware & CM Chart Review</i> . Reported by case managers.

Quality of life of Ryan White clients is improved or maintained over time.	Increased percentage of aggregate clients in Acuity Levels #1 and 2, over a twelve month period of time	Case manager reported acuity level results for individual clients every twelve months.	Sources: <i>CM Chart Review & CARE Ware</i> . Reported by case managers.
Number of clients adhering to HIV medications regime increases over time.	Increased percentage of aggregate clients who are assessed in the Adherence Life Stage at Acuity Level #1 and #2, over a twelve month period of time.	Case manager reported Adherence acuity level results for individual clients every twelve months.	Source: <i>CM Chart Review & CAREWare</i> . Reported by case managers.
Number of clients receiving HIV-related treatment that adheres to PHS standards increases over time.	<p>Increased percentage of aggregate clients who have current (within past 12 months) labs in their case management files.</p> <p>Increased percentage of aggregate clients who have a CD4 or VL test result reported in the database within the past 12 months.</p>	<p>Current labs appear in the client file.</p> <p>Case manager reported CD4 and VL for individual clients every twelve months.</p>	<p>Source: <i>CM Chart Review</i>.</p> <p><i>CAREWare</i>. Reported by case managers.</p>

	<p>Increased percentage of clients in CAREAssist who report having a CD4 or VL within the past 6 months on their re-certification application.</p> <p>Increased percentage of statewide aggregate clients in HARS with a CD4 or VL test in the first 6 months of the reporting period and the second 6 months of the reporting period.</p>	<p>Client reported CD4 and VL test dates on CAREAssist re-certification application every 6 months.</p> <p>CD4 and VL tests reported to surveillance by laboratories.</p>	<p><i>CAREAssist database.</i></p> <p><i>HARS database.</i></p>
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<p>Number of clients receiving HIV-related treatment that adheres to PHS standards increases over time.</p>	<p>Increased percentage of statewide aggregate clients in HARS with a CD4 test in the first 6 months of the reporting period and the second 6 months of the reporting period or a VL test in the first 6 months of the reporting period and the second 6 months of the reporting period.</p>	<p>CD4 and VL tests reported to surveillance office by laboratories.</p>	<p>Source: <i>HARS database.</i></p>
<p>Persons with HIV are identified early in their disease progression and are able to access services earlier with better health outcomes.</p>	<p>Decreased number of individuals newly reported with HIV infection who also have an AIDS diagnosis.</p>	<p>Number of individuals newly reported with HIV infection who also have an AIDS diagnosis vs. total number of individuals who were reported.</p>	<p>Source: <i>HARS database.</i></p>
<p>Persons with HIV are accessing HIV treatment to slow the progression of HIV to AIDS.</p>	<p>Decreased number of individuals who progress from HIV to AIDS within a 12 month period.</p>	<p>Number of individuals newly reported with HIV (not AIDS) who progress to an AIDS diagnosis within 12 months of HIV diagnosis vs. total</p>	<p>Source: <i>HARS database.</i></p>

		number of individuals newly reported with HIV.	
Persons with HIV are successfully accessing HIV treatment.	Decreased number of individuals with HIV who die within 12 months of their diagnosis.	Number of individuals who die within 12 months of their HIV diagnosis vs. total number of individuals who were newly reported with HIV.	Source: <i>HARS database.</i>

Quality Assurance/Process Evaluation

Criteria	Indicators	Data Elements	Data Sources & Methods
Ryan White funds are used as payer of last resort.	<ol style="list-style-type: none"> 1. Standard income verification form completed with allowable documents attached in client file. referrals and follow-up in client file. 2. Case management progress notes and CARE Assist event records document all referrals and follow-up to referrals. 	<ol style="list-style-type: none"> 1. Number and percent of client files with appropriate documentation for income verification. 2. Number and percent of client files with documentation in progress notes or event records of all referrals and follow-up activities. 	Source: <i>CM Chart Review & CAREWare.</i> Case Manager Reported.
Every client accessing Ryan White Part B services will have a case manager.	Every client record contains the name of their case manager.	Number and percent of Ryan White Part B clients with a case manager listed in their record.	Source: <i>CARE Ware & CARE Assist.</i> Collected annually through data reports.
All clients in case management will receive at least one Nurse Assessment per year.	Clients receiving at least one RN Assessment or Re-assessment and documented in CAREWare.	Number and percent of clients with documentation of an RN Assessment or Re-assessment.	Source: <i>CAREWare.</i> Case Manager Reported.

