End HIV/STI Oregon Statewide Planning Group (OSPG) Meeting Notes

June 3, 2026, 1 – 4 p.m.

Announcements

- Upcoming HIV Awareness Days:
    - June 5 is HIV Long-Term Survivors Awareness Day.
    - June 27 is National HIV Testing Day.
    - July 21 is Zero HIV Stigma Day.
    - August 20 is Southern HIV/AIDS Awareness Day.
    - August 30 is National Faith HIV/AIDS Awareness Day.
- June is also Pride month, a commemoration of the Stonewall Rebellion that took place on June 28, 1969. Pride celebrations are happening across Oregon throughout the summer and early fall.

Overview/Background of Oregon's Integrated HIV Prevention & Care Plan, 2027-2031

What is the Integrated HIV Prevention & Care Plan?

- Our roadmap for ending new HIV/STI transmissions in Oregon
    - Considers local data, systems, contexts
    - Defines goals and objectives – uses metrics to track progress
    - Reflects community priorities
    - Includes syndemic information (STI, VH, substance use, incarceration...)
    - A document whose main audience is federal funders, not Oregonians
- The plan is community-driven, with a statewide focus
    - Developed with planning groups and broad community input
- In Oregon, our Integrated Plan is locally known as the End HIV/STI Oregon Strategy or End HIV/STI Oregon Initiative

Who Is Involved?

- Federally-funded Ryan White Part A and B Programs and HIV Prevention are required to submit a 5-year plan.
- Part A/B programs can work together or create their own plans.
    - Multnomah County chose to submit a joint plan with OHA.
    - Multnomah County and OHA are joint authors of this plan.
- Integrated = Part A + Part B + Prevention
- Specific list of mandated involvement by consumers, all RWCA grantees, providers, etc.

What Is the Role of OSPG?

- OSPG is an advisory group to OHA on issues related to the HIV status neutral continuum and syndemic issues (STI, VH, incarceration, SUDS)
- OSPG must submit a Letter of Concurrence; the options are:
    - Concurrence
    - Concurrence with reservations
    - Nonconcurrence
- OSPG members will vote on concurrence with the plan.
    - Voting will happen by email, from 6/8 – 6/12
    - OSPG members and partners will be informed of voting results by 6/19

How Is Community Feedback Included?

- Plan draws data from over 40 data sources
- OSPG and Part A Planning Council engage in continuous cycles of data/program review and input
- Additional community input in planning year:
    - Four town halls re: Ryan White priority services
    - Live Q&A with Community Members
    - Public Comment Period from 5/11-5/29

What Is Different about the 2027-2031 Plan?

Content is Similar. Packaging Is Different.

- Oregon has submitted two previous integrated plans (2016-2020) and (2022-2026)
    - Prior to 2016, care and prevention were not integrated, and Parts A and B worked separately.
- The 2027-2031 plan is an update to previous plans
    - Needs assessment, epi data, and financial data have been refreshed to reflect current realities.
    - Goals and objectives have remained largely the same, as have community priorities.

Biggest Change = Language

- The 2027-2031 Plan uses general language to comply with the requirements of our federal grants. Examples:

Previous Plans	2027-2031 Plan
Expansive gender categories	Male & Female
Equity, "leading with race/ethnicity," "ending inequities," "structural inequities"	Ensuring access for people with limited access to health care
Harm reduction, syringe services, syringe exchange	Services for people who use drugs, health & safety services

Previous Plans	2027-2031 Plan
Priority populations	People and communities disproportionately impacted by HIV
COVID-19 pandemic	2020

Discussion:

- Comment: concern that using generalized language generalizes people. The Portland Metro area has subcommittees to address different needs of different PLWH in the city, and the subcommittees don't talk to one another. Clients get lost in the shuffle. Generalized language could make services less equitable.
    - OHA's intention is that services will not change, but these are legitimate concerns.
- Comment: when language changes like this, people with lived experience feel invisible.
- What alternative is there that doesn't risk federal funding?
    - The point of generalized language is to not jeopardize OHA's federal funding. OHA's grants require that we comply with the Executive Orders.
    - Partners who have submitted reports to CDC with noncompliant language have been rejected, as have OHA's Viral Hepatitis Program, HIV prevention Program, and Family & Child Health Programs.
    - The audience of the Integrated Plan is the federal government.
    - HST section has been communicating with Oregon Department of Justice on every new guideline, executive order, etc., that will have significant impacts on Oregonians. HST has written declarations that have been included in federal lawsuits and letters to our federal funders to defend our policies. DOJ's responsibility is to fight orders legally. HST's job is to ensure that funding continues, and we continue to provide services to Oregonians who need them.
- Comment: If OHA flattens the data into generic categories to satisfy federal compliance, you are effectively blinding the Planning Council. If we cannot see the granular intersections of race, gender, and geography on our local dashboards, we cannot legally justify targeted funding allocations. Compliance for Washington D.C. cannot come at the expense of local erasure.
    - Answer: HIV data available locally is intact and will be available to the Planning Council, etc. Although this information will not be included in our federally required reports and dashboards, it is available and will continue to be available.
    - HST continues to collect and report on intersectional data (e.g., race, gender, sexual orientation, and language spoken). Staff review these data internally and have the methodologies to resume reporting on them publicly when permitted.

