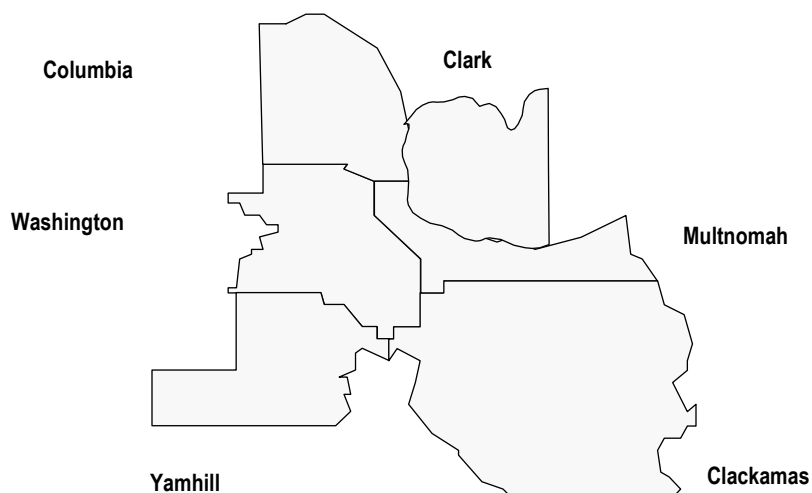


**Annual Client Services Data Report  
2008-2009**

**for Ryan White Part A-Funded Agencies  
Portland Transitional Grant Area (TGA)**

**June 2009**

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**HIV Care Services Program**

**Multnomah County Health Department**



# **Acknowledgements**

Special thanks to the individuals and programs that contributed to the content and analysis in this report. The information contained in this document is the result of many hours of work by service providers who collect these data from clients and regularly submit quantitative and qualitative reports throughout the year. The HIV/STD/TB Program at the Oregon Department of Human Services provided regular updates on the scope of the HIV/AIDS epidemic and unmet needs of persons living with HIV/AIDS. Program Design and Evaluation Services at the Oregon Department of Human Services assisted in collecting information on client satisfaction and service needs. Information Technology at Multnomah County Health Department work on the Title One Unduplicated Reporting System (TOURS) established access to much of the data contained in this report. And lastly, we wish to thank our clients for their time in sharing this information with us.

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## How to Read and Use This Report

### **What is the purpose of this report?**

This report provides an overview of the HIV/AIDS epidemic in the Portland transitional grant area (TGA), and of clients receiving services supported by Ryan White Part A funding.<sup>1</sup> Ryan White Part A funds are federal grant monies given to TGAs to fill gaps in services for low-income persons living with HIV/AIDS (PLWH/A). The Portland TGA consists of five counties in Oregon (Clackamas, Columbia, Multnomah, Washington, and Yamhill) and one in Washington (Clark). Information on service utilization, client characteristics and outcomes are also detailed in this report for the 10 service categories funded by Part A. Comparisons are made between the TGA HIV/AIDS epidemic, the total clients receiving Part A-funded services, and clients receiving specific services. This report is intended to be used for the planning of Part A services and activities. This information may also be valuable to local health agencies, HIV/AIDS providers, and policy makers for program planning.

### **How is this report organized?**

The report begins with an overview of the HIV/AIDS epidemic in the Portland TGA, and the service needs of PLWH/A in Section 1. Section 2 describes the population receiving HIV core and support services from Part A-funded providers in 2008 and compares their demographic characteristics to those of the TGA epidemic. This section also provides information on other client characteristics, including reports on special or emerging populations and an overview of client

acuity. Section 3 presents an overview on patterns of client service utilization and data for the 10 service categories funded by Part A, including how many clients accessed these services, client characteristics, and service cost. Section 4 provides a summary of some Part A quality management activities, focusing on service outcomes among Part A providers and client satisfaction.

### **What time period is reported?**

Data are presented from the most recent time period available. Data as of December 31, 2007 are reported for the TGA HIV/AIDS epidemic. Client, service utilization, and outcomes data are reported for FY 08-09 (March 1, 2008 to February 28, 2009). As a new client-level data collection system was implemented in 2005, much of the data presented are for either the last four years or current year only. When possible, trends are reported.

### **What kinds of data are used?**

Service utilization data are presented in numbers. Client demographics/other characteristics and HIV/AIDS epidemic information are often presented as percentages so that comparisons can be more easily made across different groups.

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<sup>1</sup> As of the passing of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, Ryan White Title I is now referred to as Part A. The eligible metropolitan area or EMA for these funds is now referred to as the transitional grant area or TGA.

## Summary of Findings

### People Living with HIV/AIDS in the TGA

The highest concentration of HIV/AIDS cases in Oregon is in the Portland metropolitan area, with the majority of cases being located in Multnomah County. As of the end of 2007, close to 4,000 people were estimated to be living with HIV/AIDS in the TGA (n=3,971).

Though males represent the majority of the epidemic (89%), females account for an increasing percentage of HIV (non AIDS) cases. As of the end of 2007, women comprised 14% of HIV (non AIDS) cases, while accounting for only 9% of all AIDS cases. The majority of PLWH/A in the TGA are white, non-Hispanic (80%). However, HIV/AIDS continues to disproportionately affect the African American/Black community. The prevalence rate among African Americans/Blacks is approximately 3 times higher than Whites.

### Unmet Need in the TGA

Each year, an estimate is generated of PLWH/A who have an unmet need for medical care, as indicated by the lack of CD4 or viral load testing. These estimates have become more accurate as Oregon rule changes made all viral load and CD4 results reportable to State surveillance. These estimates show that close to three out of four PLWH/A in the TGA (73%) have accessed medical care in Oregon in 2007. Among Part A clients, 92% had received CD4 or viral load testing in Oregon in 2007.

In a needs assessment survey conducted in late 2008, at least one in two TGA clients reported outpatient medical care, health insurance, dental care, case management, financial assistance for housing, and mental health counseling as their top service needs. Close to one-fourth of respondents reported gaps in dental care. Other top service gaps included financial assistance with housing and other housing help, case management, mental health therapy and support services.

In 2009, a series of community forums with clients were initiated to better understand what difficulties or barriers consumers faced in accessing these services. Primary barriers in accessing dental, housing, mental health, psychosocial and food services were described, including service inconvenience, such as appointment times scheduled far out, inconvenient timing of services and classes (e.g. during working hours only, etc.), and services being closed during certain days. Participants also described poor provider communication, not knowing what services were available and fluctuations in provider quality as barriers to services.

### Ryan White Part A Client Characteristics

In 2008, 2,548 clients received services through Part A-funded providers, an increase of 238 clients served from 2007 (n=2,310). Part A clients in 2008 represent close to two-thirds of all TGA cases (64%). As a system designed to fill gaps for low-income PLWH/A, the Part A-funded system of care generally over-represents vulnerable and special needs populations. As observed in the past three years, females and racial/ethnic minorities received Part A-funded services in 2008 in greater proportion than their representation in the epidemic.

Part A clients continue to be severely affected by poverty, lack of stable housing, and reductions in publicly-funded insurance and medication programs. At the end of 2008, close to one-fifth of clients did not have permanent housing (18%). A higher percentage of Black/African-American clients (29%) are without permanent housing in comparison to other racial/ethnic groups. Approximately 70% of clients had incomes at or below 100% of the federal poverty level (FPL), while 13% did not have medical insurance coverage at the end of 2008. However, over the course of the year, an estimated one in four clients was uninsured (24.4%) at some time.

### Client Acuity

Acuity scores are a reflection of the severity of client needs; higher acuity scores indicate greater client needs. A higher percentage of female clients had acuity scores 29 and above (44%) in

comparison to male clients (35%). A greater proportion of clients with injection drug use (IDU) as their primary risk factor also had higher acuity scores (61%). The majority of clients though were assessed to need service access services (64%; scores <29), as opposed to more intensive case management services.

### **Patterns of Service Utilization**

In 2008, 95% of all Part A clients received at least one HIV core health care service from Part A-funded providers, including outpatient medical care, medical case management, health insurance, dental care, mental health therapy, substance abuse treatment, and early intervention services. Approximately 28% of all clients received at least one support service, similar to 2007. Support services include housing, psychosocial support, and food/home-delivered meals. Approximately 23% of all clients received both core and support services from Part A-funded providers. Close to half of all clients (47%) accessed services from two or more Part A providers in 2008.

In 2008, nearly all Part A providers consistently met or exceeded their service goals and fully expended Part A funds (99.1%) allocated for services.

### **Part A-Funded HIV Core Services**

Women and racial/ethnic minorities continue to access and utilize medical, medical case management and early intervention services in greater proportion than their representation in the epidemic.

Several issues impacted core service providers last year. Outpatient medical care, medical case management and dental care providers continued to see increasing numbers of clients, with flat or decreased funds. The percentage of outpatient medical care clients who are underinsured increased substantially in the last 5 years, placing a strain on the ability to provide full wrap-around services. However, mental health parity legislation related to health insurance plans resulted in less reliance on Part A funds to fill mental health coverage gaps for clients, and has

allowed some funds traditionally allocated to mental health services to be reallocated to other service areas in 2008.

### **Part A-Funded Support Services**

Part A-funded support services are offered to vulnerable or special-need clients. These services assist them with basic needs, and promote their retention in medical care and adherence to treatment.

As seen over the past two years, a significantly higher percentage of clients receiving support services were persons of color, female, non-permanently housed and had incomes at or below 100% FPL in comparison to clients not receiving support services. In comparison to 2007, there was a small increase in funds allocated to support services, though an ongoing reduction of some services continued in 2008 from the previous year. A slight increase in housing clients was seen in 2008, while the number of clients receiving psychosocial and home-delivered meal services remained stable.

### **Part A Quality Management**

In comparison to 2007, most service category-specific outcomes remained relatively stable in 2008. Medical case management and medical care providers met their target benchmarks for medical care access and client CD4 count results. Part A providers also distributed a client satisfaction survey in 2008. Clients ranked the quality of Part A services very high, with 96% of clients ranking the services they received in the past year as “excellent” or “good”. Fewer African Americans/Blacks were satisfied with the level of respect and care received in comparison the clients of other racial/ethnic groups, while clients aged 45 or older were more likely to feel that services “helped a great deal” than clients under 45. No differences in satisfaction by gender existed.