<p>Ryan White funded providers will ensure that every client receives information about:</p> <ul style="list-style-type: none"> • Informed Consent • Client grievance • Client rights & responsibilities 	<p>All client files in all Ryan White Part B funded programs utilize the standard forms for client information and all forms are signed and dated by the client.</p>	<p>Percent and number of client files with all forms included, signed and dated by the client.</p>	<p>Source: <i>CM Chart Review</i>. Collected annually</p>
<p>Eligibility will be documented for all clients receiving Ryan White Program services:</p> <ul style="list-style-type: none"> • HIV status • Income 	<p>All client files in all Ryan White Program funded programs utilize the standard forms for eligibility determination and include the allowable documentation.</p>	<p>Percent and number of client files with standard forms completed and allowable documentation attached.</p>	<p>Source: <i>CM Chart Review</i>.</p>
<p>All clients receiving Ryan White Part B services will have a current Release of Information in their file.</p>	<p>All client files in all Ryan White Part B funded programs utilize the standard form for Release of Information and all forms are current, signed and dated by the client.</p>	<p>Percent and number of client files with current, signed and dated ROI form.</p>	<p>Source: <i>CM Chart Review</i>.</p>
<p>Clients will be satisfied with the Ryan White Part B services they receive.</p>	<p>A majority of clients responding to the client satisfaction survey will indicate they are satisfied with the services they have received.</p>	<p>Number and percent of client responses to questions about their satisfaction with specific services.</p>	<p>Source: <i>CARE Assist Client Satisfaction survey & statewide Part B Program Client Satisfaction survey</i>. Annual written survey mailed to CARE Assist clients and annual written survey distributed to clients through the local case management programs.</p>

Case management services meet the program's case management standards for clients.	Change in the percent of indicators for standards criteria being met by local case management programs.	Percent of a case management site's activities that meet standards requirements.	Source: <i>CAREWare & CM Chart Review</i> .
CARE Assist services meet the program's standards.	Change in the percent of indicators for standards criteria being met by the CARE Assist program.	Percent of CARE Assist program activities that meet standards requirements.	Source: <i>CARE Assist client files</i> . Collected through CARE Assist annual client file review.
CARE Assist program staff comply with the program's Policies & Procedures.	Change in percent of indicators for compliance with Policies & Procedures being met by the CARE Assist program staff.	Percent of CARE Assist program activities that comply with the Policies & Procedures.	Source: <i>Annual assessment of Policies/Procedures by internal team</i> . Collected through review of CARE Assist client files, data files and financial records.
Clients are successfully accessing and remaining in HIV treatment.	Decrease in the percent and number of clients who leave CAREAssist.	Percent of clients leaving CAREAssist for all reasons vs. total number of active clients.	Source: <i>CAREAssist database</i> .
	Decrease in number of clients in "pending" status more than 4 weeks when they risk treatment disruption.	Percent of clients in "pending" status more than 4 weeks vs. total number of clients assigned pending status.	<i>CAREAssist database</i> .
	Increase in number of clients who successfully transition from the "Bridge" program into CAREAssist.	Percent of clients in "Bridge" program who successfully transition to active CAREAssist status at the end of each quarter vs. total number of clients in "Bridge" program.	<i>CAREAssist database</i> .
	Increase in the number of clients who	Percent of clients who are re-certified each month vs. number of	<i>CAREAssist database</i> .

	successfully re-certify for CAREAssist every 6 months.	clients due for re-certification.	
CAREWare data is accurate.	Increase in the overall average for criteria that measure accuracy and completeness of data compared to the client paper file.	Percent of CAREWare data that match the paper charts.	Source: <i>CM Chart Review & Program site visits.</i>

Quality Improvement Capacity Building

The HIV Care & Treatment Program continues to build QI capacity through the Ryan White Program funded system of service delivery by regularly implementing the following activities:

