# ANNUAL PROGRESS REPORT (APR)

# PS12-1201: Comprehensive HIV Prevention Programs for Health Departments

# OREGON

# Reporting period covers January 1, 2015 – June 30, 2015

# Table of Contents

**SECTION I: CATEGORY A: Required Core HIV Prevention Program**

All four required core components should be implemented during this reporting period.

X HIV Testing
X Comprehensive Prevention with Positives
X Condom Distribution
X Policy Initiatives

***Please provide responses to the following questions for the required core components for Category A. Responses to questions should include all four required components.***

1. Did you make **substantial changes** to your HIV prevention program for any of the four required core components funded under Category A during the reporting period? If yes, please describe the changes made for the specific program component.

**HIV Testing:** In April 2015, the Oregon Health Authority (OHA) released an interactive, 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 training across the state and to reduce the costs associated with delivering in-person trainings. "HIV Prevention Essentials" meets the training requirements for staff conducting HIV testing funded by the OHA HIV Prevention Program (as described in Program Element #07, OHA's contract with funded local health departments). The training includes information about HIV and other sexually transmitted infections, testing, linkage to care, risk reduction counseling, condom distribution, and various prevention strategies. The training takes approximately six hours to complete, and modules may be completed separately as time allows. "HIV Prevention Essentials" includes knowledge checks (quizzes) and virtual scenarios to observe and practice HIV test counseling. Participants are encouraged to observe and to be observed as HIV test counselors by their colleagues and supervisors, as well. While this training represents a change in how trainings are delivered to HIV test counselors in Oregon, OHA HIV Prevention Program staff will continue to monitor local testing practices and capacity building needs via ongoing communication with partners, quarterly report reviews, and triennial program reviews. OHA staff also retain the ability to observe HIV test counseling sessions conducted by contractors and subcontractors. Moreover, "HIV Prevention Essentials" has increased access to prevention information and skill-building tools for HIV care staff throughout the state, furthering program integration.

**Comprehensive Prevention with Positives:** The OHA STD Program continued planning for a transition to a new model for supporting Partner Services for HIV and other STDs. Historically, the role of OHA disease intervention specialists (DIS) focused on providing Partner Services directly and routinely. As of July 1, 2015, LHDs are responsible for conducting Partner Services, and the OHA DIS will continue to help build local capacity and assist 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 requirements have changed and OHA STD Program staffing has changed accordingly. OHA staff must take on duties (e.g., epidemiology, technical assistance) to fulfill newer, more population-based activities. Throughout the past year OHA DIS have been helping LHDs (e.g., communicable disease nurses) build capacity to implement Partner Services through provision of on-site technical assistance, training opportunities, and educational materials. Our local partners have reported feeling very supported by our program in expanding their capacity to follow-up on HIV and STD cases and engage in more robust prevention activities.

**Condom Distribution:** 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). The Multnomah County Health Department purchased additional condoms using CDC funds from OHA.

**Policy Initiatives:** During the reporting period, there were no significant changes to policy initiatives.

2. Describe **successes** experienced with implementing your HIV prevention program for each of the four required core components funded under Category A during the reporting period. Please specify the program component associated with the successes.

**HIV Testing:** With decreased funding, Oregon has continued to better target limited resources. While HIV testing at OHA-funded test sites has decreased (2,398 test events from January–June 2015 vs. 3,605 test events from January–June 2014), the newly diagnosed positivity rate has increased (0.96% from January–June 2015 vs. 0.83% from January–June 2014). We believe the

increase in positivity is due to the progress made toward OHA's goal of targeting at least 70% of HIV tests to priority populations.

"HIV Prevention Essentials" training has been an effective tool for building the capacity of Oregon's HIV test counselors. Of the staff that completed both the online training and evaluation to date (N=15), most agreed that the training was a valuable use of their time (100%) and provided new information or ideas they will use (93%) and felt confident in their ability to discuss sexual health with clients (93%).

To promote routine HIV screening in health care settings, OHA developed and released a Communicable Disease (CD) Summary (http://bit.ly/CDS-HIV) on this topic in February. This and other CD Summaries are distributed to thousands of health care providers throughout Oregon. Our CD Summary provided information about federal screening recommendations, expected outcomes of routine screening in Oregon, and recommendations for implementation (e.g., opt-out screening, electronic health record reminders).

**Comprehensive Prevention with Positives:**

**Linkage to care:** Surveillance data suggest that the majority of people diagnosed with HIV in Oregon are linked to care successfully. More than 86% of Oregon residents newly diagnosed with HIV from 2009–2013 were linked to care within 90 days of diagnosis, and 90% were linked to care within 365 days (based on CD4 count and viral load data reported to the OHA). The actual proportion engaged in care is likely higher because OHA does not receive all lab results (e.g., from people who moved to another state or are receiving care outside of Oregon). Of persons newly diagnosed with HIV in 2015, we expect that the proportion linked to care remains just as high.

**Viral suppression:** 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. The OHA HIV Community Services (Ryan White Part B) Program has continued to advance its focus on viral suppression. The program established a performance measure in CAREWare

to help case managers easily identify clients who are not virally suppressed and take steps to identify barriers and solutions related to medication adherence.

**Re-engagement in care:** OHA and LHDs have continued implementing the Out of Care Project to identify, locate and re-engage persons who are out of care. For this project, OHA identifies persons without a CD4 or viral load test result reported in the last 12 months, seeks additional data to determine whether they are currently residing in the county in which they resided at the time of the initial case report, are alive, and not receiving adequate medical care. LHDs then make efforts to contact persons living with HIV (PLWH) that were not determined to have moved out of the county, died, nor to have accessed medical care. OHA has now completed an out of care analysis for each county in Oregon. Staff members are discussing continuation of the project in future years. While this project primarily utilizes HIV surveillance and care staff, positions funded by the CDC HIV Prevention grant have been involved in the initiative, as well.