# 1

## Scope of HIV/AIDS Epidemic in the Transitional Grant Area (TGA) and the Needs of PLWH/A

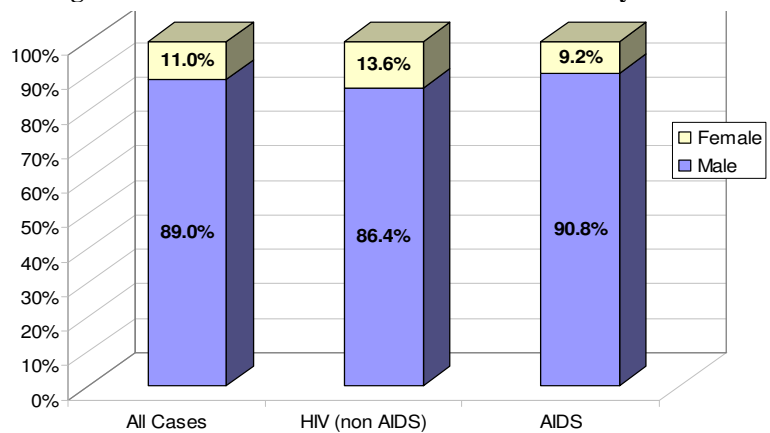
### HIV/AIDS Prevalence in the TGA

Prevalence represents the number of cases present in a given population at a point in time. In the example of HIV disease, prevalence equals the number of cases minus the number of deaths.<sup>2</sup> Understanding the distribution of living HIV/AIDS cases within the TGA by age, gender, race/ethnicity, risk category, and geographic location can assist in guiding service and health care planning for people living with HIV/AIDS (PLWH/A). For the purposes of this report, AIDS prevalence is defined as the number of people living with AIDS as of 12/31/2007; a diagnosis of AIDS remains a permanent diagnosis. HIV prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS, the advanced stage of HIV disease).

### Distribution of Prevalence by Gender, Age, Race, Risk Category and County

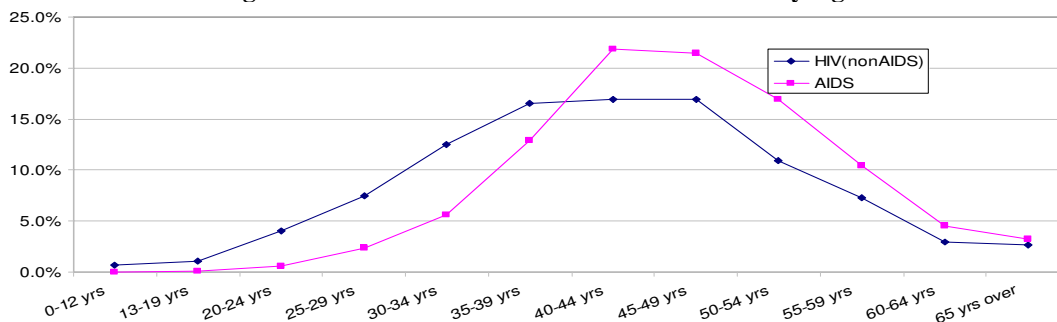
As of December 31, 2007, a total of 3,971 people were estimated to be living with HIV/AIDS in the TGA. Of those, 1,627 people were estimated to be living with HIV, while 2,344 were diagnosed with AIDS. Males accounted for 89.0% of all living HIV/AIDS cases, while females accounted for 11.0%.

Figure 1.1 Percent of TGA HIV and AIDS Cases by Gender



The graph below displays the distribution of HIV and AIDS cases in the TGA by age. The population living with HIV/AIDS is getting older. Older PLWH/A represent a greater proportion of AIDS cases; 56.5% of AIDS cases are among individuals 45 years of age or older, compared to 40.8% of HIV cases. A lower percentage of female PLWH/A (40.3%) are 45 years of age or older in comparison to male PLWH/A (51.3%).

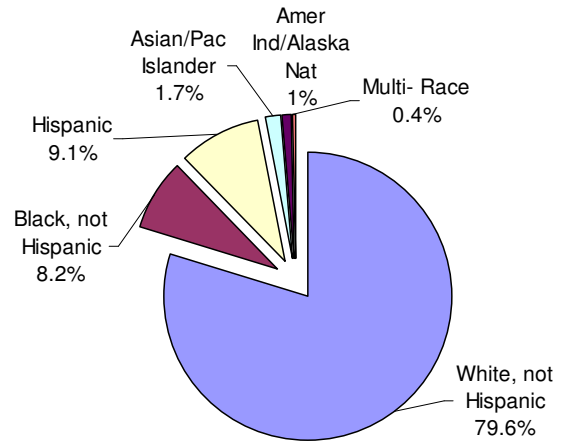
Figure 1.2 Percent of TGA HIV and AIDS Cases by Age



<sup>2</sup> HIV/STD/TB Program, *HIV/AIDS Epidemiological Profile: 2004*, Oregon Department of Human Services.

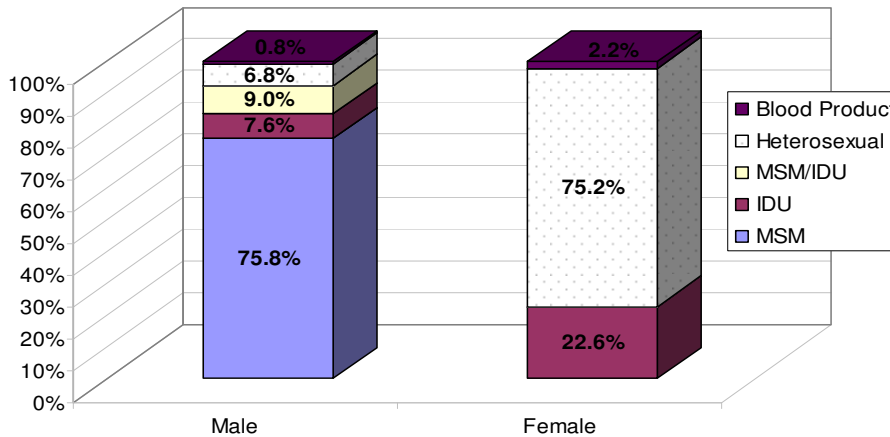
Figure 1.3 shows the distribution of HIV/AIDS cases by race/ethnicity in the TGA. HIV/AIDS has had a disproportionately high impact on Black/African Americans in the TGA. Though accounting for fewer than 10% of all living HIV/AIDS cases, the prevalence rate among Black/African Americans was 2.9 times higher than the rate among Whites. The prevalence rate among other racial/ethnic groups is comparable to the rate among White. The impact of HIV/AIDS is even more pronounced among female PLWH/A of color. Approximately 39% of all women living with HIV/AIDS in the TGA are racial/ethnic minorities.

**Figure 1.3 HIV/AIDS Prevalent Cases by Race/Ethnicity**

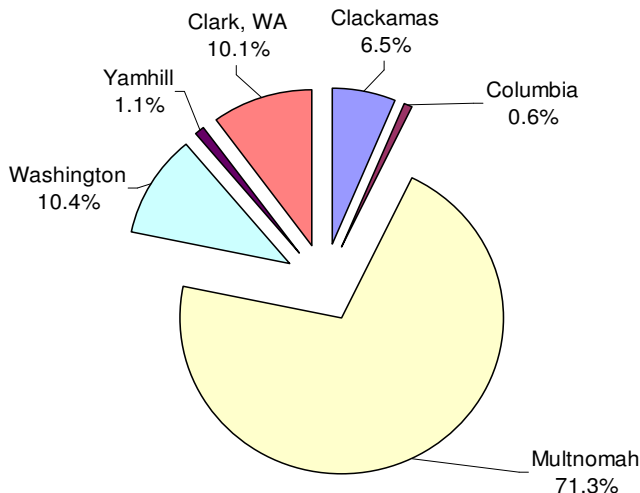


The predominant reported risk category among *all* PLWH/A in the TGA is men who have sex with men (MSM). MSM accounted for 67.7% of all living adult HIV/AIDS cases, followed by those with heterosexual risk (14.8%), and intravenous drug use risk (IDU; 9.6%). Reported risk varies substantially by gender. Heterosexual contact was the predominant risk category for adult females (75.2%), and MSM is the predominant risk category for adult males (75.8%; see chart below).

**Figure 1.4 HIV/AIDS Cases by Risk Category**



**Figure 1.5 HIV/AIDS Cases by TGA Counties**



Approximately 71% of all living PLWH/A in the TGA live in Multnomah County, followed by Washington County (10.4%), Clark County (10.1%), Clackamas County (6.5%), Yamhill County (1.1%), and Columbia County (0.6%). Previous reports indicate that a higher proportion of female PLWH/A reside outside Multnomah County than male PLWH/A.

