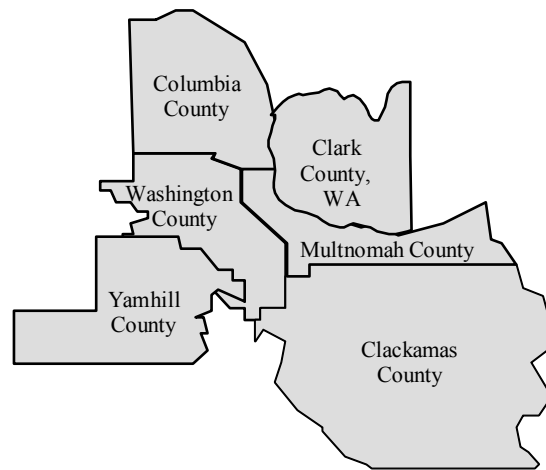


*Portland Area HIV Services Planning Council
Comprehensive Care Plan
2009-2011*



VISION: *All persons living with HIV/AIDS in the Portland Transitional Grant Area have a right to quality care.*

MISSION: *Through community partnerships we create opportunities and advocate for access and continuity of a full range of quality care for all persons affected by HIV.*

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Portland Area HIV Services Planning Council

Advocacy and planning for people affected by HIV in the Portland metro area

Ryan White Program, Part A



December 31, 2008

Shonda Gosnell
Division of Grants Management Operations
5600 Fishers Lane, Room 7-27
Rockville, MD 20857

Dear Ms. Gosnell:

On behalf of the Portland Area HIV Services Planning Council, we are pleased to express our support for the Portland Area TGA HIV Planning Council 2009-2011 Comprehensive Plan and to provide the following assurances:

1. Council representatives served on the Statewide Coordinated Statement of Need working group and actively participated in drafting or reviewing documents for the final document.
2. The HIV Services Planning Council Comprehensive Plan was based on the goals developed by the SCSN working group.
3. The Operations Committee of the Planning Council participated in formulation of the strategies to implement the goals of the SCSN and create specific objectives for the Council and the TGA Grantee.

The Council continuously works to improve the system, tools and policies that foster a high quality, community-based continuum of care. Together with our community partners we look forward to meeting the challenges of the coming years.

Sincerely,

David Heal, Co-Chair
Portland Area HIV Services Planning Council

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Portland Area HIV Services Planning Council

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**Portland Area HIV Services Planning Council
Three Year Comprehensive Care Plan 2009-2011
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Introduction

Federal Ryan White funding provides resources to fill gaps in services for low-income persons living with HIV/AIDS. Part A of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic. The Portland TGA consists of six counties (Yamhill, Multnomah, Columbia, Washington, Clackamas in Oregon and Clark County in Washington) The Portland Area HIV Planning Council, in partnership with the Part A Program of the Multnomah County Health Department works to create, implement and monitor a quality continuum of care for the Portland TGA. The Planning Council has responsibility for needs assessment, service continuum planning and for the allocation of service dollars to general service categories. The Multnomah County Health Department manages grant requirements, designs and procures services and monitors the quality of the services provided in the continuum.

The HIV Planning Council membership includes consumers, local providers, representatives from public and private safety net services and representatives from other Ryan White Parts. A minimum of 33% of members must be non-aligned consumers of Part A services. The Ryan White Part A system is a model for healthcare planning and decision making that has shaped a responsive, empowering and responsible approach to a growing and changing epidemic.

Comprehensive Planning is an opportunity to plan for the future. The Comprehensive Plan for 2009-2011 reflects the Council's deeply held values and shared belief in the importance of health care planning that reflects and solicits input from the communities most affected.

The Comprehensive Plan is organized into four sections:

Section I: Current System of Care

- A. Description of the Portland Transitional Grant Area
- B. HIV/AIDS Epidemiology
- C. Assessment of Need in the TGA
- D. Emerging Service Populations with Special Needs and Barriers to Care
- E. Description of the Local, Regional and State Responses to the Epidemic
- F. Description of the Current Continuum of Care

Section II: Where Do We Want to Go?

Section III: Goals and Objectives

Section IV: How Will We Monitor Our Progress?

Executive Summary

The Comprehensive Plan reflects the long range planning collaboration between the Portland TGA HIV Planning Council, the Grantee, the State and local service providers addressing the specific needs of people living with HIV and AIDS in our community.

3,971 persons living with HIV/AIDS (PLWH/A) reside in the six-county Portland Transitional Grant Area (TGA). Almost three fourths (71.3%) of PLWH/A reside in Multnomah County. Although HIV increasingly affects women in the EMA, 89.0% of PLWH/A in the EMA are men. Minority racial/ethnic populations account for 20.5% of all PLWH/A. Overall, the composition of PLWH/A in the TGA has remained fairly constant over the past several years, with only slight increases in percentages of Hispanics and older PLWH/A.

In FY 2008, the Part A system will serve over 2,400 clients, 60% of all PLWH/A in the TGA. The system includes an array of services: primary medical care, medical case management, early intervention services (EIS), substance abuse and mental health treatment, dental care, health insurance, psychosocial support, housing and home-delivered meals.

HRSA requires the Part A program to annually estimate the number of PLWH/A who are aware of their HIV infection, but not receiving medical care. During the 2007, 72% of PLWH/A living in the TGA received HIV primary medical care services. While almost three-fourths are in care this leaves over a quarter (28%) who are not receiving medical care according to the standard of at least one CD4 or viral load laboratory test per year. Estimating unmet need highlights the necessity for targeted outreach to the newly diagnosed and out-of-care PLWH/A.

The Portland TGA faces a major challenge in implementing a system of care that reaches all affected populations across our community. Several populations with special needs and barriers to care have been identified. These include PLWH/A who are: age 50 and older; foreign-born; women; dually diagnosed with mental health and substance abuse issues; formerly incarcerated; unstably housed; youth age 13-24; and/or males with a heterosexual transmission risk.

Goals, objectives and strategies were developed by the Statewide Coordinated Statement of Need (SCSN) Workgroup in 2008. These cross-cutting goals are also adopted by this comprehensive plan and are further articulated for the TGA. The four statewide and TGA comprehensive plan goals are as follows:

Goal 1: Preventing New HIV Infections

Goal 2: Finding HIV+ People Who Need Care and Treatment Services

Goal 3: Engaging HIV+ People in Care and Treatment Services

Goal 4: Retaining HIV+ People in Care and Treatment Services

The TGA has implemented the Chronic Care model as a means to create an environment in which productive interactions and relationships between providers and clients can thrive. This

model has been used to help the TGA develop and define the objectives and strategies put forth in this document.

The charting of these goals, objective and activities will involve the triangulation of different data sources. The TGA's Quality Management team, already monitoring the Clinical Quality Management Program, will work to measure our success in achieving the goals presented in this document.

**Portland Area HIV Services Planning Council
Three Year Comprehensive Care Plan
2009-2011**

I. Current System of Care

A. Description of the Portland Transitional Grant Area

General demographics of the TGA

The Portland Transitional Grant Area (TGA) encompasses over 5,000 square miles, spans two states, and includes: five Oregon counties, Clackamas, Columbia, Multnomah, Washington, and Yamhill; and Clark County in Washington State. The 2007 population estimate for the TGA is 2,149,020. 2007 population estimates show 78.2% of the TGA population is White (not Hispanic), 5.7% Asian/Pacific Islander, 2.8% African American, 2.4% biracial, and less than 1% Native American. Hispanics are the fastest growing ethnic group in the TGA, accounting for 10.1% of the TGA population. 38.2% of all people of color, including 68.8% of all African Americans in the TGA live in Multnomah County.

Brief description of the continuum of care offered in the TGA

HIV counseling, testing and referral services are provided at public and private health care sites throughout the TGA, including projects that focus on reaching high-risk populations. Primary care services include medical care, medications, early intervention services, dental care, substance abuse treatment, mental health therapy and medical case management. Support services include, housing, health insurance, food, transportation and psychosocial support. These support services help clients meet basic needs and promote retention in medical care and adherence to treatment. Primary care and support services are provided and funded through a combination of public and private resources, through public and private health systems and at community agencies in the TGA.

Geography of the TGA with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities

An estimated 71.3% of PLWH/A are in Multnomah County; followed by 10.4% in Washington County, 10.1% in Clark County, 6.5% in Clackamas County, 1.1% in Yamhill County, and .6% in Columbia County. For the most part, PLWH/A travel to Portland to access a well-established health care and social services system. A highly accessible public transportation system serves most PLWH/A in the TGA. The two Part A medical providers are the Multnomah County Health Department HIV Health Services Center and the Oregon Health & Science University HIV Clinic. These clinics have a long history of collaboration due to their common mission of serving as a safety net for uninsured and low-income PLWH/A. Combined, the clinics serve over 1,300 PLWH/A per year. Many PLWH/As who qualify for the Oregon Health Plan (Medicaid) or other health insurance receive medical services through the private sector. Access points for other HIV primary care, case management, and support services are distributed throughout the TGA.

B. HIV/AIDS Epidemiology

HIV/AIDS Prevalence in the TGA

Prevalence represents the number of cases present in a given population at a point in time. Understanding the epidemiology of HIV/AIDS in the TGA is a key component of health services planning. As of 12/31/07 there were 3,971 PLWH/A living in the TGA as reported by Oregon's HIV/AIDS Reporting System (HARS). 2,344 (59%) of these individuals are living with AIDS and 1,627 (41%) living with HIV.

Key facts about TGA PLWH/A population include:

- Over the past three years, the number of PLWA in the TGA has increased by 11.9%. During the same time period the number of PLWH increased 6.8%.
- Minority racial/ethnic populations account for 20.5% of all PLWH/A.
- The majority of all cases continue to be among men who have sex with men (MSM).
- Males account for 89% of all PLWH/A in the TGA. Within the male population, MSM account for 71.3% of all PLWA and 79.0% of PLWH.
- Women account for 13.6% of all persons in the TGA living with HIV (non-AIDS) and 9.2% of all persons living with AIDS.
- Within the female population, IDU account for 23.3% of PLWA and 19.4% of PLWH, and heterosexual contact accounts for 71.2% of PLWA, 70.7% of PLWH.
- Approximately 39% of all female PLWH/A in the TGA are racial/ethnic minorities, in comparison to 18% of male PLWH/A.
- Persons aged 25-44 account for 42.7% of all PLWA and 53.4% of all PLWH. Persons 50 years and above now account for 30.5% of total cases, 35% of all AIDS cases and 24% of HIV cases.
- Approximately 42% of racial/ethnic minority PLWH/A were foreign-born.
- Overall, the composition of PLWH/A in the TGA has remained fairly constant over the past several years, with only slight increases in percentages of Hispanic and older PLWH/A.

HIV/AIDS Incidence in the TGA

HIV/AIDS incidence is defined as the number of new cases diagnosed during a specific time period. In 2003 there were 13.3 new cases every 100,000 individuals in the TGA population compared with a reduced rate of 10.3 new cases every 100,000 in 2007. In 2007 there were 221 new HIV/AIDS diagnoses in the TGA.

Key facts about new cases in the TGA include:

- 340 new AIDS cases and 357 new HIV cases were reported during the past two years (1/1/06-12/31/07).
- 11.2% of HIV cases and 10.0% of AIDS cases diagnosed from this 2-year time frame occurred in women.
- Hispanics account for 9.4% of all PLWA and 8.7% of all PLWH, but comprise 11.5% of new AIDS cases and 12.6% of new HIV cases.
- Whites continue to be the largest group affected by HIV/AIDS, accounting for 77.9% of new AIDS cases
- Persons aged 25-44 account for 62.4% of new AIDS cases.
- Between 2002 - 2006, around 39% of newly diagnosed individuals had already progressed to AIDS or did so in 12 months.
- Since 2003, more than 60% of all newly diagnosed HIV/AIDS cases among Black and Hispanics in the TGA were foreign-born.

Co-morbidities

In general, the prevalence of co-morbidities is much higher within the PLWH/A population than the general population, greatly increasing the complexity and cost of care within the Ryan White system. When compared to the general population, rates of sexually transmitted infections (STIs), homelessness, and poverty are significantly higher for PLWH/A. Primary care providers of patients with co-morbidities such as hepatitis C and substance abuse must closely monitor drug interactions and coordinate medications with HIV antiviral therapies. Patients with mental illness often have trouble following treatment regimens, and low-income or uninsured patients often postpone care until conditions are urgent. Case managers spend time locating clients without permanent housing, coordinating appointments, enrolling clients in any available insurance program, and filling urgent needs such as prescription drugs, food, and transportation.