    - OHA's surveillance team sent the expanded gender categories for presentation to the Planning Council and it was included in the annual file presentation.
- Question: How will this plan impact Oregon's ability to collect data? HIV Alliance is committed to supporting all PLWH in Oregon and the data helps with this work.
    - Answer: It does not affect staff ability to collect data locally. HST will continue to collect data and use it for planning.
- Question: Does a letter of concurrence with reservations or a letter of non-concurrence put the plan at risk?
    - OHA's understanding is that it does not put the plan at risk. If submitting "non-concurrence," OSPG would have to write a letter explaining why. If OSPG concurs with reservations, the group can say what the reservations are.
    - OHA does not know how the federal government will respond.
    - OHA has been told that grantees will need to respond to non-concurrence, but that non-concurrence will not change whether the plan is accepted. Non-concurrence may result in more reporting and check-ins with federal project officers.
- Each year, grantees review and update plans. If federal policies change, we can update the plan.
- Question: What programming impact does the plan truly have? Does it impact funding and what people do on the ground?
    - Work plans are based on high level objectives, which have not changed. OHA's opinion is that the plan would not affect work happening on the ground.
- Question: Will the language change affect what LPHAs and CBOs can do in public facing work, data presentations and education? AETC seemed to be deeply impacted by the limitations from federal funding. Excluding people by not naming them causes harm.
    - Mountain West AETC is more conservative than the national level AETC, but language restrictions are pervasive in written materials/slides. You will see more centering of lived experience and less recorded presentations. Centering the work on what benefits people and transforms health systems to serve those with multiple barriers to accessing care. Health access has been a way to maintain momentum in our state.
- Comment: Reminder that we are a whole state and request that participants look broadly at the impacts, the continued need and support. The TGA is an additionally funded region, and I always wish to uplift my rural colleagues in different spaces.
- Comments:
    - While there are fewer PLWH outside Portland, Part B funding is literally lifesaving in counties where there is a lack of other resources.
    - Individuals often travel to urban areas from across the state. If the cases in urban areas are delayed to linkage to care or need more complex

support from local public health to reengage in care, staffing losses in those areas will lead to a rise in cases across the state. Substance use disorder rates in urban areas are creating a bigger burden for local public health.

- Most states that have big urban areas of course have Part B and also Part A (California has several Part A communities). But most of these places with urban areas were also awarded Ending HIV Everywhere (EHE) grants. Those are flexible dollars that are often used to fill in these gaps. Oregon doesn't have those extra dollars in recent years, sadly.
    - While additional funds are always welcomed, Oregon doesn’t receive EHE funds because our rates don't qualify us as an EHE jurisdiction. This is a good thing, and the stability of the epidemic and high viral suppression in Oregon is thanks to so many participants of this call.

People and Communities Disproportionately Impacted by HIV

Key Goal	People and Communities Disproportionately Impacted by HIV	How People and Communities Identified
Diagnosis	People who use drugs People who live in rural & frontier areas	Higher rates of late diagnosis
Prevention	People under 30 People who are Black/African American People who are Hispanic/Latine Men who have male sexual contact (MMSC) People who use drugs	disproportionate rates of new diagnoses, low PrEP use
Treatment	People with unstable housing People who live in rural & frontier areas People who use drugs	Lower rates of linkage to care and viral suppression
Response	Varies based on real-time surveillance	ongoing surveillance activities, cluster analysis

- These are populations about which OHA collects surveillance data – we know that other populations have special needs and concerns, too.

Our Outcomes Have Improved Since We Submitted Previous Plans

- Our ADAP (CAREAssist) is #1 in the US, with the highest proportion of virally suppressed clients.
- Linkage to care rates have increased.
- Number and proportion of people on PrEP has increased.
- STI rates have decreased.

Context Has Changed

- Have seen HIV clusters and increased cases in rural and frontier parts of Oregon where we had not previously seen cases.
- Huge changes at the federal level, with consequent uncertainty about federal grant funding, Medicaid coverage, and other supports on which we previously counted on.
- New federal policies create regressive environment for HIV/STI prevention and care work.

Community Input: Cross-Cutting Themes

Who Is Responsible for What?

- Multnomah County Health Department is the Part A grantee, responsible for HIV care & treatment services in 5 Portland metro counties and Clark County, Washington
- Oregon Health Authority (OHA) is the Part B grantee, responsible for CAREAssist statewide, and for HIV care & treatment services in the 31 counties outside the Portland metro area.
    - OHA contracts with HIV Alliance and EOCIL to provide these services on behalf of those 31 counties
- OHA is responsible for statewide HIV prevention and surveillance

Decentralized Public Health Governance

- In Oregon, public health authority is held by Local Public Health Authorities (LPHA), not OHA:
    - Counties hold legal responsibility for public health services in their jurisdiction
    - Two counties (Curry, Wallowa) transferred responsibility to the state
    - OHA must review and seek approval from the Coalition of Local Health Officers (CLHO) for funding of public health services delivered in counties
    - CLHO includes representatives from all LPHA (www.oregonclho.org)
    - LPHA previously administered Part B Ryan White Case Management (RWCM) but provided authorization/declined direct funds to receive local services through a regional model (HIV Alliance and EOCIL)

Balancing Urban & Rural Oregon's Needs

- The Portland metro area has the highest number and rate of HIV cases and higher concentrations of some people and communities at disproportionate impact for HIV.
    - Multnomah County has the highest rate of new HIV cases (incidence).
- People living with HIV (PLWH) in rural and frontier areas of Oregon face inequities, including late diagnosis, longer time to linkage to care, and lower viral suppression rates.
    - Increase in cases in counties that previously had none/few.
    - Several HIV clusters in Part B jurisdictions.
- Caseloads in urban (Part A) and rural (Part B) Oregon have increased over the past 8 years: 16.7% more PLWH in Oregon overall. Part A caseloads have grown 13.8%; Part B caseloads have grown by 18.5%

Are Funds for Client Services Distributed Equitably?

