Oregon's Jurisdictional HIV Prevention Plan

Contents

Populations and Communities Most Impacted by HIV in Oregon

Oregon's most current Epidemiologic Profile is available at 1.usa.gov/HIVdataOR. This document outlines the most updated information regarding populations and communities most impacted by HIV in Oregon.

Description of Oregon's Public Health Infrastructure

The Legislative Assembly of the State of Oregon finds that each citizen of Oregon is entitled to basic public health services which promote and preserve the health of the people of Oregon. To provide for basic public health services the state of Oregon, in partnership with county governments, shall maintain and improve public health services through county or district administered public health programs. This is achieved through the work of the Oregon Health Authority (OHA), Public Health Division with the assistance of the Oregon Public Health Advisory Board. The Board advises the OHA on policy matters related to public health programs, reviews statewide public health issues and participates in public health policy development. Based on this partnership, public health in Oregon is a shared-services system between federal, state and county governments who provide resources to meet the public health needs and expectations of the communities in Oregon.

There are 34 Local Public Health Departments (LPHDs) in Oregon that serve 36 counties. Two counties (Wasco and Sherman) joined to form one health department, and Gilliam County never established a public health department. Oregon statute designates county governments (or health districts) as the Local Public Health Authorities (Oregon Revised Statute 431.414). LPHDs function under the Local Public Health Authority's control. LPHDs are responsible for the protection, prevention and health monitoring of residents and visitors of Oregon. All LPHDs in Oregon ensure the public's health by using both personal and population-based public health interventions and best practices. Some LPHDs provide primary medical and dental care as well. In addition to their own communicable disease testing and treatment activities, state law requires that private providers and laboratories report cases and positive disease tests to the state for treatment and contact tracing.

According to the Oregon Revised Statute (ORS 431.416) public health authorities must enforce public health laws and are responsible for providing the five areas of state-mandated services. These five areas of services are: (a) Epidemiology and control of preventable diseases and disorders (under which HIV falls); (b) Parent and child health

services, including family planning clinics as described in ORS 435.205; (c) Collection and reporting of health statistics; (d) Health information and referral services; and (e)Environmental health services. Based on these five state mandated service areas, the Oregon Health Authority and the local public health authorities use intergovernmental agreements to list the specific minimum services LPHDs will provide to the residents/visitors of the counties.

In addition to Oregon's unique structure, where public health authority is shared at the local and state levels, Oregon has a guiding committee for public health practices, the Conference of Local Health Officials (CLHO). CLHO is a statewide group that consists of all local health officers and public health administrators, appointed pursuant to ORS 431.418 and such other local health personnel as may be included by the rules of the conference. The Oregon Health Authority provides funding to the local public health authorities based on a per capita or other equitable formula basis. Funding formulas are determined by the department with the concurrence of the Conference of Local Health Officials.

The strengths of this shared system of public health planning and service delivery rest in the combined skills, perspectives, and professional backgrounds of the people involved. Through the utilization of collaborative processes to collect data, identify needs and develop strategies to address needs, communities throughout the state have the opportunity to create community-based, evidence-informed solutions. Oregon can work together to improve a community's health by implementing effective policies and programs. Oregon can work across jurisdictions and reduce barriers to service provision.

Challenges arise from the different needs and structural support available in urban and rural communities. Rural communities have access to fewer resources related to public health, and to HIV prevention and care. In some parts of Oregon, individuals have to go to neighboring states (Washington and Idaho) to seek HIV prevention and care services. In addition, Oregon has been faced with an overall lack of funding for public health and this has led to severe deterioration of the public health infrastructure. While public health workers at all levels are creative and resourceful, lack of funding has created tension between local and state public health authorities. Finally, there is a lack of support from local leadership for services addressing the needs of MSM and people who inject drugs, lack of hepatitis funding and support.

Movement to come in line with the National HIV/AIDS Strategy

Representatives from both state and local Oregon jurisdictions attended the National HIV/AIDS Prevention Conference in Atlanta when the public input component of the National HIV/AIDS Strategic (NHAS) planning process was initiated. These individuals attended the listening session and made a commitment to implement a process for eliciting input from Oregon residents. A statewide request for input to the call to action was distributed through the Statewide Prevention Planning Group and member email lists. This request included a short informational segment on the strategic planning process and the timelines for completion and distribution. Recommendations were sent to the national office.

When CDC released the PS 12-1201 funding announcement in 2011, state staff shared the document on the state HIV prevention website and elicited input at State Planning Group meetings. Drafts of the application were posted on the state HIV program website with requests for review and input. Since funding has been received, additional planning meetings with membership from state and local health departments have occurred to work in an on-going way to ensure that the goals of the NHAS are implemented in an environment of reduced funding.

Concrete examples of how the NHAS is structuring HIV prevention in Oregon include: a state performance measure that 70% of HIV tests funded by the PS12-1201 grant are done on members of Oregon priority populations (Oregon's priority populations are men who have sex with men (MSM), people who use injection drugs (PWID), and partners of people living with HIV/AIDS (PLWH/A)) requiring LHD HIV prevention program plans to address stigma and cultural competency, and a redirection of funding to the counties in Oregon that bear the highest burden of HIV disease. For more information, please refer to our grant application.

Needs Assessment, Gaps to be Addressed and Rationale

This needs assessment serves to prioritize 1) populations, 2) geographic areas and 3) services for resource allocation. This assessment was informed by reviewing:

- Existing resources in Oregon
- Epidemiologic research and surveillance data
- Federal guidance on priority activities
- Information reported to the Oregon Health Authority (OHA) from partners (e.g., local health departments, planning group members)

Prioritizing populations, geographic areas and services to guide the allocation of limited resources naturally results in service gaps. HIV infection is not limited to the populations and geographic areas activities that have been prioritized, nor are community needs

limited to the services that have been prioritized. With diminishing resources, the gaps to be addressed are those that are a priority and/or feasible to address.

Priority populations: Needs assessment

Priority populations are those which have a demonstrated need warranting HIV prevention resources. Oregon's three priority populations are:

1) Persons living with HIV (PLWH) and their sex or injection partners
2) Men who have sex with men (MSM) whose HIV status is unknown or was negative at last test
3) Persons who inject drugs (PWID) whose HIV status is unknown or was negative at last test

PLWH

As of December 31, 2011, there were an estimated 7,406 PLWH in Oregon, with 1,340 (18%[1]) unaware of their HIV status.[2] Statewide, HIV diagnosis rates were six times higher among males than females (13 vs. 2 per 100,000). The average age at diagnosis is 37 years. People of color continue to be disproportionately impacted by HIV in Oregon. Blacks/African Americans accounted for 6% of new HIV diagnoses from 2005-2009, with a new diagnosis rate 3.5 times higher than that among whites. Hispanics (non-white) accounted for 17% of new HIV diagnoses from 2005-2009, with a new diagnosis rate 1.2 times higher than that among whites. Other races/ethnicities accounted for less than 5% of all diagnoses.[3]

MSM

MSM comprise an estimated 2 - 4% of Oregon's population,[4] but 77% of the state's 1,189 HIV diagnoses from 2005-2009 with a determined mode of infection (90% of all cases); 11% of MSM cases also reported injection drug use (IDU). Of the cases with only MSM risk:

- The average age at diagnoses was 36.5 years.
- More than one-third (34%) had an AIDS diagnosis at the time of or within 12 months of their HIV diagnosis.
- 77% were white, 14% Hispanic and 4% black/African American.

[1]Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 U.S. dependent areas—2010. HIV Surveillance Supplemental Report 2012; 17(no. 3, part A). http://www.cdc.gov/hiv/topics/surveillance/resources/reports/. Published June 2012 Accessed June 22, 2012.
[2]Oregon Health Authority. Unpublished data. Electronic HIV/AIDS Reporting System. March 5, 2012.
[3]Oregon Health Authority. Epidemiologic Profile of HIV/AIDS in Oregon, 2009.
[4]Oregon Behavioral Risk Factor Surveillance System: 2.7% of men identify as having a gay or bisexual sexual orientation. CDC estimates 4% of men are MSM.

- 13% were foreign-born.
- 17% reported having sex with females.

Additionally, 1% of HIV cases diagnosed from 2005-2009 with a determined mode of infection were among persons reporting heterosexual contact with an MSM.[5]

PWID

PWID who inject heroin, cocaine, meth, or other stimulants are estimated to comprise less than 1% of the American population.[6] However, PWID account for 17% of the state's 1,189 HIV diagnoses from 2005-2009 with a determined mode of infection; half (51%) of the HIV cases among PWID also reported MSM risk. Of the cases among PWID with IDU as the sole potential transmission route:

- Nearly half (47%) of men and more than one-third (33%) of women had AIDS at the time of or within 12 months of their HIV diagnosis.
- 80% were white, 11% Hispanic, 3% black, 2% Asian, 2% Pacific Islander, 1% American Indian/Alaskan Native and 1% multiracial.
- The largest age group at the time of diagnosis was 35–39 years.

Additionally, 3% of HIV cases diagnosed from 2005-2009 with a determined mode of infection were among persons reporting heterosexual contact with a PWID.[7]

Diversity within the priority populations

It is important to recognize that the priority populations encompass a wide range of subpopulations that warrant attention and engagement in services, including:

- HIV-positive transgender persons
- Transgender persons with HIV-positive partners
- Female sex partners of HIV-positive MSM
- Sex partners of HIV-positive PWID, including females
- HIV-positive males with undisclosed risk
- Persons over 50 year of age
- Incarcerated persons
- Hispanics/Latinos, including day laborers
- African Americans/Blacks, including immigrants
- American Indians and Alaska Natives
- Homeless persons, including youth

[5]Oregon Health Authority. Epidemiologic Profile of HIV/AIDS in Oregon, 2009.
[6]National Survey on Drug Abuse & Health, 2006-2008. Annualized average of past-year IDU was .17% for the civilian, noninstitutionalized population age 12+.
[7]Oregon Health Authority. Epidemiologic Profile of HIV/AIDS in Oregon, 2009.

Priority populations: Gaps to be addressed

OHA will continue to enhance program planning, monitoring and evaluation, and technical assistance (TA) activities that help providers increase their focus on Oregon's priority populations (i.e., PLWH and their partners, MSM and PWID). For the seven LHDs receiving CDC HIV prevention grant funding through OHA, new OHA funding requirements include: 1) spending at least 75% of funds on HIV testing and comprehensive prevention with positives and 2) ensuring at least 70% of HIV tests are conducted among priority populations. Agencies receiving condom distribution supplies from the OHA HIV Prevention Program are also required to target at least 70% of supplies to priority populations. Agencies contracting with OHA (i.e., LHDs, Local Health Departments and CBOs, Community Based Organizations) are required to submit a plan to address health disparities among communities of color. These plans address efforts to provide services (e.g., HIV testing, condoms, social marketing) that reach populations with health disparities. LHDs must also provide plans to address stigma and provide culturally competent services to our state's priority populations.

Priority populations: Rationale for addressing gaps

An increased focus on Oregon's priority populations is intended to optimize the use of diminishing funding for HIV prevention, align programs with federal guidance and help meet the goals of the National HIV/AIDS Strategy. The state's HIV testing data also suggest a need to better focus resources. While 92% of the state's HIV/AIDS cases reported from 2005-2009 with a determined mode of infection (N=1,189) were among MSM (68%), IDUs (8%), MSM/IDUs (9%) and persons who had heterosexual contact with an HIV-positive partner (7%), these populations account for less than half (42%) of the 15,510 publicly funded tests conducted from April 2010 to March 2011. Oregon epidemiologic data also support an increased focus on persons of color within the priority populations; new HIV diagnosis rates from 2005-2009 by race/ethnicity were 3.5 times higher among Blacks/African Americans and 1.2 times higher among Hispanics than among whites.[8]

Priority geographic areas: Needs assessment

Seven of Oregon's 36 counties had at least 15 new HIV diagnoses reported from 2009-2011 (by county of residence). These seven counties accounted for 89% of Oregon's 724 diagnoses reported during this period:

- Multnomah (48% of diagnoses statewide)
- Washington (13%)
- Clackamas (10%)
- Marion (7%)

[8]Oregon Health Authority. Epidemiologic Profile of HIV/AIDS in Oregon, 2009.