**Partner Services:** In 2014, OHA developed an online training to help expand the capacity of LHDs to conduct Partner Services for HIV and other STDs (available at http://bit.ly/trainHIV). This training has continued to be used to build capacity in 2015. Of the staff that have completed both the online training and evaluation (N=16), most agreed that the training met its objective of providing a basic understanding of how to conduct Partner Services (100%) and felt confident in their ability to conduct an interview with a patient or contact (81%). OHA staff also provided an in-person STD case reporting and interviewing training to LHD staff members (e.g., communicable disease nurses) attending the Oregon Epidemiologists' Meeting Pre-Conference in May. Of the attendees that completed an evaluation (N=30), all agreed that the training was a valuable use of their time (100%) and provided new information they will use (100%). The HIV and STD Prevention Programs also collaborated with the CDC's Disease Intervention Specialist Training Centers to provide two "Passport to Partner Services" trainings in the state. One was held in April in Eugene and the other in Portland in June. A total of 21 individuals from 11 different local health departments attended one of the two trainings. Qualitative feedback collected by the trainers after the two courses was universally positive with participants describing the training as "excellent," "helpful," and "well delivered."

**Condom Distribution**: Oregon agencies have maintained many partnerships with other organizations and businesses that support targeted condom distribution (CD). CD sites continue to display posters promoting condom use that were developed and distributed in 2013.

**Policy/Structural Initiatives**: OHA made changes to its Statewide HIV Electronic Records (sHIVer) database (Oregon's HIV testing database) to improve the quality of our HIV testing data. Some OHA staff are now able to view names of clients tested (for de-duplication and linkage to care), and staff at local health departments are now able to view whether clients they encounter have previously tested at other local health departments. To reduce data entry burden and errors, client risk data is now entered only once per testing event.

3. Describe **challenges** experienced with implementing your HIV prevention program for each of the four required core components funded under Category A during the reporting period. Please specify the program component associated with the challenges.

**HIV Testing:** Local health departments and community-based organizations (CBO's) that receive CDC funding to support HIV testing continue to seek new and more effective practices for identifying persons living with HIV who don't know their HIV status.

**Comprehensive Prevention with Positives:** Many of Oregon's LHDs and community-based organizations (CBOs) funded to conduct HIV testing have strong systems for facilitating linkage to care, but lack a reliable mechanism to confirm and report these linkages to OHA (e.g., access to client health care information). Thus, the OHA HIV Prevention Program linkage data do not reflect the successful linkages that occur in Oregon. Oregon uses its surveillance system to evaluate linkage to care instead of the current CDC project approach to report this service as testing data. The OHA HIV Data and Analysis Program is able to monitor linkage to care for reported HIV cases (diagnosed in the public and private sectors) using CD4 and viral load test results reported to OHA. These data are described in the "Successes" section above.

**Condom Distribution:** During the reporting period, there were no significant challenges related to condom distribution.

**Policy/Structural Initiatives**: During the reporting period, there were no significant challenges related to policy/structural initiatives.

4. Describe **anticipated changes** to your HIV prevention program for any of the four required core components funded under Category A for Year 5 (including proposed changes in venues, contracts, target populations, testing technologies or algorithms, objectives, staffing/personnel, funding resources, etc.). Please specify the program component associated with the anticipated change(s).

**HIV Testing:** There are no anticipated changes related to HIV testing.

**Comprehensive Prevention with Positives:** There are no anticipated changes related to Comprehensive Prevention with Positives.

**Condom Distribution:** There are no anticipated changes related to condom distribution.

**Policy/Structural Initiatives:** There are no anticipated changes related to policy/structural initiatives.

**HIV Testing and Comprehensive Prevention with Positives**

1. Provide the annual HIV testing objective for healthcare settings and non-healthcare settings for both Year 4 and Year 5.

**Annual HIV testing objective for healthcare settings (Year 4):** 4,098
**Annual HIV testing objective for non-healthcare settings (Year 4):** 1,648
**Annual HIV testing objective for healthcare settings (Year 5):** 3,688
**Annual HIV testing objective for non-healthcare settings (Year 5):** 1,483

2. Provide information on Partner Services (PS) for newly diagnosed index patients for the reporting period.

See Appendix A: Partner Services.

**Condom Distribution**

1. Provide the condom distribution objective and total number of condoms distributed overall (to HIV-positive individuals and high-risk HIV-negative individuals) during the reporting period.

**Overall Condom Distribution Objective for Year 4:** 400,000
**Total number of condoms distributed overall:** 372,325
**Percentage of condoms distributed:** 93%

**Policy Initiatives**

1. What policy initiatives did you focus on during the reporting period? Please indicate the type/level of intended impact for each policy initiative (e.g., change on a local level, health department level, or statewide/legislative level) as well as the stage of the policy process (e.g., identification, development, implementation, evaluation). If no policy initiative was focused on during the reporting period, please explain.

| **Policy topic** | **Stage of policy process** (identification, development, implementation, evaluation) | **Progress made** | **Level of intended impact** (local, OHA, statewide) |
|---|---|---|---|
| Condom availability | Implementation | OHA HIV Prevention Program and the OHA HIV CAREAssist Program (Oregon's AIDS Drug Assistance Program) continued implementation of a free, mail-order condom distribution program for PLWH enrolled in Oregon's Medication Therapy Management Program (MTMP). MTMP offers assistance with HIV medication adherence to clients who have had late medication refills or other indicators of non-adherence. MTMP clients receiving medications via a mail-order pharmacy are asked if they would like to receive a large supply of condoms and lubricant with their medications every three months. Once this option is selected, condom shipments are automatic and sustained. | Statewide |
| Required trainings for HIV case managers | Implementation | HIV case managers in Oregon rarely received training on risk reduction counseling for PLWH. To help build staff capacity and further integrate HIV prevention into care settings, OHA developed an online HIV Prevention Essentials Training (http://bit.ly/trainHIV). The training was released in April 2015 and shared with HIV care staff throughout the state. Selected modules from HIV Prevention Essentials are now required of case managers in the Ryan White Part B service area. | Statewide |