- All of the funded providers are contractually required to perform a client chart review once a year, utilizing a standard protocol provided to them by the program. These results are reported in October of each year. The program then compiles the results and produces a report of all the results that is sent to each provider, is included in the annual Quality Management Report presented to the Oregon HIV Care Coalition and is posted on the program's web site.
- The results of all evaluation activities (such as the Case Management Client Satisfaction Survey, the Case Manager Satisfaction Key Informant interviews, the CAREAssist Client Satisfaction Survey, the Out of Care Study, etc.) are published in a printed report that is presented to the Oregon HIV Care Coalition, are sent to all the contracted providers and are posted on the program's web site.
- The program's site visits and chart reviews are summarized in a report for each provider site visited and the results are summarized in the annual Quality Management Report.
- The program convened a Transition Team in the summer 2007 to assist in planning for making significant improvements to the service delivery system funded by Ryan White Program, Part B. This process has resulted in a plan to pilot a new regional Care Coordination Center and a contract has been issued to a CBO to develop capacity in preparation for piloting the new center in Southern Oregon. This QI planning process has been documented and a presentation developed as part of an application to the Ryan White HIV/AIDS Treatment Modernization Act All Grantees Meeting in August 2008 to present the process at a workshop.
- The Medical Case Management Task Force is open to all HIV Case Managers funded by the program and meets regularly to review and improve the HIV Medical Case Management Standards of Service and the statewide standardized forms. This QI process offers a direct opportunity to provide QI training and technical assistance to all of the front-line providers.
- CAREAssist (ADAP) staff meet regularly to review the CAREAssist QI data and work as a team to develop strategies for improvement.

Quality Management Program Evaluation

The Quality Management Team regularly assesses the effectiveness of the QM Program by:

- Reviewing the data and analysis for applicability to planning needs and effectiveness in answering key questions required in monitoring the quality of the service system, as well as the program itself;
- Reviewing and revising the indicators/performance measures (including revising the definitions of the numerator and the denominator used to collect the data) to assure that the most accurate measures are being trended to help determine the quality of all services delivered;
- Reviewing and improving the site visit protocol and the local, contractually required chart review protocol;
- Reviewing and improving the contract language and requirements;
- And meets regularly to review all evaluation projects regularly undertaken by Program Design & Evaluation Services. The results of these evaluation projects are used to make system improvements (for example: the Acuity Scale Evaluation resulted in significant improvements in the HIV Medical Case Management Acuity Scale being implemented July 1, 2007).

Finally, the regular reporting of the Quality Management Plan implementation outcomes to both the statewide Quality Management Task Force and to the Oregon HIV Care Coalition results in a feedback mechanism that, not only holds the program accountable for implementing the plan, but provides good input and advice from an entire community of experts

Report on Quality Management Program Outcomes – 2007

Program Outcomes/Quality Improvement Initiatives

The Oregon HIV Care & Treatment Program has been involved in a number of Quality Improvement initiatives in 2006/2007. The data following is a summary of all the outcomes measured and improvement initiatives throughout the year.

I. Retention Rate in CAREAssist Project

Improvement Interventions:

- ♦ Bridge Program (program initiated by the medical provider where all of a client's medications are paid for while they complete necessary applications and activities to enter a medical payer program (CAREAssist, Oregon Health Plan, Medicare, etc.)
- ♦ Restricted Program (a three month "probation" period to attempt to help clients who have missed cost share payments or have not submitted a current Re-certification.)
- ♦ CAREAssist Staff have been assigned a case load and are expected to work more closely with clients and HIV case managers to help clients successfully remain in CAREAssist.

- ◆ A new application was released in May 2008. This application is shorter, easier to complete and can be downloaded and completed on a computer and then printed out to be mailed to CAREAssist.
- ◆ A new, shorter Re-certification application is currently being developed.