- Lane (6%)
- Jackson (3%)
- Deschutes (2%)

Priority geographic areas: Gaps to be addressed

Because our core HIV prevention funding is currently limited to seven of 36 counties, OHA has dedicated a few resources to help meet prevention needs for the remaining 29 counties. While unmet needs will remain, services available to "non-funded" counties include:

- OHA reimbursement for the cost of HIV testing (conventional blood draw) among persons with MSM and/or IDU risk.
- The Oregon HIV/STD Hotline and its marketing efforts.
- Free educational and marketing materials available to download on the OHA website.
- Technical assistance from OHA HIV Prevention staff.
- A limited supply of condoms and lubricant for distribution to priority populations (15 counties are eligible).
- An online HIV Prevention Essentials training (to become available later in 2012)
- The use of an automated HIV test reminder service and/or medication adherence reminder service available by text, voice message, or email (to become available later in 2012).
- Funding to collaborate with partners to add HIV prevention content to their websites.

Priority geographic areas: Rationale for addressing gaps

The 29 counties in Oregon with LHDs not receiving HIV prevention funding represent 11% of the state's new HIV diagnoses[9] and require continued support to help control HIV transmission in their areas.

[9]Oregon Health Authority. Epidemiologic Profile of HIV/AIDS in Oregon, 2009.

Prevention services

HIV testing

Routine testing for all Oregonians: Needs assessment

Routine testing is likely to result in earlier diagnoses of HIV and increase the proportion of Oregonians who have tested for HIV. Only 42% of Oregonians have ever tested for HIV (excludes blood donation testing).[10] Of the 1,380 HIV cases diagnosed during 2004-2008, approximately 40% had AIDS at the time of or within 12 months of their initial HIV diagnosis. While the proportion of persons diagnosed late exceeded 30% in each transmission category and racial/ethnic group, late diagnoses were more common among the following groups:

- Hispanics (compared to non-Hispanic whites)
- Men with injection drug use or unknown HIV risk (compared to MSM)
- Rural residents (compared to urban residents)
- Older persons — people over age 40, with relative risk of late diagnosis highest among those age 60+ (compared to people < age 40)[11]

Research suggests that perceived low risk for HIV infection and fear of testing positive are the primary reasons for avoiding HIV testing.[12] Interview data (2010) from Hispanics in Oregon recently diagnosed with HIV (N=23) suggest that HIV stigma and a social norm of not accessing medical care unless one is sick may also contribute to delayed HIV testing and diagnosis for this population.

Previously, Oregon statute required health care providers to conduct a special informed consent before voluntary HIV testing of patients. Senate Bill 1507, passed in February 2012, removed this requirement and substituted a requirement that patients be notified that HIV testing is intended and given an opportunity to decline. SB 1507 permits verbal or written notification, including a notification that HIV testing might be performed on a general consent for treatment at the time of presentation for health care.

[10]Oregon Health Authority. Behavioral Risk Factor Surveillance System. 2009. Available at: http://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/brfssresults/09/Pages/index.aspx
[11]Oregon Health Authority. Epidemiologic Profile of HIV/AIDS in Oregon, 2009.
[12]Mackellar DA, Hou SI, Whalen CC, et al. Reasons for not HIV testing, testing intentions, and potential use of an over-the-counter rapid HIV test in an internet sample of men who have sex with men who have never tested for HIV. Sex Transm Dis. 2011 May;38(5):419-28; CDC. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—five US cities, June 2004–April 2005. Morb Mortal Wkly Rep 2005; 54:597–601; Kellerman SE, Lehman JS, Lansky A, et al. HIV testing within at-risk populations in the United States and the reasons for seeking or avoiding HIV testing. J Acquir Immune Defic Syndr 2002; 31:202–210.

Routine testing for all Oregonians: Gaps to be addressed

A workgroup is currently reviewing all Oregon Administrative Rules related to consent for HIV testing. These rules are expected be finalized to reflect the new law in 2012. At that time, OHA will provide guidance and take further action to help promote and implement these changes.

Routine testing for all Oregonians: Rationale for addressing gaps

Streamlining the HIV test consent process and normalizing it as a routine practice for all Oregonians is expected to help address a number of barriers (e.g., time, perceived low risk, and stigma), ultimately increasing the proportion of Oregonians tested and decreasing the proportion of late diagnoses. These efforts will help align Oregon's HIV test consent process more closely with CDC's 2006 revised recommendations for HIV testing in healthcare settings.[13]

Routine testing (e.g., every 3-6 months) for MSM and PWID: Needs assessment

HIV testing is prioritized as a core component of the CDC HIV prevention grant, and grant funds used for HIV testing target Oregon's priority populations. For populations with high HIV incidence (e.g., MSM, PWID), annual HIV testing may be insufficient. In a CDC study (2008) involving HIV testing among urban MSM, nearly half (45%) of those newly diagnosed and previously unaware of their infection reported testing for HIV within the previous 12 months.[14] Reducing the time period in which persons have undiagnosed infection by even a few months may contribute significantly to preventing onward transmission, particularly if diagnosis occurs during the three months after seroconversion (the primary infection stage) when infectiousness is increased.[15] Thus, many HIV prevention service providers who target services to Oregon's priority populations currently promote HIV testing as a routine practice every 3-6 months. All seven LHDs receiving CDC HIV prevention grant funds in Oregon are currently implementing HIV testing programs for Oregon's priority populations. Such programs include testing during non-traditional hours, the delivery of test results by phone, walk-in hours and integrated testing efforts (e.g., for other STDs and Hepatitis C).

Routine testing (e.g., every 3-6 months) for MSM and PWID: Gaps to be addressed

To build upon existing efforts promoting routine HIV testing among MSM and PWID, in 2012, OHA will implement an automated HIV test reminder system delivering messages

[13]Centers for Disease Control and Prevention. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006;55(RR14):1-17.
[14]Centers for Disease Control and Prevention. Prevalence and awareness of HIV infection among men who have sex with men --- 21 cities, United States, 2008. Morb Mortal Wkly Rep. 2010 Sep 24;59(37):1201-7.
[15]Hollingsworth TD, Anderson RM, Fraser C. HIV-1 transmission, by stage of infection. Journal of Infectious Diseases. 2008 Sept 1;198(5):687-93.

every three to six months. The service will be promoted through service providers and a comprehensive social marketing campaign. This initiative is funded through Category C of the CDC HIV prevention grant, PS12-1201 Comprehensive HIV Prevention Program for Health Departments.

Routine testing (e.g., every 3-6 months) for MSM and PWID: Rationale for addressing gaps

Early and routine HIV testing is critical for preventing new infections. Persons diagnosed with HIV commonly reduce risk behaviors[16] and access medication,[17] both of which help reduce the risk of transmission.

Testing when entering or in a relationship: Needs assessment

HIV testing, when entering or in a relationship, may help prevent new infections. It has been estimated that approximately two-thirds (68%) of HIV infections among MSM are from main partners (e.g., a boyfriend or significant other). Transmissions from main partners appear to be driven by 1) undiagnosed HIV infections, combined with the tendency of MSM to engage in both 2) a greater number of sex acts and 3) riskier sex acts (e.g., unprotected, receptive) with main partners than with non-main partners.[18] While less is known about the types of sexual partnerships associated with HIV transmission to partners of PWID, Oregon surveillance data indicate that heterosexual contact with a PWID accounted for 2% of HIV diagnoses from 2005-2009 (11% of female cases and 1% of male cases).[19]

Testing when entering or in a relationship: Gaps to be addressed

A number of HIV prevention service providers in Oregon will be attending training on HIV test counseling with couples in 2012 and will offer testing for couples as a result. Messages delivered by providers will promote testing and communication about sexual health when entering or in a relationship.

[16]Marks G, Crepaz N, Senterfitt JW, Janssen RS. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: Implications for HIV prevention programs. *J Acquir Immune Defic Syndr*. 2005;39:446–453.
[17]Gardner EM, McLees MP, Steiner JF, et al. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. Clin Infect Dis. 2011 Mar 15;52(6):793-800.
[18]Sullivan PS, Salazar L, Buchbinder S, et al. Estimating the proportion of HIV transmissions from main sex partners among men who have sex with men in five US cities. AIDS. 2009 Jun 1;23(9):1153-62.
[19]Oregon Health Authority. Epidemiologic Profile of HIV/AIDS in Oregon, 2009.

Testing when entering or in a relationship: Rationale for addressing gaps

Prevention messages and services should be responsive to research describing the types of partnerships in which HIV transmission is likely occurring.

Comprehensive prevention services with positives (PLWH)

Comprehensive prevention with positives is prioritized as a core component of the CDC HIV prevention grant. An estimated half (51%) of HIV transmissions are from PLWH who have been diagnosed and are aware of their HIV status.[20] Linkage, retention, and re-engagement in care and prevention services for HIV, other STDs and Viral Hepatitis are critical to reducing risk behaviors and viral load preventing HIV transmission from PLWH who engage in risky behaviors. All seven LHDs receiving CDC HIV prevention grant funds in Oregon are currently implementing comprehensive prevention with positives services with HIV prevention grant funds. These services mostly focus on linkage to HIV care for persons testing positive, including providing information and referrals; assisting clients with scheduling, remembering and attending appointments; and following up with both persons who have been newly diagnosed and who have fallen out of care. Many other critical services for PLWH described below are supported by Ryan White Program funding.

Access to medical care: Needs assessment

Oregon surveillance data indicate that one in four (25%) PLWH/A may be out of care (i.e., did not have any reported CD4 or viral load tests during 2009). A number of subpopulations had a higher proportion of unmet need for medical care:

- Hispanics (36%) compared to whites (23%)
- Native Americans (36%)
- Blacks or African Americans (33%)
- Males with IDU risk (37%) or MSM/IDU risk (38%) compared to MSM (23%)
- Female PWID (27%) compared to females with heterosexual risk (19%)
- Rural PLWHA (33%) compared to urban PLWHA (24%)
- Foreign-born PLWHA (31%) compared to US-born PLWHA (24%)

Qualitative data from interviews and group sessions conducted in 2011 indicate that many current Ryan White clients in the Part B area of Oregon (29 counties outside the Portland metropolitan area) were not receiving HIV medical care at some point in their infection, despite knowing their status. The main reasons clients cited for being out of care included denial and depression, side effects of HIV medications or fear of starting medications, and alcohol and drug abuse.

[20]Hall HI, et al. (2012). HIV transmission rates from persons living with HIV who are aware and unaware of their infection, United States. *AIDS*; 26:000-000.

The two leading reasons clients gave for entering HIV medical care (or re-entering it after falling out of care for a while) were 1) being forced into care because of illness and 2) being connected through the efforts of a family member, friend, or another individual who reached out. Based on these data from PLWH/A, we believe some of the needs of people aware of their HIV+ status but not in HIV medical care include mental health services, alcohol and drug treatment services, better education regarding HIV medicines and treatment, social support and early intervention services that foster a smooth transition between testing and entry into care.[21]

For PLWH who are receiving HIV care in Oregon, the majority of their care needs are being met. Medical Monitoring Project (MMP) data collected from a representative sample of PLWH receiving public or private HIV medical care throughout Oregon indicate that:

- 98% reported having health insurance or coverage, and only 6% reported an insurance gap at some point in the past 12 months.
- 100% reported having a "usual source of HIV care" in the past 12 months.
- 95% of those diagnosed in the past 5 years had their first HIV medical visit within 3 months of diagnosis; 5% entered care between 3-12 months post-diagnosis.
- Three quarters (75%) had 3 or more CD4 counts in the past year.

Transportation assistance remains an important care access issue. Approximately 1 in 9 MMP participants reported difficulty getting to HIV medical care. Approximately 1 in 8 said their travel time to HIV medical care is more than one hour each way, and 1 in 4 said they needed transportation assistance in the past year. Medical transportation assistance is provided through gas cards, public transportation (e.g., bus tickets), taxi fare and, occasionally, special medical transport for clients who need a higher level of assistance due to serious illness and/or mobility limitations. Transportation assistance needs are particularly notable for rural and frontier clients.[22]

Access to medical care: Gaps to be addressed

There is a new emphasis on linkage to care in Oregon. Comprehensive prevention with positives activities, such as linkage, retention and re-engagement in care, are now a required focus for contractors receiving HIV prevention grant funds through OHA. Thus, contractors will continue building upon existing efforts and implement new strategies that support access to care. Such efforts include providing care information and referrals; assisting clients with scheduling, remembering and attending medical appointments; following up with both persons who have been newly diagnosed and who have fallen out of care; and enhancing partnerships with care staff.