### Additional Key Epidemiological Facts

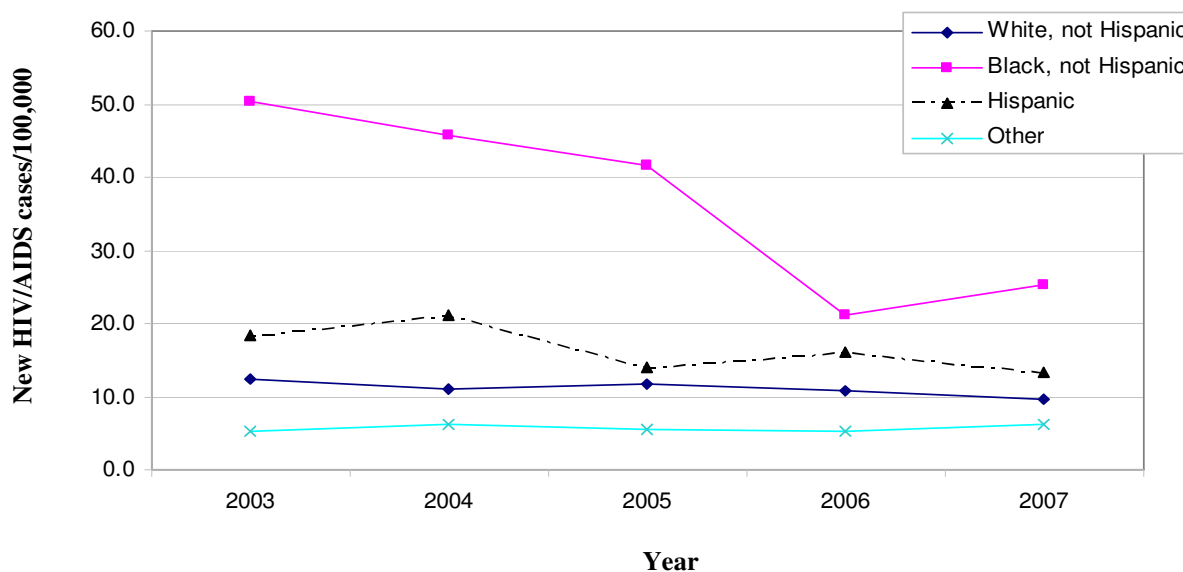
**TGA Incidence (2002-2007):** Incidence is the number of new disease cases in a population in a specific period of time. HIV incidence can be estimated from the number of newly reported HIV/AIDS cases within the year of diagnosis, though many persons with HIV/AIDS do not know precisely when they were infected. Since 2002, the incidence of HIV/AIDS TGA diagnoses has averaged about 12/100,000 persons or about 250 new cases per year. In 2007, the rate of new HIV/AIDS diagnoses among men was about 8 times the rate among women. Infection rates also varied by age group, with persons aged 25-34 years of age having the highest rate (21 cases/100,000 residents) followed by those 35-49 years of age (19 cases/100,000 residents), and 13-24 years of age (10 cases/100,000 residents).

Disparities in the incidence of HIV/AIDS continue to persist among racial/ethnic minorities in the TGA. The average rates of infection (2003–2007) by race/ethnicity are:

- Hispanics 16.9 cases/100,000 residents
- Whites 11.1 cases/100,000 residents
- African American/Black 36.5 cases/100,000 residents

The rate of infection was higher among African Americans/Blacks over the last five years. The number of cases diagnosed though has averaged around 20 cases per year, with almost half of these being immigrants from Africa (average 8 cases per year). The 2007 rate of infection for African Americans/Blacks was a slight increase from the 2006 incidence rate. However, it remained significantly lower than previous years, indicating continued stabilization. HIV infection rates have been level for Hispanics and Whites since 2003 (see chart below).

**Figure 1.6 HIV/AIDS Incidence Rate by Race/Ethnicity**



**Clinical stage at diagnosis in Oregon, 2002–2007:** Individuals diagnosed later in their HIV disease progression may receive an AIDS diagnosis when diagnosed with HIV for the first time or progress to AIDS within 12 months of their diagnosis. 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 better targeting of HIV prevention efforts. Between 2002 – 2007, 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 heterosexual, were 1.3 times more likely than MSM to be diagnosed later in their course of disease.

**Sexually Transmitted Diseases among PLWH/A in Oregon, 1996-2007:** The risk of STD infection after HIV/AIDS diagnosis was 4 times higher in men than women among PLWH/A. The risk of infection was 4.5 times higher in younger men (ages 13-24) than in older men (25-44) and almost 25 times higher in younger women than older women. In comparison to the general population of the TGA, the incidence rates for both gonorrhea and syphilis are significantly higher among PLWH/A. For instance, while the incidence of gonorrhea in the entire TGA is 39.6/100,000 population, this number is dramatically increased to 1,743/100,000 among PLWH/A in the TGA. Similarly, the incidence rates for syphilis are 0.8/100,000 general population versus 177/100,000 PLWH/A.

Disparities in STD infection rates exist among PLWH/A, mirroring those seen with HIV/AIDS. The risk of STD infection among PLWH/A was 4 times higher among men than women. PLWH/A with MSM risk were at 5.5 times higher risk for STD infection than PLWH/A males with IDU risk and at 3 times higher risk than PLWH/A males with heterosexual risk. Among females, the risk of infection is 4.6 and 9.2 times higher for Hispanic and African American/Black PLWH/A, respectively, in comparison to White PLWH/A.

**Unmet Medical Care Needs**

Each year, the Health Resources and Services Administration (HRSA) requests an estimate of the number of PLWH/A who have not accessed basic HIV medical care. “Met need” has been defined as the number of PLWH/A with at least one viral load or CD4+ lymphocyte laboratory test collected during that calendar year.

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. Oregon rule changes made all viral load and CD4 results reportable to State surveillance as of April 17, 2006. Prior to this, only CD4 results less than 200 cells/μl and detectable viral load results were reported. As a result, the number of CD4 tests and viral load tests submitted to HIV/AIDS surveillance has doubled, and more accurate met need approximations can be made. The number of cases with at least one CD4 or viral load test during 2007 is represented in the table below.

**Table 1.1 Portland TGA Unmet Need**

	HIV(nonAIDS)		AIDS		Total	
Number who did NOT receive primary medical services	415	26%	628	30%	1,042	27%
Number who did receive primary medical services	1,169	74%	1,627	70%	2,796	73%

Further analysis was conducted to determine demographic and other differences in unmet need in the Portland TGA. In 2007, there was a suggestive difference in unmet need between people with HIV (not AIDS) and AIDS (26% vs. 30%). 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%).

The previous year, additional analysis was conducted to match clients in TOURS (Title One Unduplicated Reporting System) at Part A to HARS (HIV/AIDS Reporting System) and TRIO at State surveillance to determine how many Part A clients were not receiving primary medical services. Out of the TOURS clients that could be matched to HARS and TRIO (77%), 92% had received at least one CD4 or viral load in 2007. No significant differences were found by client gender, race, risk factor, or age when examining who among Part A clients received at least one CD4 or viral load test.

### ***Needs, Gaps, and Barriers to Services***

Each year the Planning Council engages in a process of collecting information from people living with HIV/AIDS 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 2009, two different sources of information gathered from the community were reviewed: 1) a needs assessment survey that 592 Part A clients completed at the end of 2008/beginning of 2009; and 2) community discussions that were held with 44 clients in five different locations in 2009. The process and results of these efforts are summarized below.

#### ***Needs Assessment Survey***

In 2008-09, HIV Care Services and Program Design & Evaluation Services (PDES)<sup>3</sup> conducted an evaluation of the needs of PLWH/A receiving Part A services in the TGA and how well the current HIV care system was meeting their needs. This evaluation was designed to answer the following:

- What are the most important service needs for clients living with HIV/AIDS?
- To what extent are those needs being met by the current care system?

A combined needs assessment and client satisfaction survey was distributed to clients through all 10 Part A-funded agencies on a staggered schedule between July and December, 2008. In order to improve response rates, two agencies distributed surveys during a second time period in February and March 2009. Part A analysts received 625 completed questionnaires out of 1549 that were distributed. Four additional surveys were also completed via telephone. The total final sample was 629 completed surveys; the final return rate was 40%.

In order to reduce duplication of the needs assessment data collected from clients across Part A agencies, the survey included a question asking whether the client had already completed the survey at another agency, and if so, instructed them to only complete the section related to satisfaction with services at the distributing agency. Six percent of clients said they had filled out the survey at another agency, for a total of 592 clients participating in the needs assessment portion of the survey.

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<sup>3</sup> PDES is a joint program between Oregon State Public Health and Multnomah County Health Department that conducts health services evaluation and research.

**Key Findings**

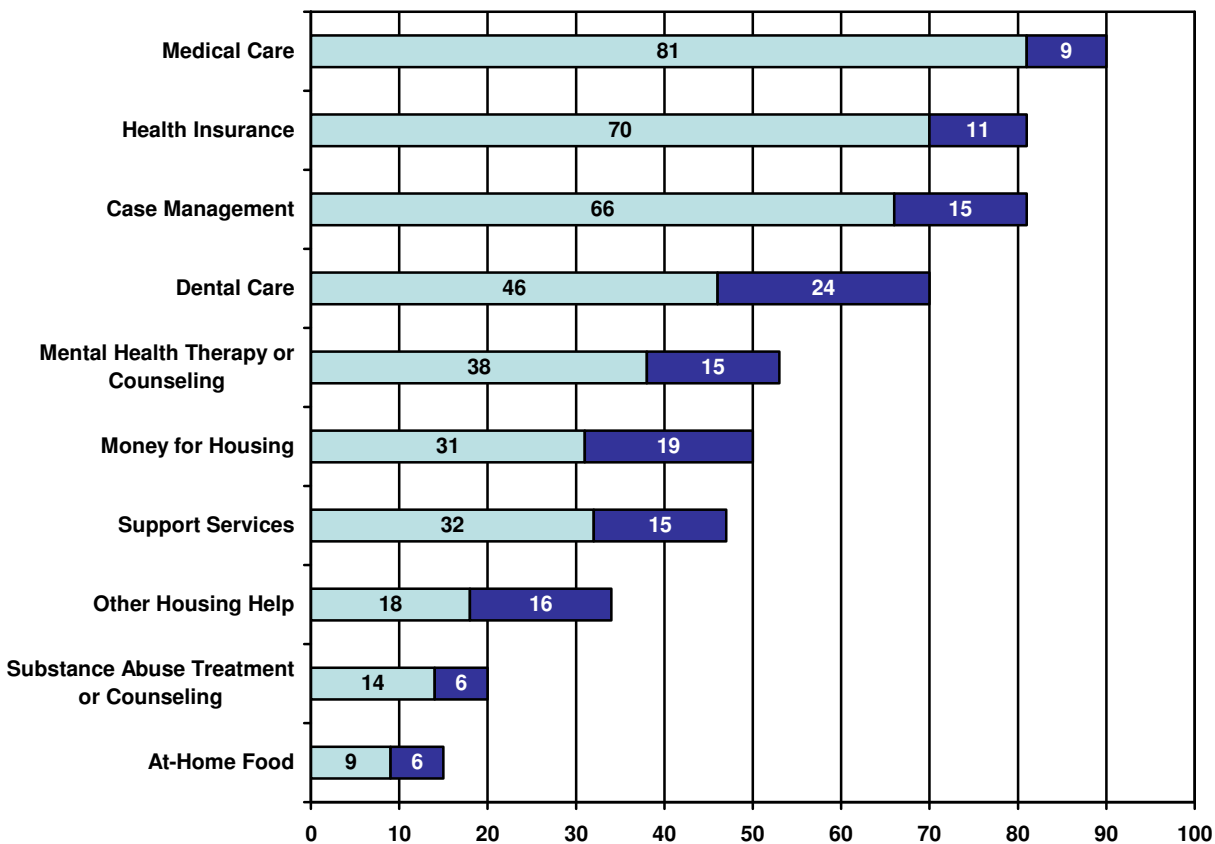
Clients were asked “In the past year, did you ever need this service?” to assess whether a client needed a specific services, and then “When you needed this service, did you receive it?” to assess whether there was a gap in service (a “service gap” was indicated by response of “sometimes” or “not at all”).