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| HIV test consent process and linkage to care | Implementation | 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 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. In early 2014, OHA published guidance on methods for implementing opt-out HIV screening (http://bit.ly/HIVtestOR) in accordance with revised Oregon Administrative Rules. | Statewide |
| Routine HIV screening | Implementation | OHA has continued supporting the implementation of routine HIV screening. OHA staff conduct outreach to clinicians to discuss routine HIV screening and share our fact sheet promoting routine HIV screening (http://bit.ly/HIVscreen). After discussions with Legacy Health (which consist of six hospitals and more than 50 clinics in Oregon and southwest Washington), the organization agreed to add HIV screening prompts in its electronic medical records system (EPIC). The OHA HIV Prevention Program also 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. | Statewide |
| Confidential HIV Testing | Implementation | In late 2013 and early 2014, OHA engaged stakeholders and obtained support for a policy 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 | Statewide |

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|---|---|---|---|
| | | 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 (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. | |
| HIV laws education | Implementation | OHA revised its HIV laws guide (http://bit.ly/HIVlaws) to better educate service providers and the public about rules and statutes relating to HIV testing, confidentiality, HIV in the workplace, HIV and insurance, and comprehensive sexuality education in schools. | Statewide |
| Adult video/book stores | Identification | OHA plans to meet with partner agencies to explore possibilities for pursuing policy-structural interventions that would promote the sexual health of persons who engage in risk behaviors at adult video and bookstores. | Statewide |
| HIV testing data quality | Implementation | In early 2014, OHA staff met with LHD partners to discuss HIV testing data discrepancies and quality improvement options (e.g., regarding new vs. previous positive diagnoses and linkage to care). All parties agreed that OHA staff can add and edit client records in the Statewide HIV Electronic Record (sHIVer) database, which contains data entered by LHDs initially. OHA staff is now updating sHIVer data as needed based on laboratory records reported to OHA through the Oregon Public Health Epidemiologist User System (ORPHEUS). It has been determined that the new data management practices could be implemented without revising the current data agreement between OHA and LHDs. | Statewide |
| Viral | Implementation | OHA has integrated data systems to allow HIV care | Ryan White Part |

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|---|---|---|---|
| suppression monitoring | | providers in the Ryan White Part B service area who agree to follow strict data security and confidentiality protocols to access client viral load data through CAREWare. Regular monitoring of viral load data can help care agencies identify clients who 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. | B (all Oregon counties other than Clackamas, Columbia, Multnomah, Yamhill, and Washington) |

2. Please indicate if you have an HIV outbreak response plan in place. If yes, please describe. If no, please indicate steps that will be taken towards implementing a response plan.

OHA has an outbreak detection, investigation, and response plan for STDs, including HIV. Local and state staff monitor HIV data on an ongoing basis. If an outbreak is suspected, local and state staff will:

1) Meet with key partners to discuss the potential outbreak.
2) Assess the completeness and accuracy of case data.
3) Analyze data to understand demographic, geographic and temporal factors.
4) Evaluate the STD surveillance system.
5) Review other surveillance data sources (e.g, family planning).
6) Review clinical and laboratory data.
7) Review clinical presentation and risk factor data.
8) Evaluate changes and needs related to disease investigation, clinical, and laboratory services.
9) Generate and test hypotheses by reviewing data sources described above and by collecting qualitative data from stakeholders and impacted populations.
10) Develop, implement and evaluate interventions to interrupt transmission.

**CATEGORY A: Recommended Components**

Please indicate which recommended components were implemented during this reporting period. *If none, please indicate none and go to the required activities section.*

- ☐ Evidence-based HIV Prevention Interventions for High-Risk Negative Individuals
- **X** Social Marketing, Media and Mobilization
- **X** PrEP and nPEP
- ☐ None

1. Have you made **substantial changes** to your HIV prevention program for any of the recommended components funded under Category A during the reporting period? If yes, please describe the changes made for the specific program component.

**Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:** There were no changes related to evidence-based interventions for high-risk negatives; no interventions were implemented during this period.

**Social Marketing, Media and Mobilization**: During the reporting period, there were no substantial changes to social marketing, media and mobilization activities.

**PrEP and nPEP**: During the reporting period, there were no substantial changes to PrEP and nPEP activities.

2. Describe **successes** experienced with implementing your HIV prevention program for each of the recommended components funded under Category A during the reporting period? Please specify the program component associated with the successes.

**Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:** There were no successes related to evidence-based interventions for high-risk negatives; no interventions were implemented during this period.

**Social Marketing, Media and Mobilization:** Mobilization activities in Lane and Marion counties have successfully utilized volunteers, community members and businesses to help distribute materials promoting HIV testing, recruit persons for testing, and promote and attract media coverage for awareness days. Social marketing activities in Clackamas and Washington counties have involved weekly outreach using mobile applications (e.g., Scruff) and the distribution of materials promoting HIV testing.

**PrEP and nPEP:** In April, OHA launched an online HIV Prevention Essentials Training (http://bit.ly/trainHIV). The training seeks to build staff capacity in a number of areas including knowledge and skills for discussing PrEP and nPEP with clients. The training includes information and key messages about PrEP and nPEP guidelines, safety, effectiveness, and resources. In June OHA staff also created and provided a half-day training for medical providers in Lane County regarding how to incorporate PrEP into clinical practice. The training covered an

overview of PrEP clinical trials, cost effectiveness data, clinical guidelines for PrEP, and paying for PrEP, along with interactive case scenarios. Our program is currently looking into a partnership with the Oregon AIDS Education and Training Center to offer similar PrEP provider trainings throughout the state. We also assisted Cascade AIDS Project, an AIDS Service Organization in Portland, with adding more providers outside the Portland-Metro area to their statewide directory of PrEP providers.