[21]Oregon Health Authority. Oregon Statewide Coordinated Statement of Need. January 2012.
[22]Oregon Health Authority. Oregon Statewide Coordinated Statement of Need. January 2012.

Access to medical care: Rationale for addressing gaps

The new emphasis on prevention staffs helping clients access to HIV medical care is a result of new research highlighting the prevention value of access to care and treatment adherence,[23] the comprehensive prevention with positives funding category within the CDC HIV prevention grant, and Oregon surveillance data indicating that one in four (25%) PLWH/A may be out of care (i.e., did not have any reported CD4 or viral load tests during 2009).[24]

Medication adherence support: Needs assessment

MMP data indicate that four in five (80%) participants had at least one undetectable viral load test result in the past year, suggesting adherence to HIV medication.[25]

Medication adherence support: Gaps to be addressed

With Category C PS12-1201 HIV Prevention grant funds, OHA will implement a medication adherence reminder service in 2012. With this service, clients will be able to receive reminders via text message, voice message or email to take medications daily and to refill prescriptions routinely.

Medication adherence support: Rationale for addressing gaps

Supporting medication adherence aligns with the new focus on comprehensive prevention with positives within the CDC HIV prevention grant and ultimately serves to prevent HIV transmission by helping patients achieve a suppressed viral load.

Case management: Needs assessment

One in 20 (5%) MMP participants reported an unmet need for HIV case management services in the past year. The main barrier to receiving case management services was confusion about where to go or whom to call for services.

Case management: Gaps to be addressed

Oregon's comprehensive prevention with positives activities includes linking clients to case management. Contractors will continue building upon existing efforts and

[23]Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med. 2011 Aug 11;365(6):493-505. Epub 2011 Jul 18.
[24]Oregon Health Authority. Oregon Statewide Coordinated Statement of Need. January 2012.
[25]Oregon Health Authority. Oregon Statewide Coordinated Statement of Need. January 2012.

implement new strategies that support entry to case management. Such efforts include providing care information and referrals; assisting clients with scheduling, remembering and attending appointments; following up with both persons who have been newly diagnosed and who have fallen out of care; and enhancing partnerships with care staff.

Case management: Rationale for addressing gaps

Case management is a gateway to a number of critical services for PLWH that may impact both client health outcomes and HIV transmission, such as CAREAssist (Oregon's AIDS Drug Assistance Program), housing assistance and substance abuse treatment.

Risk reduction support: Needs assessment

MMP data collected in 2009 and 2010 (N=522) suggest that one in eight (12%) people receiving HIV care in Oregon have had unprotected vaginal or anal sex with a partner of negative or unknown HIV status in the past 12 months (9% among men, 26% among women). An additional one in five (20%) MMP participants reported unprotected sex only with HIV-positive partners, which warrant concern about STD transmission.[26] Qualitative data collected in Multnomah County (2007)[27] suggest that many PLWH take steps to reduce the risk of transmission, though some of these efforts may still result in considerable risk. Such efforts include serosorting (unprotected sex with partners of the same HIV status) based on assumptions rather than direct communication, seropositioning (an HIV-positive partner takes the receptive role in anal sex with a partner of HIV-negative or unknown status), and engaging in unprotected sex with HIV-negative partners when one's viral load is undetectable.[28]

[26]Greene, K., He, H. & Schafer, S. Prevalence of Risky Sexual Behaviors in HIV-Positive Patients in Oregon: Findings from the Medical Monitoring Project. Unpublished raw data. 2012.
[27]Drach, L., Anderson-Nathe, B., Smith, C. Community PROMISE Community Identification Methods and Findings: A Report from the Tri-County Community PROMISE Workgroup. Program Design & Evaluation Services: Portland, OR. 2007.
[28]Politch JA, Mayer KH, Welles SL, et al. Highly active antiretroviral therapy does not completely suppress HIV in semen of sexually active HIV-infected men who have sex with men. *AIDS*. 2012 Mar 23. [Epub ahead of print]

Risk reduction support: Gaps to be addressed

Comprehensive prevention with positives activities are now required for LHDs receiving HIV prevention funding from OHA; these efforts may include risk screening, risk reduction counseling and evidence-based behavioral interventions for PLWH. Thus, LHDs are enhancing these types of activities and increasing collaboration with care service providers. Additionally, Cascade AIDS Project receives funding to implement Healthy Relationships, a multisession, small-group, skills-building program for PWLH. OHA HIV prevention and care staff will encourage risk reduction with PLWH through activities such as the dissemination of materials and trainings supporting risk reduction (e.g., intake forms for PLWH in care settings, marketing materials). Risk screening will be encouraged so that efforts may be focused on PLWH who engage in risk behaviors with persons of HIV negative or unknown status.

Risk reduction support: Rationale for addressing gaps

PLWH who engage in unprotected sex with persons of negative or unknown HIV status (an estimated 16% of all diagnosed PLWH in the U.S.) may have an even higher transmission rate than persons unaware of their HIV infection and are estimated to account for half of all HIV transmissions.[29] Thus, conducting risk screenings among PLWH and assisting those engaging in risk behaviors with risk reduction goals are critical to preventing onward transmission. Moreover, risk reduction is part of comprehensive prevention with positives, which is now a core component of the CDC HIV prevention grant.

Linkage to substance abuse treatment: Needs assessment

Approximately 1 in 7 (15%) MMP participants (2009-2010) reported binge drinking on one or more days in the past month. Binge drinking was defined as 4 or more drinks in one day for women and 5 or more for men. Nearly 1 in 3 (29%) reported use of other drugs in the past 12 months, including recreational use of marijuana[30] (26%), other non-injection drugs (15%), and injection drugs (5%). Almost 1 in 10 participants (9%) reported daily recreational marijuana use. Past-year use of substance abuse treatment services was noted in 10% of MMP participants' medical records in 2007-2008, the most recent MMP data available on this topic, and 2% of MMP participants reported past-year use of inpatient drug and alcohol treatment. Only 1% of MMP participants reported an unmet need for drug and alcohol counseling and treatment in 2009-2010. In 2009, 7% of CAREAssist clients self-reported having a problem with drugs or alcohol.

[29] Holtgrave DR, Maulsby C, Wehrmayer L et al. Behavioral factors in assessing impact of HIV treatment as prevention. *AIDS Behav*. 2012. 16:1085–1091.

[30] Recreational marijuana use was measured separately from medicinal use of marijuana to treat HIV symptoms or side effects.

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. Nearly all CAREAssist clients are eligible to receive substance abuse treatment services as defined within the primary health insurance coverage purchased by CAREAssist or to which the client has access. CAREAssist pays deductibles and/or copayments on behalf of the client. Recruitment into mental health services by peer mentors is also funded through a treatment project in the Transitional Grant Area. Peers will also help link clients with co-occurring substance abuse issues into appropriate treatment. The HIV Health Services Center also offers harm-reduction based treatment open to any PLWH, regardless of where s/he receives medical care or whether s/he live in the Transitional Grant Area.

In 2010, Part B-funded substance abuse treatment services were provided to two clients in the Balance of State. In 2010, 27 clients in the Transitional Grant Area received Part A-funded substance abuse treatment services. These numbers have always been somewhat low because of challenges discussed below. However, changes in health insurance related to the parity act now allow these services to be billed through insurance plans, which may also decrease the numbers served through Ryan White Program funds.

Case managers and other service professionals working with PLWH 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 providers who will accept a client's 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 or cultural competence dealing with the lesbian, gay, bisexual, transgendered, and queer (LGBTQ) populations, especially within certain geographic areas. In addition, funding in-patient treatment is a challenge because Ryan White funds cannot be used, and most clients lack other options. Clients echoed these themes in 2011 listening sessions and interviews.[31]

Linkage to substance abuse treatment: Gaps to be addressed

Linkage to substance abuse treatment will be emphasized in our previously described efforts to support risk reduction (e.g., trainings, materials dissemination) and promoted by prevention and care staffs working with HIV-positive clients.

Linkage to substance abuse treatment: Rationale for addressing gaps

Substance abuse treatment helps prevent new infections. Drug treatment programs have shown to improve access and adherence to antiretroviral treatment, and persons

[31]Oregon Health Authority. Oregon Statewide Coordinated Statement of Need. January 2012.

in substance abuse treatment are significantly more likely to achieve sustained viral suppression, making HIV transmission less likely.[32]

Linkage to mental health services: Needs assessment

About half of CAREAssist clients (54%) reported "depression, anxiety or emotional problems" in 2009, and indicators of emotional health were somewhat poorer than that of the general adult population. About 1 in 3 MMP participants (36%) reported needing mental health services in 2009-2010. In addition, 1 in 3 (35%) participants reported being diagnosed or treated for depression and 1 in 4 (24%) for anxiety in the past year. Just over 1 in 4 MMP participants (28%) showed moderate to severe depression on a standardized measure (the PHQ-9 scale) based on reports of their mood over the past two weeks.

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 (e.g., psychiatrists, psychiatric nurse practitioners, licensed social workers, or licensed professional counselors). The state's Part B ADAP (CAREAssist) purchases insurance, the vehicle by which some clients access mental health services. CAREAssist pays deductibles and copayments behind the primary health insurance (including OHP and Medicare Part B) on behalf of the client. Because Medicare Part B pays at a low percentage on mental health services, the annual allocation to medical service copayments provided by the CAREAssist program may be exhausted prior to the end of the coverage year. In this case the responsibility for paying the copayments may default to other Ryan White funds. Mental health treatment services are provided by contracted mental health agencies and through a mental health provider stationed at Cascade AIDS Project, supported through Oregon HIV Behavioral Health Initiative (OHBHI) HOPWA grant funds. Recruitment into mental health services by peer mentors is also a funded treatment project in the Transitional Grant Area. The HIV Health Services Center provides mental health services by a Psychiatric Nurse Practitioner, as well as limited counseling from a Part D-funded social worker.

Two percent of MMP participants reported past-year admission to an inpatient mental health facility. Eleven percent of MMP participants reported needing, but not getting mental health services in 2009-2010. The main barriers to receiving mental health services were psychological (e.g., not feeling ready), not knowing where to go or who to call, and cost/lack of insurance. In 2010, 129 clients in the Transitional Grant Area received Part A-funded mental health services, about 23% fewer than in 2007. Providers report this is largely due to implementation of mental health parity laws so clients do not need to access Ryan White funds to complete their treatment. In 2010, five clients in the Balance of State received Part B-funded mental health services. Similar to substance abuse services, the numbers accessing Ryan White Program-

[32]Metzger DS, Woody GE, O'Brien CP. Drug treatment as HIV prevention: a research update. J Acquir Immune Defic Syndr. 2010 Dec;55 Suppl 1:S32-6.

funded mental health services have always been somewhat low because of challenges discussed below. Changes in health insurance related to the parity act now allow these services to be billed through insurance plans, which may also decrease the numbers served through Ryan White Program funds. The Coordinated Care Organizations newly formed in Oregon integrate mental health and physical health so it is hoped that linkage into mental health services for Medicaid clients will be less challenging.

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 barriers look similar to those identified by MMP clients, and include a client's lack of treatment readiness, lack of providers who accept a client's 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 or cultural competence dealing with the LGBTQ population, especially within certain geographic areas. Lack of availability of Spanish speaking counselor has also been mentioned as a barrier. In 2011, clients in Part B Listening Sessions also identified access to "HIV-knowledgeable" mental health providers as an unmet need.

Linkage to mental health services: Gaps to be addressed

The importance of linkage to mental health services will be emphasized in our previously described efforts to support risk reduction (e.g., trainings, materials dissemination) and promoted by prevention and care staffs working with HIV-positive clients.

Linkage to mental health services: Rationale for addressing gaps

Linkage to mental health services is an important component of HIV prevention given the association between mental health and HIV risk behavior.[33]

Prevention, testing and treatment of co-infections: Needs assessment

Sexually transmitted diseases (STDs) are indicators of ongoing sexual behavior that could transmit HIV, and having a concurrent STD may increase the likelihood that a PLWH/A could transmit HIV to uninfected partners. Rates of STI are much higher among persons with previously reported HIV infection, particularly male PLWH. For example, average annual rates among male PLWH during 2005-2009 were:

- 116 times higher for early syphilis (233/100,000)

[33]Parsons JT, Grov C, Golub SA. Sexual compulsivity, co-occurring psychosocial health problems, and HIV risk among gay and bisexual men: further evidence of a syndemic. Am J Public Health. 2012 Jan;102(1):156-62. Epub 2011 Nov 28.