Reported cases of chlamydia, gonorrhea, and syphilis among people with previously reported HIV infection in Oregon (> 1 month) have risen steeply since 1999. During 2007, PLWH/A in the TGA accounted for 27% of all syphilis cases and 6% of all gonorrhea cases.

Co-infection with hepatitis B and/or hepatitis C is of concern for health services planning, but hepatitis C did not become reportable in Oregon until 2005, so data are limited and should be considered a minimum estimate. During 2007, 25% of PLWH/A living in the TGA were co-infected with hepatitis C.

Oregon has never observed a substantial number of TB/HIV co-infections and in the TGA only 0.12% of confirmed TB cases in Oregon from 2001-2007 were co-infected with HIV. (See Table 2 in Appendix A for a prevalence data on primary co-morbidities).

Case Fatalities

Age-adjusted case fatality rates were similar among men and women (1.82/100 person years for men vs. 1.42/100 person years for women). Likewise, there were no statistical differences by race/ethnicity in age-adjusted HIV/AIDS case fatality statewide. These data suggest that among people aware of their status, treatment outcomes do not differ substantially by age, race/ethnicity, or gender.

Native Americans comprise 1% of all PLWH/A in the TGA. However, from 2001-2005, in Multnomah County the Native American population had the highest HIV mortality rates of any group in the county (15.9/100,000 vs. 4.9/100,000 for non-Hispanic whites), and this disproportionate rate has been cited by county officials as “a health disparity that requires intervention” (Bhat, 2008).

C. Assessment of Need in the TGA

Unmet Need Estimate

HRSA requires all states and metropolitan areas that receive federal support for HIV/AIDS health care under the Ryan White HIV/AIDS Treatment Modernization Act of 2006 to estimate annually the number of PLWH/A who are aware of their HIV infection, but not receiving medical care. Laboratory results for CD4 and viral loads are used as a proxy for medical care for the purpose of calculating these estimates.

During calendar year 2007, an estimated 26% of PLWH and 30% of PLWA did not have a CD4 or viral load test done, indicating an unmet need for medical care (see Table 3 in Appendix A for Unmet Need Table).

Within the Portland TGA, an analysis of the unmet need report shows that there was a suggestive difference in unmet need between people with HIV (not AIDS) and AIDS (26% vs. 30%) in 2007. Unmet need seemed to increase with age (19% age 25-29) up until the late 40s/early 50s (31% age 45-54), and then began to decrease (19% age 65+). Male PLWH/A had a higher unmet need than females (29% vs. 23%). Black and Hispanic PLWH/A had a higher percentage of unmet need (37% and 33% respectively) than White PLWH/A (27%). Male PLWH/A with IDU (36%), heterosexual (41%), and non-identified (43%) risk factors had higher unmet need in comparison to MSM (27%). PLWH/A who were newly diagnosed with AIDS or progressed to AIDS 12 months after diagnosis (33%) also had higher unmet need than those diagnosed with HIV that progressed to AIDS after more than 12 months (25%). These data also suggest that rural cases may be more likely than urban cases to have unmet need (38% vs. 29%).

How the results of the Unmet Need Framework were used in planning and decision making

Over the past two years, the Planning Council and HIV Care Services staff have developed the Unmet Need Framework in partnership with the State. The Planning Council has reviewed and taken into consideration Unmet Need Framework findings as part of the decision making for the

priorities and allocation process. The Framework results highlighted the need for targeted outreach to the newly diagnosed and out-of-care PLWH/A. An emphasis on reaching the out-of-care and keeping PLWH/A in quality care is woven into all aspects of all Part A funded services.

Late Diagnoses with HIV

Examining whether an individual who is diagnosed for the first time is diagnosed with AIDS or progresses to AIDS within 12 months after first diagnosis can indicate whether individuals are being diagnosed later in their disease progression. Understanding who is being diagnosed with HIV/AIDS later in disease progression can provide information on which populations may not be accessing care or which populations need focused targeting of HIV prevention efforts. Between 2002 – 2006, nearly 39% of newly diagnosed individuals had already progressed to AIDS or did so within 12 months. Late diagnosis (having AIDS within 12-months of first diagnosis) was more likely with increasing age at diagnosis and among Hispanics compared to non-Hispanic whites. Males with reported risk of IDU, heterosexual or presumed heterosexuals, were more likely than MSM to be diagnosed late in their course of disease.

Estimated level of service gaps among PLWH/A in the TGA

HIV Care Services and the Planning Council utilized three different sources of information to assess the service needs and gaps of PLWH/A in the TGA: 1) *We Listened: 2005 Survey for People Living with HIV and AIDS*; 2) preliminary interview data (2007-2008) from the statewide Medical Monitoring Project; and 3) community forums held in 2008. *We Listened (2005)*, the most recent assessment of service needs, gaps, and barriers for PLWH/A in the Portland TGA, was conducted as a follow-up to an initial assessment conducted during 2002. During the survey, case management clients were asked if they had needed 12 specific services in the past year, and whether they always received the services when they needed them (See Table 4 in Appendix A for Service Needs and Gaps Summary of Findings). Those who had not always received services when needed were considered to have a service “gap.” While most clients were able to access the outpatient medical services they needed, respondents reported significant gaps in access to dental care, mental health counseling and substance abuse treatment. Many clients also reported a gap in support services such as groceries or meals, transportation, and emergency rent/utility assistance.

To obtain more recent information on the service needs and gaps of the TGA, HIV Care Services has looked at the preliminary results of the Medical Monitoring Project (MMP) and at the outcomes of a series of community forums held within the last year. The MMP is a national study sponsored by the CDC to collect data from selected states on issues such as access and barriers to care, unmet need, quality of care, patient behaviors, and co-morbidities. Preliminary data from 144 client interviews and chart audits that took place between September 2007 and February 2008 support the needs and gaps that were identified in the *We Listened* survey. Case management services, mental health counseling, housing, help with meals/groceries, dental care, and other social support services were identified as services with high need and significant gaps.

In 2008, the Planning Council initiated a series of community forums with Ryan White Part A consumers to better understand consumers’ perceptions regarding which services best support engagement and retention in care. Within the context of these discussions, needs, gaps, and barriers to services were identified. As with the previous assessments, high need and significant

gaps were identified for dental care, housing services, mental health counseling, transportation, groceries/meals, and case management/information regarding available services and resources.

All three assessments have shown that overall, the Ryan White system of care is doing well in ensuring key health care services for many PLWH/A in the Portland TGA. However, PLWH/A are heavily dependent on public systems, and significant gaps in access to specialty and supportive services exist. Of particular concern over the past several months has been access to mental health counseling and substance abuse treatment services. In April, the largest behavioral health organization in the TGA, providing mental health counseling, housing assistance, and substance abuse treatment services, was on the brink of bankruptcy and greatly reduced services. As other local social services agencies begin to struggle with increased costs and dwindling funds, it is likely that access will continue to decrease. The Ryan White care system must continue to address the challenges created by reductions in other health coverage and service systems, minimize the negative impact on PLWH/A, and assure continuous access to care.

D. Emerging Service Populations with Special Needs and Barriers to Care

The Portland TGA faces a major challenge in implementing a system of care that reaches all affected populations across our community. The Portland TGA encompasses six counties in two states, covers more than 5,000 square miles, and centers on a large metropolitan area surrounding the City of Portland. Multnomah, the most populated county in the TGA, has approximately 71.3% of the persons living with HIV/AIDS in the TGA, and the remaining 28.7% are dispersed throughout the five outlying counties. Residents in the six counties travel to Portland to varying degrees in order to access a well-established health care and social services system. The majority of PLWH/A in need of HIV services are generally well served by the care system. However, the TGA includes small and diverse communities of PLWH/A that are difficult to reach through mainstream providers and systems.

The SCSN has identified seven populations with special needs and barriers to care. These include PLWH/A who are: age 50 and older; foreign-born; women; dually diagnosed with mental health and substance abuse issues; formerly incarcerated; unstably housed; and/or males with a heterosexual transmission risk. In addition, the TGA has identified youth 13-24 as a population with specific needs and barriers.

PLWH/A Aged 50 Years or Older

The number of PLWH/A age 50 and older in the U.S. has increased 77% from 2001 to 2005, and now comprise a quarter of all cases nationally. In the TGA, 30.5% of PLWH/A are aged 50 and older, including 23.9% of PLWH and 35% of PLWA. Within the population of PLWH/A aged 50 and older, as of 12/31/07, 91% are male and 9% are female. The majority of this population, 84.5%, is white, 7.7% are Black/African American, and 5.3% are Hispanic. The most common risk factor was MSM (72%), followed by heterosexual transmission (12.1%) and IDU (7.6%).

Population increases within this age category are due to both the success of antiretroviral medications in treating HIV/AIDS and increases in the number of persons aged 50 and older being diagnosed with HIV/AIDS for the first time; about 1 in 6 PLWH/A diagnosed in 2007 (15%) were aged 50 or older.

PLWH/A aged 50 and older face several unique challenges within their care. Many older people living with HIV face serious co-morbid medical conditions, including cardiovascular disease, diabetes, certain cancers, osteoporosis, and depression, which further complicates medical care and compromises quality of life. PLWH/A that have been living with HIV/AIDS for long periods of time may begin to lose their motivation to continue to follow drug treatment regimes, especially when these regimes come with negative side effects. Newly infected patients within this population are often diagnosed late and have already progressed to AIDS. This population also has higher rates of infection with drug resistant strains of the virus. In general, PLWH/A aged 50 and older are more socially isolated and report higher rates of depression and loneliness, poverty, housing concerns, and poor nutrition. These issues are compounded by frequent losses of important social networks, as partners and friends die of AIDS and aging-related illnesses.

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

A cost analysis of Multnomah County Health Department HIV Health Services Clinic (HHSC) clients in 2007 showed that the average annual cost of care for PLWH/A client aged 50 and older was \$4,996, 78.4% higher than the HHSC client with a single diagnosis of HIV (average annual cost \$2,801). Factors contributing to these higher costs include case management services, mental health services, and a higher number of medical visits resulting from the progression of HIV to AIDS and other diagnosis related to age. Other costs not covered by HHSC include oral health care, specialty services, hospitalization, and supportive services such as emergency financial assistance, transportation and housing.

Foreign-Born PLWH/A

In June 2005, the Office of Refugee Resettlement ranked Multnomah County sixth nationally in terms of concentration of refugees compared with the area's general population and the five-year new arrival rate. Though the number of new refugees in the TGA has fallen dramatically due to new legislation, over the past 5 years 178 foreign-born individuals received an initial HIV diagnosis within the TGA. Since 2003, more than 60% of all newly diagnosed HIV/AIDS cases among Blacks and Hispanics in the TGA were foreign-born, and as of 12/31/07 approximately 42% of racial/ethnic minority PLWH/A were foreign born. Within the foreign-born population, 42.1% of PLWH and 14.8% of PLWA are women, and the majority of PLWH/A are between the ages of 30 and 49. The highest risk of infection within this population is heterosexual transmission (46.8%), followed by MSM (41.7%). Within the TGA, 59.3% of foreign-born PLWH/A originated from Central/South America or the Caribbean, 22.8% originated from Africa, and 11.1% originated from Asia. The majority of the foreign-born Hispanic and Asian PLWH/A are men, while most African PLWH/A are women.

Foreign-born PLWH/A face a number of unique challenges that create substantial barriers to accessing and remaining in care. One of the largest barriers is language. Providers within the TGA do not have the resources to offer their services in the native languages of all of their

clients; this service gap is particularly acute outside of urban areas. This challenge has increased dramatically over the past ten years as new waves of immigrants and refugees have arrived. Language barriers are compounded when clients refuse translation services for fear of being outed as HIV+ within their community. Cultural issues and health literacy levels present another unique challenge to accessing care. Health education messages, patient instructions, and service delivery methods must be tailored to be culturally competent and effective. Finally, immigrants and refugees face many of the same challenges that other PLWH/A populations in the TGA face, including poverty and lack of health insurance.