3. Describe **challenges** experienced with implementing your HIV prevention program for each of the recommended components funded under Category A during the reporting period? Please specify the program component associated with the challenges.

**Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:** There were no challenges related to evidence-based interventions for high-risk negatives; no interventions were implemented during this period.

**Social Marketing, Media and Mobilization**: During the reporting period, there were no substantial challenges related to social marketing, media and mobilization.

**PrEP and nPEP**: There continues to be substantial variation in provider knowledge, comfort level, and overall willingness to prescribe nPEP, particularly in the settings where individuals are most likely to present for nEPP such as hospital emergency rooms.
Among health care providers, there is a variation in knowledge, comfort with patient risk assessments, availability of medication, and willingness to provide nPEP "starter packs" due to cost concerns relating to pills that are dispensed (patients may not be able to afford them) and to pills that are not dispensed (opening medication advances the expiration date of the entire supply). Moreover, addressing these barriers for nPEP clients within 72 hours of exposure can be challenging. However, a number of helpful tools are available to help address some of these barriers, including local fact sheets, OHA publications with clinical recommendations, and NASTAD's fact sheet with information about PrEP and nPEP patient assistance programs. Stigmatizing perceptions of PrEP and nPEP users (e.g., reckless, promiscuous) and misperceptions about the drugs (e.g., PrEP is a cure, serious side effects of PrEP are common) also impact our ability to promote these tools. We will continue to share information that addresses these misperceptions. Lastly, one of the greatest challenges observed (particularly in

the last year with the increasing popularity of PrEP in several parts of Oregon) is the need for nPEP/PrEP patient case management/navigator type programs and the lack of funding and resources to support this type of assistance. The need for someone to help others navigate the nPEP/PrEP "delivery system" from finding a provider to applying for financial assistance programs is particularly acute in populations who are also less likely to regularly engage in healthcare such as youth, people of color, and people who inject drugs.

4. Describe **anticipated changes** to your HIV prevention program for any of the recommended components funded under Category A for Year 5 (including proposed changes in venues, contracts, target populations, interventions, objectives, staffing/personnel, funding resources, etc.). Please specify the program component associated with the anticipated change(s).

**Evidence-based HIV Prevention Interventions for High-Risk HIV-negative Individuals:** There are no anticipated changes related to evidence-based interventions for high-risk negative individuals.

**Social Marketing, Media and Mobilization**: There are no anticipated changes related to evidence-based interventions for high-risk negative individuals.

**PrEP and nPEP**: There are no anticipated changes related to evidence-based interventions for high-risk negative individuals.

**Evidence-based HIV Prevention Interventions for High-Risk HIV-Negative Individuals**

☐ **Not applicable**

1. Indicate if you are supporting evidence-based HIV prevention interventions for high-risk HIV-negative individuals during the reporting period?

   ☐ Yes ☒ No

   If yes, briefly describe which populations and what activities are being supported?

**Social Marketing, Media and Mobilization**

☐ **Not applicable**

1. Indicate if you are promoting and/or supporting a CDC social marketing campaign during the reporting period.

☒ Yes ☐ No

If yes, please indicate the specific CDC social marketing campaign.

CDC campaigns are promoted on the OHA website and social media (e.g., Facebook, Twitter) and also via LHD and CBO social media. CDC campaigns promoted include:

- Testing Makes Us Stronger
- HIV Screening. Standard Care.
- Prevention is Care
- Take Charge. Take the Test.
- Let's Stop HIV Together
- Reasons
- Act Against AIDS
- Start Talking. Stop HIV.

**Pre-exposure Prophylaxis (PrEP)**

☐ **Not applicable**

1. Are you currently supporting PrEP?

   ☒ Yes ☐ No

   If yes, briefly describe which populations and what activities are being supported?

OHA's efforts related to PrEP have focused on information sharing. Recently, OHA has shared information about PrEP through social media, the online HIV Prevention Essentials training, community presentations. We have also begun to offer trainings for providers on how to incorporate PrEP into their clinical practices as outlined above and have assisted with efforts to create a statewide directory of PrEP providers.

**Non-occupational Post-exposure Prophylaxis (nPEP) Services**

☐ **Not applicable**

1. Are you currently supporting nPEP for high risk populations?

   ☒ Yes ☐ No

   If yes, briefly describe which populations and what activities are being supported?

OHA's work related to nPEP has focused on information sharing. Recently, OHA has shared information about nPEP through social media, the online HIV Prevention Essentials training, and community presentations.

**CATEGORY A: Required Activities**

All three required activities should be conducted during this reporting period.

- **X** Jurisdictional HIV Prevention Planning
- **X** Capacity Building and Technical Assistance
- **X** Program Planning, Monitoring and Evaluation, and Quality Assurance

**Jurisdictional HIV Prevention Planning**

1. Have you made any changes to your HIV planning group (HPG) to realign with the FOA, NHAS and the current HIV planning group guidance (e.g., changes in composition or structure, bylaws, frequency of meeting, etc.). If yes, please describe the changes made.

There were no substantial changes to the Oregon HIV/Viral Hepatitis/Sexually Transmitted Infection Integrated Planning Group (IPG) during the reporting period.