- 450 times higher for gonorrhea (1,351/100,000)
- 3 times higher for Chlamydia (902/100,000)

Prevalence estimates of hepatitis C (HCV)/HIV coinfection vary, depending on the data source; they range from 7% (Epidemiologic Profile, 2011) to 11% (CAREAssist 2009) to 21% (MMP, 2011). Approximately 5% of PLWH in Oregon are estimated to have HIV/hepatitis B (HBV) co-infection. From 2005-2009, at least 5% of deaths among PLWH in Oregon were liver-related, most from chronic hepatitis C.

Prevention, testing and treatment of co-infections: Gaps to be addressed

The importance of addressing STDs and Viral Hepatitis will be emphasized in our previously described efforts to support risk reduction (e.g., trainings, materials dissemination) and promoted by prevention and care staffs working with HIV-positive clients.

Prevention, testing and treatment of co-infections: Rationale for addressing gaps

Addressing STDs and Viral Hepatitis among PLWH support HIV prevention given their shared modes of transmission.[34] The presence of STDs or Viral Hepatitis infections within a community or population suggests HIV risk behaviors and a need for HIV screening. Moreover, if left undiagnosed or treated, these infections may also increase the risk of HIV transmission.[35]

Condom distribution (CD): Needs assessment

While CD has long been part of HIV and STD prevention in Oregon, it is now prioritized as a core component of the CDC HIV prevention grant. As has been found in a meta-analysis of structural-level CD interventions, CD can result in a number of outcomes that may help prevent new HIV infections, including 1) increased condom use, 2) increased condom acquisition or condom carrying, 3) delayed sexual initiation or abstinence among youth, and 4) reduced incident STDs.[36] Of the 15 counties eligible to receive CD supplies purchased with HIV prevention grant funds (i.e., counties with at least four new HIV diagnoses from 2009-2011), eleven have agencies currently

[34]Sherman, K. and others. Hepatitis C virus prevalence among patients infected with human immunodeficiency virus: a cross-sectional analysis of the U.S. Adult AIDS Clinical Trials Group. *Clinical Infectious Diseases* 34(6): 831-837. March 15, 2002.
[35]Institute of Medicine, National Academy of Sciences, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*, 1997; Brown JM et al., Incident and prevalent herpes simplex virus type 2 infection increases risk of HIV acquisition among women in Uganda and Zimbabwe, *AIDS* 2007;31;21(12):1515-23.
[36]Charania MR, Crepaz N, Guenther-Gray C, Henny K, Liau A, Willis LA, Lyles CM. Efficacy of structural-level condom distribution interventionns: A meta-analysis of U.S. and international studies, 1998-2007. AIDS Behav. 2011 Oct;15(7):1283-97. doi: 10.1007/s10461-010-9812-y.

implementing or preparing to implement CD programs. These agencies must target at least 70% of CD supplies to Oregon's priority populations.

CD: Gaps to be addressed

Given the new CDC focus on CD and new OHA requirements on targeting CD supplies, agencies are continuing to identify new CD venues and prioritize existing CD venues to reach Oregonians most impacted by HIV. These efforts are include further integrating CD in HIV care settings.

CD: Rationale for addressing gaps

Integrating CD with existing services and venues serving Oregon's priority populations is an important part of HIV prevention as CD is a scalable, evidence-based activity that often requires minimal staff time.

Structural and policy initiatives: Needs assessment

Structural and policy initiatives have been prioritized as a core component of the CDC HIV prevention grant. Of the seven LHDs receiving CDC HIV prevention grant funding in Oregon, none report currently implementing or preparing to implement a structural or policy initiative. OHA is continuing to work on a number of initiatives such as Oregon Administrative Rule changes related to HIV testing consent, the integration of HIV prevention with HIV care and other public health programs, and data sharing.

Multnomah County Health Department is also working on several structural interventions, including routine testing in emergency rooms, integrating care and prevention and preparing for integration of testing into primary care sites.

Structural and policy initiatives: Gaps to be addressed

OHA and its partners will support and implement a variety of changes to structures, policies, and regulations to create an enabling environment for HIV prevention; these initiatives will address 1) condom availability, 2) required trainings for HIV case managers, 3) the HIV test consent process, 4) OHA access to HIV testing data, 5) billing procedures for HIV testing, 6) infrastructure for implementing Internet-based Partner Services statewide, and 7) guidance and information available to pharmacy staffs on interacting with PWID.

Structural and policy initiatives: *Rationale for addressing gaps*

With diminishing resources for HIV prevention, identifying and pursuing structural and policy initiatives that may result in sustained, environmental changes promoting HIV prevention are vital.

Community mobilization: Needs assessment

Community mobilization (e.g., the use of volunteers, partner businesses and agencies, and community members to promote HIV prevention) is a recommended component of the CDC HIV prevention grant. Of the seven LHDs receiving CDC HIV prevention grant funding in Oregon, two (Marion and Deschutes) are currently implementing or preparing to implement community mobilization initiatives. These efforts involve awareness days (e.g., National HIV Testing Day), special events (e.g., Pride) and venues serving priority populations. Volunteers help distribute condoms and marketing materials, discuss risk reduction, recruit for HIV testing and link PLWH to care. Moreover, volunteers play a critical role as Oregon HIV/STD Hotline counselors at Cascade AIDS Project. OHA staff members are aware of additional mobilization efforts which may be supported with other funding sources. These activities include the use of volunteers for conducting HIV testing and condom distribution at targeted venues, as well as the use of social media to engage communities and further disseminate prevention messages across social networks. Numerous agencies (e.g., Cascade AIDS Project, HIV Alliance) mobilize community members (using non-CDC funding) to fundraise, donate and participate in community AIDS walks.

Community mobilization: Gaps to be addressed

Assessing service gaps for community mobilization is difficult, as only two contracted LHDs reported supporting community mobilization initiatives with CDC HIV Prevention grant funds. OHA will continue to promote community mobilization as a way to help reach program goals and maintain or expand services.

Community mobilization: Rationale for addressing gaps

Community mobilization may help increase peer support for HIV prevention and combat complacency, which has been associated with risk behaviors.[37] The greatest reductions in HIV incidence in the U.S. occurred at a time when communities were highly mobilized around HIV/AIDS. However, the American public's sense of urgency about HIV/AIDS as a health problem has declined, as has the proportion of people who report having seen, heard, or read about the epidemic in the past year (from seven in ten in 2004 to four in

[37]MacKellar DA, Hou SI, Whalen CC,et al. HIV/AIDS complacency and HIV infection among young men who have sex with men, and the race-specific influence of underlying HAART beliefs. Sex Transm Dis. 2011 Aug;38(8):755-63.

ten in 2011).[38] Moreover, relying solely on Oregon's diminishing funding to prevent new infections presents a significant challenge; the use of volunteers and partners to help deliver services and messages may help fill service gaps.

Social marketing: Needs assessment

Social marketing is a recommended component of the CDC HIV prevention grant. Current social marketing activities conducted in Oregon involve posters, websites, social media, transit advertisements, Governor's Proclamation for World AIDS Day and the dissemination of marketing materials. The majority of marketing efforts implemented with CDC HIV prevention grant funds promote HIV testing and/or the Oregon HIV/STD Hotline. The hotline has a statewide marketing campaign that includes targeted efforts to reach rural communities and communities of color. Of the seven LHDs receiving CDC HIV prevention grant funding in Oregon, only one (Lane County) is currently using funds to support social marketing efforts. OHA staff members are aware of additional social marketing efforts in the Portland Metropolitan Area supported with other funding sources.

Social marketing: Gaps to be addressed

To address the ongoing need to promote HIV awareness and prevention, Oregon will continue to support local and statewide social marketing campaigns supporting HIV testing, the Oregon HIV/STD Hotline, HIV/AIDS awareness days, prevention among PLWH and condom access and use. To help maximize the use of free social marketing materials that become available (e.g., from CDC and other agencies), OHA will continue to make such materials available to download on the OHA website and post them via OHA social media accounts. New social marketing efforts promoting enrollment in automated reminder services for routine HIV testing and for medication adherence will be implemented in 2012.

Social marketing: Rationale for addressing gaps

Social marketing is a recommended component of the CDC HIV prevention grant and may help address the declining sense of urgency about HIV/AIDS as a health problem.[39] Social marketing campaigns have the potential to be far-reaching and effectively influence behavior.[40]

[38]Kaiser Family Foundation. 2011 Survey of Americans on HIV. June 2011. Available at: http://www.kff.org/kaiserpolls/upload/8186-T.pdf
[39]Kaiser Family Foundation. 2011 Survey of Americans on HIV. June 2011. Available at: http://www.kff.org/kaiserpolls/upload/8186-T.pdf
[40]Hausser D, Michaud PA. Does a condom-promoting strategy (the Swiss STOP-AIDS Campaign) modify sexual behavior among adolescents? Pediatrics. 1994;93: 580–585; de Vroome EM, Paalman ME, Sandfort TGM, Sleutjes M, deVries KJM, Tielman RAP. AIDS in the Netherlands: the effects of several years of campaigning. Int J STD AIDS.

Evidence-based interventions for HIV-negative populations: Needs assessment

Evidence-based interventions for HIV-negative populations are a recommended component of the CDC HIV prevention grant. Of the many interventions for persons with unknown or negative HIV status, OHA has prioritized those that effectively promote HIV testing (e.g., Social Networks Strategy [SNS]). Of the agencies receiving CDC HIV prevention grant funding through OHA, three (HIV Alliance and Multnomah and Marion County Health Departments) are currently implementing or preparing to implement an SNS program. Three LHDs (Deschutes, Lane, and Multnomah) are implementing syringe services programs using state general revenue funds. Additionally, Cascade AIDS Project receives funding to implement RESPECT, a two-session, individual-level intervention for HIV-negative persons.

Evidence-based interventions for HIV-negative populations: Gaps to be addressed

Online adaptations of Social Networks Strategy HIV testing programs will be further supported with PS12-1201 Category C funding as of September 2012.

Evidence-based interventions for HIV-negative populations: Rationale for addressing gaps

It is important to prevent the spread of HIV to those who are not already infected. Targeted, evidence-based strategies for HIV testing are needed to help reduce the number of people living with undiagnosed HIV infection (currently estimated to be more than 1,300 Oregonians[41]). Knowledge of HIV-positive status is critical to preventing new transmissions[42] and accessing life-extending medication.[43]

[NOTE] Oregon HIV Prevention training needs assessment summary attached as Appendix B.

Pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP): Needs Assessment

1990;1:268–275; The LoveLife Monitoring Team. LoveLife 2004 Report on Activities and Progress. Johannesburg, South Africa: Available at: http://www.lovelife.org.za/corporate/research/AnnualReport_2004.pdf.

[41]Oregon Health Authority. Unpublished data based on the CDC estimate that 18.1 percent of people infected with HIV in the U.S. have not yet been diagnosed. Source: March 5 2012 eHARS.

[42]Marks G, Crepaz N, Senterfitt JW, Janssen RS. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: Implications for HIV prevention programs. *J Acquir Immune Defic Syndr*. 2005;39:446–453.

[43]Gardner EM, McLees MP, Steiner JF, et al. The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. Clin Infect Dis. 2011 Mar 15;52(6):793-800.

PrEP and nPEP are recommended components of the CDC HIV prevention grant. While CDC HIV prevention grant funding may not be used to purchase medications to support these efforts, resources are being assessed and information and referral systems are being developed to link interested clients to PrEP or nPEP in a timely manner. Oregon HIV/STD Hotline data suggest there may be a small but growing level of interest and/or awareness of nPEP resources; from mid-2011 to early 2012, the hotline's referrals to nPEP each quarter increased from one to five. Of the seven LHDs receiving CDC HIV prevention grant funding through OHA, none report using these funds to formally implement PrEP or nPEP referral programs. However, numerous agencies are responding to client questions and interest in nPEP and PrEP by providing information and referrals.