As demonstrated in the prevalence data in the previous paragraph, the two major groups of foreign-born PLWH/A in the TGA are Hispanics and Africans, and each group has unique characteristics. Both national and Oregon state data has shown that Hispanic immigrants are the least likely to have health insurance or a regular source of health care. Many of the foreign-born Hispanics in the TGA are fearful of government institutions and concern about deportation provides another unique barrier to accessing care. These fears have recently been heightened within the TGA after a series of INS employment raids during 2007 resulted in the detainment and deportation of many area residents. Migrant workers face additional barriers to care as they tend to have unstable employment and a transient lifestyle. The African population has a separate set of unique challenges. This population consists of highly isolated and stigmatized communities that are dependent on translation and case management services for care. Many members of the African population are here as refugees from war-torn nations and must deal with conditions related to malnutrition and post-traumatic stress, and the separation from friends, family and their traditional way of life.

The challenges discussed above have resulted in a number of service gaps for immigrants and refugees in the TGA, including translation, and culturally competent services and education materials. Other gaps include access to outpatient medical and oral health care, case management and social supports, resources for prescription and over the counter medicines, and assistance with transportation, housing, food, and other basic needs.

A cost analysis of HHSC clients in 2007 showed that the average annual cost of care for a foreign-born PLWH/A client was \$3,814, 36.2% higher than the HHSC client with a single diagnosis of HIV (average annual cost \$2,801). Factors contributing to these higher costs include translation services, case management services, and a higher number of medical visits. Additional costs not covered by HHSC include substance abuse treatment services, housing, emergency financial assistance, transportation and child care.

Women

As of December 31, 2007, women comprised 11% of PLWH/A in the Portland TGA. Approximately 39% of all women living with HIV/AIDS in the TGA are racial/ethnic minorities. Among women, the primary method of transmission is heterosexual contact, accounting for 70.9% of all living HIV/AIDS cases and 75.3% of newly diagnosed cases; followed by IDU, accounting for 21.3% of all living HIV/AIDS cases and 23.3% of newly diagnosed cases. Black/African American and Hispanic women are more likely to be infected with HIV/AIDS through heterosexual contact than White women. These trends are mirrored within the female Part A client population, where the most commonly reported risk factors are also heterosexual

contact (71.2%) and IDU (23.5%). Female Ryan White clients are significantly poorer than men, with 81.4% at or below 100% of the Federal Poverty Level (FPL), compared to 69.3% of men. In 2007, 32.3% of female Ryan White clients received Medicaid, 13.5% were uninsured (up from 11.1% in 2006), and 21.3% lacked permanent housing (up from 19.2% in 2006). Acuity levels of female Ryan White clients were also significantly higher than men, with 45.3% of female clients having an acuity level of 29+, compared to 35.9% in men, indicating a greater need for case management.

There are several unique challenges around provision of and access to care for women. Women need comprehensive HIV/AIDS primary care and support services within a well-managed continuum of care. This includes accessible primary care providers who have specialized knowledge of HIV and women's health, as well as coordinated access to specialists for treatment of HIV related illnesses and common co-morbidities such as mental disorders, substance abuse, and co-infection with hepatitis or an STI. Psychosocial support services directed to female PLWH/A should be delivered through multi-service agencies that women perceive as accessible and are designed to meet their particular needs. Case management services are particularly important for this population to help coordinate care and keep clients engaged. Women need to receive HIV prevention and early intervention messages in conjunction with their HIV care, and in places where they congregate. All services for female PLWH/A must be gender and culturally appropriate, and childcare should be available to clients while they are receiving other services.

According to *We're Listening: 2002 Survey for People Living with HIV and AIDS in Oregon*, gaps and access to primary care are significant issues for female PLWH/A because they are less likely to have health insurance, have higher poverty rates, and are likely to forego their own health care needs in favor of children and other family members for whom they provide care. This study also reported proportionately higher needs by women for psychosocial support services, referral services, emergency financial assistance, outpatient substance abuse treatment, and child care. *We're Listening* also indicates that women were more likely to need emergency rent/utilities and housing assistance. Additionally, women who depend on employment to support themselves and their families are more likely to lack adequate transportation and childcare compared with other subpopulations of PLWH/A in the Portland TGA. *We're Still Listening*, a follow-up survey conducted in 2005, reported that women faced significant gaps in their ability to obtain prescription medications, groceries/meals, and transportation to and from appointments. Barriers to addressing these issues were most often related to system capacity issues such as wait times and lack of knowledge about services.

A cost analysis of HHSC clients in 2007 showed that the average annual cost of care for a female PLWH/A client was \$4,020, 43.5% higher than male clients (average annual cost \$2,801). Factors contributing to higher costs include case management services, mental health services, and a higher number of medical visits resulting from mental illness, substance abuse, and poverty. Additional costs not covered by HHSC, include substance abuse treatment, housing, emergency financial assistance, transportation and child care.

Dual Diagnosis of Mental Illness and Substance Abuse

Within the TGA, mental illness and substance abuse are found across all gender, race/ethnicity, age, and risk populations. Mental illness among PLWH/A in the TGA increased from 40% of the

population in 2005 to 53% of the population in 2007. The percentage of PLWH/A in the TGA with a dual diagnosis of mental illness and substance abuse has increased from 21.1% in 2005 to 23.6% in 2007. However, these numbers understate the prevalence of substance use and abuse by PLWH/A with a mental illness, as substance use and abuse is not always diagnosed. An analysis of 2007 service utilization data shows that women, minority populations, persons aged 20-44, and persons with heterosexual and MSM/IDU risk factors have higher rates of mental health service utilization rates, and Black/African Americans, persons aged 20-44, and persons with MSM/IDU and IDU risk factors have higher rates of substance abuse treatment services.

PLWH/A with mental illness and/or substance abuse diagnosis face several challenges to engaging and remaining in care. PLWH/A with mental illness and substance abuse are more likely to experience unemployment, homelessness, and poverty than the general population. They also have higher rates of incarceration than other PLWH/A, with each episode of incarceration having the potential to interrupt their treatment for HIV disease. People within this population require primary treatment by specialists who understand the dynamics of both illnesses, and who are prepared to deal with their potential effects, particularly those related to drug interactions that may create a higher mortality risk when combined with certain antiviral medications. Mental illness and substance abuse can adversely affect the ability of PLWH/A to follow scheduled medical treatment and to adhere to HIV drug treatment regimes. High levels of case monitoring and service coordination are required to reduce the interference of psychiatric disorders, medications, and illegal drugs with HIV medical treatment. These services, particularly mental health services, must be designed and delivered in a manner that is culturally appropriate for ethnic and sexual minority populations. As both mental illness and substance abuse are chronic conditions, access to appropriate services must be assured for extended periods of time, and treatment must be adjusted to varying levels of acuity over time.

The needs and gaps of this population are similar to the needs faced by other populations. Medical care, along with basic needs such as food, housing, and transportation, are needs strongly felt by people with mental illness and/or substance abuse. In addition to these needs, this population faces a gap in case management services, client advocacy services, culturally competent mental health services, and substance abuse treatment services, including out-patient and residential care. Mental health and substance abuse treatment services must be able to be accessed quickly in the case of an emergency, and must be coordinated with primary HIV care.

A cost analysis of HHSC clients in 2007 showed that the average annual cost of care for a PLWH/A client with any mental illness was \$4,902, 75.0% higher than the average HHSC client with a single diagnosis of HIV (annual cost \$2,801), and the average annual cost of care for a PLWH/A client with a substance abuse diagnosis, including IDU, was \$4,800, 71.4% higher than the cost of the average HHSC client. Factors contributing to these higher costs include case management services, mental health services, and a higher number of medical visits resulting from these conditions. Additional costs not covered by HHSC include substance abuse treatment services, emergency financial assistance, transportation and housing

Formerly Incarcerated PLWH/A

The formerly incarcerated population is another group that is disproportionately impacted by HIV/AIDS. Reports from State and County correctional systems support national statistics that illustrate this disproportionate impact. The Oregon Department of Corrections reports that 58

inmates self-identified as HIV+ during 2007, and estimates that 1.2-1.8% of their incarcerated population is infected with HIV, up to four times the number of those who self-identified.

Approximately 60% of their PLWH/A population is released to the TGA each year. Multnomah County Corrections reported that 152 inmates detained at its correctional facilities were identified as PLWH/A during 2007 either through jail testing or self-identification. However, as in the Oregon State facilities, this is very likely an under-estimate. The HIV Health Services Center, the largest HIV primary care provider in the state, reports that in 2007, 5.6-8.5% of its patient population had a history of recent incarceration. Cascade AIDS Project (CAP), one of the largest HIV service organizations in the TGA, reports that of the 890 clients it served in 2007, 29.4% reported a recent criminal history. Of those clients, 84% were male, 27.5% were racial/ethnic minorities, and 74.5% were between the ages of 35-54. The majority of the PLWH/A incarcerated population face several co-morbidities including poverty, substance abuse, and mental illness. A 2006 survey of CAP PLWH/A clients found that 28% reported a recent criminal history. Of those 28%, 25% reported lack of insurance and 40% reported no income. PLWH/A with criminal histories were almost three times as likely to report active or past substance abuse (85% vs. 29%) and about twice as likely to report mental health issues (60% vs. 32%), compared to clients without criminal histories.

PLWH/A with a history of incarceration often face several co-morbidities, including poverty, substance abuse, and mental illness. They also face many unique challenges in accessing and remaining engaged in medical care and support services. Ex-offenders have particular difficulty securing employment and stable housing due to the stigma attached to being an ex-convict, landlord policies prohibiting criminal backgrounds, poor or nonexistent credit, rental and employment histories, and lack of funds for deposits and rent. Lack of health insurance is also a substantial challenge to accessing care. When entering the jail system, inmates are taken off of public insurance programs, and upon release must go through a re-application process that can take over six months. Even with insurance, lack of resources for co-payments results in barriers to care. Many former inmates also struggle with active mental health and/or substance abuse issues and have limited family and community support systems in place.

Recently incarcerated clients responding to the 2005 PLWH/A Needs Assessment were significantly more likely to report homelessness in the past two years (46% vs. 17%) or living in a place not meant for housing, such as a car or abandoned building (30% vs. 6%). Those who had managed to secure housing reported greater unmet need for emergency assistance with rent and utilities than PLWH/A without a criminal history (44% vs. 29%). Statewide, PLWH/A ex-offenders also reported greater need for medical care, help with prescriptions, substance abuse treatment, mental health counseling, ongoing help with housing, transportation to appointments, and assistance with food, than PLWH/A without recent incarceration. Although HIV care providers have reached out to corrections staff throughout the TGA and are available to provide consultation, a significant service gap is the lack of adequate discharge planning as these patients leave the corrections system. The upcoming implementation of an electronic medical record system within Multnomah County Corrections Health should improve discharge planning.

The direct costs experienced by the Ryan White program do not represent the true cost or complexity of care for the recently incarcerated population. A large percentage of the recently

incarcerated PLWH/A population in the TGA rotate in and out of corrections systems throughout the year. During periods of incarceration, HHSC patients are not seen by TGA service providers, and thus do not incur costs to the TGA. However, when receiving TGA services, the complexity of their care, due to co-morbidities such as mental illness, substance abuse, poverty and homelessness, is greatly increased. Specific costs for this population include case management services, mental health services, substance abuse treatment services, housing, and other supportive services such as emergency financial assistance and transportation.

Unstably Housed PLWH/A

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

Similar to other parts of the nation, housing for PLWH/A continues to be an area with high service needs and gaps in the Portland TGA. PLWH/A living in the Portland metropolitan area were more likely to have experienced unstable housing in the past year (31%) than those living in other parts of the state (19%).

This challenge has grown exponentially over the past few years as more people have moved to the Portland metropolitan area. The annual inventory report of *Northwest Pilot Project* states the number of affordable, low-income housing units within downtown Portland has fallen to 3,330 units in 2007, from 4,554 units in 1994. A 2007 HOPWA program evaluation states that PLWH/A living in the Portland metropolitan area were more likely to have experienced unstable housing in the past year than those living in other parts of the state. While the affordable housing stock in Portland is declining, surrounding areas have also experienced high levels of gentrification, pushing low-income PLWH/A further outside the city limits. As PLWH/A are forced to spend more of their limited income on housing, other necessities such as food, heat, and medical care become out of reach, and their quality of life and level of health falls drastically. Lack of affordable housing within city limits has also resulted in new access barriers as patients are forced to travel to service locations that are no longer easily accessible from their homes. The 2007 HOPWA study referenced above found that the location of affordable housing in relation to service providers was the barrier mentioned most frequently by both clients and case managers. Stable housing has a direct and significant impact on health, and within the TGA, has been found to be a more significant predictor of health status, healthcare use, emergency room use, and medication adherence than other individual characteristics.