Out of the 10 service areas clients were asked about needing and receiving in the past year, at least 1 in 2 clients mentioned needing the following services: Medical Care (90%); Health Insurance (81%); Case Management (81%); Dental Care (70%); Mental Health Therapy or Counseling (53%); and Financial Assistance for Housing (50%). Similarly, in a separate question, over half of clients rated four of these services as “essential to helping maintain HIV medical care;” these included (in rank order) case management, health insurance, medical care, and dental care. Two supportive services, food/groceries and financial assistance with housing, were rated as essential to maintaining medical care by more than 4 in 10 clients.

Reported service needs varied across client subgroups. Women reported significantly higher needs for support services, while younger clients reported higher needs for substance abuse treatment and counseling. Latinos were less likely to report needing dental care or substance abuse treatment or counseling, whereas White clients were less likely to report needing financial assistance with housing, other housing help, or at-home food. Black/African American clients were more likely to report needing substance abuse treatment or counseling services.

The following figure shows the percent of total clients with a met need and service gap.

**Figure 1.7: Percent of Total Clients with Met Needs and Service Gaps by Service Category**



Dental care emerged as the top service gap for the total population of Part A clients, with almost 1 in 4 respondents (24%) saying they were unable to get the service every time they needed it during the past year. This was followed by financial assistance with housing, for which nearly 1 in 5 clients (19%) reported a service gap. About 1 in 6 or 7 clients (15 –16%) reported service gaps in the areas of ‘other housing help’ (e.g. education or counseling related to housing needs), case management, mental health therapy or counseling, and support services (e.g. support groups or community meals).

Other services had high service gaps proportionate to the number of people who needed them, but were needed by fewer people overall. For example, only 15% of all clients reported needing at-home food, but of those who needed it, 41% experienced a service gap. Another service area that had a high service gaps in proportion to the number of people who needed them was substance abuse treatment; 29% of clients needing substance abuse treatment or counseling experienced a service gap.

There were no differences in reported service gaps by gender, race/ethnicity, or age.

### ***Community Forums***

In 2009, the Planning Council initiated a series of community forums with consumers about services provided through the Ryan White Part A program. Specifically, the Planning Council seeks to better understand consumers’ experiences regarding which HIV services they can get or not get. These community discussions complement the needs assessment findings described above, in addition to other Council activities implemented for obtaining consumer input, including membership and public testimony. Specifically, these community forums were designed to answer the following questions:

- What barriers or difficulties are PLWH/A facing in accessing Part A services?
- What would assist PLWH/A in obtaining services?
- What other services not in the Part A continuum of care are difficult to access when needed?
- Considering the economic downturn, are there community services that are becoming more difficult to access that are essential to maintaining health and well-being?

In April 2009, Planning Council/Operations Committee members and Care Services staff conducted a series of five community dialogues in the Portland TGA at the following locations: Clark County, Yamhill County, the Men’s Wellness Center at Cascade AIDS Project, Quest Center for Integrative Health, and the HIV Day Center.

44 consumers participated in this process.

- 41% were from outside Multnomah County
- 61% were male; 39% were female
- 30% were PLWH/A of color.

In-depth notes were taken by an assigned note-taker at each community forum. These notes were then analyzed to assess major and minor themes emerging from the community discussions.

## ***Key Findings***

***Barriers/difficulties in accessing Part A services:*** Community forum participants reviewed the findings of the 2008 needs assessment and were asked their opinions on what made obtaining Part A services difficult. Some major themes on barriers to care emerged for the following services:

- ***Dental Care:*** Participants communicated that getting timely dental appointments was difficult, and that it often took 2 – 3 months to get a dental appointment. Participants also stated that there were not the resources to handle urgent dental care needs, current client loads, and other procedures such as oral surgery, implants, painful procedures, etc. One community forum also mentioned fluctuations in dental service and provider quality and that there appeared to be a lack of continuity of care (e.g. having to explain patient history at each visit, different dental providers at each visit, etc.). Participants also mentioned specific agencies at which they felt they had received poor care.
- ***Housing:*** Participants agreed that housing was a critical component of HIV care. Barriers to housing included having a criminal history, poor rental or credit history, maintaining housing when in and out of addiction treatment services, and long waiting lists. Barriers to obtaining housing services included inconvenient timing of housing services and classes (e.g. during working hours), inexperienced staff, and poor communication by case managers or case workers (e.g. unclear guidelines, being told different information by different staff, not hearing from case managers enough, etc.). One community forum mentioned that there were not enough housing services available for the “working poor” who needed services, but could not qualify for them:

*“They want you to destroy your life before they help you. A safety net is needed before families lose everything.”*
- ***Mental Health:*** Participants also discussed that mental health services were an essential part of care, but that mental health counseling was only really available through one main provider. Barriers to mental health services included being in crisis and not being able to get immediate assistance, finding a qualified mental health provider to treat specific needs, and not getting mental health support from medical services (e.g. providers not advocating or making mental health referrals, being provided a psychiatrist instead of a counselor, etc.).
- ***Psychosocial Services:*** Participants communicated the importance of psychosocial support services, such as drop-in centers and group meetings. Barriers to psychosocial support services include hours of operation (e.g. not being available all days or evening hours), not having psychosocial support services located outside of Portland, and drop-in centers lacking a “clean and sober” environment.
- ***Case Management:*** Two community forums brought up the barriers to accessing case management services, including case managers and case workers not communicating across programs, not knowing what specific case managers are responsible for or what services they could provide, having to continuously advocate for services, wanting more services, case manager formality, and case manager lack of knowledge around service referral.
- ***Food Services:*** Two community forums mentioned home-delivered meal services. Barriers to these services included meals only being delivered to those with medical necessity, and not in times of crisis or in general, and not knowing that these services were available.

Barriers/difficulties in accessing other services: In addition to describing barriers to services supported or delivered by specific Part A-funded agencies, community forum participants also brought up other services in which they had difficulties accessing. These services included:

- *Food and Nutritional Counseling:* Participants communicated that access to food and food assistance was important to maintaining health and remained difficult to access. Primary barriers to food were eligibility requirements around food stamps, the increasing price of food, and assistance in transportation to/shopping for food at certain facilities. One community forum mentioned the need for nutritional supplements, while another mentioned the need for nutritional counseling and diet assistance.
- *Transportation:* Participants also brought up the need for transportation services. Primary barriers to transportation include the price of transportation (e.g. gas, cars, etc.), programs that have ended providing transportation support, long wait times for public transportation, and the moving of medical transport stops. Many participants described the difficulties of living far from where HIV services are most centrally located. One community forum stated that transportation was most essential during winter months when weather was poor, while another forum mentioned the importance of transportation during the summer months, especially for families and children.
- *Medication Management Assistance:* Participants stated that more medication management assistance was needed. Barriers to medications included needing financial assistance with medication co-payments, not knowing about drug interactions between HIV medications and other non-HIV medications (e.g. blood pressure medication, asthma medication, etc.), and needing verbal, instead of written information on medications. Participants wanted more interaction time with pharmacists to become educated on medication side effects, drug interactions, and what to expect with medication.
- *Health Insurance:* Participants communicated that more health insurance assistance was needed, including bridging the gap for health insurance. Two community forums specifically mentioned difficulties with CareAssist or OMIP, including losing coverage due to inability to meet co-payments and billing issues such as the accumulation of bills.
- *Peer mentor support:* Two community forums communicated the need for peer mentors for information sharing, support for alcohol and drug recovery, and as a connection to others with HIV.

Individual community forums brought up other services needs, such as professional development services, including career training, job placement and employment assistance, and educational opportunities. Other needed services mentioned included alternative health care, exercise programs, men's sexual health support group, telecommunications assistance (e.g. phone and computer access to communicate with providers, etc.), financial assistance, mortgage assistance, utility assistance, and basic/personal item needs (e.g. shampoo, hygiene products, etc.).

Service Access Facilitators: Participants were also asked for their opinions on what would assist them in obtaining care. Community forums came up with the following suggestion for specific services:

- *Dental Care:* Participants stated that dental care access would be facilitated if more dentists would accept Medicaid and if preventive care appointments were more available. Participants also mentioned that the scheduling of the next dental appointments at the end of each dental visit and reminder phone calls would assist them in going to appointments.
- *Housing:* Participants communicated that better provider communication within and across agencies is needed, as well as clearer guidelines around housing and housing eligibility.

Participants also wanted more involved case workers, with whom they could communicate more frequently.

- *Medication Management Assistance:* Two community forums stated that group medication education sessions or “Town Hall” like meetings with pharmacists would be useful. Participants also wanted more information on new data regarding medications and other treatment options.
- *Transportation:* Several participants advocated for free bus passes and tickets to be made available at several agencies and for better communication tools about where bus passes are available. One group suggested that a van be specifically purchased for transporting HIV clients.
- *Communication:* Participants wanted a broader distribution of HIV literature and available services beyond referrals or information from case management. One community forum advocated more service advertisement through television ads, brochures, and bulletin boards. Another group mentioned that more information was needed in other languages, including the use of bilingual staff and assistance with English language and health literacy (especially related to medications). A forum held outside of Multnomah County requested additional information on events that were occurring in the Portland area.