2. Describe the engagement process for your HIV planning group during the reporting period (e.g., communication, engaging stakeholders, data sharing, etc.). *Please ensure the letter of concurrence, letter of concurrence with reservation, or letter of non-concurrence is submitted.*

The IPG has had two meetings, and a third meeting in 2015 is planned. The group agreed that each IPG meeting in 2015 would focus on one of three key questions that reflect the largest gaps in Oregon's continuum of care cascade. These questions are:

1) How can we increase HIV testing among people with undiagnosed infection?
2) How can we better address STIs and viral hepatitis among people living with HIV?
3) How can we improve viral suppression among people who are receiving HIV care?

To date, the meetings have involved lively discussions and generated ideas relating to the key questions above. At each meeting, the group prioritized suggestions through a voting process. These suggestions will help in the development of Oregon's Integrated HIV Prevention and Care Plan (2017–2021).

Email is the primary communication method used to engage IPG members between meetings. IPG members receive regular messages via:

- Emails from co-chairs with OHA updates, meeting evaluation summaries, and Executive Committee decisions (approximately one message per month)
- OHA's HIV/Viral Hepatitis/Sexually Transmitted Infection email listserv, which is used to share a wide variety of information, resources, and learning opportunities (approximately one message per week)
- The OHA HIV Prevention and STD Program newsletter, which highlights key program updates, news, resources and best practices (bimonthly)

To engage the IPG to provide input on Oregon's Jurisdictional HIV Prevention Plan addendum, OHA drafted an addendum to Oregon's Jurisdictional HIV Prevention Plan outlining key changes in HIV Prevention in Oregon. The addendum was emailed to the IPG on August 12 with a request for input and for each member to vote by email (concurrence, concurrence with reservations, or non-concurrence).

The majority of members submitted a vote of concurrence. On August 26, 2015, the co-chairs completed a letter of concurrence on behalf of the IPG. On August 26 2015, Oregon's letter of concurrence and updated jurisdictional HIV prevention plan were emailed to CDC (ps12-1201@cdc.gov and ynt0@cdc.gov).

Current information about the IPG is available on the OHA website (www.healthoregon.org/ipg), including the mission, structure, meeting agendas and minutes, orientation materials for members, and an application for interested persons.

3. Describe **successes** experienced with implementing your HIV prevention planning activities during the reporting period.

IPG member responses to 2015 meeting evaluations suggest that planning to date have been successful. In each evaluation, the majority (95% to 100%) of members agreed that the meeting was a good use of their time and resources. The success of the IPG is largely related to evaluation and planning by the Executive Committee, which consists of the IPG co-chairs, at-large, sub-committee members, and OHA staff. The Executive Committee meets after each IPG meeting to review meeting evaluations. Findings are used to help plan the next IPG meeting agenda and to change policies and procedures as needed.

4. Describe **challenges** experienced with implementing your HIV prevention planning activities during the reporting period.

There were no substantial challenges related to HIV prevention planning during the reporting period.

5. Describe **anticipated changes** to your HIV prevention planning activities for Year 5.

In Year 5, IPG meetings will focus on developing Oregon's Integrated HIV Prevention and Care Plan (2017–2021) using the IPG's recommendations and findings from needs assessment activities.

## Capacity Building and Technical Assistance (CBA/TA)

1. Did you access CBA/TA services during the reporting period? Yes ☒ No

Our program did not formally request any Capacity Building or Technical Assistance support through the CRIS system during this period.

2. If any of the CBA/TA provided did not meet your needs/expectations.

N/A

3. Please provide the type of CBA/TA received and the name(s) of CBA/TA provider(s) for any non-CDC provided CBA.

**NASTAD MEETING**

| (Meeting) | Date | Met Expectations |
|---|---|---|
| **"Sustainability and Innovation for HIV Prevention in a Changing Health Care Landscape?"** | **Jan 8-9, 2015** | **Yes** |

**Northwest Center for Public Health Practice**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| **"Data for Addressing Health Disparities?"** | **Jan 13, 2015** | **Yes** |

**Patient Advocacy Leaders' Regional Summit**

| (Conference) | Date | Met Expectations |
|---|---|---|
| "Regional HIV Patient Advocacy Leaders' Summit?" | Jan 21, 2015 | Yes |

**Positive Women's Network**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| "Eliminating Stigma from the Language of HIV Communications." | Feb 3, 2015 | Yes |

**NCHP**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| "Are Your Attitudes About PrEP Influencing Client-Risk Reduction?" | Feb 26, 2015 | Yes |

**CDC DSTD**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| "STDs in Space – Insights into the underlying epidemiology of STDs and guidance for intervention" | March 12, 2015 | Yes |

**NASTAD**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| "Leveraging the House & Ball Community for Better HIV Testing Engagement." | March 17, 2015 | Yes |

**National Coalition for LGBTQ – LGBT Health Awareness Week**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| "It's Time for Trusting Relationships" | March 25, 2015 | Yes |

**Cicatelli Associates, Inc.**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| "High-Impact Prevention of HIV: The Critical Role of Healthcare Workers." | March, 31 2015 | Yes |

**Partner Services Training**

| (Training) Webinar | Date | Met Expectations |
|---|---|---|
| "Passport to Partner Services Training" | April 7-9, 2015 | Yes |

**YTH**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| "YTH – LIVE" | April 26, 2015 | Yes |

**CDC**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| "Hepatitis C Prevention Opportunities among People Who Inject Drugs – Confronting the Growing Epidemic" | April 28, 2015 | Yes |

**NASTAD**

| Training (Webinar) | Date | Met |
|---|---|---|

| | | Expectations |
|---|---|---|
| **"Engaging Individuals Along the HIV Care Continuum: The Role of Incentives"** | **May 2, 2015** | **Yes** |

**San Francisco Department of Public Health**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| **"Changes in the HIV Lab Testing Algorithm:** | **May 7, 2015** | **Yes** |

**Health HIV**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| **"Empowering and Promoting Leaders in MSM of Color Communities"** | **May 19, 2015** | **Yes** |