- The Resource Inventory in the plan begins to answer this question:

- Identifies state and federal funding sources supporting the HIV care continuum in Oregon
- Need more inputs to include in further gap analysis
- Analysis of statewide resources is underway, including consultation with NASTAD
- Main focus of gap analysis will be client services like case management, housing, food, transportation ...

Quick Reminder About 340B Program Income

- Many questions about CAREAssist's Program Income from 340B drug reimbursements:
    - There are more than 300 covered entities in Oregon using 340B $ to support their programs
    - There are 3 entities receiving program income specifically connected to Ryan White grant funds (OHA/CAREAssist, MCHD's HIV Clinic, HIV Alliance)
- CAREAssist program income supports 80% of the ADAP program budget
- Also supports:
    - Services in the 31 county Balance of State
    - Statewide End HIV OR services, including housing and behavioral health, early intervention, outreach, provider education, and communications & outbreak support.

Include More Info on Specific PLWH Populations

- More information has been included on PLWH who are women, older PLWH, and PLWH with disabilities.
    - 13% of PLWH in Oregon are female – specific medical and social needs.
    - Over 50% of PLWH in Oregon are over 50 years old – added context about aging, social isolation, unmet needs for housing, end-of-life care, legal issues.
    - 38% of Medical Monitoring Project participants reported a disability – higher than Oregon overall. PLWH with disabilities report more unmet services needs and poorer clinical outcomes.

Discussion:

- Average age of a CAREAssist client is 56.5 years.
- Average age of Part A/TGA clients is 48 years, and TGA serves 114 people over age 70.
- Do EOCIL or HIV Alliance offer services for long-term survivors/aging PLWH?
    - One of the biggest issues of long-term survivors is isolation.
    - HIV Alliance doesn't have a specific program, but targets events toward these communities, including a long-term survivor dinner this Friday for clients in the four main office locations.
    - EOCIL, other Oregon Centers for Independent Living, and Area Agencies on Aging offer a broad range of services that can benefit aging community

members. They often address many of the challenges that can arise with aging, including independent living supports, benefits navigation, housing stability, transportation, caregiver supports, social connection, and access to community resources. There is a meaningful opportunity for collaboration across our systems to ensure aging community members are aware of and connected to the supports that help them remain healthy, independent, and engaged in their communities.

What is being done for American Indian/Alaska Native (AI/AN) people and tribes?

- Rates of HIV among AI/AN people in Oregon (8.7/100K) are higher than the rate for Oregonians overall (5.0/100K)
- OHA has inter-governmental relationships with the Nine Federally Recognized Tribes and NARA NW (the Urban Indian Health Program), and works with the Northwest Portland Area Indian Health Board (NPAIHB) and Raven Collective
    - SB841 (2025): tribal-state data sharing
    - OHA works with the 9 Tribes and NARA NW on tribal public health modernization projects ($10,249,801 for 25-27 biennium)
    - HST funds the Confederated Tribes of Siletz Indians (CTSI) to do HIV Outreach
    - NPAIHB awarded grants to CTSI and the Confederated Tribes of Grand Ronde
    - Raven Collective is conducting a tribal DIS training in July

PWID vs PWUD

- Many comments that we should refer, wherever possible, to People who **use** drugs (PWUD) vs. People who **inject** drugs (PWID)
- Changed throughout the document, except in the Epi Profile section
    - We collect surveillance information on injection drug use, not drug use generally
    - Need to balance data accuracy with the broader conceptual framework (e.g., that people who use non-injection drugs have additional HIV risk, as well – not just IDU as risk factor)

What are we doing about PLWH leadership development?

- Added an objective to the Response Section of the Plan:
    - **Objective 4.1 Direct resources to people and communities disproportionately affected by HIV**
        - 4.1.4 Invest in PLWH leadership development to ensure thoughtful succession planning and ongoing PLWH-directed advisory groups and advocacy
- We have supported PLWH in the community in attending trainings and conferences but want to formalize this process.
    - PLWH work in all of our organizations.

- A goal to develop an ongoing PLWH-led development and training space is in the works. We will report on this at a future OSPG meeting.

Discussion:

- AETC is happy to explore building workforce pipelines for lived experience, feel free to reach out with your ideas and we can see what is possible: dmorrison@orpca.org
    - AETC can support anyone in a professional role which includes staff and CABs and building pathways for more representation in the healthcare workforce.

Diagnosis and Prevention

Goals and Themes: HIV Diagnosis & Prevention

- Goals:
    - Increase testing so people with HIV know their status and have rapid access to treatment
    - Optimize every available tool to prevent new infections of HIV/STI
- Priorities: integrated testing, increase HIV/STI awareness, increase access to PrEP/PEP
- Specific populations have higher rates of new diagnosis, late diagnosis, and lower PrEP use
- Page 53+ includes specific objectives
- Comments/questions about HIV/STI Statewide Services (HSSS)

HSSS: How Did We Get Here?