# 2

## Overview of Ryan White Part A Clients

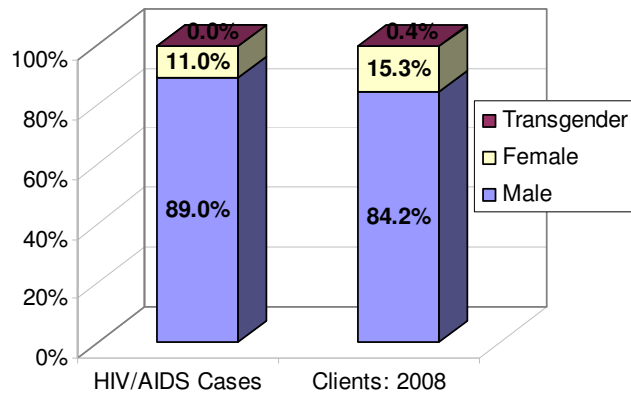
The following section provides an overview of clients who received services through Part A-funded providers in 2008. Not all services provided to clients are paid for exclusively by Part A funds. Please see Appendix A for a list of total funds utilized in each service category. The data in this section were primarily obtained from the Title One Unduplicated Reporting System (TOURS). For further information on data sources used, see Appendix C.

### ***Distribution of Clients by Gender, Age, Race, Risk Category, and County***

During 2008, 2,548 clients received Ryan White Part A eligible services. This is an increase of 238 clients served from 2007 (n=2,310).

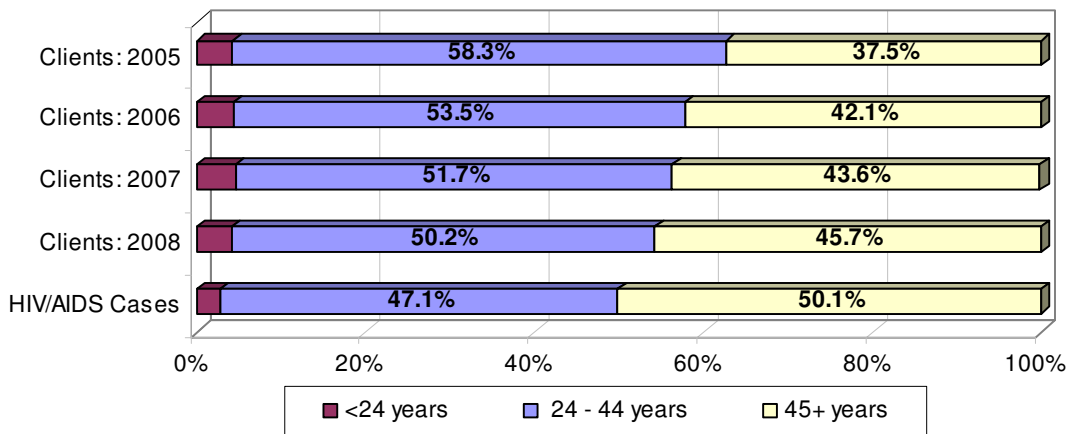
The majority of Part A clients in 2008 were male (84.2%). Women are consistently served in greater proportion than their representation in the epidemic; females accounted for 15.3% of all clients, while representing 11.0% of all cases in the TGA. Transgendered individuals accounted for 0.4% of Part A clients.

**Figure 2.1 Part A Clients and HIV/AIDS Cases by Gender**



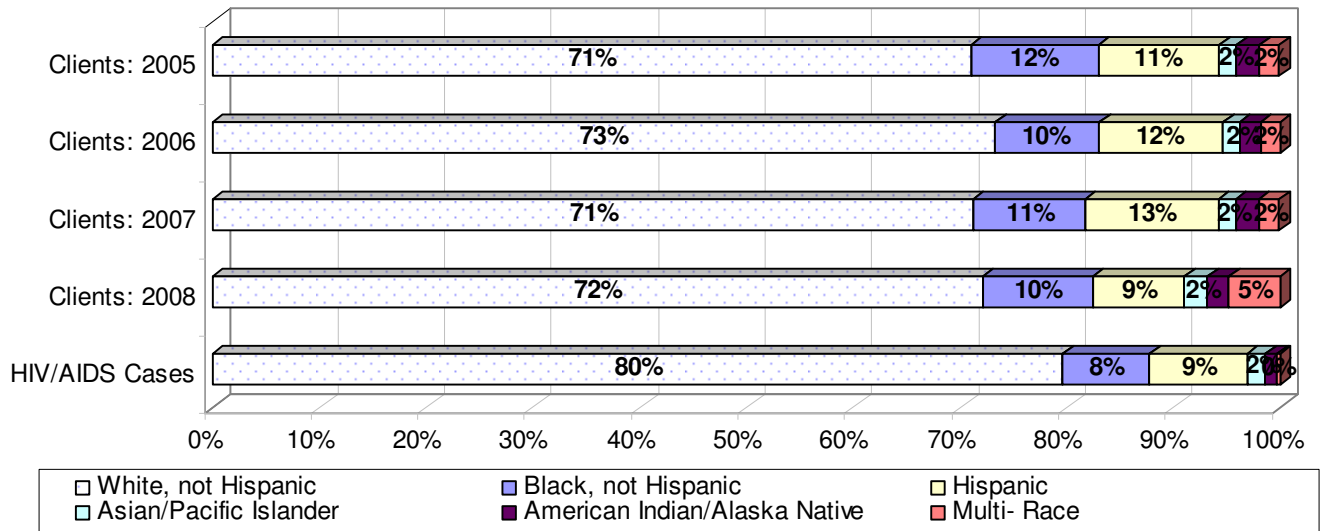
Since 2005, an increasing percentage of Part A clients are 45 years of age or over (see table below). However, a lower percentage of clients in 2008 were 45 years of age or over in comparison to the epidemic.

**Table 2.2 Part A Clients and HIV/AIDS Cases by Age**



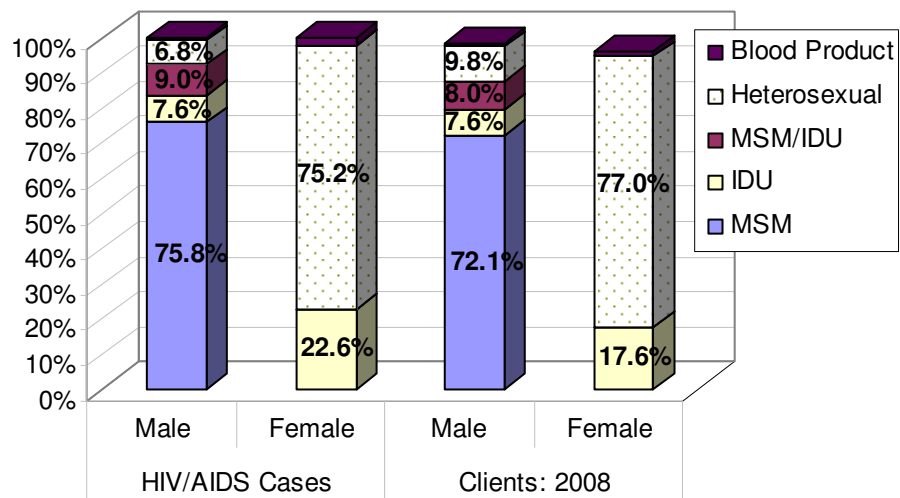
A higher percentage of clients of racial/ethnic minorities received Part A services (27.9%) in comparison to their representation among all living cases (20.4%; see graph below).

**Figure 2.3 Part A Clients and HIV/AIDS Cases by Race/Ethnicity**



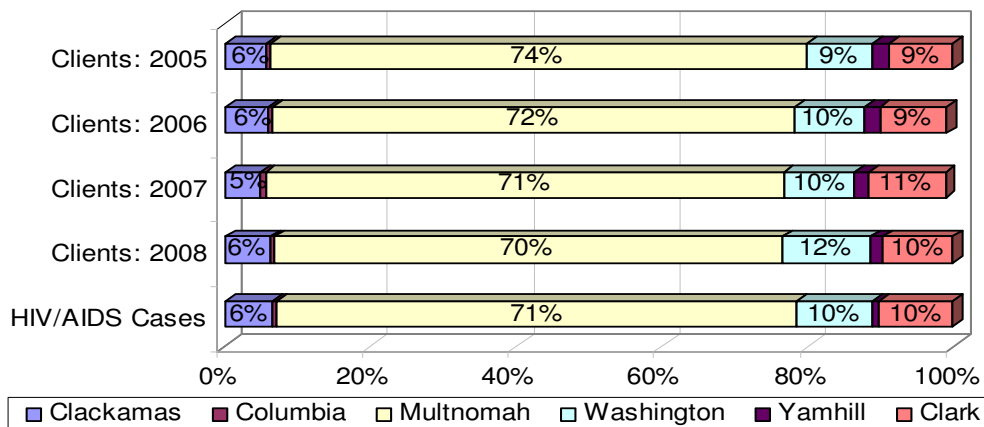
As is true in the overall epidemic, the most common reported risk category among male clients receiving Part A-funded services was men who have sex with men (72.1%; see chart below). This is a slightly lower than their representation among male living HIV/AIDS cases (75.8%). The most common reported risk category among female clients was heterosexual contact (77.0%) similar to their representation among female HIV/AIDS cases (75.2%). The proportion of female clients with IDU (17.6%) as a risk category is slightly lower than their representation in the epidemic (22.6%).

**Figure 2.4 Part A Clients and HIV/AIDS Cases by Risk Category**



The proportion of clients living in each of the six counties is similar to the distribution of HIV/AIDS cases by county in the TGA (see chart below). In 2008, a higher percentage of female clients (37.5%) resided outside Multnomah County than male clients (30.5%). A lower percentage of Hispanic clients (58.1%) resided in Multnomah County (22.1% were from Washington County), while a higher percentage of Black/African American clients (79.5%) resided in Multnomah County.