Data:

Criteria	2006	2007
Percentage of clients who leave CAREAssist for all reasons.	1.4%	1.2%
Of clients leaving, percentage who lose benefits because of not paying cost share or not re-certifying.	28%	15%
Percent of clients in “Restricted” status.	N/A	1.49%
Percent of clients in the Bridge Program who successfully enrolled in CAREAssist.	N/A	68%
Percent of clients who successfully re-certify.	92%	98%

II. Medical Case Management Program Improvement Project

Improvement Interventions:

- ◆ All contracted HIV case management providers are required to do an annual client chart review utilizing the standardized protocol provided by the Program and implemented by someone outside of the case management program. These chart review reports are submitted to HIV Care & Treatment in October of each year and a full summary report is prepared, sent back to the Administrators, Nurse Supervisors and Case Managers at each site, as well as posted on the Program web site.
- ◆ The Program now does site visits to 5 sites per year to verify the CM Chart Review information, to evaluate the quality of the data being entered in CAREWare by comparing the data to the written notes and to evaluate the quality of the case management services being delivered, looking at referral follow-up and nursing interventions delivered after a need was identified during the Nurse Assessment.
- ◆ The HIV Case Management Task Force met in November 2006 and reviewed the Case Management Standards of Service and the case management forms package. A lengthy QI process was undertaken with this group to improve the standards and forms. The revised and improved standards and forms were July 1, 2007.
- ◆ Based on the results of the a special evaluation “Evaluating Oregon’s Ryan White Program, Part B HIV Case Management Acuity Scale”, the case management Acuity Scale was revised to provide life areas that align with the core responsibilities of Medical Case Management with focus on medical status, nutritional status, adherence status, oral health and HIV transmission risk

reduction. A new QI Initiative is beginning in June 2008 to monitor the level of Medical Case Management interventions that high acuity clients receive.

- ♦ The HIV Medical Case Management/Support Services Program completely revised the Program Manual (includes: Case Management Standards of Service, the forms package, State Managed Services Program/CAREAssist/OHOP Policies and Procedures, Required Reporting Package and instructions, CAREWare Data Entry Manual, a Glossary and a Contact List) effective July 1, 2007.
- ♦ The HIV Medical Case Management Program began piloting a new “short version” re-assessment form (developed by one of the Nurse Case Managers) in three sites in January 2008. The Nurse Case Managers using the new form will participate in a forum to improve the form in July 2008 and the new form will be released for use in December 2008.

Data:

Criteria	2006		2007	
Percent of persons living with HIV/AIDS in HIV case management.	68%		65% ⁱⁱⁱ	
Percent of clients who received at least one face-to-face case management service.	86%		85%	
	<i>Chart</i>	<i>CAREWare</i>	<i>Chart</i>	<i>CAREWare</i>
Clients with a current acuity.	92%	91%	98%	72%
Adherence Assessment documented.	76%	64%	81%	71%
Received at least one Nurse Assessment in the year.	81%	81%	84%	77%
Client files with current labs.	79%	63%	86%	67%

Regional Care Coordination Pilot Project

The HIV Care and Treatment Program convened a planning body consisting of local, state and national experts to address a number of system challenges currently facing the program. Participants included representatives from three of the four largest case management provider agencies (who also represented the three current models of service delivery), Nurse Case Managers, Psychosocial Case Managers, program supervisors, HIV certified physicians/national consultants, AETC RN Specialist/Trainers, CLHO-HIV, HRSA sponsored National Quality Center (NQC) and included a consumer representative.

The meeting agenda included a review of the current Ryan White Program; Part B funded case management and support services care model and a discussion of the strengths and weaknesses of the current model. The meeting outcome included improvement recommendations and a timeline for the development of a program improvement plan.

ⁱⁱⁱ Requirement to be in case management if in CAREAssist removed.

Improvement Goals

1. Revise and strengthen the current HIV Medical Case Management model so that it complies with the federal legislative requirements.
2. Align case management activities and goals with the acute and chronic HIV disease management needs of PLWH/A.
3. Strengthen communication between the HIV Medical Case Manager and the client's health care provider to encourage client access to and successful adherence with medical treatment.
4. Reduce the disparities in client access to care coordination and supportive services.
5. Provide a short-term client education intervention coordinated by an HIV Medical Case Manager for all newly diagnosed clients.
6. Provide greater access to expertise in key areas of client need: (a) nursing assessment and interventions for treatment adherence, nutrition, oral health, liver health/Hep C disease management and HIV exposure risk reduction; (b) targeted assessment and interventions for mental health and substance abuse issues; (c) chronic disease management/self management training; (e) AIDS Drug Assistance Program case management and benefits coordination; (f) housing case management; and (g) supportive services information, referral and access coordination.
7. Improve the clinical outcomes of people living with HIV in the Oregon.