- HIV Early Intervention & Outreach Services (EISO) was designated as a priority project in 2016 (during the first cycle of integrated planning):
    - Initially based on poor linkage to care numbers
    - Started a pilot in 2016 with eight (8) LPHAs
    - Continued in the 2022-2026 plan due to improved linkage to care and viral suppression results.
- HIV/STI Statewide Services (HSSS) was launched in July 2025; it replaced and expanded HIV EISO.

What Is HSSS?

- HSSS is a statewide, status-neutral, integrated approach to prevention and linkage to care.
- Includes:
    - Integrated HIV/STI testing
    - Disease intervention and partner services
    - Linkage to HIV care, treatment, and supportive services
    - Outreach
    - Condom distribution
    - Harm reduction
    - Education

    - Outbreak and cluster response

Why the Change?

- Changes were made to:
    - Address longstanding funding gaps in the state
    - Respond to shifts in HIV/STI disease burden across the state – HIV cases identified in many parts of the state that had not seen cases/lacked capacity to respond
    - Ensure counties were equipped to respond to cases and outbreaks
    - Create a more coordinated and integrated system, and
    - Combine, leverage and maximize funding – do more with less
- With HSSS, every county receives some funding for HIV/STI prevention and linkage to care.
    - For over two decades, a handful of OR counties received HIV prevention funding.
    - A 2021 CDC effort to build the disease intervention workforce, in the remaining 26 counties, was later rescinded by Congress.
- Since 2021, data showed rising HIV and syphilis cases in rural and remote parts of the state.
    - CDC flagged many counties due to increased case counts.
    - Many of these areas had few resources to respond.
- PLWH in rural and frontier Oregon have disparities
    - More likely to be diagnosed late
    - Less likely to be linked to care quickly or be virally suppressed
- As of 2025, 30 counties reported a syphilis diagnosis in a pregnant person and 24 reported a congenital syphilis (CS) case.

This Approach Works (EISO → HSSS)

- Integrated HIV/STI testing is critical
    - 10% of EISO enrollees diagnosed with multiple STIs, either syphilis or rectal gonorrhea, later acquired HIV over a four year period. (Source: Oregon's EISO Four Year Report, 12/2023).
    - Consequently, people with STIs is a priority population for testing, prevention, and care/treatment.
- Improves linkage to care and time to viral suppression (VS)
    - E.g. 95% of EISO enrollees diagnosed with HIV got linked to care within 30 days
    - Similar linkage to care and VS results with HSSS
- In 2025:
    - OHA-funded HIV testing has increased 20% across the state
    - Orders for rapid HIV and syphilis test kit orders through Take Me Home increased 30%
- Oregon is seeing a decline in cases of syphilis, gonorrhea, and chlamydia

Discussion:

- Is DoxyPEP responsible for decline in STI rates?

- It’s hard to identify just one cause, but DoxyPEP prescribing could have to do with the decline. Syphilis rates are also declining nationally.

What/Who is Being Funded?

- HSSS activities among 33 LPHAs and their CBO subcontractors
- HIV Outreach with the Confederated Tribes for Siletz Indians
- Mail-order HIV/STI Testing (Take Me Home) and condom distribution (ONE at Home)
- Subsidized HIV/STI Testing through Oregon's State PH Lab
- STI medications (e.g. Bicillin Access Program)

What OHA Funding Supports HSSS?

- As of July 1, 2025, HST awarded $10 million/year to LPHA and their CBO subcontractors for HSSS activities.
  - This is a three-year award and includes funding previously directed to HIV EISO and added an additional $2.3 million/year.
- From January 2026 – June 2027, OHA Partnership for Community Health Program (not HST) awarded $3M to 13 CBOs for statewide HIV/STI prevention. **Public Health Modernization funding.*
- Multiple funding sources:
  - CDC HIV Prevention & Surveillance Grant (PS24-0047)
  - HRSA RW Program Income
  - CDC STI Prevention & Control Grant (PS19-1901)
  - State General Funds

Discussion:

- Are any of these grants affected by drug companies? Some CBOs have lost funding, from Gilead for example.
  - OHA doesn’t know every source of CBO funding and isn’t aware of any AIDS service organizations that had been receiving funding from pharmaceutical companies and lost it.
  - Gilead used to fund HIV Alliance and CAP for hepatitis C testing, but that project has ended.
- Where can OSPG members and partners find information about what was funded before and what’s changed? How much does each county get?
  - HST funds are a small part of funding that counties receive. Other OHA funds go toward LPHAs’ core public health activities, and all counties receive Public Health Modernization funds as well.

How was HSSS funding for LPHAs determined?

- The Conference of Local Health Officials (CLHO) reviews and approves public health funding and service plans impacting counties/LPHA.
- In January 2025, CLHO approved the HSSS allocation of funds and a funding formula.
  - Funding formula uses a three-year average of county HIV, syphilis and gonorrhea data in addition to indicators of health, such as population, rurality, and community health.

    - CLHO is represented by 36 county administrators, who voted their approval unanimously.