**Oregon Epidemiologist Conference**

| Conference | Date | Met Expectations |
|---|---|---|
| **"Oregon Health Authority Statewide Conference"** | **May 19-20, 2015** | **Yes** |

**CDC**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| **"2015 STD Treatment Guidelines Partner De-Brief Prior to Release."** | **May 28, 2015** | **Yes** |

**CDC**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| **"STD Prevention Science Series** | **June 4, 2015** | **Yes** |

| | | |
|---|---|---|
| **Webinar: Public Health in a Hostile Environment: Racial Inequality and STD/HIV in the U.S."** | | |

**CDC**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| **"2015 STD Treatment Guidelines Webinar?"** | **June 22, 2015** | **Yes** |

**University of Washington Public Health Capacity Building Center**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| **"Promotion and Provision: Health Departments and PrEP Webinar."** | **June 29, 2015** | **Yes** |

**NASTAD**

| Training (Webinar) | Date | Met Expectations |
|---|---|---|
| **"High Impact Prevention for People Who Inject Drugs"** | **June 30, 2015** | **Yes** |

4. Do you **anticipate changes** to CBA activities for Year 5? Yes No
   If yes, please describe.

- Finding positivity in low-prevalence areas as funding to support CTRS has diminished:
- Understanding the role of stigma among our underserved/overrepresented populations and considering the impact it has on behavior among our prioritized populations in Oregon:
- Building partnerships among programs which provide services to our prioritized populations to normalize HIV messaging and increase the provision of supportive services within non-health systems.

5. Please include CBA/TA needs for Year 5.

- Specific evidence-based interventions geared toward low-prevalence states with limited resources.

**Program Planning, Monitoring and Evaluation, and Quality Assurance**

1. Have you made **substantial changes** to your program planning, monitoring and evaluation, and quality assurance activities during the reporting period?
   ☒ Yes ☐ No
   If yes, please describe the changes made.

As mentioned above in the Policy Initiatives, we have made changes to sHIVer, our HIV testing database. Staff at OHA who are responsible for managing testing data are now able to view names in sHIVer. This process has made data reporting more efficient and allows for higher quality, especially with linkage to care data. Our HIV test form was also recently revised and now includes options for testers to mark if they provided information to clients about PrEP or PEP, updated rapid test information to account for new testing technology, simplified questions regarding condom use, and added more options related to transgender individuals.

2. How are you using the most current epidemiologic and surveillance data for program planning, implementation, and evaluation purposes during the reporting period (i.e., data to care)? Include the types of data used. How are you disseminating your program monitoring and evaluation data and providing feedback to your healthcare and non-healthcare providers and other community partners? If the surveillance team is receiving updated information (e.g., updated risk, residence, contact, or linkage status information) from program staff, please explain what data and how it helps surveillance (e.g., surveillance data are more up to date and accurate).

The Oregon HIV/STD/TB Program (HST) manages several HIV-related data sources, which are used to assist in program planning, monitoring and evaluation. Our program (HST) posts HIV data reports (quarterly), the Epidemiologic Profile of HIV/AIDS in Oregon (annually), and HIV fact sheets (annually) to our website which are accessible to the general public. The data used to generate these reports come from ORPHEUS (HIV Surveillance database) and sHIVer (HIV Prevention database). Staff members in the surveillance and prevention programs have access to both data sources and frequently collaborate when generating reports. Types of data include: demographics, risk behaviors, STD, referral and linkage to care, HIV health care utilization, test results (including CD4 and viral load), and other National HIV/AIDS Strategy (NHAS) / CDC

required variables. Our partners are able to run queries for their own data and generate reports in both data sources. We have also started the process of restructuring our HIV Prevention database to enhance our reporting functionality.

3. Describe **anticipated changes** to your program planning, monitoring and evaluation, and quality assurance activities for Year 5?

We will be building more data reports for our partners at local health departments to improve data quality and provide access to real-time data to help with programmatic decisions. We are also in the process of building a data import from Multnomah County's electronic medical record to our testing database.

## SECTION III: CATEGORY C: Demonstration Projects

☐ **Not applicable**

1. Describe **successes** experienced with implementing your demonstration project during the reporting period.

**Oregon Reminders:** Oregon Reminders has continued to generate significant interest. Through June 2015, Oregon Reminders had 1,157 users receiving HIV/STD test reminders every three to six months, 347 users receiving daily medication reminders, 134 users receiving monthly prescription refill reminders, and 199 users receiving weekly health tips. Interest in the service is not limited to Oregon; approximately one-third (32%) of Oregon Reminders users have a non-Oregon ZIP code. Survey data from users suggest that Oregon Reminders is helping people maintain or improve healthy behaviors, including regular HIV/STD testing and medication adherence. These findings will be described in detail in the final Category C report.

The OHA HIV Prevention Program has promoted Oregon Reminders through collaborations with a variety of partners including YTH, CAREAssist (Oregon's AIDS Drug Assistance Program), the HIV Community Services Program (Ryan White Part B), the Northwest AIDS Education and Training Center, and a number of local health departments and community-based organizations. Other efforts contributing to the project's success include online marketing (e.g.,

Grindr, Facebook mobile) and technical assistance provided by OHA and local agencies (peer to peer).

**Social Networks Strategy:** Not applicable. Social Networks Strategy activities were discontinued December 31, 2014.

Website changes: Not applicable. Efforts to promote HIV prevention web badges and other online structural changes were discontinued on December 31, 2014.

2. Describe **challenges or lessons learned** experienced with implementing your demonstration project during the reporting period.

There were no significant challenges or lessons learned during the reporting period. However, challenges and lessons learned during the entire Category C project period will be detailed in the final project report.