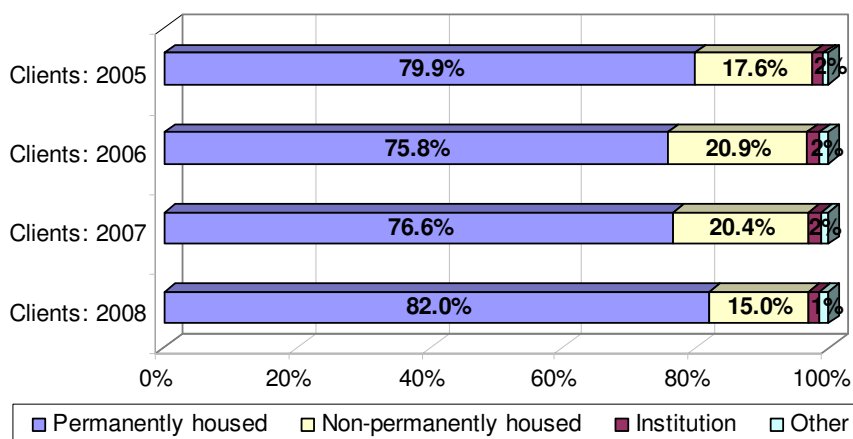
**Figure 2.5 Part A Clients and HIV/AIDS Cases by County of Residence**



### ***Housing, Insurance, and Federal Poverty Level Status of Clients***

Lack of permanent housing has been associated with poorer medical health outcomes and less adherence to HIV medications among PLWH/A. The percent of the population living at or below the federal poverty level ( $\leq 100\%$  FPL) is a common measure of poverty, which has also been tied to poorer health outcomes across the general population. Most Part A-funded services are only offered to clients at 200% FPL or below. In addition, the type of insurance coverage a client has access to will determine the range of services available to a client and has implications on the potential cost to the Ryan White care system. For these reasons, assessing the housing, FPL, and health insurance status of clients provides important insight into ongoing client service needs. The housing status, insurance type, and FPL of clients reflects these clients' status as of the end of 2008, unless otherwise indicated.

**Figure 2.6 Part A Clients Housing Status**

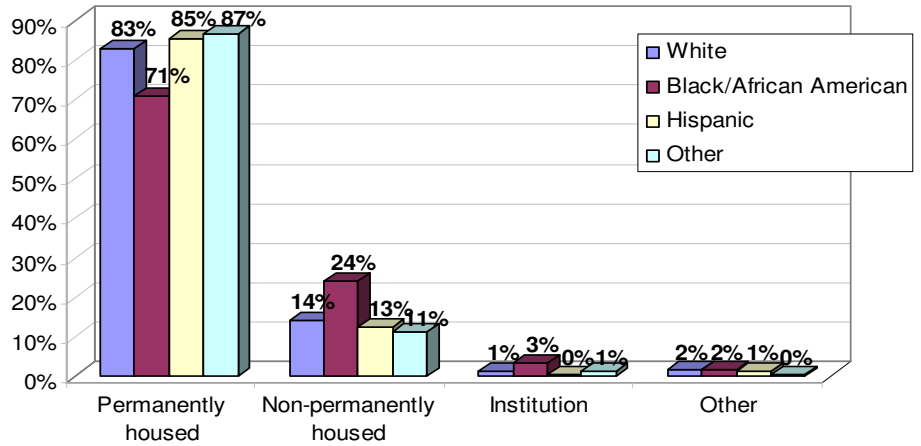


### ***Housing Status***

Approximately 4 out of 5 clients receiving services from Part A-funded providers were permanently housed in 2008 (82.0%), an increase from 2007. A lower percentage of female clients (78.1%) had permanent housing than male clients (82.6%). A lower percentage of clients 13 – 24 years of age (76.8%) had permanent housing in comparison to clients 45 years of age or older (84.0%).

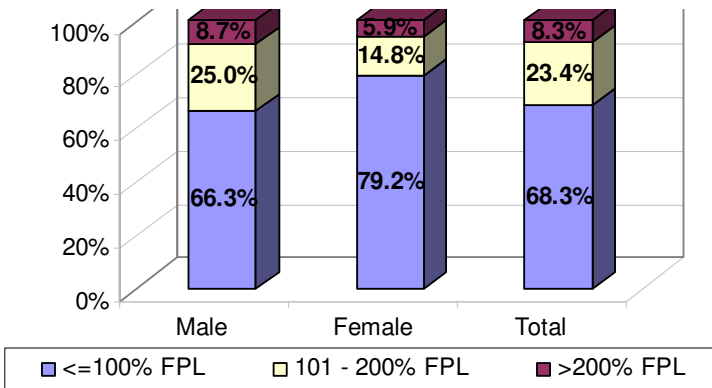
**Figure 2.7 Part A Clients Housing Status by Race/Ethnicity in 2008**

Additionally, as seen in the past three years, a lower percentage of Black/African-American clients (71%) had permanent housing in comparison to other racial/ethnic groups (see chart to right).<sup>4</sup>



**Federal Poverty Level (FPL)**

**Figure 2.8 Part A Clients FPL Status**

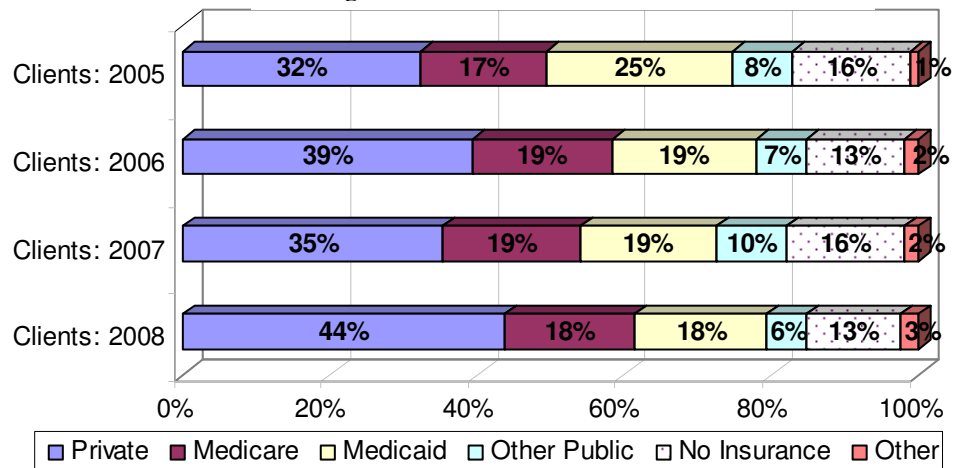


Approximately 68% of clients receiving Part A-funded services had incomes that were at or below 100% FPL. As seen with the previous three years, a higher percentage of female clients (79.2%) had incomes at or below 100% FPL, compared to male clients (66.3%; see chart to left). Additionally, a higher percentage of Black/African American clients (79.9%) and clients of other race/ethnicity (77.3%) had incomes at or below 100% FPL in comparison to White clients (69.1%).

**Insurance Coverage**

As of December 31, 2008, approximately 4 out of 10 Part A clients had public health insurance coverage (42%). The percentage of clients on Medicaid has continued to decrease over the last four years, most likely reflecting that Oregon Health Plan (OHP) new client closure/restriction. The percentage of clients with private insurance (43.7%), which includes the Oregon

**Figure 2.9 Part A Clients Insurance Status**



<sup>4</sup> As the combined proportion of American Indians/Alaskan Natives, Asians, Native Hawaiians/Pacific Islanders, and clients of more than one race was less 4% of the total population served, these racial/ethnic groups have been combined in subgroup analysis.

Medical Insurance Pool (OMIP), has continued to grow over the past four years. Though only 13% of clients had no insurance by the end of the year, the insurance status of clients can change throughout the course of the year as clients lose and gain different insurance coverage. An estimated one in four clients were uninsured (24.4%) at some time in 2008, similar to what was observed in the 2005 needs, gaps, and barriers assessment conducted by PDES (27%), making obtaining insurance coverage for clients a continuing priority for service providers.

As seen in the last three years, insurance coverage differed by gender in 2008. A higher percentage of female clients had Medicaid (33.6%) than male clients (14.9%). Additionally, a higher percentage of Hispanic clients had private insurance (56.4%) in comparison to White clients (42.2%). A higher percentage of clients 13 – 24 years of age (19.0%) were uninsured in comparison to clients 45 years of age or older (9.6%).

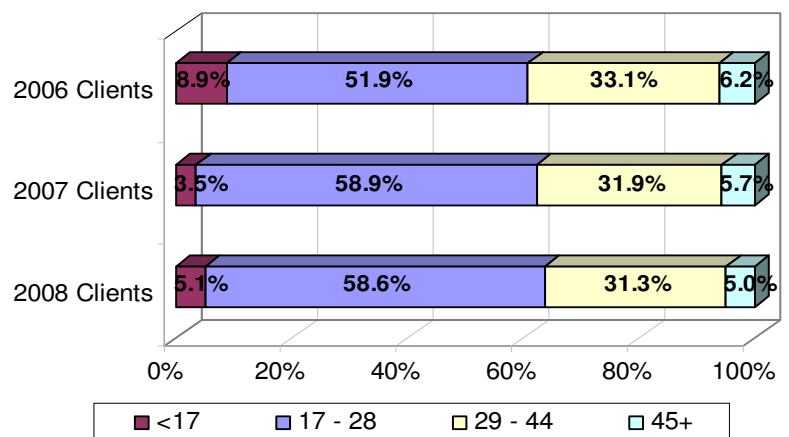
### ***Clients' Acuity Level***

Client acuity is used to measure a client's severity of need for case management. Acuity takes into account a broad spectrum of client needs, from basic necessities and life skills, to medical adherence. Clients with higher acuity scores are more likely to require more intense levels of case management, and potentially more assistance or other services. Acuity can be measured repeatedly over the course of service provision, and may act as a marker to determine whether services are having an impact on a client's health and life.