Discussion:

- Comment from planning Council: LPHAs are losing staff because they're losing funds and the HSSS model takes money away from high prevalence areas to give to the rest of the state. Now the OSPG and planning council are being asked to ratify this funding structure. I am having difficulty approving this.
    - Clarification on this comment: "Now the OSPG and planning council are being asked to ratify this funding structure. I am having difficulty approving this." OSPG and the PC are not being asked to ratify the HSSS funding structure. It was approved by CLHO 18 months ago. OSPG and the PC have no authorization over HSSS funds awarded to LPHA.
    - HST discussed this with CHLO and counties statewide, and the HSSS funding formula was unanimously approved by CLHO.
    - It's incorrect that funding is taken from high prevalence counties and given to low prevalence counties. With HSSS, the counties with the highest population and HIV prevalence receive the most money per the funding formula.
    - The funding formula weighs HIV and syphilis incidence at 35%, HIV prevalence at 15% and gonorrhea prevalence at 15%. The formula also includes social determinants of health inputs.
    - Some counties, like Multnomah, were awarded more money than they were previously. Other counties did see a decrease. Every Oregon County is getting some funds, and the awards range from $13,000 per year (Wheeler County) to $2.7 million per year (Multnomah County).
    - For the first 2 years of HSSS, no county receives less money than they'd previously received from HST.
        - Some counties are deeply concerned about year 3.
            - County administrators can bring concerns to CLHO at any time.
    - Any change would have to be approved by CLHO. HST invited LPHA to offer alternative funding formulas that they would prefer, but none were suggested. HST explored 15 different funding formulas, but they all had similar trends.
- Comment: It's challenging to be a CBO focused on HIV Prevention but not being a part of CLHO or knowing what happens there.
- Comment: OHA's approach would be fantastic with unlimited funds. Multnomah and Clackamas Counties have seen devastating cuts to Public Health funding. The most marginalized people are the ones most impacted by the cuts. HSSS is not nimble, it's not set up to effectively manage the crisis in the way it needs to. Our concurrence with reservations would be to somehow make the funding formula more nimble and revisit it to see what happens when funds are taken away.
    - Clarification: Multnomah County did not receive a cut in HSSS funds; they received an increase.

- Comment: Washington County has concerns about year 3. LPHA will be facing cuts that result in staff cuts and CBO partnerships ending. Washington County just lost two staff due to Measure 110 cuts and might have to give up partnerships with Centro Cultural and HIV Alliance. These cuts impact the communities most impacted by HIV.
- Comment: Mid-count counties along the I-5 corridor seem to be the most hit by budget cuts.
- Comment: We can't say for sure that current impacts to work on the ground are directly related to HSSS, especially since no county is receiving less funding than in the past for the first two years. It is true that HST is funding 26 counties that weren't funded before. This is because outbreaks are happening in those areas and HST has observed disproportionate treatment/care of PLWH in those areas.
    - Counties see flat funding as a loss.
- Comment: It's important to remember where the highest disparities in HIV outcomes exist in our state and it's not tri county (Clackamas, Multnomah, Washington Counties). HSSS is a mechanism to build rural capacity, especially in anticipation of rural/frontier clusters. This is key to ending new infections and not leaving anyone behind.
- Comment: One area for growth is creating more intentional opportunities for ongoing dialogue, information exchange, and mutual collaboration with LPHA. Stronger engagement between local public health authorities and the disability community can generate valuable insights, strengthen partnerships, and support more inclusive and effective responses to community needs.
- Comment: More conversation on HSSS is appreciated. When Oregon limited funding to 7 highest prevalence counties, it left CBOs to raise funds for rural counties and ultimately led to disparities. I am glad to see funds going back to those counties and also frustrated by the loss that represents to some of our larger counties. A difficult time.
- Comment: One participant offers to share information about their experience working at Clackamas County from the beginning of EISO through the transition to HSSS and being part of the CLHO CD group that voted on the various funding formulas when moving to HSSS.
- Comment: LPHA administrators also have a say in how HSSS funds are spent. They decide which positions/priority areas to fund with these funds, especially when they become more limited.

Response

Monitor the Progression of HIV in Oregon

- Ensure information and resources are available to respond quickly and effectively to any trends we are seeing.
- Our five-year goals are:
    - Identify and respond to HIV clusters and outbreaks