PrEP and nPEP: Gaps to be addressed

To meet client needs for PrEP and nPEP, Oregon will continue to assess PrEP and nPEP resources, improve its referral systems (e.g., the Oregon HIV/STD Hotline), and distribute information to clients, service providers and medical providers. Referral systems will include medication assistance programs offered through the private sector as available.

PrEP and nPEP: Rationale for addressing gaps

Both PrEP and nPEP are recommended components of the CDC HIV prevention grant. PrEP has demonstrated efficacy in reducing HIV acquisition.[44] While there is limited evidence on the effectiveness of nPEP, studies of the effectiveness of occupational PEP suggest nPEP may also be a valuable for preventing HIV transmission.[45]

Scalability of Activities

As of September 2012, the seven funded counties in Oregon underwent program planning for fiscal year 2013. OHA HIV Prevention Program Plan for scalable activities reflects evidence based interventions of the National HIV/AIDS Strategy. LHDs are required to implement HIV testing and comprehensive prevention with positives. OHA has the lead on coordinating condom distribution orders and shipments to agencies and venues that then distribute the supplies to Oregon's priority populations. OHA also has the lead on implementing policy/structural changes that promote HIV prevention. The other components, such as evidence-based interventions for HIV negative populations

[44]Centers for Disease Control and Prevention Interim Guidance: Preexposure Prophylaxis for the Prevention of HIV Infection in Men Who Have Sex with Men. MMWR 2011;60:65-68.
[45]Bryant J, Baxter L, Hird S. Non-occupational post exposure prophylaxis for HIV: a systematic review. Health Technol Assess. 2009 Feb;13(14):iii, ix-x, 1-60; Centers for Disease Control and Prevention. Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States. MMWR 2005;54(RR02):1-20.

at highest risk, social marketing and community mobilization, are recommended but not mandatory for LHDs. These high-impact prevention activities cover anti-retroviral therapy treatment, testing, linkage and retention/re-engagement to care, partner services, behavioral risk reduction, substance abuse treatment, access to condoms and STD screening/treatment.

Listed below are specific prevention interventions being conducted among the seven funded LHDs, funded by CDC HIV prevention grant as well as other funding resources. The combination of all these activities demonstrates Oregon HIV prevention population-level impact, with regards to LHDs capabilities to meet local and surrounding area priority population needs. The ability to expand these approaches to HIV prevention will be monitored and evaluated according to quarterly performance measures. Additionally, a recently convened workgroup among OHA staff is tasked to streamline various HIV/STD/TB Section and Integrated Planning Group strategies in efforts to, among other things, determine which combination of approaches will continue to have the greatest impact on HIV/AIDS in Oregon each year through 2016. Factors that influence the scalability of interventions will prove cost effectiveness, consider distribution of resources as they are predicted to decrease in Oregon, and address needs determined by epidemiologic data for at-risk and priority populations (including racial and ethnic groups) – to be analyzed annually.

- HIV testing and linking to care
- Antiretroviral therapy
- Access to condoms and sterile syringes
- Prevention programs for people living with HIV and their partners
- Prevention programs for people at high risk of HIV infection
- Substance Abuse Treatment
- Screening and treatment for other sexually transmitted infections

<u>HIV Testing</u>
Several HIV testing activities are being implemented:

Services Being Offered in Oregon's Funded Counties	**# of Counties**
Confidential HIV testing	7
Anonymous HIV testing	7
HIV testing during non-traditional hours (e.g., after 5pm)	5
Delivery of HIV positive test results to clients via phone	4
Delivery of HIV negative test results to clients via phone	4

Walk-in hours where clients may receive their test results without an appointment	3
Both Hepatitis C and HIV testing combined	5
Both STD and HIV testing combined	7
Couples Testing Program	4
Billing insured clients for HIV testing	3

There are 35 public testing sites within the 7 funded counties; 15 are healthcare facilities and 20 are non-healthcare facilities. As priority populations are the focus, all sites aim to prioritize testing among Partners of HIV+, MSM and/or PWID populations.

County	# of Testing Sites	# of Healthcare Facilities	# of Non-Healthcare Facilities
Clackamas	4	1	3
Deschutes	5	4	1
Jackson	7	4	3
Lane	11	1	10
Marion	3	4	2
Multnomah	19	10	9
Washington	2	1	1

Comprehensive Prevention for Positives

The implementation of new processes and systems, as they relate to Comprehensive Prevention for Positives, are to improve linkage to HIV medical care, treatment adherence support and retention/re-engagement procedures. Specific activities that will contribute towards providing HIV care to PLWH include:

Comprehensive Prevention for Positives Services	# of Counties
Provide information and referrals to care services	7
Assist clients with making appointments	4
Remind clients of upcoming appointments	1
Follow up with clients to assess whether they made their	5

appointments and address any barriers	
Provide transportation assistance (e.g., bus vouchers) for appointments	2
Escort clients to their appointments	1
Utilize volunteers (e.g., to help clients navigate the care system, remembering appointments, etc.)	1
Implement Positive Self-Management Program	1

Condom Distribution

There are at least 44 condom/lubricant distribution sites among the seven counties; 17 are healthcare facilities and 27 are non-healthcare facilities. Many of the venues are health departments, HIV/AIDS service providers, substance abuse treatment agency, school/student organizations, dance club/bar and sex establishments. As priority populations are the focus, 70% of the approximate 80,000 condoms distributed will be for HIV+, Partners of HIV+, MSM and/or PWID populations; 30% will be designated for the general population.

County	**# of CD Sites**	**# of Healthcare Facilities**	**# of Non-Healthcare Facilities**
Clackamas	4	1	3
Deschutes	11	3	8
Jackson	6	4	2
Lane	8	1	7
Marion	12	7	5
Multnomah	5	1	4
Washington	3	1	2

Evidence-Based Interventions for HIV Negative Populations at Highest Risk

Five counties intend to work on harm reduction activities. While no syringe services are funded by CDC, there are Oregon and local general funds that support these services. Deschutes, Jackson, Lane, and Multnomah counties aim to ensure PWID have access to clean syringes and supplies for HIV and Hepatitis C prevention. Additionally, Marion County provides HIV and Hepatitis C presentations and classes to PWID. Elements of

syringe services that are conducted in the four counties providing syringe services include:

Program Elements for Syringe Services Programs	# of Counties
Fixed exchange site (in a location that does not change such as a building)	4
Mobile site (e.g., van)	3
Delivery of syringes	2
Drop boxes for syringe disposal in public venues	2

Syringe Services, which includes syringe exchange, individual-level and group-level harm reduction sessions to promote harm reduction among persons who inject drugs, is an evidence-based intervention previously implemented utilizing the Oregon Harm Reduction Outreach and Care Services model. In addition, Marion County continues to provide HIV and Hepatitis C presentations and classes to PWID.

On different notes, Marion, Multnomah and Jackson counties continue to implement a culturally-based program, called Cuidate, designed to reduce HIV sexual risk among Latino youth. Also, strategies to identify and recruit high risk HIV negative persons within Deschutes, Lane, Marion and Multnomah counties, including persons in HIV-discordant relations (with HIV+ partner) are listed below:

Identify/recruit high risk HIV negative persons strategies	# of Counties
Referrals from other agencies/programs	4
Risk screening	4
Staff outreach/recruitment at targeted physical venues	4
Staff outreach/recruitment in targeted online venues	1
Volunteer outreach/recruitment	3

Social Marketing

Lane County is doing social marketing with CDC HIV prevention grant funds; and other counties use social marketing as well though not necessarily through their block grant funds. Their messaging to increase HIV awareness and testing will be done via online profiles on dating/sex-seeking websites (e.g., Adam4Adam.com) or mobile apps (e.g., Grindr), pamphlets, flyers, or palm cards. Efforts are also made via social networking sites (e.g., Facebook, Twitter) and websites. The majority of marketing efforts implemented with CDC HIV prevention grant funds promote HIV testing and/or the Oregon HIV/STD Hotline. The hotline has a statewide marketing campaign that includes targeted efforts to reach rural communities and communities of color.

Community Mobilization

Two of the seven LHDs will be implementing Community Mobilization plans, Deschutes and Marion counties. Occasions like World AIDS Day, Human Dignity Coalition DRAG show, Pride Event and National Testing Day lend opportunities to reach priority populations in various community settings in order to make a substantial difference in preventing new infections with practical large scale strategies at reasonable costs. With the partnership collaborations, at least sixteen activities have been proposed and at least nine locations will have information/informational materials about local HIV testing services.

In the Portland Metropolitan Area, several agencies, including the Multnomah County Health Department, Cascade AIDS Project, Planned Parenthood, the Urban League of Portland, the Portland Chapter of the Links, the Albina Ministerial Alliance and the Oregon Health Authority HIV Prevention Program continue to support collaborative targeting priority populations within the African American/Black community. This collaborative, known as the African American AIDS Action Awareness Alliance (A6), hosts four HIV/AIDS Awareness events including the National Black HIV/AIDS Awareness Day, World AIDS Day, the Balm in Gilead week of Prayer, and the National HIV Testing Day, and also partners with community stakeholders to support annual Black Pride events, the Parents, Family and Friends of Lesbian and Gays (PFLAG), the annual African American Youth Summit, and the "Good in the Hood" annual event which occurs in the inner-Northeast community of Portland. HIV counseling and testing is offered at each event, and these concerted efforts have proven to be instrumental in mobilizing the African American and Black community around important issues such as knowing one's HIV status, encouraging HIV testing among individuals who rank within Oregon's prioritized populations, and in normalizing discussions around the issues of HIV/AIDS that disproportionately impact African Americans and Blacks in the Portland Metropolitan Area.

Primary strategies community members (i.e., volunteers or businesses) will use to promote HIV prevention are described below. Please note, these are activities documented by LHDs during program planning, funded by CDC block grant and other sources.

Community Mobilization	**# of Counties**
Distributing condoms	2
Displaying or disseminating marketing materials	2
Discussing risk reduction or sexual health with others	1
Identifying key stakeholders from prioritized populations	1
Linking HIV+ persons to care and treatment services	1
Recruiting/ referring others to HIV testing or other prevention services	1

Identifying trends, venues, and events where prioritized populations often convene	1

PrEP and nPEP

Jackson County works innovatively towards implementing PrEP and nPEP into their HIV prevention plan by taking the following action steps:

- Research and review algorithms already in place at various emergency departments (EDs) throughout the state and country for determining the need for HIV nPEP
- Develop a draft protocol/policy for EDs, health department, and urgent care clinics based on a chosen algorithm
- Share draft policy/protocol with directors of local EDs, urgent care clinics, and health departments and obtain feedback
- Distribute chosen algorithm to local EDs, urgent care clinics, and health department
- Research availability and access of medications for HIV prophylaxis via health department
- Distribute chosen algorithm to local EDs, urgent care clinics, and health department

Relevant timelines

A. HIV Testing Goals: Reach 1.0% rate of newly identified HIV-positive tests among Oregon's targeted populations of MSM, PWID and partners of PLWH by 2014.

Process Objective 1: Ensure LHD partners progress towards 70% of the CDC grant funded HIV tests being targeted towards Oregon's high risk populations of MSM, PWID, and partners of PLWH and reach that goal by 2014. This will be monitored and measured in reports submitted to OHA quarterly. OHA feedback is provided during on-going technical assistance. This will contribute towards identifying Oregon's 1,300 unknown positive cases and, ultimately, towards NHAS efforts to lower the annual number of new infections by 25%.

Outcome Objective 1: Seventy percent of all CDC grant funded HIV tests in Oregon are specifically targeted towards Oregon's high risk populations of MSM, PWID, partners of PLWH by 2015.

Process Objective 2: Ensure LHD partners progress towards a positivity rate of at least 1.0% for newly identified HIV-positive tests through 2014, monitored and measured in reports submitted to OHA quarterly. OHA feedback is provided during on-

going technical assistance. This will contribute towards NHAS efforts to increase from 79 to 90% of people living with HIV who know of their infection.

Outcome Objective 2: From grant funded testing events in Oregon, 1.0% or results will be newly identified HIV-positive tests by 2014.

B. Comprehensive Prevention with Positives Goals: Ensure 85% of newly HIV-positive people are linked to care within 3 months from diagnosis by 2014.