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

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

Youth

Youth 13-24 comprise 2.5% of the HIV/AIDS cases in the TGA, but they comprise 5.1% of the HIV cases, and accounted for 15.7% of newly diagnosed HIV(non-AIDS) cases between 1/1/06 and 12/31/07 (up from 8.2% reported during 1/1/05-12/31/06). The majority of these new cases (80%) occurred in persons aged 20-24, indicating that infection is occurring in their late teens and early twenties as they begin to explore their sexuality and are exposed to high-risk activities. The demographics of this population are particularly important as they can provide insight into the future composition of PLWH/A in the TGA. As of 12/31/07, 73% of PLWH/A aged 13-24 were men and 27% were women, compared to 89% and 11% in the TGA overall. 60% are white (compared to 79.6% in the TGA overall), 18% are Hispanic (9.1% in the TGA) and 13% are Black/African American (8.2% in the TGA), making this age category of PLWH/A much more diverse than the overall PLWH/A population in the TGA. The risk breakdown for this population is as follows: 55% MSM, 8% IDU, 7% MSM/IDU, 17% heterosexual, and 10% Mother with HIV risk. The rates of both MSM and heterosexual transmission have gone up since last year, by 8% for MSM and by 4% for heterosexual contact.

Youth need a well-managed continuum of care that includes comprehensive HIV/AIDS primary care and support services. This includes accessible primary care providers who have specialized knowledge in the treatment of HIV, along with coordinated access to specialists for treatment of common co-morbidities such as mental disorders, substance abuse, and co-infection with hepatitis or STIs. Access to primary care is a significant issue for youth because they are less likely to have health insurance, have high poverty rates, and they are likely to deny or minimize the severity of their HIV disease. Youth particularly need targeted outreach and high quality case management to link them to primary care and social support services and maintain them in care. They require psychosocial support services, referral services, emergency financial assistance, outpatient substance abuse treatment, and housing. Youth are more reliant on social support services, since issues of poverty, hunger, and lack of affordable housing are magnified in this population. This population presents a particular challenge for case management and coordination, since many do not have stable addresses, and may be out of contact with providers for long intervals. Support services directed to youth should be delivered through multi-service agencies that youth perceive as safe, accessible and appropriate to their particular needs.

The *We're Listening: 2002 Survey for People Living with HIV and AIDS in Oregon* report indicates that 1) younger PLWH/A had a longer period between HIV diagnosis and entering care; 2) younger PLWH/A were more likely to lack access to group/peer support; and 3) this population was more likely to need drug reimbursement assistance. The *2005 Survey for People Living with HIV and AIDS in Oregon* also indicated that younger PLWH/A were more likely to have had an unstable housing situation in the past year. For youth who know their HIV status, this report identifies barriers to care as lack of knowledge about services, transportation problems, paperwork, finances, appointment wait times, and lack of insurance.

A cost analysis of HHSC clients in 2007 showed that the average annual cost of care for a PLWH/A client aged 13-24 was \$3,653, 30.4% higher than the HHSC client with a single diagnosis of HIV (average annual cost \$2,801). Factors contributing to these higher costs include case management and mental health services. Additional costs not covered by HHSC, include substance abuse treatment, housing, emergency financial assistance and transportation.

Male PLWH/A with Heterosexual/Presumed Heterosexual Transmission Risk

The identification of male PLWH/A as a special population is primarily in response to qualitative information gathered at community forums along with initial data indications that this is a population that may need special attention. Inclusion in the Comprehensive Plan emphasizes the need to conduct further research, and collect more specific demographic data about this group.

Data that indicate higher needs include the fact that in 2006, male PLWH/A with heterosexual transmission risk in Oregon were 1.5 times more likely than MSM to be diagnosed with HIV at or within 12 months of their AIDS diagnosis; males with presumed heterosexual risk were almost twice as likely to be diagnosed late. Early HIV diagnosis is crucial to an individual's long-term health, quality of life, and positive treatment outcomes. New studies indicate that the ideal time for initiation of HAART is earlier in the course of infection than previously thought (at the time of this document, TGA-specific data was not available).

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

E. Description of the Local, Regional and State Responses to the Epidemic

Multnomah County Health Department (MCHD) has a strong history of planning and implementing programs related to the provision of services to PLWHA in the Portland TGA. From the early days of the epidemic MCHD has provided medical care to HIV infected individuals, through its primary care clinics. To respond to the growing number of HIV/AIDS clients, and the demand for specialized care from "expert" providers, MCHD applied for and was awarded Ryan White Part C (originally called Title III) Early Intervention funds in 1990. MCHD is the only agency in Oregon with Ryan White Part C Early Intervention funds. These funds established the HIV Health Services Center in 1990, and the clinic has been in operation since that time. This Center serves a six-county area that includes Multnomah, Washington, Clackamas, Columbia, Yamhill and Clark counties. In 1995, MCHD became a Ryan White Care Act Part A (originally called Title I) grantee at which time the HIV Planning Council was formed. A diverse network of community based organizations and public health departments provide Part A Services.

ADAP programs in Oregon and Washington assist clients with health insurance and medications, CareAssist. In Oregon, the Oregon Medical Insurance Pool (OMIP) provides insurance to many

PLWH/A who would otherwise be unable to obtain health insurance. Clients with incomes below 300% of FPL who have OMIP or other insurance can receive help paying for premiums, co-pays, and deductibles through CAREAssist, the state Part B ADAP program. The program also covers the full cost of medications on the ADAP formulary for uninsured clients. CAREAssist also operates a Bridge Program, providing short-term supplies of medications for clients in the process of applying for insurance. CAREAssist currently serves 1,500 PLWH/A in the TGA. Clark County clients are covered by Washington State drug assistance and early intervention programs first; those who are not eligible can enroll in a Part A health insurance program.

See Table 5 in Appendix A for a summary of Part A funding in the context of local, regional and state resources. The public funding described in this table supports the continuum of care as described in the next section.

F. Description of the Current Continuum of Care

The TGA's Established Continuum of HIV/AIDS Care

The TGA continuum of care goals are: informed public support through education and advocacy; knowledge of serostatus for persons at risk; maintenance of negative status; early access to a coordinated system of primary care and support services for PLWH/A; and prevention with high risk positives to reduce transmission of HIV. In FY 2008, the Part A system will serve over 2,400 clients, 60% of all PLWH/A in the TGA. Council guidance requires that historically underserved populations including women, children, youth, and racial/ethnic minorities be served at least in proportion to their representation in the HIV/AIDS prevalence. The system of care emphasizes reaching out to newly affected, emerging, and underserved groups through HIV prevention services, primary care, case management, and support services. An overview of the continuum care includes:

HIV counseling and testing, and prevention services. Publicly-funded outreach, counseling, testing and referral services target at-risk groups including men who have sex with men (MSM), racial/ethnic minorities, substance abusers, youth, and women. Locations include health department community test sites and STD clinics, correctional facilities, drug treatment agencies, and other high-risk community settings, e.g., needle exchange sites, bars serving MSM, and community events. Rapid testing is available at many test sites. Clackamas, Multnomah, and Washington county health departments collaborated on an evidence-based HIV prevention intervention, Community Promise, targeting the highest risk MSM, with special emphasis on Black/African American MSM. A peer advocate model focuses on outreach to sexual networks of high risk MSM, influencing behavior change through use of role model stories, providing risk reduction supplies, and recruiting MSM into HIV/STD testing. A website-based intervention also makes role model stories accessible to the target population along with community resources and testing information. Locally funded needle exchange services provide new sterile syringes, health supplies, prevention counseling and referrals. Prevention services are integrated into Part A programs. The lead case management agency, the Partnership Project, provides a prevention-funded *Supporting Healthy Options for Prevention* (SHOP) program for individuals who engage in high risk behaviors. Clark County delivers *Partnership for Health*, a prevention intervention for case management clients. The HIV Health Services Center adopted the *Options* program, a prevention intervention for PLWH/A receiving outpatient services.

Primary Care. The full range of primary care services are provided through a combination of public and private health systems and community-based agencies. PLWH/A with private or public insurance access primary care through their designated health care providers. High-risk insurance pools in Oregon and Washington provide access to insurance for individuals who are rejected by private insurers. Veterans can access a range of primary care services through two VA medical clinics. In Oregon, clients with incomes below 300% of FPL who have insurance can receive help paying for premiums, co-pays, and deductibles through CAREAssist, the state Part B ADAP program. The program also covers the full cost of medications on the ADAP formulary for uninsured clients. CAREAssist also operates a Bridge Program, providing short-term supplies of medications for clients in the process of applying for insurance. CAREAssist currently serves 1,500 PLWH/A in the TGA. Clark County clients are covered by Washington State drug assistance and early intervention programs first; those who are not eligible can enroll in a Part A health insurance program. Our House of Portland, a community provider, delivers a continuum of services covered by public and private resources for advanced stage PLWH/A. Services include residential and hospice care, assisted living in adult care homes, and a neighborhood program that combines stable housing with in-home medical, occupational therapy, and social work services. Several substance abuse treatment and mental health providers offer services that target vulnerable populations affected by HIV, including racial/ethnic minorities, women, youth, and gay/bisexual men. For uninsured clients and clients with limited coverage, Ryan White programs provide a safety net, including two HIV specialty medical clinics, the HIV Health Services Center (HHSC) at Multnomah County Health Department and the HIV Clinic at Oregon Health & Science University (OHSU). These two clinics serve over 1,300 PLWH/A. Other Part A primary care services include two community dental clinics; three mental health providers; and two substance abuse treatment agencies. Over 90% of Part A clients will receive at least one core service from Part A contractors in FY 2008.

Access Services – Early Intervention Services and Medical Case Management. In FY 2008, Part A early intervention services (EIS) will enroll at least 90 recently diagnosed PLWH/A and other PLWH/A who have not engaged in primary medical care. To recruit clients, this program works with a network of service providers that serve as key points of entry for PLWH/A who are either newly diagnosed or out of care. These service providers include public and private HIV counseling and testing sites, substance abuse and mental health treatment programs, detox centers, correctional facilities, homeless shelters, health and social service agencies serving youth and racial/ethnic minorities, and local health department HIV prevention programs and STD clinical services. The process of engaging EIS clients is based on the core concepts of relationship and trust building, assessment of perceptions and access barriers, assessment of past HIV care engagement, and readiness to engage in care. Staff provide HIV education, care systems orientation, skill building around accessing services, practical support, and advocacy. Staff follow a client-centered goal plan to guide each client through the engagement process and can work with clients for three to six-months to ensure successful linkage with primary care.

Medical case management is coordinated with the major medical health systems and funded by both mainstream and Part A resources. Most medical case management services in the TGA are provided by a consortium called the HIV Case Management Partnership Project (Partnership Project). This project offers HIV medical case management services to clients in a four county

area where 89% of PLWH/A in the TGA live (Clackamas, Columbia, Multnomah, and Washington Counties). Through a collaborative effort, nine public and private agencies contribute staff, financial support, and expertise to the partnership, thus extending the reach of each agency's fiscal and program resources. Service agencies in the partnership include Oregon Health & Science University, Multnomah County Health Department, Legacy Health System, Providence Health System, and Cascade AIDS Project (CAP). Other consortium members who contribute specialized resource experts are State Aging and Disabilities Services, the CAREAssist Program, the Social Security Administration, and Cascadia Behavioral Healthcare. Medical case management is linked with medical care at several clinic locations and is also provided at community sites throughout the service area based on client need. The Partnership Project will serve over 1,250 clients in FY 2008. The Partnership Project and CAP also provide Minority AIDS Initiative (MAI) case management services for high acuity Black/African American and Latino PLWH/A, serving 55 clients in FY 2008. To further assure geographic accessibility, Part A funds case management through local health departments in Clark County and Yamhill County where 10% and 1% of PLWH/A in the TGA reside, respectively. These two programs will serve over 200 clients in FY 2008. More than 65% of all Part A clients will receive access services from Part A contractors in FY 2008.