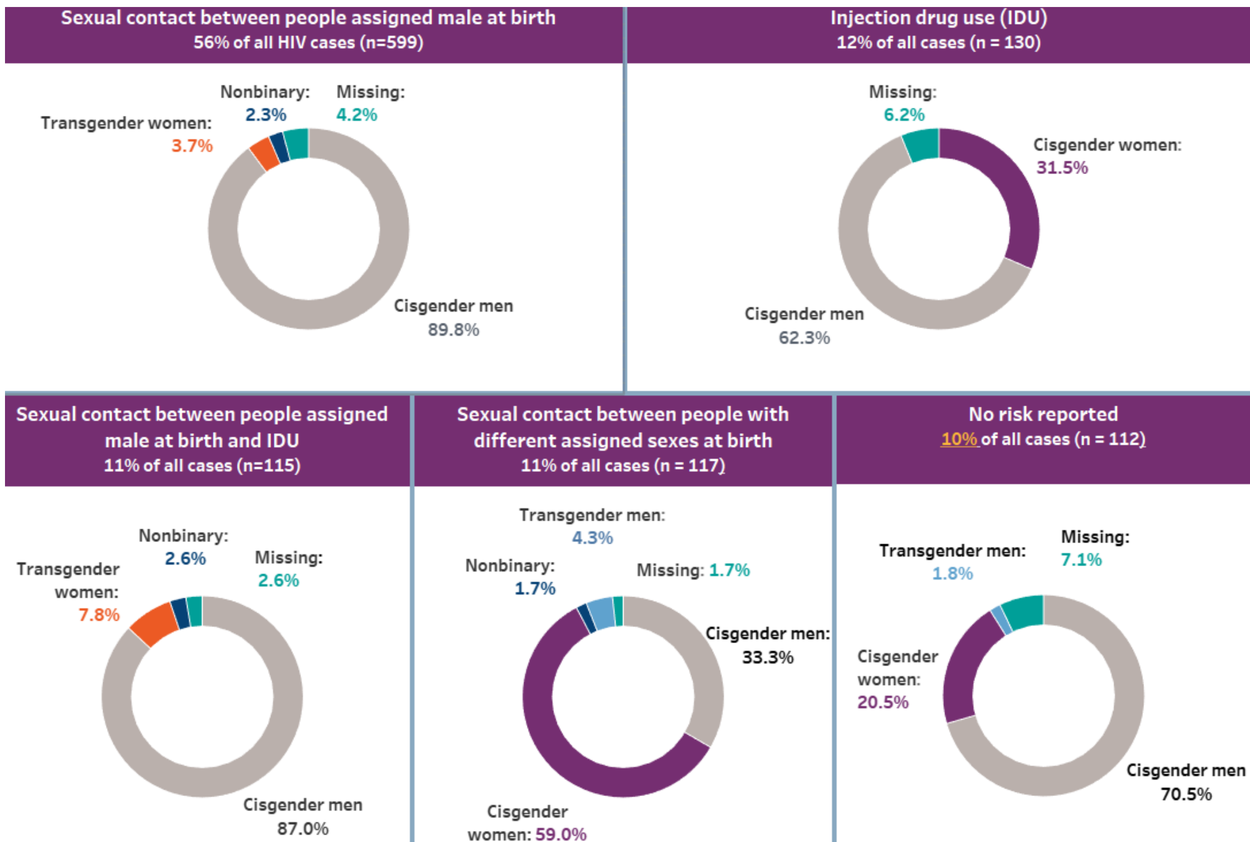
    - Increase linkage to HIV medical care and HIV prevention services among those in networks affected by rapid transmission
    - Ensure people living with HIV in Oregon have access to healthcare to optimize positive health outcomes and prevent further transmission
- The people and communities who are priorities for Response work change – it really depends on what we are seeing in the data.

What Data Are Collected?

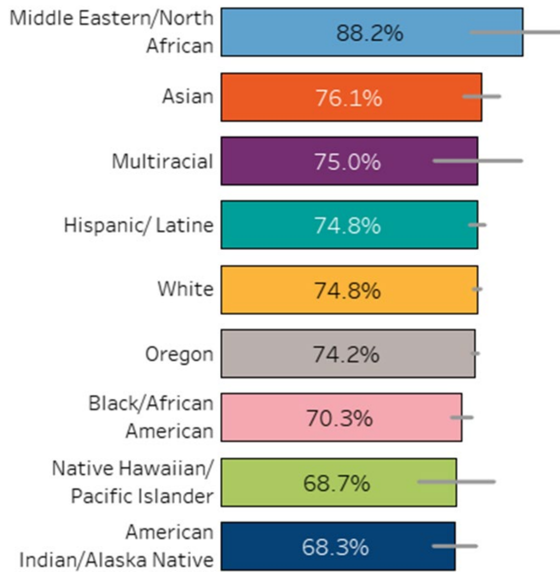
- CDC Required Variables
    - Patient Name (not transmitted to the CDC)
    - Date of Birth
    - County of Residence
    - Race/Ethnicity
    - Testing data
- Additional Variables Sent to the CDC
    - Risk/Exposure information
    - HIV testing history
    - PrEP, PEP, ART history
    - HIV lab data
- Additional Data Variables Currently Collected in Orpheus
    - SOGI (Sexual Orientation and Gender Identity)
    - REALD (Race, Ethnicity, and Language, Disability)

Data Behind the Scenes

- Although some demographic variables and references to health equity, social determinants of health, and root causes have been removed from public reporting, we continue to review these data internally and are prepared to share them publicly when possible.
- Behavior and Gender Identity, End HIV Oregon Dashboard (2023):