3. Provide the following information below for HIV testing, linkage to care, partner services, and/or use of surveillance data for your demonstration project, if conducted during the reporting period.

**HIV Testing ☒ Not applicable**

Total number of newly-diagnosed HIV-positive test events[1]:
Total number of previously-diagnosed HIV-positive test events[1]:
Total number of HIV test events:
[1]Includes unconfirmed preliminary positive testing events plus confirmed positive testing events.

**Linkage to Care ☒ Not applicable**

Total number of newly-diagnosed HIV-positive persons*:
Number of newly-diagnosed HIV-positive persons linked to HIV medical care:
Total number of previously-diagnosed HIV-positive persons that are out of medical care**:
Number of previously-diagnosed HIV-positive persons out of medical care who were re-engaged in HIV medical care:
*Includes unconfirmed preliminary HIV-positive persons plus confirmed HIV-positive persons
**Only includes confirmed previously-diagnosed HIV-positive persons

**Partner Services ☒ Not applicable**

Total number of HIV-positive persons* interviewed for Partner Services:
Number of partners elicited from these HIV-positive persons:
Number of partners elicited that were tested for HIV:
Number of newly-diagnosed confirmed HIV-positive test events from these elicited partners:
*Includes confirmed newly-diagnosed and previously-diagnosed HIV-positive persons

**Use of Surveillance Data ☒ Not applicable**

Briefly describe how surveillance data were used for your demonstration project:

4. Provide additional project outcomes not mentioned above.

Not applicable. No additional project outcomes occurred during the reporting period.

5. Describe the most important ways that Category C work has helped your HIV program (e.g., infrastructure changes, increased coordination of prevention and care/treatment, bringing together program and surveillance, changed how program does its routine work, documented value of Partner Service-related HIV testing enhancing the ability to find persons who are newly diagnosed with HIV, etc.).

With a focus on the innovative use of technology, this demonstration project has helped Oregon:

- Implement new methods of sexual health promotion (e.g., text messaging, video, web badges and widgets) that are accessible that meet user needs, and that help achieve program goals (e.g., increased HIV testing and viral suppression)
- Establish new partnerships, including those with businesses commonly associated with risk taking (e.g., gay dating apps and bathhouses)

These outcomes will be described in detail in the final Category C project report.

6. Please describe plans to sustain Category C activities beyond the funded period (such as folding activities under Category A work after Category C funds end).

At this time, OHA has no plans to sustain Category C activities with Category A funding. However, OHA has identified alternative (non-Category A) funding that will support YTH to maintain and promote Oregon Reminders as a tool to support regular HIV and STD testing, medication adherence, and PrEP. While HIV Alliance and the Multnomah County Health Department have discontinued implementing a Social Networks Strategy HIV testing program, they have the option to do so using Category A funding for HIV testing. OHA will continue to discuss the potential use and outcomes of this strategy with contractors. While Oregon is not

planning to continue promoting online structural changes promoting sexual health, we expect that, in many cases, the outcomes related to online sexual health promotion achieved during the demonstration project period will be sustained. After a badge or widget has been added to a website or mobile app, it should remain available unless the business decides to remove the badge or widget.

## SECTION IV: STAFFING AND MANAGEMENT

1. Please indicate any organizational and/or key staffing changes (i.e., health department staff responsible for implementing interventions and services for PS12-1201) that occurred during the reporting period. Please indicate any vacant staff positions and provide a detailed plan with timeline for hiring/filling vacancies. Were there any delays in executing contracts during the reporting period? If so, please explain and include any program implications?

During this reporting period the HIV Prevention Program did not experience any organizational or key staffing changes. In December 2013 the HIV Prevention Program manager had become the STD Program manager as well. So, during this reporting period both programs were now being managed by the same individual, which began the improvement in furthering some integration of the programs. There were no delays in executing contracts during this reporting period.

## SECTION V: RESOURCES ALLOCATION

**Category A:**

1. Include the percentage of Category A funding resources allocated to the required and recommended program components for Year 4 (2015) and what is being proposed for Year 5 (2016)? *Note: Percentage should be inclusive of both internal health department expenses (e.g., personnel and administrative cost) as well as funding resources being allocated external to the health department for the required and recommended components. This information should be reflected within the budget.* ***Percentages for required and recommended components should total 100%.***

**Year 4 (2015):**

| | |
|---|---|
| Required components: | 100% |
| Recommended components: | 0% |
| Total: | 100% |

**Proposed for Year 5 (2016):**

| | |
|---|---|
| Required components: | 100% |
| Recommended components: | 0% |
| Total: | 100% |

2. Please identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease. **See Appendix C: Resource Allocation.**

## SECTION VI: BUDGET

1. Did you submit a 424A form and separate budgets for Categories, A and B? *See Budget Information and Justification under the instructions section.* **Yes**

2. Are you requesting new Direct Assistance (DA) in lieu of Financial Assistance (FA) for Year 5? If yes, please outline DA staffing needs. **No**

3. In states that have directly funded cities, both funded entities must have a Letter of Agreement (LOA) in place detailing the understanding that has been reached regarding the delivery of service, including any funding implications, within the directly funded city. If there have been any changes to the LOA, please submit the updated LOA with this submission and indicate the funding percentages/amounts to be provided to each entity. If there are no changes to the current LOA, then please confirm that the current LOA will remain in place for the new budget period (Year 5: January 1, 2016 – December 31, 2016).

**Not applicable**

4. Please ensure that you allocate funds for staff travel to attend a 2016 grantee meeting in Atlanta, GA (at a minimum, 2 staff for 3 days). **Yes**

## SECTION VII: ASSURANCES OF COMPLIANCE

**Instructions:** Submit the completed forms for all materials used or proposed for use during the reporting period of **January 1, 2016 – December 31, 2016.** Attach the following Assurance of Compliance Forms to the application through the "Mandatory Documents" section of the "Submit Application Page" on Grants.gov. Select "Other Documents Form" and attach as a PDF file (**See Appendix D for template)**.