Pilot Region

The HIV Care and Treatment Program will pilot program enhancements in the southwest region of the State in fiscal year 2009 (July 1, 2008 through June 30, 2009). This area will include clients and service providers in Lane, Josephine, Coos, Curry. This region was primarily chosen because all four county Public Health Departments have officially opted out of providing Ryan White services.

The program will contact major HIV medical providers in southwest Oregon in 2008 to explore their interest in the co-location of HIV medical case management staff in medical practice settings. Any changes to the location of case management services would not occur until 2009.

[HIV case management and support services contracts will remain unchanged for Ryan White Program Part B funded service providers not included in the pilot region through FY 2009.]

I. Data & General Program Improvements

Improvement Interventions:

- ♦ A new "Consent for Care" that covers all program elements (OHOP, CAREAssist & HIV Medical Case Management/Support Services) has been distributed to all clients in all of those programs and is now required.
- ♦ OMIP query developed for the HRSA/HAB required Group 1 Clinical Measures.
- ♦ OMIP data received and is being analyzed. Modifications to the query will be undertaken in July 2008 to improve the quality of the data.

- ♦ CAREAssist database enhancements and structural re-writes are currently being undertaken by the program to improve the quality of CAREAssist data.
- ♦ Clients and providers can provide feedback on-line through the program web site, effective March 2008.

Appendix A: SCSN Work Group Participants

Annick Benson-Scott

Oregon DHS, HIV Care and Treatment Program Coordinator, Part B Services

Terry Bonnett*

Multnomah County Health Department
Part A Planning Council

Elaine Brady-Mahoney*

Cascadia Behavioral Health
Social Worker

Jodi Davich*

Multnomah County HIV Health Services Center/ Part C
HIV Clinic Manager

Ryan Deibert

HIV Care and Treatment Program
HOPWA Coordinator

Linda Drach*

Program Design & Education Services Facilitator

Robert Duehmig*

Oregon Office of Rural Health
Communication Director

Victor Fox*

Oregon DHS, HIV Care and Treatment Program Manager/CAREAssist Manager

Denise Fry*

Oregon DHS
HOPWA Housing Coordinator

Becky Harmon*

Cascade AIDS Project
Associate Executive Director
Quality Management Task Force Co-Chair

Graham Harriman*

Multnomah County Health Department, HIV/HCV Programs/Part A Grantee
Acting Manager, Part A

David Heal

Clark County (WA) Health Department

Oregon Department of Human Services
Ryan White Part B Program

Program Manager
Part A Planning Council Co-Chair

Phyllis Heims*
Kaiser Permanente
Social Worker/HIV Case Manager

Alfredo Hernandez*
Part C Clinic, Boise, ID
Social Worker

Brad Howell*
Oregon HIV Care Coalition Co-Chair
Consumer

Bob Johnson
Dentist/Administrator
Part F/Russell St Dental Clinic

Amanda McClusky*
HIV Alliance
Part F/SPNS Grant
Dental Program Coordinator

Marisa McLaughlin*
Multnomah County Health Department
Research/Evaluation Analyst, Part A Services

Allison Millar
Part C Clinic, Walla Walla, WA
HIV Nurse Case Manager

Wayne Miya*
Our House of Portland
Director/HOPWA Grantee

Karen Pancheau*
Part A Planning Council
Consumer

Amanda Parker*
Oregon Department of Corrections

Debby Parrish
Multnomah County HIV Health Services Center/Part C
Pharmacist

Steven Pierson*

AIDS Education & Training Center (AETC)
The Research & Education Group
Program Manager

Margy Robinson*

Multnomah County Health Department
HIV Care Services Manager, Part A
Quality Management Task Force Co-Chair

Valerie Rux*

Oregon Department of Human Services
Division of Medical Assistance Programs
Healthy Kids Program Coordinator

Sean Schafer

Oregon DHS HIV Data & Analysis Program
Medical Epidemiologist

Ann Shindo*

Oregon DHS HIV Prevention Program
Hepatitis C Program Coordinator

Renee Yandel*

HIV Alliance
Part B Regional Case Management Demonstration Project manager

Donna Yutzy*

Part B Grantee Consultant

*In attendance, SCSN Workgroup Meeting 10/21/08

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Appendix C: HIV Resources

The following table summarizes available HIV-related resources in Oregon and includes services provided, funds allocated, and number of clients served annually. Data are from each grantee's most recent reporting period, either calendar year 2007 or fiscal year 2007/2008.