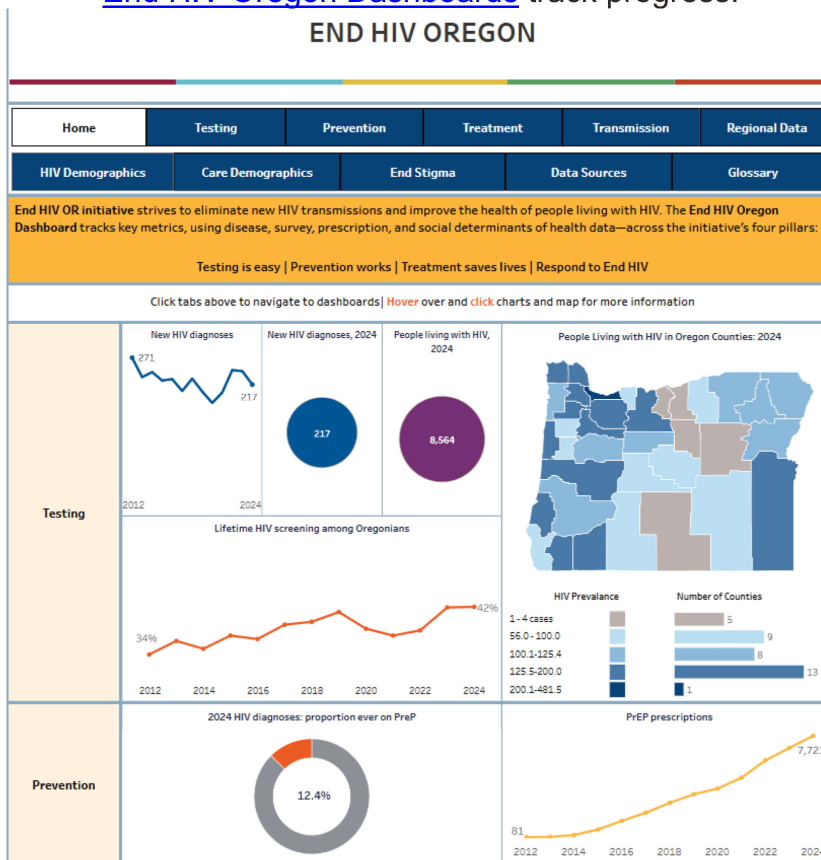


- We continue to disaggregate data as much as we can, and there is room for improvement
- The collection of REALD data allows us to present more granular information
- Viral suppression at the most recent viral load test within the past 12 months by primary race or least common race, End HIV Oregon Dashboard (2024):



How do You Measure Outcomes?

- End HIV Oregon Dashboards track progress:



- Annual Report posted on World AIDS Day

'Not In Care' (Out of Care)

- “Out of care” masks the difference between never-in-care and fallen-out-of-care – how can we take a more granular approach to these data that will help us address the problem?
- Not in care/out of care process:
    - Determine current residence and vital status for all reported HIV cases with last known residence in Oregon
    - Estimate prevalence of unmet medical need
    - Re-engage PLWH in Oregon into regular medical care
    - Requirement of CDC PS24-0047 grant
    - Not in Care list criteria in Oregon is no viral load or CD4 Count reported in 16 months

3 Phases of ‘Out of Care’

- Never in Care
    - No record of HIV care post HIV diagnosis. Case investigation remains open until there is a record of care initiation AND viral suppression (defined as less than 200 copies of HIV per milliliter of blood) or the person is eligible for the Not in Care (NIC) list.
    - For cases newly diagnosed in 2025, 9/225 persons currently meet this criteria.
- Never reach viral suppression
    - Case investigation remains open until there is a record of care initiation AND viral suppression or the person is eligible for the NIC list.
    - For cases newly diagnosed in 2025, 28/209 persons currently meet this criteria.
        - 11/225 newly diagnosed persons have moved out of Oregon.
        - 5/225 are deceased.
- Fallen out of Care/Not in Care
    - No record of a reported viral load or CD4 Count for 16 months.

Discussion:

- Data look at a point in time, and things shift rapidly. HIV cases are increasing in rural Oregon. These counties aren’t used to responding to HIV and need a lot of support. Clusters are popping up in areas that haven’t had them before.
- HST is happy to provide collected data to Oregon agencies.
    - Viral suppression data by race/ethnicity is available on the End HIV OR dashboard.
    - A variety of HIV/STD/TB data dashboards are at this link.
    - Request additional data with this form or reach out to HST with data questions at prevention.info@odhsoha.oregon.gov.
- HST data team’s support has been vital to the TGA’s data quality. Staff are glad that SOGI and REALD data will still be available in Oregon.

Treatment

Goals and Themes: HIV Care & Treatment

- Goals:
    - Treat HIV quickly and effectively
    - Ensure viral suppression is achieved and maintained
    - Find and reconnect PLWH who are out of care or never in care
- Priorities: case management, housing, behavioral health, linkage and access to medical care for PLWH
- Specific populations have lower rates of linkage to care and viral suppression, including unstably housed, rural/frontier, and PWUD.
- Page 60+ includes specific objectives
- Comments/questions about medical, social, and structural determinants of health.

Themes/Input Related to Treatment

- Frame housing and other support services explicitly as treatment interventions – e.g., not supplementary, but fundamental
- What metrics are used to measure case management success?
- How do we plan to conduct provider education in the current environment?
- Whole-person care includes families – this is a barrier in RWCA
- CAREAssist eligibility for undocumented people

Housing Is Health Care (& So Are Other Services)

- This is true!
- First page of the plan underscores this point:
    - "*The plan recognizes that for people living with HIV, treatment includes not just medical visits and medications, but also the structural supports which ensure people start and stay in care (e.g., housing, food, transportation, oral health care, and more).*"
- There are many sections dedicated to specific service areas and they are all listed in the treatment section, in recognition that these are essential components to maintaining viral suppression.

How Do We Measure Case Management Success?