Process Objective 1: By 2014, ensure funded county partners are working towards establishing seamless systems to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV. Progress of processes/procedures are monitored and measured in reports submitted to OHA quarterly. Final procedural document is provided to OHA by 2014. OHA feedback is provided during on-going technical assistance. This will contribute towards the NHAS anticipated results of increasing the proportion of RW HIV/AIDS Program clients who are in continuous care from 73% to 80%.

Outcome Objective 2: By 2014, all funded county health departments will have a procedural document that describes their established seamless system to immediately link people to continuous and coordinated quality care for individuals who are diagnosed with HIV.

C. Condom Distribution Goals: Increase condom use among Oregon's high-risk populations of MSM, PWID, and PLWH by identifying at least 60 different CD sites to distribute condoms by 2013. Out of the 60 different CD sites, 35 sites will be maintained as regular sites by 2016.

Process Objective 1: Sixty CD sites targeting Oregon's high-risk populations of MSM, PWID and PLWH will be identified among 11 county partners by 2013. Updates on viable CD sites will be made on a quarterly basis through 2016, monitored and measured in reports submitted to OHA quarterly. OHA feedback is provided during on-going technical assistance. This strategy adheres to NHAS' recommended action to intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.

Outcome Objective 1: Among 11 CDC funded counties for condom distribution, 35 sites will be identified and maintained to distribute condoms to MSM, PWID and PLWH by 2016.

D. Policy Initiative Goals:

i. Revise Oregon Administrative Rule (OAR) for HIV testing informed consent

Process Objective: OHA will identify the process to change an OAR, plan steps to be taken and a means to evaluate the activities to reduce barriers of informed consent for HIV testing by 6/2013.
Outcome Objective: A revised OAR is in place to reduce barriers of informed consent for HIV testing by streamlining it into a general medical consent by 12/2013.

ii. Implement data sharing among partners

Process Objective: OHA will identify means to implement the removal of duplicated confidential test data via unique IDs by 6/2013.

Outcome Objective: OHA can make testing histories for people who test confidentially, which allows OHA to have a better sense of testing patterns by 9/2012. This contributes towards the NHAS goal of developing improved mechanisms to monitor and report on progress toward achieving nationals goals.

iii. Meet with the Oregon Board of Pharmacy to assess and discuss info and guidance available to pharmacist on selling syringes to IDUs

Process Objective: OHA staff will meet with CAREAssist/AIDS Drug Assistance Program Manager and Oregon Board of Pharmacy contacts to identify the need and feasibility of structural initiatives on identified pharmacies selling syringes to IDUs by 5/2013.

Process Objective: An implementation strategy will result from decisions made for guidelines and timelines for the selling of syringes to IDUs by identified pharmacies by 8/2013. Continued discussions will take place during bi-weekly OHA team meetings, thereafter.

Process Objective: A monitoring and evaluation process will be defined, along with the guidelines, and made available to participating pharmacies by 2/2014.

Outcome Objective: IDUs will not experience barriers in purchasing syringes among identified pharmacies that use the guidance provided by OHA by 6/2014.

iv. Expand infrastructure for internet and text-based Partner Services (PS) statewide

Process Objective 1: Met with Multnomah County PS staff and the OHA STD Lead, to discuss expanding Multnomah County's internet and text-based Partner Services statewide by 7/2012.

Process Objective 2: Based on decisions, plans will be made accordingly to develop policies/procedures, evaluation process, trainings, implementation and timelines by 12/2012 – to be monitored and documented during bi-weekly OHA team meetings.

Process Objective 3: Expansion of PS infrastructure will be underway by 2/2013, monitored and measured in reports provided by Evaluation Web.

Outcome Objective: PS staff are able to contact potential partners of PLWH via internet and text-based services by 6/2013. These services allow the expansion of PS, supporting the NHAS to expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.

v. Convene stakeholders to assess the feasibility and interest in having traditional and mail-order pharmacies distribute condoms to RW clients with medications

Process Objective 1: Met with CAREAssist/AIDS Drug Assistance Program Manager, to identify stakeholders and needs of traditional and mail-order pharmacies distribution of condoms by 8/2011.

Process Objective 2: Based on decisions made during initial meeting, plans will be made accordingly with stakeholders to develop guidelines and timelines by 1/2013. Implementation activities will be discussed monthly bi-weekly OHA team meetings, thereafter.

Process Objective 3: Guidelines, including a monitoring and evaluation process, will be ready for distribution to pharmacies to distribute condoms to RW clients by 2/2013.

Outcome Objective: RW clients will have the option to receive condoms with their traditional and mail-order medications by 5/2013.

vi. Explore legislation on CD in businesses offering public sex environments

Process Objective 1: Meet with stakeholders to develop a workgroup on CD in businesses offering public sex environments by 6/2013.

Process Objective 2: The workgroup will convene quarterly, starting 8/2013, to explore resources, timelines, M&E processes, partnerships, collaborations and assess the feasibility of legislative action to distribute condoms in businesses offering public sex environments.

Outcome Objective: Condoms will be offered in public sex environments of business due to legislation that supports CD by 2015.

vii. Meet with Oregon Department of Corrections Health Services Administration to propose a Condom Distribution (CD) pilot project in at least 1 prison

Process Objective 1: OHA will prepare proposal for CD pilot project, identifying potential prisons to participate by 2/2014.

Process Objective 2: OHA will meet with Oregon Department of Corrections Health Services Administration to introduce pilot project and determine next steps in planning/timelines, implementation, and evaluation by 6/2014.

Outcome Objective: A CD pilot project will be conducted in an Oregon prison by 3/2015. This will coordinate with on-going Oregon prison interventions, including Reach One Teach One – a peer education program on blood borne pathogens done at 5 prisons, and increase the coordination of HIV programs across the Federal government and between federal agencies and state, territorial, tribal, and local governments as stated in the NHAS.

viii. Develop a risk reduction counseling training for HIV case managers and housing case managers

Process Objective 1: OHA HIV Prevention and Care/Treatment staff meets to identify needs of a risk reduction counseling training and will initiate plan for implementation by 3/2014.

Process Objective 2: OHA will meet with stakeholders to get feedback on training/webinar draft and make changes accordingly by 7/2014.

Process Objective 3: Risk reduction counseling training for HIV case managers and housing case managers is accessible via webinar by 10/2014.

Process Objective 4: Use of training is encouraged for all new HIV case managers and housing case managers throughout Oregon through reminder communications (newsletters, emails, technical assistance, etc.) in 2015-2016.

Outcome Objective: A risk reduction counseling training for HIV case managers and house case managers by 10/2014, which contributes towards NHAS' recommended action to educate all Americans about the threat of HIV and how to prevent it.

ix. Recommend to Oregon's Coordinated Care Organization Criteria Workgroup that Oregon's state sponsored insurance program add routine HIV testing of persons ages 13-64 as an essential (covered) service

Process Objective 1: OHA will prepare recommendation statement for CCO workgroup and meet with CCO leaders by 7/2014 to discuss how OHA can support adding this routine essential testing service.

Process Objective 2: OHA, along with CCO partners, will define next steps in planning/timelines, implementation, and evaluation of state sponsored insurance program adding routine HIV testing as a covered service by 10/2014.

Outcome Objective: Persons ages 13-64 can take home a routine HIV test at Coordinated Care Organization clinics throughout Oregon, which will be covered via the state's sponsored insurance program by 2016.

x. Eliminate anonymous testing

Process Objective 1: OHA will meet with stakeholders to develop a workgroup eliminating anonymous testing by 1/2015.

Process Objective 2: The workgroup will convene quarterly in 2015 to explore resources, M&E processes, partnerships, collaborations, assess the feasibility and implementation strategy of eliminating anonymous testing in Oregon.

Outcome Objective: Anonymous testing will be eliminated by 2016, in order to meet NHAS' goal of developing improved mechanisms to monitor and report on progress toward achieving national goals.

E. Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV Goal: Through 2016, reduce sexual and drug use risk behaviors while increasing protective behaviors for HIV-negative persons through the individual level intervention (LI) of Social Network Strategies (SNS).

Process Objective: Define county appropriate ILI to be implemented via program planning process by December 2012 and annually thereafter.

Outcome Objective: Funded counties will have implemented ILIs that are appropriate for high-risk negatives persons in their areas.

F. Social Marketing, Media, & Mobilization Goals: Broaden the promotion of HIV prevention messages and programs via social marketing, media, and community mobilization through resources/ materials, campaigns and technology through 2016 – appropriate to individual county needs.

Process Objective 1: Identify social marketing resources, materials and tools to be used for HIV prevention activities by December 2012 and make available according to partners.

Process Objective 2: Work with funded counties to implement social marketing strategies into their work plans by 2013, monitored and evaluated on quarterly basis, thereafter.

Outcome Objective: Social marketing resources, materials and tools will be used for HIV prevention activities throughout Oregon by 3/2013.

G. PrEP and n-PEP Goals: Broaden the promotion of PrEP and nPEP services that are available in Oregon via the development of referral systems in order to link interested clients in timely manner by the end of 2013. Currently, no counties are conducting PrEP and nPEP activities with CDC HIV Prevention grants.

Process Objective 1: OHA will continue to keep abreast of new PrEP and nPEP research and practices as they arise and share the information, promotion materials, resources, guidance with partners as they are needed/available through 2016 via participation in community workgroups, newsletters, meetings and program communications.

Process Objective 2: OHA will continue to work with county partners on a quarterly basis, during technical assistance check-ins, to assess the need for support and implementation of PrEP and nPEP services, to include M&E processes, through 2016.

Outcome Objective: Support of PrEP and nPEP services are offered to partners to MSM/high-risk populations through 2016.

H. Category C Goals:

i) Text/email HIV test reminders goal – 2,500 people will enroll in the service by 7/2013, 60% of participants will report an increased frequency of HIV testing (post-enrollment compared to pre-enrollment).

Process Objective 1: OHA will sign contract, and confirm M&E requirements, with contractor to implement service by 9/2012.

Process Objective 2: OHA will identify partners to implement service through competitive funding process by 9/2012.

Process Objective 3: OHA/contractor will implement a comprehensive media campaign targeted to MSM and IDUs to promote text/email HIV test reminders by 10/2012.

Process Objective 4: OHA will provide materials, online resources, ongoing trainings and technical assistance for local health departments (LHDs), community based organizations (CBOs), and community members in order to get targeted populations to register for text/email HIV test reminders by 11/2012.

Outcome Objectives: Text/email HIV test reminders will be available for enrollment by 11/2012; 2,500 people will enroll in the service by 7/2013; 60% of

participants will report an increased frequency of HIV testing (post-enrollment compared to pre-enrollment) by 7/2013.

ii) Ryan White client medication adherence text/email reminders goal: 150 RW clients will enroll in the service by 7/2013. Participants will demonstrate improved indicators of adherence (based on self-reported data on missed refills, doses, and appointments) by 6/2014.

Process Objective 1: OHA will sign contract, and confirm M&E requirements, with contractor to implement service by 9/2012.

Process Objective 2: OHA will identify partners to implement service through competitive funding process by 9/2012.

Process Objective 3: OHA/contractor will implement a comprehensive media campaign targeted to RW clients to promote RW medication adherence reminders by 10/2012.

Process Objective 4: OHA will provide materials, online resources, ongoing trainings and technical assistance for LHDs, CBOs, community based organizations, and community members in order to get targeted populations to register for RW client medication adherence text/email HIV reminders by 11/2012.

Outcome Objectives: RW client medication adherence text/email reminders will be available for enrollment by 11/2012; 150 RW clients will enroll in the service by 7/2013; participants will demonstrate improved indicators of adherence (based on self-reported data on missed refills, doses, and appointments) by 7/2013.

iii) Online behavioral interventions goal: 500 HIV-positive or high-risk negative clients will complete an evidence-based online behavioral intervention by 1/2013.

Process Objective 1: OHA will identify partners to implement online behavioral interventions through competitive funding process by 9/2012.

Process Objective 2: OHA will provide materials, online resources, ongoing trainings, M&E requirements and technical assistance for LHDs, CBOs and community members to prepare for implementation of online behavioral interventions by 10/2012.

Outcome Objective: 50 HIV-positive or high-risk negative clients will complete an evidence-based online behavioral intervention by 1/2013.

iv) Structural changes to websites and mobile applications goal: 30 agencies will implement a change to their website promoting HIV prevention by 1/2013.