Services Provided	Funds Allocated	Number of Clients Served
Part A:		
Portland Metropolitan Transitional Grant Area		
<i>Core Services:</i>		
Dental Health Care	\$274,749	619
Early Intervention Services	\$95,300	64
Health Insurance Premium Payment	\$19,654	27
Medical Case Management	\$852,400	1,497
Mental Health Services	\$123,481	167
Outpatient/Ambulatory Outpatient	\$650,000	1,091
Substance Abuse Outpatient	\$37,574	43
<i>Support Services:</i>		
Psychosocial Support Services	\$106,286	299
Food Bank/Home Delivered Meals	\$85,762	263
Housing Services	\$330,746	485
Part B: Oregon Department of Human Services		
<i>Core Services:</i>		
ADAP Funds/Health Insurance Premiums	\$4,186,545	1,928
Dental Health Care	\$118,624	109
Home Health Care	\$3,486	3
Medical Case Management	\$299,457	883
Medical Nutritional Therapy	\$21,281	222
Mental Health Services	\$30,994	22
Outpatient/Ambulatory Outpatient	\$36,960	80
Pharmaceutical Assistance	\$18,978	85
Substance Abuse Outpatient	\$2,559	3
<i>Support Services:</i>		
Psychosocial Case Management	\$532,392	549 ^{iv}
Emergency Financial Assistance	\$45,676	350
Housing Services	\$81,770	161
Linguistics Services	\$2,183	23
Medical Transportation Services	\$28,605	311

^{iv} Included in 883 total clients receiving Medical Case Management; all clients in Part B CM receive Medical CM provided by an RN but only 62% receive case management services from both an RN and a psychosocial case manager.

Services Provided	Funds Allocated	Number of Clients Served
<i>Part C: Multnomah County HIV Health Services Center</i>		
Early Intervention Services	\$767,508	824
<i>Part F: Russell Street Clinic</i>		
Community-Based Dental Grant	\$780,393	653
<i>SPNS Dental: HIV Alliance</i>		
5-year HRSA-SPNS dental health grant	\$400,000	225
<i>AIDS Education & Training Center</i>		
Provider Clinical Consultation, Individuals and Groups	\$120,443	203
<i>HOPWA</i>		
HOPWA-SPNS (OSSCR)—Part A	\$178,786	13
HOPWA-SPNS (OSSCR)—Part B	\$281,773	38
HOPWA-SPNS (OHBHI)—Part A	\$211,878	30 (projected)
HOPWA-SPNS (OHBHI)—Part B	\$141,775	20 (projected)
HOPWA Formula	\$335,000	21
HOPWA Competitive ^v	\$228,660	79
City of Portland HOPWA	\$943,000	138
Our House HOPWA	\$345,667	50

^v July 2008-June 2009 is the final year of this non-renewable HOPWA grant. Budgets for the grant were approximately \$400,000 per year (the final year budget is lower as it reflects the remaining unspent balance.) No additional HOPWA funds are currently available to replace this lost funding. All budgets reflect calendar year except for HOPWA competitive which is based on a fiscal year.

Appendix D: Notes from SCSN 2008 Workgroup Proceedings

A full day meeting was held on 10/21/08 to identify and address significant care and treatment issues related to the needs of people living with HIV and AIDS (PLWH/A) in Oregon, and to maximize coordination, integration, and effective linkages across all Ryan White Program Parts.

The following issues and themes (in alphabetical order, by broad category) were discussed by the group:

Aging Population/Geriatric Issues:

- Nursing Homes/Assisted Living don't provide HIV care
- Need providers that understand HIV and can deal with multiple comorbid conditions found in older PLWH/A

Behavioral Health:

- There is a need for integrated behavioral health services, rather than separate “silos” of mental health and substance abuse services—the OHBHI grant provides a good example of integrated both services with housing. Mental health specialists are also included as part of the care coordination team in the part B regional demonstration project.
- Active substance abuse impedes medical care—need staff to provide integrated treatment.
- Peer mentors can help engage clients in MH/SA; keep them involved.
- Spectrum of SA treatment modalities are needed:
 - Most systems are not on board with a spectrum, e.g. only have abstinence-based programs, which don't meet some clients where they are at
 - Insurance often doesn't fund harm reduction approach
 - Treatment readiness is an issue
 - 1-1 counseling and groups also needed
 - Needs are individualized; need more options