Support Services. Support services promote retention in medical care and assist clients in meeting basic needs. These services are provided through a combination of public agencies and private community-based organizations. The TGA *HIV/AIDS Resource Guide* lists over 150 agencies that provide a wide range of services. HIV-specific support services in the community include:

- Housing services: permanent alcohol and drug-free housing at the Rosewood Apartments; housing with supportive services for clients with mental illness; permanent subsidized housing for homeless PLWH/A; housing for homeless women through the *Safety off the Street* program; emergency housing for youth; and transitional housing for formerly incarcerated clients. As mentioned earlier, Our House of Portland provides assisted living through an HIV-specific adult care home and coordinates provision of in-home services.
- Emergency services: Esther's Pantry and Martha's Pantry emergency food programs provide food and personal care supplies for over 200 clients each month. The Tod's Corner program provides clothing, household goods, pet food, cleaning and personal care items.
- Services for youth/children: The Kid's Connection program provides social support and helps HIV-affected youth, children, and their families access medical and support services such as counseling, child care and parenting skill-building.

Part A-funded support services address gaps in the mainstream systems. Part A case managers coordinate transportation services to ensure that client in outlying communities and those who have difficulty using public transportation have access to primary care and case management. Although transportation is not offered as a stand-alone program, medical care and case management contractors may budget a small portion of their materials and services budget (about \$6,000 across all providers) for bus tickets and gas vouchers. Two Part A housing contractors, Cascade AIDS Project (CAP) and Clark County Health Department, deliver housing education, advocacy, emergency rent assistance, and transitional housing services that are coordinated with HOPWA and with services offered through local housing authorities. The Part A home-delivered meal program, *Daily Bread Express*, serves clients who have difficulty

maintaining adequate nutrition and cannot travel to a group meal program. Two Part A psychosocial support programs help clients build and sustain personal support systems through support groups, one-to-one problem-solving, peer support, and assistance with activities of daily living. The Quest Integrative Health Center *Women of Wisdom* program provides psychosocial support services for HIV-positive women and their families and uses a peer-based model to recruit clients and bring them into services. The Ecumenical Ministries of Oregon *HIV Day Center* delivers psychosocial support services for other vulnerable populations, including very low-income clients, the homeless, multiply-diagnosed clients, and clients with a criminal history. The *HIV Day Center* also provides group meals four days a week and gives clients transportation to the Esther's Pantry emergency food program each month. Over 20% of all Part A clients will receive at least one support service from Part A contractors in FY 2008

Mechanisms within the TGA that enable newly infected, underserved, hard-to reach individuals and/or disproportionately impacted communities of color to access and remain in primary medical care

The HIV services system in the TGA is designed to link clients with primary care and sustain participation in primary care over time. Contracts require that all Part A contractors screen new clients for access to a medical provider and health insurance. New clients without a provider are referred to a Part A-funded clinic as an immediate source of care, and into medical case management for long-term planning. Case managers and medical care providers conduct eligibility screening for public programs (e.g. Oregon Health Plan, CAREAssist) to give clients access to the full range of primary care services covered by insurance. All Part A case management and medical providers have referral relationships with agencies that serve as points of entry for clients needing HIV services. In an analysis of new clients served by the Part A care system in 2006, three out of four clients entered the care system through primary medical care or case management providers.

The primary medical care system responds to the service needs of emerging and underserved populations. Multnomah County HIV Health Services Center (HHSC) providers meet regularly with county medical staff in the jails to case conference on treatment plans for HIV-positive inmates and develop transition plans upon discharge. The HIV Clinic at OHSU provides direct HIV medical care to inmates at two state corrections facilities and a drug treatment center. The HHSC works with homeless youth programs to coordinate care for young HIV-positive clients. The HHSC and OHSU provide comprehensive services for older PLWH/A that address both HIV care needs and co-morbidities associated with an aging population. The HHSC works with community agencies to track refugee arrival trends and offer services to HIV-positive refugees. The HHSC is the largest provider of HIV care for African refugee women in the TGA, and also has bilingual medical providers and other clinical staff to serve Hispanic clients. Both clinics provide comprehensive interpreter services to serve other non-English speaking clients. The HHSC and OHSU have modified their service delivery system to improve retention in care. Both clinics have integrated on-site mental health and substance abuse counseling into a "one-stop" service model. The HHSC and OHSU have also strengthened medical adherence support for their clients through on-site pharmacy services.

The principal objective of case managers is keeping people in medical care and compliant with their treatment regimen, with the overall goal of interrupting the progression of the disease. Case

managers help clients negotiate complex systems that can seem overwhelming. Substantial amounts of staff time are spent on insurance issues. With fewer options available for insurance, case managers also link clients with pharmaceutical company medication assistance programs, crucial for continuity of care. Medical case managers provide treatment adherence support and also deliver services through home visits as needed to help clients reduce use of emergency rooms and the need for hospitalization. A Fuzeon support group helps clients stay in compliance with treatment and cope with side effects. All case managers coordinate transportation services for clients in outlying communities and clients who have difficulty using public transportation. Outreach and strong referral systems with other providers ensure that clients from vulnerable and disproportionately impacted communities are connected to medical case management. Medical case managers track their clients who move in and out of the correctional systems to ensure continuity of care and assist with corrections discharge planning for clients who are new to the community. Bilingual case managers serve Hispanic clients and the MAI case management project provides intensive services that support retention in care for Hispanic and Black/African American clients. In FY 2007, less than 2% of Part A case management clients were lost to follow-up. To support our clients' ability to manage their own care, one of our medical case management contractors, Partnership Project, coordinates the TGA's *HIV Positive Self-Management Program*, a series of training sessions for clients, co-facilitated by a person living with HIV. The Partnership Project also leads the Case Management Network, providing monthly networking meetings with the goal of keeping health and social service providers throughout the community informed about services for their clients and about changes in the service system that can affect their clients. FY 2007 service data showed that primary medical care and case management programs served women, youth, racial/ethnic minorities and multiply-diagnosed PLWH/A in greater proportions than their representation in the TGA's living HIV/AIDS cases. This emphasis on special populations continues in FY 2008.

The support services system has also implemented programs that respond to the needs of emerging and underserved populations. Psychosocial support services offer stability for a marginalized population that leads to more consistent participation in care. A drop-in day center serves PLWH/A who have difficulty dealing with activities of daily living, many of whom have substance abuse and mental health issues and are homeless or living in temporary housing. The center provides regular supportive activities, meals, peer support, and a place for clients to meet with social service providers. Another center provides services for women and their families, including child care while women participate in support groups and other center activities. The housing program includes the *Positive Directions* education program to work with clients who have a history of homelessness, substance abuse and other challenging life situations. Workshops include a Ready-to-Rent series, tenant education, employment, health, budgeting, and parenting education. Landlords give special consideration to Ready-to-Rent class graduates. Bilingual staff deliver workshops in Spanish. Specialized housing has been established for clients with substance abuse problems, clients with a recent criminal history, clients with mental illness, and for families affected by HIV, including refugee families who are new to the area. Staff provide supportive services for diverse PLWH/A populations living in transitional and permanent housing to promote long-term stable housing. FY 2007 service data showed that a higher percentage of clients receiving support services were female (19.9%), persons of color (34.5%), poor (80% <100% FLP) and non-permanently housed (39.5) than those receiving core services only. This emphasis on support services targeting vulnerable populations continues in FY 2008.

In 2006, the Portland TGA adopted the Chronic Care Model (CCM) as a framework for providing services and addressing quality improvement. The model aims to transform the health care environment into one which is proactive and centered in keeping clients healthy, rather than reactive and focused on illnesses, thereby optimizing the best health outcomes for clients. Particular emphasis is placed on client self management and the interrelationship of the patient and the provider team. The Chronic Care Model is comprised of six interrelated components that contribute to high quality care for people living with chronic illness. Quality management goals within this framework include:

- Health system – the organization of health care: To strengthen organizational support among Part A programs for quality improvement and for coordination of care across systems, furthering linkages between Ryan White Part A, B and C programs in the state.
- Decision support: To deliver Part A services which are consistent with standards of care and follow current guidelines for the treatment of HIV/AIDS.
- Client information system: To maintain the Part A/Title I Unduplicated Reporting System (TOURS) to monitor the performance of the service system, assess trends in client demographics and utilization, and measure progress in achieving outcomes.
- Delivery system design: To incorporate quality expectations into Part A contracts, provide technical assistance to ensure delivery of culturally competent services that reflect best practice, and to assess client satisfaction with services as a feedback loop to contractors.
- Self-management support: To empower and prepare clients to manage their care through promotion and integration of self-management skills in Part A programs.
- Community – resources and policies: To enhance resources to meet client needs through advocacy and partnerships with community-based organizations.

The focus on the Chronic Care Model in the entire system of care strengthens the Ryan White continuum. Each contracting provider is annually required to address two or more of the CCM elements in their quality improvement efforts. Sharing this framework has bolstered the ability of our providers to work together on common goals and ensure that the overall system is being improved for the clients that we serve.

II. Where Do We Want To Go?

The following guiding principle, first articulated in the TGA Quality Management Plan, is also the vision which guides the current and future system of HIV care and treatment.

The provision of a universally accessible continuum of high quality care in which people living with HIV/AIDS take a pro-active approach to managing their health.

While adhering to the above principle, goals have been outlined below which will serve as a roadmap for HIV care and treatment in the TGA for the next 3 years. These goals, first formulated and outlined in the 2009 Statewide Coordinated Statement of Need (SCSN), were the result of a collaborative process involving partners across the Ryan White continuum of care. Although presented individually, these goals intersect and the proposed strategies listed traverse and impact the continuum of care for clients.

Goal 1: Preventing New HIV Infections:

- Develop stronger linkages between HIV care and treatment and HIV prevention
- Develop and disseminate consistent messages around HIV testing and linkage to care & treatment that can be used in a variety of sites (e.g. private providers, hospitals, emergency rooms, correctional settings)

Goal 2: Finding HIV+ People Who Need Care and Treatment Services:

- Gather data to better understand why people are out of care
- Develop evidence-based systems to follow up on people who fall out of care
- When looking for people who may be out of care, go beyond “emerging populations” and consider larger social determinants of disease transmission (e.g. poverty, marginalization)

Goal 3: Engaging HIV+ People in Care and Treatment Services:

- Shore up early intervention services
- Identify and reduce system barriers (possibly via peer advocates/health navigators)
- Develop flexible models of care that better reflect client needs and do not attempt a “one size fits all” approach

Goal 4: Retaining HIV+ People in Care and Treatment Services:

- Develop client-centered approaches to care (relationship building between providers and clients, reminder phone calls, anniversary/incentives)
- Implement and promote self-management programs and tools for clients further along disease management continuum
- Develop strong linkages between systems (“warm hand off”) so clients don’t fall through the cracks
- Engage in evaluation/assessment/continuous quality management to ensure that services are accomplishing intended goals.

In 2006, the Portland TGA adopted the chronic care model as a framework for addressing quality improvement within the service delivery system. This model has proven to be effective in

producing positive outcomes in long-term treatment of individuals with other chronic illnesses. The model is comprised of six interrelated components as outlined below.

Component 1: Build Healthy Public Systems and Policy

Development and implementation of systems and policies designed to improve population health, and creation of a culture and mechanisms that promote quality care.

Component 2: Community

Mobilize community resources to meet needs of PLWH/A

Component 3: Self-management support

Empower and prepare PLWH/A to manage their health and health care

Component 4: Delivery system design

Assure the delivery of effective, efficient clinical care and self-management support

Component 5: Decision support

Promote clinical care that is consistent with scientific evidence and consumer preferences.

Component 6: Client information system

Organize consumer and population data to facilitate efficient and effective care

This model will serve as a method to further define and operationalize the four overarching TGA goals. Each of the goals will be framed within the context of these components and specific objectives and strategies will be outlined in the following section.

III. Goals and Objectives

The Part A Planning Council is responsible for developing measurable objectives and specific activities for each of the broad goals identified in the previous section. The chronic care model will help operationalize each of the four broad goals and shape them into action. Hence, for each three year objective, activities are outlined within the six elements of the Chronic Care Model (CCM) with shorter term process objectives following. Since there is some overlap between the elements, some process objectives are repeated.

