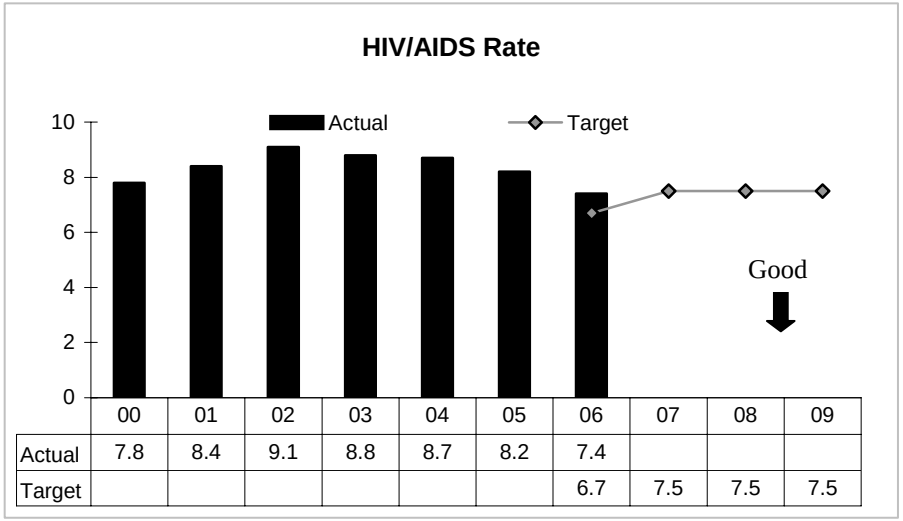
III. KEY MEASURE ANALYSIS

KPM #24	HIV/AIDS RATE The annual rate of newly acquired HIV/AIDS infections per 100,000 persons.	Measure since: 2000
Goal	People are healthy.	
Oregon Context	HIV diagnosis, Communicable disease	
Data source	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/AIDS Reporting Systems (HARS) database & PSU Census	
Owner	Public Health Division, Office of Disease Prevention & Epidemiology, HIV/STD/TB Program, DHS, Jeff Capizzi, 971-673-0182	

* The data and targets reflect a correction to prior calculations in order to be consistent with the original intent and definition of this measure.



	00	01	02	03	04	05	06	07	08	09
Actual	7.8	8.4	9.1	8.8	8.7	8.2	7.4			
Target							6.7	7.5	7.5	7.5

1. **OUR STRATEGY**
   DHS designs and administers state and federal programs for HIV prevention and treatment. Innovative HIV prevention programs include educational campaigns, partner notification and counseling, and HIV testing (anonymous and confidential). Over 19,000 HIV tests were performed by the Oregon State Public Health Laboratory during 2005 - the majority of these funded by programs administered by DHS. HIV treatment programs serve approximately 2,000 people living with HIV statewide and include case management, housing assistance, medication, and health insurance to persons living with HIV and AIDS.

2. **ABOUT THE TARGETS**
   Our goal is to reduce the number of new HIV infections per year. Therefore, we have established initial targets for 2006 consistent with a 20% reduction in the measured rate of new infections from 2004.
   Changes in HIV case reporting rules implemented during 2006 are likely to increase the proportion of new cases detected (completeness of reporting) leading to an anticipated increase in rates beginning in 2007. These increases in reported rates will reflect better public health surveillance, not a true increase in rates of new infection.

3. **HOW WE ARE DOING**
   Slight declines in new case rates have occurred since 2002. This has occurred despite the fact that increasing survival with HIV infection means that the pool of people who might infect others increases continuously. This implies that the average person with HIV/AIDS infects fewer new persons each year and that prevention and care programs have been effective in curtailing the epidemic. Meeting optimistic targets of a further 20% reduction for 2006 and beyond must occur as a result of behavioral changes such as a reduction of high-risk behavior by those infected or at risk, possibly complemented by new treatment of those already infected to reduce their infectivity.

4. **HOW WE COMPARE**
   The Centers for Disease Control and Prevention estimated that 19.8 HIV infections were diagnosed per 100,000 people during 2005 in 33 states that required HIV case reporting by name for at least 5 years. (Oregon switched to named reporting on April 17, 2006.) Oregon's 2005 rate of 8.2 cases per 100,000 residents is well below that level.

5. **FACTORS AFFECTING RESULTS** DHS invests several million dollars each year in care for persons with HIV and AIDS and in prevention of new infections. The HIV Care Program provides case management services to over 2000 persons with HIV in Oregon each year, helping them sustain access to medical care and treatment. These services extend life expectancy among people with HIV and AIDS and reduce risk of subsequent HIV transmission. The HIV Prevention Program invests over a million dollars annually in HIV testing and counseling. These efforts detect newly infected persons early, leading to treatment and prevention of new cases. In addition the HIV Prevention Program makes large annual investments in counseling partners of persons newly diagnosed with HIV infection and in numerous social marketing campaigns to reduce behaviors that lead to reduction in HIV transmission.

6. **WHAT NEEDS TO BE DONE**
   HIV prevention efforts in Oregon should continue to focus on effective strategies to reduce behaviors that increase risk of infection, such as unprotected sex, sex with multiple partners, and injection drug use or sharing and reuse of drug paraphernalia. HIV testing should remain readily available to enable those at risk to obtain early diagnosis and, if infected, get into treatment. Barriers to HIV testing should be removed. Technology to shorten the interval between infection and positive laboratory tests should be adopted. More newly infected people should receive counseling about reducing the risk of transmission to sex and drug use partners. People with HIV infection need to be encouraged and assisted to identify a stable source of medical care, which has the potential to reduce risk of transmission through counseling and, while not offering a cure, through reduction of infectivity to others.

7. **ABOUT THE DATA**
   Reporting cycle – calendar year. Currently, the median delay between diagnosis and inclusion in the HIV case reporting system is approximately 2 months. Fifteen percent of newly diagnosed cases are reported more than 6 months after diagnosis. Because of reporting delay, HIV rates are typically reported in July for the preceding calendar year. Centers for Disease Control and Prevention have estimated that 25% of people infected with HIV are unaware of their infection. In addition, about 10% of diagnosed cases are not captured by the reporting system. Therefore, reported rates probably represent less than 75% of the true number of new infections. As outlined above, changes in HIV case reporting rules were implemented during 2006. These include increased laboratory reporting requirements and a switch to named HIV case reporting. These changes have made case reporting more complete, and comparison with earlier years somewhat misleading. For interested readers, the HIV/STD/TB program publishes an annual epidemiologic profile for HIV. It is available at http://egov.oregon.gov/DHS/ph/hiv/data/docs/final.pdf.DHS APPR Revised Template_107BF04a.doc.