Building Bridges to “Mainstream” Social Services:

- Referrals outside of the RWCA system are hard—a facilitated referral (“warm hand off”) works better than just telling people where to go and hoping they get there; clients have better follow through.
- There's not enough money to create an entirely parallel system, so we must work on creating effective linkages (referral alone is not enough)
- HOPWA is an example of effective, sustainable way to move clients between RWCA/HIV specific systems and mainstream systems—moves people from HIV-specific program onto Section 8, into other “mainstream” housing options.
- HHSC/Part C clinic is example of HIV specialty clinic within a bigger system.

Case Management Issues:

- In general, there is system overload and chaos:
 - Increasing case loads, stable funding/staff
 - One size does not fit all clients

- Social work/case management—standards for case loads? Peer mentors?
- Triage clients by acuity
 - In-house, intensive services for high acuity
 - Requires lots of training
 - Funding issues, HRSA doesn't fund training, supportive CM

Evaluation and Assessment:

- Need for ongoing evaluation to ensure we are using limited dollars in most efficient manner.
- Need scales that are validated/ evidence-based (ex: tools for important domains, CM adherence)
- Let's get beyond "do they like me?"
- CBPR—a possible way to develop client ownership of medical home

Funding:

- Need alternate/diversified funding sources (possible sources include health disparities \$, Robert Wood Johnson Foundation)

HIV Testing:

- People postpone HIV testing and entry into care because of fear, denial, lack of education (some more than others? Seems so from late diagnosis data)
- Increase responsibility for HIV testing across medical system; ID new positives and get them into care early.
- DIS follow up on all new HIV+ cases now
- Can AETC be used for prevention initiatives? It's possible, but clinical training is their primary focus.

Housing:

- Need links between clinical case managers and housing case managers to ensure that clients are getting seamless services
- Integration of behavioral and social services into housing is ideal; links people to medical care. Housing can be a "carrot" for getting people into needed care.
- Housing First model=housing as bridge to other issues

Out of Care:

- Who are they? How do we find them?
- Use outreach model; look for most vulnerable populations

Prevention:

- With HIV+ and their social networks
- HIV prevalence density and funding need to be connected
- Strategies to increase testing and decrease transmission among MSM are primary focus

Promising Models for Delivering Care and Treatment:

- Medical home—people get services somewhere; let’s find them; build on existing services
 - Medical CM co-located or close to medical care
 - Collaborative care
- One size does not fit all
 - Need strategic thinking for different regions
 - Honest assessment of feasibility and capacity
- Maximizing engagement with care across wider continuum of services and entry points (e.g. dental , housing)
- Centers for Excellence type model (ex: Kaiser, Washington State RWCA)

Rural Issues:

- Multidisciplinary teams are unrealistic in rural areas when we can’t even get 1.0 FTE dedicated to HIV in some counties/regions
- Can’t recreate urban systems in Balance of State (BOS)
- Sunset of timber dollars means that the public health departments (PHDs) in many rural communities may vanish; 4 or 5 PHDs have already “opted out” of HIV care.
- Rural areas must build networks (need demonstration \$ to build on assets); make “tepid (if not warm) hand offs,” where possible.
- Lack of public infrastructure makes partnering with private MDs and other agencies crucial.
- Few medical providers rurally—workforce development and attention to next generation of providers is important
- Use the phone—deliver services remotely, use centralized services, where possible or necessary.

Structural Factors/Health Disparities:

- Poverty, unstably housed, people with MH/SA issues, migration: let’s think about what factors put people at risk for HIV, and get beyond just looking at behavior

Systemic Issues:

- Prevention and care need to be linked
- Focus on integrated behavioral health and HIV services
- Better links between corrections and HIV service system (OSCCR grant is a model)
- Identify and remove client barriers, wherever possible (e.g. use common intake forms, provide client centered care, track appointments and make follow up calls, get provider input and engagement, triage)

Upstream Agenda:

- Educate policy makers
- Find ways to make small numbers meaningful in face of competing priorities