Though case management systems vary, the acuity scores of clients in the TGA are assessed using the Washington State Department of Health System Acuity Measurement (SAM) scale. Acuity scores measured with this scale will determine the level of client service needs in one of four categories. Acuity scores of 16 or less indicate that ongoing case management is not required; scores between 17 and 28 indicate that less intensive services are required; scores between 29 and 44 indicate the need for case management, while acuity scores above 45 indicate the need for intensive case management. For most clients receiving Part A-funded case management services, clients with acuity scores equal to or below 28 would receive service access specialist services, while clients with acuity scores above 28 would receive case management services.

In 2008, when examining Part A clients' last acuity scores, scores ranged from 14 to 78. The average score was 27.5. The majority of clients assessed did not require either case management or intensive case management (63.7%). The percentage of clients with acuity scores equal to or below 28 has remained relatively stable over the last three years (see graph to right), indicating lower severity of need among clients and potential positive life outcomes.

**Figure 2.10 Part A Client Acuity, 2006 - 2008**



Similar to the previous year, differences in acuity scores by gender and risk category were observed (see table below). A higher percentage of female clients and clients with IDU as their primary risk category had acuity scores 29 and above than their counterparts. Though it does appear that a higher percentage of Black/African American and Hispanic clients have acuity scores 29 and above, this was the first year in the last four years where this difference was not statistically significant ( $p = 0.065$ ). No differences were found by client age or county of residence.

**Table 2.1 Client Acuity Score by Gender, Race/Ethnicity, Transmission Mode, Age, and County of Residence**

Client Demographics	2006 Client Acuity Scores	
	<29	29+
<i>Gender</i>		
Male	65.2%	34.8%
Female	56.1%	43.9%
<i>Race/Ethnicity</i>		
White	65.4%	34.6%
Black/African American	57.3%	42.7%
Hispanic	58.6%	41.4%
Other Race/Ethnicity	64.6%	35.3%
<i>Mode of Transmission</i>		
MSM	71.5%	28.5%
MSM/IDU	60.0%	40.0%
IDU	39.0%	61.0%
Heterosexual	61.8%	38.2%

As acuity score is correlated with the client severity of need, it is also not surprising that a higher percentage of clients who were non-permanently housed, uninsured, or at 100% FPL or below had higher acuity scores. In fact, when clients' housing status, FPL status, and insurance status were controlled for in analysis, differences in acuity by gender did not exist.

### ***Emerging Populations with Special Needs***

The Portland TGA has identified six emerging populations: women; youth (aged 13-24); PLWH/A aged 50 and older; refugees and immigrants; PLWH/A with a dual diagnosis of mental health and substance abuse; and recently incarcerated PLWH/A. Additionally, Ryan White funded programs have been created using Minority AIDS Initiative (MAI) funds for the purposes of improving HIV-related health outcomes for PLWH/A of color and reducing racial and ethnic health disparities. As such, an overview of PLWH/A of color will also be included in this section.

### ***PLWH/A of Color***

Minority racial/ethnic populations account for 20.4% of all persons living with HIV/AIDS (through 12/31/07). Blacks/African Americans account for 8.2% (through 12/31/07), and make up 5.9% of newly diagnosed persons (1/1/06 through 12/31/07). The number of Hispanic PLWH/A continues to increase in the Portland TGA, though the HIV incidence rate in this population has remained stable. Hispanics account for 9.1% of all PLWH/A, but make up 13.3% of newly diagnosed cases (1/1/06 through 12/31/07). Combined, Asians, Pacific Islanders, Native Americans/Alaska Natives, and multi-racial persons account for 3.1% of all PLWH/A (through 12/31/07), and make-up 5.3% of newly diagnosed cases (1/1/06 through 12/31/07). Since 2003, more than 50% of newly diagnosed Black and Hispanic HIV/AIDS cases in the TGA were foreign-born, and as of 12/31/06 approximately 42% of racial/ethnic minority PLWH/A were foreign born, though the number of newly diagnosed black, foreign-born HIV/AIDS cases has steadily decreased in the last three years.

Among all African American/Black, Hispanic and PLWH/A of other race/ethnicities, the most commonly reported risk factor was MSM, followed by heterosexual contact and IDU, though the percentage of clients comprising each exposure category by race/ethnicity varied greatly (e.g. 40% of African American/Black PLWH/A had MSM as an exposure category compared to 73% of White PLWH/A).

In the Portland TGA, HIV has disproportionately impacted Blacks/ African Americans. The prevalence rate among Blacks/African Americans is 2.9 times higher compared to Whites. This impact is more evident among African American females, who comprise approximately 23% of all female HIV/AIDS cases. With the exception of the Black/African American population, the impact of HIV/AIDS is fairly proportionate to the TGA population. However, a 2008 assessment of HIV/AIDS mortality rates among PLWH/A residing in Multnomah County revealed that American Indians/Alaskan Natives had 3.3 times higher mortality rates than Whites.

Several challenges and needs have emerged when examining Black/African American and Hispanic care access in the TGA. Data has shown that:

- African American/Black and Hispanic client have a greater severity of need for services and support;
  - This has been indicated by consistently higher acuity scores over the past years, and higher rates of unmet medical care needs.
  - Black/African American clients are more likely to have low incomes, be less permanently housed, and experience more gaps in medical care.
  - Hispanic clients are less likely to have Medicaid or other public health insurance coverage, experience gaps in access to prescription medications, and have problems meeting basic needs for housing, food, and transportation. Over 40% of Hispanic clients live outside Multnomah County.

Part A uses Minority AIDS Initiative (MAI) funds for targeted medical case management services for African American/Black and Latino clients. Providers of these services have reported that:

- The clients in the Latino MAI program appear to have been HIV positive for relatively long periods of time and their disease seems to be more progressed. Multiple cultural barriers exist to engaging fully in treatment, such as:
  - Regularly visiting a health care provider is an unfamiliar practice;
  - Skepticism of foreign methods of treating disease;
  - Engaging fully in treatment interferes with the goal of coming to the U.S to earn money to send home to support family members.

Also unique to the Latino population is:

- A type of depression originating from HIV diagnosis combined with multiple cultural barriers;
  - Homeland Security laws and current anti-immigrant rhetoric which exacerbate the difficulty of finding housing;
  - Difficulty obtaining or renewing driver licenses, increased fear of being detained, etc. which may also contribute to increased social isolation.
- Among the African born clients in the African American/Black MAI program, cultural barriers also exist which interfere with treatment, such as:
    - Many clients do not seem to worry about their health and don't take their medications, or only take their medications when they are sick;
    - Mistrust of the U.S. health care system;

- Not seeing nursing case management as a need or wanting the MAI case manager to help with their medications.
- Disclosure has been another major issue with many African clients. Many of the children and partners of these clients do not know their status. Case management time has also been spent assisting with disclosure and partner testing since the beginning of this program. Clients have started to disclose to their families and several partners have been tested, all of whom were found to be HIV-negative.

In 2008, 27.9% of all of the Part A client population served were racial/ethnic minorities; 10.3% of clients were African American/Black, 8.6% were Hispanic; and 9.0% were Asian/Pacific Islander, Native American/Alaska Native, and multi-racial persons. A lower percentage of Hispanic clients (26.7%) and clients of other race/ethnicities (33.2%) are over 45 years of age than White clients (49.4%). A higher percentage of African American/Black clients (32.9%) and clients of other race/ethnicities (19.8%) are female in comparison to White clients (12.4%). Within the African American/Black Part A client population, the most commonly reported risk factors are heterosexual contact (45.6%), followed by MSM (32.8%), and IDU (10.8%). Among Hispanic clients and clients of other race/ethnicities, the most commonly reported risk factors are MSM (62.5% and 54.5% respectively); heterosexual contact (27.4% and 29.2% respectively), and MSM/IDU (4.2% and 6.7% respectively).

In 2008, a higher percentage of African American/Black clients (79.9%) and clients of other race/ethnicity (77.3%) had incomes at or below 100% FPL in comparison to White clients (69.1%). A higher percentage of African American/Black clients lacked permanent housing (29.2%) in comparison to White clients (17.3%). A lower percentage of Hispanic clients had any form of public insurance (22.3%) in comparison to White clients (43.4%).

Differences in acuity levels between clients of color and White clients still exist (though not statistically significant); 42.7% of African American and 41.4% of Hispanic clients had an acuity level of 29+, indicating a greater need for case management services, compared to 34.6% among White clients.

### **Women**

Women make up 11.0% 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 mode of transmission is heterosexual contact, accounting for 75.2% of all adult HIV/AIDS female cases and 75.3% of all newly diagnosed female cases. This is followed by IDU risk, accounting for 22.6% of all adult and newly diagnosed HIV/AIDS female cases. Black/African American and Hispanic women are more likely to be infected with HIV/AIDS through heterosexual contact than White women.

There are several unique challenges around provision of and access to care for women. Research has shown that female PLWH/A in Oregon:

- Have gaps in access to primary care;
  - Barriers were related to women having higher poverty rates and foregoing their own health care needs in favor of children and other family members.
- Needed psychosocial support services, referral services, emergency financial assistance, outpatient substance abuse treatment, and child care; and
- Required assistance with emergency rent/utilities and housing.

- Barriers were most often related to system capacity issues such as wait times and lack of knowledge about services.

Part A Agencies with programs that serve women in the TGA have reported that:

- When referred to alcohol and drug free housing and treatment, many women choose to remain in current conditions due to family obligations.
- Women's psychosocial support groups have seen increasing number of older HIV+ women attendants.
  - The issues older women with HIV face differ from those of younger women, particularly with regard to memory challenges associated with long-term treatment as well as the onset of menopause, creating a need for targeted services.
- Peer mentor models have proved successful in developing trust among women and ensuring they are connected with the services they need.
- Providers of housing services have seen an increase in women requesting services, many of whom have severe medical issues not directly related to HIV.

In 2008, 15.3% of the Part A client population served were women. A lower percentage of female clients are over 45 years of age (37.6%) than male clients (47.3%). Approximately 43% of all Part A female clients are racial/ethnic minorities; 22.4% are Black/African American, 7.4% are Hispanic, and 11.6% are either Asian/Pacific Islander, Native American, or more than one race. Within the female Part A client population, the most commonly reported risk factors are also heterosexual contact (77.0%), followed by IDU (17.6%); however, Part A is serving a slightly lower proportion of women infected through IDU contact than their representation in all female adult cases (22.6%).