- Statewide Performance Measures (Part A / Part B, CY 2025)
    - Linkage-to-Care within 30 days (93% / 92%)
    - Retained in Care (94% / 90%)
    - Viral Suppression – last viral load (94% / 94%)
    - Viral Suppression – within 90 days of dx (76% / 43%)
- Enrollment in RWCM among PLWH (45% / 43%)
- Service Utilization

How Will We Conduct Provider Education?

- AETC is our main resource for provider education in Oregon.
    - AETC receives funding from the Federal government (Part F) and OHA.

- AETC provides a range of services across Oregon, including communities of practice, 1:1 provider TA/support, conferences and trainings, and practice transformation projects.
- Expert faculty are compensated by AETC to provide services across Oregon.

Whole-Person Care Includes Families

- In most cases, Ryan White funding is only for PLWH, not family members or partners who do not have HIV.
    - This can create fragmented systems of care for PLWH with HIV negative family members.
    - RWCA does fund childcare and HIV testing for partners – a limited scope
    - RWCMs work to connect clients to all local and available resources
- This concern was listed as a “limitation.” We understand the current rules but documented this concern.
- Ryan White funding has a very limited definition of family, but HOPWA has a more open definition of “household.”

CAREAssist Eligibility

- We had feedback that included the statement: *“Persons that are unable to obtain OHP and do not have documents to obtain insurance cannot access CAREAssist.”*
- CAREAssist clients ineligible for public or private insurance or do not accept public insurance qualify for the following: Full-cost coverage for a monthly 30-day supply for any medication on the Bridge/UPP/Restricted formulary. (14 classes of medications.)
- CAREAssist clients ineligible for public or private insurance also qualify for the following: Full-cost coverage on specific, limited, CPT codes for medical services listed on the Bridge/UPP CPT code list.
- Lack of insurance or lack of documentation to obtain insurance doesn’t impact CAREAssist eligibility.

Discussion:

- With rapid start of medications, has time to viral suppression gone up or down?
    - HST has been tracking viral suppression within 90 days since 2021. Across the board, suppression within 90 days has increased. Linkage to care within 30 days has significantly increased as well – 60-70% in 2019 to 70+ in 2025.
    - Clients might not be virally suppressed but they’re getting connected to care.
- Just a note for later consideration. For viral suppression within 90 days of diagnosis, I'm wondering if we see a comparison that includes Part A clients who have had early intervention services and outpatient medical? Some of our highest-needed clients aren't enrolled in medical case management (MCM).
- At the recent client town hall, the inability to get a case manager was called out as a big unmet need. A lot of PLWH don’t have access to case management. Is that just because of capacity? Some resources require a case manager to access.

- In Part B, there are no wait lists and anyone who comes into see a case manager at EOCIL or HIVA will get connected to a non-medical case manager and a MCM as well depending on needs.
    - Multnomah County staff are happy to discuss Medical Case Management in the TGA. There are 2916 clients in the TGA served by Ryan White, and insufficient dollars to properly staff the ideal client-to-provider ratio. But there shouldn't be barriers to anyone eligible accessing a case manager.
- Oregon AETC is part of MWAETC and receives federal funding through MWAETC. Oregon supplements that through RW program income. AETC is also housed within Oregon Primary Care Association and gets support/funding/partnerships through there.
- AETC supports clinics and LPHAs and others on projects they identify to improve the work they're doing along the continuum of HIV care. Please reach out if you have a project in mind and need support! asummer@orpca.org
    - Practice transformation projects are happening at Wallace Medical Concern, Sea Mar Salmon Creek, Northwest Human Services and elsewhere, for example
    - AETC's federal funds are focused on areas of higher prevalence and AETC's OHA funding allows them to train and provide technical assistance to providers in the balance of state, which is invaluable
- HIV Care & Treatment data dashboards for Part B, CAREAssist and OHOP are at this link. These do not include all Performance Measures (yet!) but do include viral suppression, participant, and demographic data.
- Comment: I would like to share a perspective. I understand why many view this as a moment for advocacy, and I appreciate the concerns that have been raised. Those concerns are important and deserve continued advocacy. I hope adoption of the plan is not interpreted as endorsement of every policy or requirement contained within it. This seems to be the best way forward that preserves the services and funding our communities rely on. For me, the question is how we continue to advocate for our communities while also protecting the services people depend on today. I believe both goals are important. Preserving services allows people to continue receiving support while enabling us to remain engaged and work toward meaningful improvements. The adoption of this plan, with the declared reservations, is not the end of the conversation or advocacy.

Meeting Poll

1. The information shared today was useful and relevant to the OSPG mission: to advise the Oregon Health Authority HIV/STD/TB Section on issues related to HIV care and prevention and co-occurring sexually transmitted infections and hepatitis C.
    - Strongly Agree – 60% (24/40 votes)
    - Agree – 30% (13/40 votes)
    - Neutral – 8% (3/40 votes)
    - Disagree – 0%

- Strongly Disagree – 0%

2. There were enough opportunities for discussion:
    - Strongly Agree – 55% (22/40 votes)
    - Agree – 28% (11/40 votes)
    - Neutral – 15% (6/40 votes)
    - Disagree – 3% (1/40 votes)
    - Strongly Disagree – 0%

Next Steps

OSPG admin staff will email OSPG members with instructions on voting by Monday, June 8, with votes requested by Friday, June 12.