Process Objective 1: OHA will identify partners to implement structural changes to website and mobile applications by 9/2012.

Process Objective 2: OHA will provide materials, online resources, ongoing trainings, M&E requirements and technical assistance for LHDs, CBOs and community members in order to prepare for implementation of structural changes to website and mobile applications by 10/2012.

Process Objective 3: OHA/partners will identify potential business partners to approach about implementing a structural change to their website or mobile application by 11/2012.

Outcome Objective: 30 agencies will implement a change to their website promoting HIV prevention by 1/2013.

Addendum #1

September 2013

Oregon's Jurisdictional HIV Prevention Plan serves to describe the resources, needs, and activities for preventing HIV in Oregon. The plan covers 2012 through 2016 and was last updated in mid-2012. While the plan continues to provide a meaningful description of the context and plans for HIV prevention in Oregon, some notable changes have occurred. Thus, this addendum describes significant changes in the resources, needs and activities (both planned and achieved) from mid-2012 to mid-2013.

Description of Oregon's Public Health Infrastructure

In 2013, Oregon received further reductions in federal funding at both state and local health departments. Sequestration will impact Oregon's state health department, the Oregon Health Authority (OHA), with a reduction in funding (approximately 6%). This reduction will impact work done at both the state and local level. At the local level, we have observed a decrease in the number of HIV tests being provided at sites funded by federal funds (PS12-1201). At the state level, discussions are under way regarding reorganization of state program staff; filling of two position vacancies will be delayed to help absorb budget reductions for 2013.

Epidemiology of HIV in Oregon

The trends in HIV infection described in Oregon's 2012-2016 Jurisdictional HIV Prevention Plan have continued in recent years. A current summary of HIV epidemiology in Oregon, which includes diagnoses through 2011, is available at http://1.usa.gov/1220OD0 (see "HIV Infection in Oregon").

HIV testing

Notable changes in HIV testing activities or plans since mid-2012 include the following:

- The Oregon State Public Health Laboratory has implemented a 4th generation HIV testing algorithm. This algorithm has greater sensitivity (ability to detect infection), which is expected to enhance Oregon's efforts to identify and link PLWH to care early, as well as decrease HIV transmission. The lab has also implemented a new database, COPIA.
- Following the 2013 release of the U.S. Preventive Services Task Force recommendations for routine HIV screening of all people ages 15-65, both Kaiser Permanente and the Oregon Health and Science University have implemented or committed to implementing routine, opt-out HIV screening.

- A rapid HIV testing pilot program for partners of PLWH was implemented in the Part B service area (excludes the Portland metropolitan area). The tests are conducted by AIDS Registered Nurse Case Managers.

Comprehensive prevention with positives

Notable changes in comprehensive prevention with positives activities since mid-2012 include the following:

- To support reengagement in HIV care, a pilot project was completed to identify and locate PLWH who have fallen out of care and offer assistance accessing medical care. This project involved collaboration between the OHA Data and Analysis, Community Services and HIV Prevention Programs and the Douglas County Health Department. The methods and findings for this project have since been shared with our community partners. The project has been or is in the process of being replicated in Linn, Jackson, Lane and Multnomah Counties.
- HIV Alliance is now implementing Healthy Relationships (a five-week program referred to locally as Guys Like Us) for MSM living with HIV in Marion and Lane counties, as well as a modified one-day program in Jackson and Douglas counties.

Condom distribution

Notable changes in condom distribution activities or plans since mid-2012 include the following:

- OHA developed a 2013 condom distribution (CD) plan, which is available at http://1.usa.gov/11BIrFK.
- OHA increased the number of condoms purchased in 2013 (230,832) compared to 2012 (169,284).
- Due to funding cuts, OHA purchased fewer lubricant pillows, adjusting the condom-lubricant ratio from 2:1 to 4:1.

Policy and structural initiatives

Notable changes in policy or structural initiatives since mid-2012 include the following:

- In early 2013, Oregon Administrative Rules (OAR) were revised to align with Senate Bill 1507, passed in February 2012. These policy changes allow health care providers to obtain consent for HIV testing in a manner similar to that used for other common tests (i.e., HIV testing may be included in a general medical consent). These changes also allow for more timely linkage to HIV care and treatment; The OHA Public Health Division or local public health authority may disclose the identity of an individual with an HIV-positive test to a health care

provider (e.g., physician, nurse, clinic manager) for the purpose of referring or facilitating treatment for HIV infection.

- OHA has taken a number of actions to ensure appropriate access to HIV testing data by state staff. These actions include ongoing communications from program staff and leadership to funded agencies emphasizing CDC and OHA data requirements, how data sharing supports meaningful analyses and program improvement, data entry processes and client protections, and the potential impact of non-compliance on future funding.
- The Multnomah County Health Deparment offered to conduct Internet-based Partner Services (IPS) for any county in Oregon that does not have the ability to contact partners online.This information was shared with agencies throughout Oregon in the July 2012 issue of Prevention Briefs, the HIV Prevention Program newsletter. In addition to the availability of Multnomah County's staff, OHA is developing an online Partner Services Training to expand LHD capacity and connect staff with resources for IPS.

Community mobilization

Notable changes in community mobilization activities or plans since mid-2012 include the following:

- Of the seven LHDs receiving CDC HIV prevention grant funding in Oregon, two reported currently implementing or preparing to implement community mobilization initiatives. The Marion County Health Department's mobilization efforts have continued, Deschutes County's efforts have discontinued, and Lane County has new plans for mobilization. These efforts involve the use of volunteers to distribute condoms and marketing materials.

Social marketing

Notable changes in social marketing activities or plans since mid-2012 include the following:

- The Oregon Program Review Panel for HIV educational materials reviewed and approved new Spanish radio ads and a telenovela web series addressing HIV prevention, testing and stigma among Hispanic/Latino communities.
- With input from Oregon's HIV/Viral Hepatitis/Sexually Transmitted Infection Integrated Planning Group (IPG), OHA developed and distributed posters promoting condom use to complement Oregon's CD efforts.
- With input from the IPG, OHA developed and distributed HIV awareness clings (i.e., made of non-stick vinyl that will adhere to either mirrors or glass) to help raise awareness and decrease stigma. These clings include an HIV logo with the wording, "Talk about it. Test. Stay healthy" and an HIV hotline number. They were mailed to businesses and organizations throughout the state, such as liquor stores, community centers, health care settings, schools and universities. The

clings were also made available to IPG members and other community partners interested in approaching local venues about displaying them.
- Due to analysis of hotline usage data and prioritization of other prevention services, OHA stopped contributing funds to the Oregon HIV/STD Hotline in April 2013; However, Cascade AIDS Project (CAP) has maintained the hotline with other funding sources. Regardless of these changes in funding, CAP, OHA and other Oregon agencies have continued to use online and print communication to promote the Oregon HIV/STD Hotline. Other information sources promoted in materials include the National HIV/STD Hotline and 211info.

Evidence-based interventions for HIV-negative populations

There have not been any notable changes in plans for implementation of evidence-based behavioral interventions for HIV-negative populations since the jurisdictional plan was written.

Pre- and post-exposure prophylaxis (PrEP and nPEP)

Notable changes in PrEP or nPEP activities or plans since mid-2012 include the following:

- OHA developed and distributed a CDSummary about HIV PrEP and nPEP to health care providers throughout Oregon (available at http://1.usa.gov/13U5hNt).
- A workgroup with representatives from AIDS service, public health, and health care agencies in the Portland metropolitan area are in the process of developing a plan to connect clients with nPEP.

Technology-based activities (Category C demonstration project)

In 2012, OHA was awarded Category C funding for a technology-based demonstration project. Since mid-2012, contracts for these effortshave been developed and executed and programs have been launched.

- In the last quarter of 2012, HIV Alliance, the Multnomah County Health Department (MCHD) and Cascade AIDS Project (CAP) implemented Social Networks Strategy HIV testing programs that utilize technology for recruitment and training.
- CAP and HIV Alliance have developed web badges promoting HIV prevention, which other agencies and businesses may embedd on their websites. The creation and promotion of these badges are intended to support structural changes in online settings and mobilize businesses and organizations to support HIV prevention.
- In January 2013, Oregon Reminders (www.OregonReminders.org) was launched by OHA and YTH (youth+tech+health), formerly known as ISIS. Oregon Reminders is a free service offering HIV/STD testing reminders every 3-6

months, daily medication reminders, monthly prescription refill reminders, and weekly health tips; users may choose to receive text, email or voice messages. The service is supported by a comprehensive marketing campaign, which includes online ads, posters, cards, and radio ads. Client enrollment is encouraged by local agencies, such as CAP, MCHD and HIV Alliance. OHA Ryan White Programs have also promoted Oregon Reminders via communications to CAREAssist (Oregon's AIDS Drug Assistance Program) clients and to providers in the Part B service area.

Addendum #2

August 2014

Oregon's Jurisdictional HIV Prevention Plan serves to describe the resources, needs, and activities for preventing HIV in Oregon. The plan covers 2012 through 2016 and was last updated in September 2013. While the plan continues to provide a meaningful description of the context and plans for HIV prevention in Oregon, some notable changes have occurred. Thus, this addendum describes substantial changes in the resources, needs and activities (both planned and achieved) from September 2013 through August 2014.

Description of Oregon's Public Health Infrastructure

In 2014, Oregon received further reductions in funding for HIV prevention. These reductions impact organizational capacity at both the local and state levels. At the local level, we have observed a decrease in the number of HIV tests being provided at sites funded by federal funds (PS12-1201). At the state level, two positions became vacant in 2013 and were not filled for nearly a year to absorb budget reductions. The capacity of the OHA HIV Prevention Program remains limited; two positions were filled, but the duties and funding are shared among the HIV Prevention and STD programs.

Epidemiology of HIV in Oregon

The trends in HIV infection described in Oregon's 2012-2016 Jurisdictional HIV Prevention Plan have continued in recent years. A current summary of HIV epidemiology in Oregon is available at http://bit.ly/HFS-OR (see "HIV Infection in Oregon 2012").

HIV testing

Notable changes in HIV testing activities or plans since September 2013 include the following:

- With decreased funding, Oregon has continued efforts to better target limited resources. While HIV testing at OHA-funded test sites has decreased (3,605 test events from January–June 2014 vs. 6,457 from January–June 2013), the newly diagnosed positivity rate has increased (0.83% from January–June 2014 vs. 0.53% from January–June 2013).

Other notable changes in HIV testing are included in the Policy Initiatives section below.

Comprehensive prevention with positives

Notable changes in comprehensive prevention with positives activities since September 2013 include the following:

- In 2014, the OHA STD Program began planning for a new model for supporting casework and Partner Services for HIV and other STDs. Historically, the role of OHA disease intervention specialists (DIS) focused on providing Partner Services directly and routinely. OHA DIS will help expand the capacity of LHDs to implement Partner Services and assisting with unique cases as needed. There are a few reasons for these changes. OHA staffing cannot meet the increasing need for Partner Services throughout Oregon using the previous model. STD cases have increased, federal funding and OHA STD Program staffing have decreased, and OHA staff must take on duties (e.g., epidemiology, technical assistance) to fulfill new CDC grant requirements. While local public health authorities' responsibility to address STDs is not new, OHA remains committed to supporting LHDs during this transition. In addition to offering assistance from state DIS, OHA developed an introductory online training (available at http://bit.ly/trainHIV) to help expand the capacity of LHDs to conduct Partner Services. OHA staff also provided an in-person training to LHD staff members (e.g., communicable disease nurses) attending the Oregon Epidemiologists' Meeting Pre-Conference.

- OHA and LHDs have continued implementing the Out of Care Project to identify, locate and re-engage persons out of care (without a CD4 or viral load test result reported in the last 12 months). OHA is on track to complete an out of care analysis for each county in Oregon by the end of 2014. Staff members are discussing continuation of the project in future years, as well.

- As of July 2014, Cascade AIDS Project (CAP) is using CDC direct funding to offer the Antriretroviral Treatment and Access to Services (ARTAS), a brief case management intervention to link recently diagnosed persons to care, and service navigation services for PLWH. These changes were prompted by new requirements for grantees directly funded by CDC to focus resources on initiatives designed to have the greatest impact on the epidemic. CAP is continuing to offer the Healthy Relationships (+alk) intervention.