GOAL 1: PREVENTING NEW HIV INFECTIONS	
<p>Objective 1: By 2011 the number of HIV positive individuals in Ryan White medical care who are subsequently diagnosed with an STD will be reduced by 10%. (Since a concurrent STD assists in the transmission of HIV disease and since subsequent STD diagnoses are an indication of unsafe sexual practices for an HIV + individual, a reduced number of STD diagnoses among PLWH/A can be used as a marker of increased safe sex practices within the community).</p>	
CCM Strategies	Process Objectives
<p><u>Build Healthy Public Systems and Policy</u></p> <ul style="list-style-type: none"> • Work with the State HIV Program to support efforts to increase health insurance support for HIV testing. • Participate in the process of developing new Ryan White legislative authorization to ensure that access to treatment and medications continues to be available for all PLWH/A. Reduced viral loads in those already infected with the virus is known to contribute to lower transmissibility. 	<p>By September 2009, a communication strategy will be established with the Health Department leadership and the State HIV Program to strengthen policy and advocacy efforts.</p>
<p><u>Community</u></p> <ul style="list-style-type: none"> • Ensure that consistent HIV testing information is available in all primary care sites, drug and alcohol treatment centers, mental health settings and housing providers. • Collaborate with prevention interventions occurring within the TGA. 	<p>By March 2010, current HIV testing information will be available at all primary care sites at Multnomah County Health Department.</p> <p>By March 2010, all case managers and all Ryan White providers will have received current information about prevention interventions available for their clients.</p> <p>By September 2010, current HIV testing information will be distributed to all drug and alcohol treatment centers, mental health settings and housing providers.</p>
<p><u>Self-Management Support</u></p> <ul style="list-style-type: none"> • Develop prevention messages for PLWH/A to be delivered to all Ryan White contractors. 	<p>By March 2010, a consistent prevention/care message will have been developed and tested.</p>

<p><u>Delivery System Design</u></p> <ul style="list-style-type: none"> • Ensure that population-specific prevention messages are integrated into HIV care and treatment services. • Integrate risk reduction with counseling and support groups. • Assure a coordinated referral mechanism exists between Part A and prevention programs throughout the TGA. 	<p>By March 2010, a plan for inclusion of client-level information about prevention interventions will be completed.</p> <p>By March 2010, a consistent prevention/care message will have been developed and tested.</p>
<p><u>Decision Support</u></p> <ul style="list-style-type: none"> • Develop tools to identify clients with higher risk of disease transmission who would benefit from further interventions and measure progress. • Develop tools and procedures that assist HIV care and treatment providers to better encourage their clients' partners to be tested for HIV. • Develop at least one QI activity per year to improve linkages between HIV care/treatment and HIV prevention. 	<p>By September 2009, tools to identify high risk clients will be developed.</p> <p>By March 2010 tools to assist HIV care and treatment providers to discuss sexual behaviors and risk factors will be developed .</p> <p>By September 2010 screening tools and messages will be tested and implemented by treatment providers.</p>
<p><u>Client Information Systems</u></p> <ul style="list-style-type: none"> • Facilitate better coordination of HIV care and prevention information and data systems across programs. 	<p>By March 2010, an assessment of prevention and care data systems will be completed to assess how to best share and coordinate the information therein.</p> <p>By September 2010 incorporate mechanisms to collect client-level data from Part A providers about prevention interventions.</p>
<p>GOAL 2: FINDING PLWH/A WHO NEED CARE AND TREATMENT SERVICES</p>	
<p>Objective 1: By 2011, the percentage of individuals in the TGA who are originally diagnosed with AIDS or progress to AIDS within the first 12 months, will be reduced by 10%.</p>	
<p>CCM Strategies</p>	<p>Process Objectives</p>
<p><u>Build Healthy Public Systems and Policy</u></p> <ul style="list-style-type: none"> • Support provision of HIV testing in correctional settings as a regular part of health services. 	<p>By March 2010, a system will be established to accommodate and provide assistance with access to care for any increase in the numbers of PLWH/A identified via rapid testing in TGA correctional settings.</p>
<p><u>Community</u></p> <ul style="list-style-type: none"> • Continue relationships with housing programs and organizations providing services to homeless. 	<p>By September 2009, a review of housing support services will have been completed.</p>
<p><u>Self-Management Support</u></p> <ul style="list-style-type: none"> • Providing <i>Positive Self Management Program (PSMP)</i> in correctional facilities. 	<p>By December 2009, contact will have been made with correctional facilities and necessary next steps will be</p>

	delineated.
<u>Delivery System Design</u> <ul style="list-style-type: none"> Require EIS services to create and develop partnerships with alcohol and drug treatment centers, mental health settings and housing providers. Develop relationships with primary care sites to ensure HIV tests are offered according to CDC guidelines and facilitate access to care for HIV+ individuals. Coordinate care and prevention/early intervention services for high risk, disproportionately affected communities, specifically Hispanics and male IDUs. Referral/linkage between community HIV testing and STD/TB/Hepatitis screening and treatment. 	<p>In FY 2009, EIS will enroll at least 90 recently diagnosed PLWH/A and other PLWH/A who have not engaged in primary medical care.</p> <p>By March 2009, EIS services and contracts will be adapted to better serve the highest risk populations including testing in alternate settings.</p> <p>By September 2009, presentation will be held on AIDS in the older generation, a population often overlooked for testing.</p>
<u>Decision Support</u> <ul style="list-style-type: none"> Develop tools and procedures that assist HIV care and treatment providers to consistently identify, provide prevention education and referral to partner counseling and referral services (PCRS) for any HIV+ individuals who develop STDs. 	By March 2010, a protocol will be established regarding follow-up education and partner testing for clients with HIV and successive other STDs.
<u>Client Information Systems</u> <ul style="list-style-type: none"> If permission is granted, use EMR data to ensure follow up of inmates who test positive and facilitate getting into care. Use STD data to ensure follow-up of HIV+ clients referred in PCRS. 	By December 2009, the feasibility of using corrections and STD EMR for follow up will have been investigated.
GOAL 3: ENGAGING PWLH/A IN CARE AND TREATMENT SERVICES	
Objective 1: By 2011, the percentage of individuals in the Ryan White EIS program successfully engaged in case management or medical care will increase to 85%.	
Objective 2: By 2011, the percentage of individuals with HIV disease living within the TGA who receive Ryan White medical care and/or medical case management who had a documented medical visit with clinician two or more times, at least three months apart will increase by 10%.	
CCM Strategies	Process Objectives
<u>Build Healthy Public Systems and Policy</u> <ul style="list-style-type: none"> Support Early Treatment of HIV Act and other federal actions that will increase the number of insured. 	By September 2009, a communication strategy will be established with the Health Department leadership and the State HIV Program to strengthen policy and advocacy efforts.
<u>Community</u> <ul style="list-style-type: none"> Provide information and training to primary care providers on symptoms of substance abuse and mental health issues. Strengthen communication between case managers and primary care providers. 	By March 2010, at least three Ryan White contractor meetings will have been held to facilitate delivery system improvements

<ul style="list-style-type: none"> • Maintain active referral systems with common points of entry for PLWH/A including but not limited to STD clinics and HIV counseling and testing sites, mental health and substance abuse treatment programs, correctional facilities, homeless shelters, refugee programs, and hospital emergency rooms. 	
<p><u>Self-Management Support</u></p> <ul style="list-style-type: none"> • Continue to provide <i>Positive Self Management Program</i> (PSMP) workshops on a regular basis. • Develop other Self Management support tools, such as encouraging patients to come with their top two subjects to discuss with the physician. 	<p>By March 2010, 10 PSMP workshops will have been held.</p> <p>By March 2009, other self management tools will have been developed.</p>
<p><u>Delivery System Design</u></p> <ul style="list-style-type: none"> • Strategize on how to reduce waiting time clients in need of mental health services. • Improve referral systems for clients at risk of falling out of care to mental health/substance abuse peer program or to psychosocial support programs. 	<p>By August 2009, mental health providers in Clark County will have been contacted to assess the possibility of holding mainstream mental health assessment slots open for HIV+ individuals on a monthly basis.</p> <p>By September 2009, a referral system from case management or medical care services to support systems will be established.</p>
<p><u>Decision Support</u></p> <ul style="list-style-type: none"> • Develop standards that facilitate a smooth and timely transition from EIS to other care services. • Identify system barriers faced by high acuity clients of color. 	<p>By August 2009, standards for transition from EIS to other care services will have been reviewed and expanded.</p> <p>In FY 2009, MAI-funded case managers will report on systems barriers found and will develop and implement plans to address the barriers.</p>
<p><u>Client Information Systems</u></p> <ul style="list-style-type: none"> • Use client-level data from medical facilities and medical case management programs to ensure that clients are engaging in regular medical visits. 	<p>By September 2009, the TOURS database will be improved and able to provide client-level medical visit data from the EMR.</p>
<p>GOAL 4: RETAINING PWLH/A IN CARE AND TREATMENT SERVICES</p>	
<p>Objective 1: By 2011, the percentage of individuals lost to care in the TGA medical case management system will be maintained at less than 5%.</p>	
<p>Objective 2: By 2011, the percentage of HIV+ individuals receiving medical care from Ryan White funded medical providers who have an undetectable viral load at last visit improves to and remains above 75%.</p>	

Objective 3: By 2011, the percentage of clients reporting that “Ryan White services helped them deal with their disease a great deal” increases and stays above 80%.	
CCM Strategies	Process Objectives
<u>Build Healthy Public Systems and Policy</u> <ul style="list-style-type: none"> Participate in the process of developing new Ryan White legislative authorization to ensure that access to treatment and medications continues to be available for all PLWH/A. 	By March 2010, a communication strategy will be established with the State HIV Program to strengthen policy efforts.
<u>Community</u> <ul style="list-style-type: none"> Share information about the proposed Ryan White legislation with partners on a regular basis. 	By March 2010, at least three Ryan White contractor meetings will have been held to facilitate delivery system improvements.
<u>Self-Management Support</u> <ul style="list-style-type: none"> Improve PLWH/A’s ability to self manage their participation in care and adherence to treatment through <i>HIV Positive Self Management Program (PSMP)</i>. Provide support beyond the original <i>Positive Self Management Program (PSMP)</i> workshops. 	<p>By March 2009, other self management tools will have been developed.</p> <p>By March 2010, at least two alumni sessions of PSMP and 10 PSMP workshops will have been held.</p>
<u>Delivery System Design</u> <ul style="list-style-type: none"> Explore alternative communication methods between care services and clients (i.e. text messaging, email, etc.), in addition to maintaining system for follow-up of medical care clients at risk of falling out of care. Provide transition services to support continuity of care for PLWH/A moving in and out of the Multnomah County jail system. Develop and implement action plans to reduce systems barriers for clients of color and create a more effective system to improve client outcomes. Use Peer mentor models to assist PLWHA having difficulties navigating the care system, while providing additional social support. 	<p>By December 2009, alternative communication methods to retain clients in care will be assessed.</p> <p>By December 2009, the feasibility of using corrections EMR for follow up will have been investigated.</p> <p>By March 2009, apply for technical assistance to help with identifying barriers and provide cultural competency training.</p>
<u>Decision Support</u> <ul style="list-style-type: none"> Improve on referral systems so that clients do not fall between the cracks. Use newly developed clinical performance measurement tools to identify quality improvement projects in care and treatment. 	<p>By August 2009, the council will be briefed on Peer Programs and their efficacy in improving referrals.</p> <p>By March 2010, at least one clinical quality improvement project will be developed using data from performance measurement tools, and council will be briefed on efforts.</p>
<u>Client Information Systems</u> <ul style="list-style-type: none"> Integrate client-level clinical data in the Part A data system. Develop performance measurement tools on clinical care into data system. 	By September 2009, clinical performance measurement tools will be developed in TOURS

Section IV: *How Will We Monitor Our Progress*

Improving the quality of services and measuring our success in reaching the goals outlined are necessary components of a sound comprehensive plan. Monitoring our success will also allow us to evaluate our progress and help us refine our goals for the future.

The Quality Management (QM) team, will monitor our progress on the comprehensive plan goals as part of monitoring the TGA's Clinical Quality Management Program (see the 2009 TGA Part A Application for more information). This team, established and operated by the TGA, is staffed by 1.5 FTE grant-funded staff.