- "Assurance of Compliance with the Requirements for Contents of AIDS Related Written Materials" (CDC 0.1113). Please see

http://www.cdc.gov/hiv/pdf/funding/announcements/ps12-1201/cdc-hiv-ps12-1201-attachment-xii.pdf for the fillable form.

- "Assurances and Certifications: Download and complete all applicable Assurances and Certifications from http://wwwn.cdc.gov/grantassurances/Homepage.aspx. Upload these signed documents into the Assurances website identified in the instructions."
  **Assurances and Certifications submitted electronically 07/15/15**

## SECTION VIII: CERTIFICATION OF NHM&E DATA SUBMISSION

1. As a part of the PS12-1201 Cooperative Agreement, in addition to the submission of the progress reports to CDC, grantees must also submit the required National HIV Monitoring and Evaluation (NHM&E) data variables, through the CDC-approved system (i.e., EvaluationWeb®) and commit them by the designated due date.

   **Please certify below:**

   **X** We certify that the department of health has submitted/will submit all of the required NHM&E data (HIV Testing data, Partner Services data, Risk Reduction Activities (RRA) data, as well as any other required aggregate data variables) to CDC via EvaluationWeb® and have committed/will commit them by the designated due date. And, that we have reviewed the EvaluationWeb® auto-populated PS12-1201 Data Tables.

2. Please include any additional comments and/or clarifications for your submitted NHM&E data and/or the PS12-1201 Data Tables. Please also include any justification(s) for partial/late data submission. Information provided will be used for consideration during the review process.

   ☐ No additional comments and/or clarifications needed.
   Additional comments and/or clarifications provided here:

   As mentioned earlier in this report, we made significant changes to our HIV testing database, sHIVer. Due to time that the database was offline and changes to the user interface for risk information, we feel that our numbers are lower than expected. We are beginning our QA process this fall with our local health department partners and are working to resolve these discrepancies.

## SECTION IX: ADDITIONAL INFORMATION

### 1. Additional Information

Please also provide any other explanatory information or data you think would be important for CDC to receive (e.g., additional coordination and collaborations to support PS12-1201, local processes or procedures impacting program implementation).

This reporting period included the early program implementation in which two .50 FTE positions new to the program were filled and the individuals were entrenched in orientation. Both the HIV/STD Prevention Technical Consultant and the HIV/STD Epidemiologist 1 were gaining momentum. These two positions significantly improved the ability of the program to be more quickly responsive to local partner need, technical assistance, improved timely communications, and budding improvement in our database maintenance and enhancement and technical assistance for users. It brought more dedicated problem solving time to our data reporting challenges including improving the quality of the data collected and identification of issues of integrating our local databases for the reporting requirements of Evaluation Web for HIV Prevention program reporting.

# APPENDICES

## Appendix A: Partner Services

Provide information for newly diagnosed index patients for Partner Services in the table below.

**Table 1. Newly Diagnosed, Confirmed HIV-positive Index Patients**[1]

| New HIV Cases Reported to HIV Surveillance Program[2] | Newly Diagnosed Index Patients Reported to Partner Services Program[3,4,5] | Newly Diagnosed Index Patients Eligible for Partner Services Interview[6] | Newly Diagnosed Index Patients Interviewed[7] | | Partners Named[8] | Partners Named per Newly Diagnosed Index Patient Interviewed[9] |
|---|---|---|---|---|---|---|
| | | | n | (%) | | |
| 205 | 205 | 193 | 77 | 40% | 72 | 0.94 |

[1] This table includes data for all partner services, regardless of funding source, not just those funded under PS12-1201.
[2] This is the number of new HIV case reports received by the health department surveillance program during the reporting period, based on date of report, rather than date of diagnosis.
[3] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period, from any source.
[4] New diagnosis status verified, at minimum, by cross-check with the health department surveillance system. Supplementary methods of identifying previous diagnosis, such as review of laboratory reports, medical records, or other data sources (e.g., partner services database, evidence of previous treatment for HIV), or patient interview, may also have been used. If any data source, including patient self-report, indicates previous diagnosis, diagnosis is not new.
[5] Does not include index patients classified as newly diagnosed based only on 1) self-report of having had no previous test or having had a previous negative test or 2) review of other data sources (e.g., medical records, partner services database, treatment database).
[6] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period (Column B), excluding those who are out of jurisdiction or deceased.
[7] This is the number of newly diagnosed confirmed HIV-positive index patients reported to the health department partner services program during the reporting period and eligible for partner services interview (Column C), who were interviewed for partner services by the health department or a person trained and authorized by the health department to conduct partner services interviews.
[8] This is the total number of partners named for whom the information provided by the index patient or otherwise available should be sufficient to allow the partner to be identified and notified by health department partner services workers.
[9] This is the average number of partners named by the newly diagnosed index patients who were interviewed.

### Calculations:

E = (D/C) x 100

G = F/D

## Appendix C: Resource Allocation

Identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas (or zip codes) within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease.

| Reporting of MSAs/Cities/Areas with ≥ 30% of the HIV Epidemic within the Jurisdiction | | | |
|---|---|---|---|
| **MSA/CITY/AREA** | **Percentage of HIV Epidemic within the Jurisdiction** | **Percentage of PS12-1201 Funds Allocated** | **Components and Activities Funded** |
| **Multnomah County** | **50%** | **59.93%[1]** | **HIV Testing, Comprehensive Preventions with Positives, Condom Distribution, EBI for high-risk negatives** |
| | | | |
| | | | |
| | | | |
| | | | |

1. 59.93% of funds distributed to local health departments was distributed to Multnomah County