- Oregon's Ryan White Programs have continued to play a major role in helping prevent new HIV infections by supporting access to care, medication adherence and support services for people with HIV. The success of these programs is demonstrated by Oregon surveillance data, which offer a minimum estimate of viral suppression. Of the 6,685 people living with HIV in Oregon in 2013, the majority (77%) have achieved sustained viral suppression (all viral load test results reported in 2013 were ≤ 200 copies/mL). About 20% of people with HIV thought to live in Oregon may not have had viral load test results reported because some have moved away, only recently moved to Oregon,

received care outside Oregon or received care from the Veterans Administration, which does not report to Oregon's HIV Surveillance Program.

Condom distribution

Notable changes in condom distribution activities or plans since September 2013 include the following:

- Due to funding reductions, OHA decreased the number of budgeted condoms for calendar year 2014 (196,560) compared to 2013 (230,832).

- As a result of emerging research and an advisory note from the World Health Organization related to the safety of personal lubricants (see http://bit.ly/lubeWHO), OHA discontinued purchasing water-based lubricant and instead began purchasing and distributing silicone-based lubricant.

Policy and structural initiatives

Notable changes in policy or structural initiatives since September 2013 include the following:

- OHA has continued supporting the implementation of routine, opt-out HIV screening.

    - During the reporting period, OHA published guidance on methods for implementing opt-out HIV screening (http://bit.ly/HIVtestOR) in accordance with Oregon Administrative rules (revised in 2013) and SB 1507 (passed in 2012). OHA staff continues to conduct outreach to clinicians to discuss and promote routine HIV screening.

    - Following discussions with Legacy Medical Group (which consists of six hospitals and more than 50 clinics in Oregon and southwest Washington), the organization agreed to add HIV screening prompts for patients ages 15 to 65 in their electronic medical records system (starting in September 2014).

    - The OHA HIV Prevention Program collaborated with the OHA Adolescent Health Program to update its certification standards for school-based health centers (SBHCs), requiring HIV testing to be available in SBHCs in middle and high schools.

- OHA engaged stakeholders and obtained support for a policy change requiring all HIV testing using funds from the OHA HIV Prevention Program to be conducted confidentially. This policy went into effect July 1, 2014. Anonymous HIV testing remains available to any person who purchases a home test or who

tests at an agency that offers anonymous testing using other funding sources. This policy change was approved by the Conference of Local Health Officials (CLHO). The decision was informed by findings from an ad hoc Confidential HIV Testing Workgroup, which included representatives from funded agencies and the Oregon HIV/Viral Hepatitis/Sexually Transmitted Infection Integrated Planning Group (IPG). OHA created a confidential HIV testing fact sheet (visit http://bit.ly/ConfTest) to help HIV test counselors discuss the benefits of confidential testing and address fears or myths about how client information is used and protected.

- OHA has integrated data systems to allow HIV care providers in the Part B service area who agree to follow strict data security and confidentiality protocols to access client viral load data through CAREWare, a client data management program. Regular monitoring of viral load data can help care agencies identify clients that are not virally suppressed. Agencies can use these data to target services to those with the greatest need, to coordinate adherence support interventions with medical providers, and to plan and evaluate programs. OHA will continue to explore how this initiative can be expanded statewide.

Community mobilization

There were no substantial changes in community mobilization activities or plans since September 2013.

Social marketing

There were no substantial changes in social marketing activities or plans since September 2013.

Evidence-based interventions for HIV-negative populations

Notable changes related to evidence-based interventions for HIV-negative populations since September 2013 include the following:

- As of July 2014, CAP is no longer using CDC direct funding to offer the RESPECT intervention. However, some CDC funds are supporting service navigation (e.g., substance abuse treatment, housing, mental health services) for persons at very high risk for infection. These changes were prompted by new requirements for grantees directly funded by CDC to focus resources on initiatives designed to have the greatest impact on the epidemic.

- While ¡Cuídate! is not a new program, it was omitted from the Jurisdictional HIV Prevention Plan inadvertently. ¡Cuídate! is an evidence-based HIV, STI and unintended pregnancy prevention program for Latino youth, recommended for use with grades 8-11. The program emphasizes risk reduction strategies such as

sexual abstinence and condom use. ¡Cuídate! is implemented in Marion, Multnomah, Jackson, Deschutes, Crook and Jefferson counties. ¡Cuídate! was first implemented in 2011 and is supported by the Personal Responsibility Education Program (PREP) five-year grant administered by the Family Youth Services Bureau.

Pre- and post-exposure prophylaxis (PrEP and nPEP)

There were no notable changes in PrEP or nPEP activities or plans since September 2013.

Technology-based activities (Category C demonstration project)

Category C activities in 2014 will focus on completion and evaluation of the demonstration project.

Comprehensive sexuality education in schools

While comprehensive sexuality education is not new in Oregon, a description of these efforts was omitted from the Jurisdictional HIV Prevention Plan inadvertently. Oregon's comprehensive sexuality education laws are among the strongest in the nation. Oregon Administrative Rules require each school to provide an age-appropriate, comprehensive plan of instruction[46] on human sexuality, HIV/AIDS and sexually transmitted disease (STD) prevention in elementary and secondary schools.

The comprehensive plan of instruction shall:

1) Be approved by the local school board;
2) Be balanced[47] and medically accurate;[48]
3) Avoid shame- or fear-based tactics;[49]
4) Include HIV and STD prevention education at least annually for all students during grades 6-8 and at least twice during grades 9-12;
5) Promote abstinence for school-age youth, without stigmatizing students who have had or are having sexual relationships, and mutually monogamous relationships with an uninfected partner for adults as the safest and most responsible behavior to reduce the risk of unintended pregnancy and exposure to

[46] "Comprehensive plan of instruction" (as defined by Oregon education statutes) means k-12 programs that emphasize abstinence, but not to the exclusion of condom and contraceptive skills-based education. The human sexuality information provided is complete, balanced, and medically accurate. Opportunities are provided for young people to develop and understand their values, attitudes, beliefs and decisions about sexuality as a means of helping young people exercise responsibility regarding sexual relationships and sexual health decisions.
[47] "Balanced" means instruction that provides information with the understanding of the preponderance of evidence.
[48] "Medically accurate" means information that is established through use of the scientific method. Results can be measured, quantified, and replicated to confirm accuracy and are reported or recognized in peer-reviewed journals or other authoritative publications.
[49] "Shame- or fear-based" means terminology, activities, scenarios, context, language, and/or visual illustrations that are used to devalue, ignore, and/or disgrace students who have had or are having sexual relationships. Not all curricula or activities that describe risks of sexual activities can be considered fear-based.

HIV, hepatitis B/C and other STDs;

6) Teach the characteristics of healthy relationships;[50] and
7) Use inclusive materials and language that recognize different cultures, sexual orientations, and gender identities and expressions.

[50] "Healthy relationship" means one in which both people feel a healthy sense of "self." Each person feels comfortable and safe when spending time with the other person. Two individuals try to meet each other's needs, and each can ask for help and support, within and outside of the relationship without fear of criticism or harm.

Addendum #3

August 2015

Oregon's Jurisdictional HIV Prevention Plan serves to describe the resources, needs, and activities for preventing HIV in Oregon. The plan covers 2012 through 2016 and was last updated in August 2014. While the plan continues to provide a meaningful description of the context and plans for HIV prevention in Oregon, some notable changes have occurred. Thus, this addendum describes substantial changes in the resources, needs and activities (both planned and achieved) from September 2014 through August 2015.

Epidemiology of HIV in Oregon

A current summary of HIV epidemiology in Oregon is available at http://bit.ly/HFS-OR (see "HIV Infection in Oregon"). Notably, new diagnoses of HIV have declined. However, an estimated 1,100 Oregonians were living with undiagnosed HIV infection in 2012 (the most current year for which an estimate is available).[51]

HIV testing

Notable changes in HIV testing activities or plans since September 2014 include the following:

- OHA released a comprehensive online training titled, "HIV Prevention Essentials" (http://bit.ly/trainHIV) and discontinued in-person trainings for HIV test counselors. This change was intended to increase timely access to information and skills-building tools for HIV prevention and care staff throughout the state.

Comprehensive prevention with positives

Notable changes in comprehensive prevention with positives activities since September 2014 include the following:

- The OHA STD Program transitioned to a new model for supporting Partner Services for HIV and other STDs. As of July 1, 2015, local health departments (LHDs) resumed responsibility for conducting Partner Services. OHA disease intervention specialists (DIS) provide technical assistance to LHDs and assist with unique cases as needed. The reasons for this transition were described in the 2014 addendum.

[51] Hall HI, An Q, Tang T, et al. Prevalence of Diagnosed and Undiagnosed HIV Infection -- United States, 2008-2012.*Morbidity and Mortality Weekly Report* 64(24):657-662. June 26, 2015.

- Cascade AIDS Project (CAP) is planning to implement Choosing Life: Empowerment! Action! Results! (CLEAR) for PLWH in late 2015. CLEAR is an individual-level intervention that involves skills building and goal setting and allows the counselor to tailor session topics to a client's needs. Topics may include, but are not limited to, sexual risk, disclosure of HIV status, medication adherence, and substance abuse. CLEAR will replace other interventions previously offered (i.e., Healthy Relationships, RESPECT). Despite past successes with these interventions, CAP feels it is important to shift to a new intervention for the 15-1502 CDC funding cycle. This determination was based on several factors: (1) in a recent survey of PLWH who have accessed CAP services previously, 45% noted they would like to see more one-on-one activities available; (2) the group setting used in Healthy Relationships can sometimes be a barrier to newly-diagnosed individuals; (3) with the phasing out of RESPECT, CAP no longer has an individual-level intervention available to clients; and (4) having implemented Healthy Relationships for the past 10 years, CAP has concerns about having a large enough client pool to implement the program for an additional five years.

- Oregon's Ryan White Programs have continued to play a major role in helping prevent new HIV infections by supporting access to care, medication adherence and support services for people with HIV. Based on reported laboratory results, OHA estimates that at least 59% and perhaps as many as 68% of people diagnosed with HIV in Oregon during 2009–2013 achieved viral suppression (less than 200 copies/mL) within 12 months of diagnosis. Ryan White Programs have continued to advance their use of viral load data to identify clients who are not virally suppressed and take steps to identify barriers and solutions related to medication adherence.

- OHA has now completed an out of care analysis for each county in Oregon. This initiative serves to help LHDs identify, locate and re-engage persons out of care (without a CD4 or viral load test result reported in the last 12 months).

- Partnership Project offers Prevention Counseling Services (PCS) to PLWH living in the Portland metropolitan area. PCS is a free, one-on-one, and client-centered service focusing on risk reduction. While PCS is not new in Oregon, a description of these efforts was omitted from the Jurisdictional HIV Prevention Plan inadvertently.

Condom distribution

Notable changes in condom distribution activities or plans since September 2014 include the following:

- OHA identified non-CDC funding to support condom distribution and substantially increased the number of budgeted condoms for calendar year 2015 (442,854) compared to 2014 (196,560).

Policy and structural initiatives

There were no substantial changes in policy or structural initiatives since September 2014.

Community mobilization

There were no substantial changes in community mobilization activities or plans since September 2014.

Social marketing

OHA has continued to support the Oregon Reminders social marketing campaign. OHA worked with YTH (youth+tech+health) to launch new Oregon Reminders advertisements (online and print) promoting reminders for daily PrEP and regular screening for STIs, including syphilis.

Evidence-based interventions for HIV-negative populations

Notable changes related to evidence-based interventions for HIV-negative populations since September 2014 include the following:

- As described above, CAP has discontinued RESPECT, a one-on-one counseling intervention open to both HIV-positive and HIV-negative participants.

Pre- and post-exposure prophylaxis (PrEP and nPEP)

An estimated 95% of Oregonians now have health insurance, and many people are able to access PrEP through private health care providers. To promote PrEP awareness and medication adherence among those taking PrEP, OHA worked with YTH launched new Oregon Reminders advertisements (online and print) promoting PrEP medication reminders via text or email.

Technology-based activities (Category C demonstration project)

2015 is the final year of Oregon's Category C demonstration project. CDC funding was reduced and now focuses on evaluation of the project. OHA identified other funding sources to continue supporting the Oregon Reminders activities described above.