Charting our progress will involve reliance upon diverse sets of data and information. HIV Care Services (HCS) engages in ongoing evaluation activities. Weekly staff meetings include quality management and data updates. The QM team meets monthly to assess data collection for the TOURS client-level database, which has improved our ability to monitor services and track clinical and program outcomes. The QM team completes a critical review of the annual Client Services Data Report to identify needed improvements that support Council decisions, service planning, and implementation. A senior research analyst from the joint Multnomah County/State of Oregon Program Design & Evaluation Services, provides technical support to the QM team to ensure methodologies are sound and reflect the best science. Each year, the QM Team reviews contractor requirements related to quality management, outcome measures, and data collection to assess the need for changes. This team will also assess progress toward reaching goals outlined in the Comprehensive Plan.

In 2008, HIV Care Services (HCS) in collaboration with Multnomah County Information Technology (IT) received a HRSA SPNS grant to enhance TOURS to meet 1) new client-level demographic and service reporting requirements and 2) new client-level outpatient medical care reporting requirements, as well as develop standard performance reports as outlined in the HAB HIV Core Clinical Performance Measures. While HCS already collects most of the new HRSA-required client-level demographic and service utilization data from all Part A contractors, we have not been able to collect client-level medical quality data from Part A medical contractors or generate medical care performance reports via TOURS. To better capture client medical and health indicator data, TOURS will also be enhanced to track not just current indicators, but changes to indicators over time such as CD4 count testing. Medical outcome and treatment data will be incorporated, including a history of antiretroviral medications, screening results and treatment of other diseases such as TB and Hepatitis B. A performance report suite will be developed to include measures outlined in the HAB HIV Core Clinical Performance Measures Group 1 and Group 2. The HCS QM team and the two Part A clinic directors will meet with IT staff to design standardized reports. Centralized medical and health indicator data in TOURS will improve continuity of care by giving each contractor access to information regarding the services clients receive from other medical providers. These data will also inform progress on meeting the overall goals of the comprehensive plan. The QM team will continue to meet regularly to discuss how centralized medical and service data can provide additional benefits in client care coordination and service planning.

In addition to collecting TOURS data, HCS also collects and analyzes CD4 count data for medical care clients in the Part A care system as a method of monitoring HIV-related clinical health outcomes. HCS also collaborated with the Oregon HIV Surveillance unit to compare clients participating in Part A services with those in the HIV lab reporting database. Analyzing the HIV lab reporting database also evaluates the percentage of clients who are receiving laboratory tests at appropriate intervals.

Oregon is one of the states selected by the Centers for Disease Control and Prevention (CDC) to participate in a national study examining the care that PLWH/A receive. The Medical Monitoring Project (MMP) collects data on access and barriers to care, unmet care and service needs, quality of treatment, co-morbidities, and patient behaviors (related to sex and drug risk) for patients receiving care in Oregon.

HIV and AIDS prevalence and incidence data are based on Oregon and Washington HIV/AIDS Reporting System (HARS). This system provided invaluable information about the demographic characteristics and exposure categories of HIV/AIDS cases. Using this data allows us to track shifts in the epidemic over time and monitor how our programs are impacting the epidemic. These data will be especially useful in assessing progress toward meeting the long term goals of reducing the number of new infections, and reducing the percentage of new infections who are diagnosed with, or progress to AIDS within the first twelve months.

Finally, each year, the Planning Council engages in a process of collecting information from PLWH/A about the services they need the most, services they may be having a difficult time receiving, and the barriers they are facing in accessing the services they need. In 2008, three different sources of information gathered from the community were reviewed: 1) a needs assessment survey completed by case management clients, 2) preliminary interview data from clients participating in the Medical Monitoring Project (MMP) and 3) community discussions were held in six different locations. These data will specifically inform progress on engaging and retaining clients in care. In addition a bi-annual survey of client service needs begun in 2008 will continue to be distributed through the length of this comprehensive plan.

Data from these sources and others will coalesce to inform the Quality Management Team on monitoring quality management goals as well as monitoring progress toward preventing new HIV infections, and finding PLWH/A who need care and treatment services, engaging PLWH/A in care and treatment services and retaining PLWH/A in care and treatment services. The comprehensive plan goals and objectives will be reviewed twice during each grant year – at the mid-year as part of the Priority Setting and Resource Allocation process and again as part of developing the annual Client Services Data Report.

APPENDICES

**TABLE 1: PORTLAND TGA AIDS INCIDENCE, HIV (non AIDS) INCIDENCE, AIDS PREVALENCE, AND HIV (non AIDS) PREVALENCE
BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY**

Data Source: Oregon and Washington HIV/AIDS Reporting Systems (HARS)

All numbers represent cases attributed to Oregon and Washington without adjustment for reporting delay or for incompleteness of reporting

Demographic Group/ Exposure Category	AIDS Incidence: 01/01/06 to 12/31/07*		HIV Incidence (non AIDS): 01/01/06 to 12/31/07		AIDS Prevalence as of 12/31/07		HIV Prevalence (non AIDS) as of 12/31/07		Combined HIV/AIDS Prevalence as of 12/31/07	
	<i>AIDS incidence: the number of AIDS cases diagnosed during the stated period.</i>		<i>HIV incidence: the number of HIV cases diagnosed during the stated period who have not progressed to AIDS</i>		<i>AIDS Prevalence: the number of people living with AIDS as of 12/31/07</i>		<i>HIV Prevalence: the number of diagnosed people living with HIV (not AIDS) as of 12/31/07</i>		<i>Combined HIV/AIDS Prevalence: the number of diagnosed people living with HIV or AIDS as of 12/31/07</i>	
<i>Race/Ethnicity</i>	#	%	#	%	#	%	#	%	#	%
White, not Hispanic	265	77.9%	273	76.5%	1,852	79.0%	1,307	80.3%	3,159	79.6%
Black, not Hispanic	22	6.5%	22	6.2%	186	7.9%	140	8.6%	326	8.2%
Hispanic	39	11.5%	45	12.6%	221	9.4%	141	8.7%	362	9.1%
Asian/Pacific Islander	10	2.9%	8	2.2%	50	2.1%	17	1.0%	67	1.7%
American Indian/ Alaska Native	3	0.9%	6	1.7%	26	1.1%	13	0.8%	39	1.0%
Multi- Race	1	0.3%	3	0.8%	7	0.3%	7	0.4%	14	0.4%
Unknown	0	0.0%	0	0.0%	2	0.1%	2	0.1%	4	0.1%
Total	340	100.0%	357	100.0%	2,344	100.0%	1,627	100.0%	3,971	100.0%
<i>Gender</i>	#	%	#	%	#	%	#	%	#	%
Male	306	90.0%	317	88.8%	2,129	90.8%	1,405	86.4%	3,534	89.0%
Female	34	10.0%	40	11.2%	215	9.2%	222	13.6%	437	11.0%
Total	340	100.0%	357	100.0%	2,344	100.0%	1,627	100.0%	3,971	100.0%

Appendix A

Demographic Group/ Exposure Category	AIDS Incidence: 01/01/06 to 12/31/07*		HIV Incidence (non AIDS): 01/01/06 to 12/31/07		AIDS Prevalence as of 12/31/07		HIV Prevalence (non AIDS) as of 12/31/07		Combined HIV/AIDS Prevalence as of 12/31/07	
	#	%	#	%	#	%	#	%	#	%
Age**										
0-12	0	0.0%	2	0.6%	1	0.0%	11	0.7%	12	0.3%
13-24	11	3.2%	56	15.7%	17	0.7%	83	5.1%	100	2.5%
25-34	85	25.0%	102	28.6%	188	8.0%	325	20.0%	513	12.9%
35-44	127	37.4%	110	30.8%	814	34.7%	544	33.4%	1,358	34.2%
45-49	45	13.2%	41	11.5%	503	21.5%	275	16.9%	778	19.6%
50-64	64	18.8%	38	10.6%	746	31.8%	345	21.2%	1,091	27.5%
65+	8	2.4%	4	1.1%	75	3.2%	44	2.7%	119	3.0%
Unknown	0	0.0%	4	1.1%	0	0.0%	0	0.0%	0	0.0%
Total	340	100.0%	357	100.0%	2,344	100.0%	1,627	100.0%	3,971	100.0%
Adult Male Risk/ Exposure Category	#	%	#	%	#	%	#	%	#	%
MSM	202	66.0%	243	76.9%	1,516	71.3%	1,105	79.0%	2,621	74.4%
IDU	28	9.2%	20	6.3%	190	8.9%	72	5.2%	262	7.4%
MSM/IDU	30	9.8%	29	9.2%	205	9.6%	107	7.7%	312	8.9%
Receipt of blood product	3	1.0%	0	0.0%	19	0.9%	7	0.5%	26	0.7%
Heterosexual	31	10.1%	15	4.7%	159	7.5%	77	5.5%	236	6.7%
Risk not specified	12	3.9%	9	2.8%	38	1.8%	30	2.1%	68	1.9%
Total	306	100.0%	316	100.0%	2,127	100.0%	1,398	100.0%	3,525	100.0%
Adult Female Risk/ Exposure Category	#	%	#	%	#	%	#	%	#	%
IDU	8	23.5%	9	22.5%	50	23.3%	43	19.4%	93	21.3%
Receipt of blood product	0	0.0%	0	0.0%	4	1.9%	5	2.3%	9	2.1%
Heterosexual	25	73.5%	30	75.0%	153	71.2%	157	70.7%	310	70.9%
Risk not specified	1	2.9%	0	0.0%	6	2.8%	5	2.3%	11	2.5%
Total	34	100.0%	39	97.5%	213	99.1%	210	94.6%	423	96.8%

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Demographic Group/ Exposure Category	AIDS Incidence: 01/01/06 to 12/31/07*		HIV Incidence (non AIDS): 01/01/06 to 12/31/07		AIDS Prevalence as of 12/31/07		HIV Prevalence (non AIDS) as of 12/31/07		Combined HIV/AIDS Prevalence as of 12/31/07	
<i>Pediatric Risk/ Exposure Category</i>	#	%	#	%	#	%	#	%	#	%
Mother with HIV-Risk	0	0.0%	2	0.6%	3	0.1%	19	1.4%	22	0.6%
Receipt of blood product	0	0.0%	0	0.0%	1	0.5%	0	0.0%	1	0.2%
Risk not specified	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	0	0.0%	2	0.6%	4	0.6%	19	1.4%	23	0.9%

* AIDS Incidence includes cases diagnosed prior to 2006 but who progressed to AIDS in 2006–2007

** Age was calculated for age at AIDS diagnosis, HIV(nonAIDS) diagnosis, and on 12/31/2007 as appropriate

Table 2: 2007 Co-morbidities, Poverty, Insurance Status and Medical Coverage*

Co-morbidity	General Population Prevalence: # / %	PLWH/A Population Prevalence: # / %
Tuberculosis ¹	2007 cases: 67 2007 rate/100,000 pop.: 3.1	2001-2007 average case rate: 127.3 per 100,000 PLWHA
Syphilis ¹	2007 cases: 26 2007 rate/100,000 pop. Age 13+: 0.8	7 cases 177/100,000 PLWH/A age 13+
Gonorrhea ¹	2007 cases: 1,238 2007 rate/100,000 pop. Age 13+: 39.6	69 cases 1,743/100,000 PLWH/A age 13+
Injecting Drug Users (IDU) & Other Substance Abuse ^{3,4,5,15}	IDU: 21,490 individuals 1.0% of population Other Substance Abuse 286,554 individuals 17.7% of population 18+	IDU: 574 persons (14.5%) Other Substance Abuse 590 persons (14.9%)
Homelessness ^{3,4,6,7}	32,224 individuals in a one-year period (1.6%)	568 persons (14.3%)
Severe Chronic Mental Illness ^{8,9}	171,922 persons (8.0%)	731 persons (18.4%)
All Mental Illness ^{3,4,8,9}	444,131 persons (20.7%)	2,105 persons (53.0%)
Dual Diagnosis of Substance Abuse & Mental Illness ^{3,4, 11}	Not available	937 persons 23.6% of population
Hepatitis C ¹⁰	38,682 persons (1.8%)	993 persons (25%)
No Health Insurance ^{11, 12, 16}	315,906 persons (14.7%)	655 persons (16.5%)
Poverty ^{4,11,12,16}	300% of FPL 881,098 persons (41.0%) 100% of FPL 242,839 persons (11.3%)	300% of FPL 3,888 persons (97.9%) 100% of FPL 2,919 persons (73.5%)
Medicaid Coverage ^{13, 14, 16}	207,720 persons (9.7%)	739 persons (18.6%)

*The table above provides prevalence data on primary co-morbidities, poverty, insurance status and Medicaid coverage for the general population and PLWH/A in the Portland TGA, as well as data sources and dates. Quantitative data from multiple sources have been used to describe co-morbid conditions, poverty, and insurance status. Where the number of cases varied across the data sources, a mid-point reference was taken as the best estimate of the co-morbidity for the particular condition. Population data is based on 2007 Census Estimates, 2007 Portland State University Population Estimates, and 2007 Washington State Office of Financial Management.

¹ Oregon Health Division (OHD), 2007. ² Clark County Health Department (CCHD), 2007. ³ 2002 Survey for People Living with HIV and AIDS in Oregon, 2003. ⁴ Partnership Project & Clark County Case Management Database, 2007. ⁵ Oregon Office of Alcohol and Drug Abuse County Databooks, 2002. ⁶ U.S. Conference of Mayors Report, 2007. ⁷ Clackamas Community Development, 2003-2005 Consolidated Plan. ⁸ American Psychiatric Association, July 2002. ⁹ SAMHSA: Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003. ¹⁰ CDC Data. ¹¹ MCHD EPIC, FY 2008. ¹² 2006 Oregon Population Survey. ¹³ Washington Dept. of Social & Health Services, 2007. ¹⁴ Oregon Office of Medical Assistance Programs, 2007. ¹⁵ National Development and Research Institutes, Inc. 2003 ¹⁶ Annual Client Services Data Report, 2007-2008, MCHD HIV Care Services Program.

Table 3: Portland TGA Unmet Need Framework, 2007

Population sizes	Value	Data Source
A. Number of persons living with AIDS (PLWA) aware during 01/01/07 – 12/31/07	2,309	HARS ₁
B. Number of persons living with HIV(not AIDS) (PLWH) aware during 01/01/07 – 12/31/07	1,584	HARS ₁
Care patterns – Met Need³	Value	Data Source
C. Number of PLWA who received the specified HIV primary medical care services in 2007	1,627 (70%)	HARS and TRIO ₂
D. Number of PLWH who received the specified HIV primary medical care services in 2007	1,169 (74%)	HARS and TRIO ₂
Calculated results – Unmet Need	Value	Data Source
E. Number of PLWA who did not receive the specified HIV primary medical care services in 2007	682 (30%)	A-C (Percent: E/A)
F. Number of PLWH who did not receive the specified primary medical care services in 2007	415 (26%)	B-D (Percent: F/B)
G. Number of PLWH/A who did not receive the specified HIV primary medical care services in 2007	1,097 (28%)	E+F (Percent: G/(A+B))

(1) The HIV/AIDS Reporting System (HARS) in Oregon and Washington were used to estimate the number of PLWH. HARS data was extracted in July 2008. The population includes Oregon cases living during 2007 who were 13 years of age as of 12/31/2007. Oregon initiated rules requiring reporting of all CD4 and viral loads in late 2006 and intensified surveillance activities during 2007. These changes suggest near 100% completeness of CD4 and viral load reporting (met need). It is unknown how complete case reporting currently is, but it much better than previous estimates suggest. The values in the Unmet Need table were therefore unadjusted. For more information please see section 1.g. in the Program Narrative.

(2) The Tracking HIV Reporting Information System in Oregon (TRIO) is the laboratory database used in HIV/AIDS surveillance to monitor reportable results from CD4 and viral load tests.

(3) Met need is defined as the number of PLWA and PLWH with at least one viral load or CD4 lymphocyte test collected during 2007.

Table 4: Summary of Findings Regarding Service Needs and Gaps

Service Need Category	% Surveyed Needing Service	% Surveyed Needing Service Who Faced a Gap	% Estimate of PLWH/A Who Face a Gap
Outpatient Medical Care	94%	18%	17%
Help Buying Prescription Drugs	71%	21%	15%
Oral Health Care	66%	48%	32%
Groceries or Meals:	46%	60%	28%
Mental Health Counseling	44%	52%	23%
Transportation	44%	49%	22%
Ongoing Help With Housing	41%	43%	17%
Emergency Rent/Utilities Paid	37%	73%	27%
Over-the-Counter Medications	32%	76%	24%
Acupuncture or Naturopathic Care	27%	64%	17%
Outpatient Substance Abuse Treatment	16%	56%	9%
Residential Substance Abuse Treatment	5%	52%	3%

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Table 5: FY 2009 Part A Funding in the Context of Other Public Funding for HIV Care Services

Category:	1	2	3	4	5	6	7		
	Outpatient Medical Care	ADAP	Home and Community Based Services	Other Primary Care Svcs	Oral Health Care	Substance Abuse/Mental Health Tx	Minority AIDS Initiative	Total	% of Funding
Ryan White Part A	715,300	-	611,600	1,124,050	300,200	207,500	87,426	3,046,076	17.8%
Other Federal	1,945,274	5,050,328	1,582,306	1,646,899	458,060	450,000	24,008	11,156,875	65.0%
State	-	1,151,200	-	192,817	11,284	75,000	-	1,430,301	8.3%
City/County	1,291,225	-	79,261	156,767	-	-	-	1,527,253	8.9%
Total	3,951,799	6,201,528	2,273,167	3,120,533	769,544	732,500	111,434	17,160,505	100.0%

Transitional Grant Area Resource Inventory

Providers		Description	Receives Part-A Funding for some services	Services Provided
1	CareAssist	Helps low income Oregonians living with HIV/AIDS pay for HIV medications and medical insurance, including premiums, co-pays and deductibles		Assistance with health insurance and medication payments
2	Cascade AIDS Project	Lead efforts to prevent new HIV infections, care for people affected and infected by HIV/AIDS, educate communities to eliminate stigma and shame, and advocate for immediate action in combating the pandemic.	●	Case management, Early Intervention Services, Furniture, Housing, Life Skills workshops, HIV Testing, Outreach & Advocacy, Support, Youth and Family programs
3	Cascadia	Outpatient treatment for chemical dependency. Specialized services for gay, lesbian, bisexual and transgender persons.		Alcohol & drug treatment
4	Central City Concern	Central City Concern's programs provide health, recovery, housing and employment training to help people complete a transformation toward self-sufficiency.	●	Alcohol & drug treatment, Complementary medicine, Housing
5	Clackamas County Community Health Centers	Provides HIV testing, comprehensive dental care and primary medical care for low-income Clackamas County residents		HIV testing Dental care
6	Clark Co. Public Health	The Clark County Health Department provides specialized support for people living with HIV/AIDS. In addition to prevention education and HIV testing, case managers can help direct clients to needed resources and learn new ways of coping with their disease.	●	Alcohol & drug treatment, Case management, Dental care, HIV testing and prevention education, Housing, Insurance, Prescription drug assistance,

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Providers		Description	Receives Part-A Funding for some services	Services Provided
				Mental health, Psychosocial Support, Transportation
7	Columbia County Public Health	Provides sliding fee scale for anonymous or confidential HIV testing,		HIV testing
8	De Paul Treatment Centers	Residential and outpatient alcohol and drug treatment.		Alcohol & drug treatment
9	Ecumenical Ministries of Oregon (EMO)	The EMO HIV Services program is a staff/volunteer/participant community that strives to address basic needs of individuals living with HIV/AIDS in a manner consistent with the values of respect, compassion and safety.	●	Psychosocial Support, Drop-in services, Congregate and Home-delivered meals Recovery groups, Clothing & Household items, Personal Care Services Transportation
10	Esther's Pantry	Food bank for low-income people who are medically disabled because of HIV or AIDS.		Food & some personal care items
11	Fanno Creek Clinic	HIV/AIDS specialty care.	*	Medical care
12	Friends of People with AIDS Foundation	Providing information and resources; telling our collective stories in HIV from the past, present, and future; and being the trusted independent voice of people living with HIV.		Clothing & Household items, Funeral & Cremation, Pet Care
13	Goodwill Industries	Free 30-day job search assistance for people who are disabled or disadvantaged, including due to HIV/AIDS.		Job assistance
14	Hopewell House	Inpatient hospice for terminally ill patients.		Residential care
15	Institute for Traditional Medicine	ITM provides reduced cost treatment using traditional medicine. Includes acupunctures, massage, Chinese herbal medicine and vitamins.		Complementary medicine

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Providers		Description	Receives Part-A Funding for some services	Services Provided
16	Kaiser Immune Deficiency Clinic	Specialty clinic with multidisciplinary team approach to treating HIV disease. Services patients with Kaiser health insurance.		Medical care
17	Martha's Pantry	Clothing, hygiene items, food and cleaning supplies for low-income people with HIV/AIDS in Clark or Skamania counties.	●	Clothing & hygiene items, Food
18	Multnomah Co. Health Dept.	Full-service HIV specialty care including pharmacy, nutrition, mental health services and case management.	●	Hep C testing, HIV testing, Needle exchange, HIV care, Alcohol & drug treatment,
19	Northwest Recovery Center	Alcohol, drug and mental health treatment provided in-home and at supportive community locations.		Alcohol & drug treatment
20	OHSU Russell St. Dental Clinic	Low-cost dental program for insured or uninsured people living with HIV/AIDS.	●	Dental care
21	OHSU Partnership Project	Help people living with HIV/AIDS achieve or sustain the highest possible quality of life and health and to provide those living with HIV/AIDS and their families, access to information, treatment and support services.	●	Case management, Prevention counseling, Support, Transportation
22	OHSU Internal Medicine Clinic	Statewide program manages the primary care needs of adults with HIV disease and/or Hep C. Offers on-site case management and clinical trials.	●	Medical care
23	Oregon Advocacy Center	Defends the rights of people with disabilities. Info and advice about disability benefits, and assistance with legal problems directly related to a disability.		Legal
24	Our House of Portland	Residential-care facility for people living with AIDS.		Residential care
25	Outside In	Addresses the changing needs of homeless youth and other low-income and marginalized		Hep C testing, HIV testing, Needle exchange

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Providers		Description	Receives Part-A Funding for some services	Services Provided
		people as they work toward self-sufficiency and improved health by providing innovative social, medical and mental health services and material resources.		
26	Portland VA Medical Center	For service-eligible veterans only.	*	Medical care
27	Providence PACE Clinic	Primary and infectious disease specialty care for adults, provided through the internal medicine residency program. .	*	Medical care
28	Quest Center for Integrative Health	Assists clients to sustain lifestyle changes that support healing, and to effectively strengthen those diagnosed with chronic or life-challenging illnesses, including HIV/AIDS, mental health disorders, chemical dependency, and cancer. WOW (Women of Wisdom) program provides support and education for women living with HIV and AIDS.	●	Activities, Complementary medicine, Mental health, Food & nutrition, Psychosocial Support, Substance abuse treatment
29	Sea Mar Community Health Center	Low-cost dental care for people with low incomes or no insurance.		Dental care
30	Swan House (operated by Our House of Portland)	Full-service, adult foster-care home for low-income people living with HIV/AIDS. Focus is on helping residents live as independently as possible.		Residential care
31	Washington County Health Department	Sliding fee scale for anonymous or confidential HIV testing		HIV testing
32	Vancouver Clinic	HIV/AIDS specialty medical care.		Medical care
33	Yamhill Co. Public Health	Provides HIV/AIDS services to residents of Yamhill county.	●	Case management, Hep C testing, HIV testing, Home-delivered meals, Mental health treatment

*Agency does not receive direct funding but participates in the Partnership Project HIV Case Management program therefore HIV specific case management is available on-site.

Ryan White Part A-Funded TGA Providers by Service Category

Provider		Services Categories							
		Core Services					Support Services		
		Ambulatory/ Outpatient care	Medical Case Mgt	EIS	Substance Abuse	Mental Health	Dental	Psycho- social	Housing
1	Cascade AIDS Project		●	●				●	
2	Central City Concern				●			●	
3	Clark Co. Public Health		●	●	●	●	●	●	
4	Ecumenical Ministries of Oregon						●		●
5	Multnomah Co. Health Dept HIV Health Service Ctr	●							
6	OHSU Russell St. Dental Clinic					●			
7	OHSU Partnership Project		●						
8	OHSU Internal Medicine Clinic	●							
9	Quest Center for Integrative Health-					●	●		
10	Yamhill Co. Public Health		●			●			