Female Part A clients are significantly poorer, with 79.2% at or below 100% of the Federal Poverty Level (FPL), compared to 66.3% of male clients. In 2007, 33.6% of female Ryan White clients received Medicaid, 10.1% were uninsured, and 21.9% lacked permanent housing.

Acuity levels of female Ryan White clients were also significantly higher, with 43.9% of female clients having an acuity level of 29+, compared to 34.8% of male clients, indicating a greater need for case management services. However, in terms of health outcomes, previous reports indicate that similar percentage of men and women had CD4 test results that increased to or remained above 200 (see Annual Client Services Data Report: 2007-2008, page 22).

### ***Youth aged 13-24 years***

Youth 13-24 comprise 2.5 % of the estimated 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. The majority of these new cases 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. Sixty percent 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 PLWH/A youth 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.

Youth need comprehensive HIV/AIDS primary care and support services within a well-managed continuum of care. This includes:

- Accessible primary HIV care providers, and access to specialists for treatment of common co-morbidities such as mental disorders, substance abuse, and co-infection with hepatitis or another STD;
  - Access can be an issue because youth clients are less likely to have health insurance and are poor, and wait longer periods of time to enter care.
- Targeted early intervention services and case management to link to primary care and social support services and maintain them in care.
  - Youth present 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.
- 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. One study in Oregon indicated that younger PLWH/A were more likely to lack access to group/peer support.

Providers of Part A dental care within the TGA have reported that while the largest population served has traditionally been PLWH/A aged >50, they are beginning to focus on services for younger populations. Ensuring HIV positive youth access and utilize dental care may require targeted service provision and policies, such as the hiring of younger dental providers.

In 2008, 3.4% of the Part A client population served were youth between 13-24 years of age. Similar to youth in the epidemic, 24% of youth clients receiving Part A services were women. Approximately 4 out of 10 youths receiving Part A funded services are ethnic/racial minorities (41%); 12% are Black/African American, 16% are Hispanic, and 13% are either Asian/Pacific Islander, Native American, or more than one race. About two-thirds of youth receiving Part A services have MSM (67%) as their primary risk factor, followed by heterosexual contact (20%).

A higher percentage of young Part A clients are uninsured (19%) in comparison to older Part A clients (12.5%). Close to one in four young clients are non-permanently housed (23%) and close to three in four are poor (72%) with incomes at or below 100% FPL.

However, youth clients receiving Part A services appear to be experiencing positive health and life outcomes. In 2008, there were no differences in client acuity scores by age. A previous report showed that all youth clients with CD4 tests in 2006 and 2007 had CD4 test results that increased to or remained above 200 (see Annual Client Services Data Report: 2007-2008, page 22), when engaged in care.

### ***PLWH/A aged 50 and Older***

As with the general population, the percentage of PLWH/A aged 50 and older has been increasing over the years, and will continue to do so in the future. Currently, 35% of PLWA and 23.9% of PLWH are aged 50 and older, and 21.5% of PLWA and 16.9% of PLWH are aged 45-49. Combined, this represents 56.5% of PLWA and 40.8% of PLWH in the TGA. 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. 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 is White (84.5%), 7.7% are Black/African American, and 5.3% are Hispanic. The most common risk factor was MSM (72%), followed by heterosexual transmission (12%) and IDU (8%).

PLWH/A aged 50 and older face several unique challenges within their care. Research has shown that older PLWH/A are faced with:

- Loss of motivation in following drug treatment regimes, especially when living with HIV/AIDS for long periods of time and when these regimens come with negative side effects;
- Medically complex care that is further compounded by other diagnoses associated with aging;
- Higher rates of infection with drug resistant strains of the virus;
- Loss of social networks as partners and friends die of AIDS and other related illnesses.

Gaps in care that are unique to this patient population include:

- Social support groups targeted to their needs;
- Outreach, testing, and prevention services to decrease the rates of incidence within this population and bring infected people into care as soon as possible;
- Coordination with aging and disabilities services; and
- Access to specialists for treatment of other diseases associated with aging.

Additional needs of PLWH/A aged 50 and older include case management, mental health services, housing assistance, transportation and grocery assistance.

Providers of services within the Ryan White system of care have reported that:

- PLWH/A over 50 face unique challenges as they age. Clients have expressed a lack of knowledge regarding whether physical and medical issues they encountered were a result of HIV, medication, or simply “getting older.” With this, clients also expressed insecurity in knowing whether to seek a more general health care provider at a certain age, or to remain with an HIV primary care provider.
- Older PLWH/A need increased access to alternative/ holistic health care – such as acupuncture, naturopathy, nutritional guidance – and access to comprehensive pain treatment, e.g. a pain clinic knowledgeable in neuropathy, etc.
- When asked specifically about their needs, women have cited the following:
  - Older female PLWH/A need support services, such transportation support or for volunteers to assist in shopping and daily activities; hot meals delivered when sick and around the house assistance; and social support - many older women report being alone and not having a lot of family or friends for support.
  - Case management support specific to SSI/SSD and maintaining benefits through life changes.
  - A safe place to talk about health issues, such as sexual health, hysterectomies, anemia, fatigue, and women’s issues post-menopause, specifically the effects of HIV medication post-menopause and interactions with other medications they may be taking for aging.

In 2008, close to one out of four PLWH/A receiving Part A funded services are aged 50 or older (26.2%). The majority of older Part A clients are White (79.3%); 10.5% are Black/African American, 3.8% are Hispanic, and 6.4% are either Asian/Pacific Islander, Native American, or more

than one race. The proportion of older Part A clients with MSM (56.9%) risk factor is lower than their representation in the epidemic; the proportion with heterosexual (23.1%) transmission risk is higher.

In terms of socio-economic characteristics, older Part A clients fare better than their younger counterparts. A higher percentage of older Part A clients are insured (91.7%) in comparison to younger Part A clients (85.7%), a significant percentage having insurance through Medicare (30.2%). A higher percentage of older Part A clients are permanently housed (85.6% versus 80.7% of clients under 50) and have incomes above 100% FPL (42.0% versus 28.1%). In 2008, the percentage of older clients receiving case management services with lower acuity scores was similar to those in clients under the age 50, as was the percentage of clients with CD4 tests in 2006 and 2007 that had CD4 test results that increased to or remained above 200. However, Part A clients who are aged 50 and older have been living longer with HIV/AIDS, and close to six out of ten (58.4%) have an AIDS diagnosis.

### ***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. In 2007, over 1 in 2 PLWH/A in the TGA (53%) have had a documented mental illness since their HIV diagnosis. The percentage of PLWH/A in the TGA with a dual diagnosis of mental illness and substance abuse was 23.6% in 2007, however these numbers may understate the prevalence of substance use/abuse by PLWH/A with a mental illness, as substance use/abuse is not always diagnosed.

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, in addition to higher rates of incarceration than other PLWH/A, with each episode of incarceration having the potential to interrupt their treatment for HIV disease.

Needs that are unique to this population include:

- Primary treatment by specialists who understand the dynamics of both illnesses, and who are prepared to deal with their potential effects;
- High levels of case monitoring and service coordination to reduce the interference of psychiatric disorders and medications, as well as street drugs with HIV medical treatment;
- Rapid access to mental health and substance abuse treatment service access that is coordinated with primary HIV care;
- Access to appropriate services for extended periods of time, as both mental illness and substance abuse are conditions which often require ongoing treatment.

Similar to other populations clients with mental illness and/or substance abuse diagnosis need medical care, along with basic needs such as food, housing, and transportation. Additionally, this population needs case management and client advocacy services, culturally competent mental health services and substance abuse treatment services, including outpatient and residential care.

Providers receiving Part A funds in the TGA who serve client with dual diagnoses have reported that the provision of safe, clean and sober housing for individuals with dual diagnoses last year have increased clients ability to access both substance abuse and mental health providers throughout the community.

### ***Immigrants and Refugees***

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. Between 1/1/2003 and 12/31/2007, 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 12/31/06 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 challenges that create substantial barriers to accessing and remaining in care. These challenges include:

- Access to language services;
  - Providers within the TGA do not have the resources to offer their services in the native languages of all of their clients,
  - Language barriers that are compounded when clients refuse translation services for fear of being exposed as HIV+ within their community.
- Cultural considerations and health literacy levels;
  - Health education messages, patient instructions, and service delivery methods must be tailored to be effective.
  - Programs must be cultural competent and take into account many group's unique characteristics and concerns, such as fear of government institutions and deportation, conditions related to malnutrition and post-traumatic stress, and separation from friends, family and traditions.
- Unstable employment and unemployment, poverty and lack of health insurance.

The challenges 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.

Agencies in the TGA who serve immigrant and refugee populations have reported that:

- Outreach to this population must occur in outlying counties and among migrant communities in rural settings.
- Several ongoing barriers to medical care exist for this population (see PLWH/A of Color section on page 21 and 22).

### ***Recently incarcerated persons***

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 - up to 4 times the number of those who self-identified - is infected with the disease. 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, this is very likely an under-estimate because there is

currently no standardized procedure for identifying PLWH/A in jails, or for recruiting inmates into treatment.

The majority of the PLWH/A incarcerated population face several co-morbidities including poverty, substance abuse, and mental illness. Cascade AIDS Project (CAP), a large AIDS service organization in the TGA, reports that of the 1,156 clients it served in 2006, 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 CAP clients without criminal histories. 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%).

Recently incarcerated persons (individuals who were released from federal, state or local prisons during the preceding three years), and persons with a history of incarceration, face many unique challenges in accessing and remaining engaged in medical care and support services, including:

- Difficulty securing employment and stable housing;
  - These difficulties derive from stigma attached to being an ex-convict, landlord policies that prohibit criminal backgrounds, poor or nonexistent credit, rental and employment histories, and lack of funds for deposits and rent.
- Lack of health insurance;
  - Inmates are taken off of public insurance programs when entering the jail system, and upon release must go through a re-application process that can take over six months.
- Mental health and/or substance abuse issues; and
- Limited family and community support systems in place.

Statewide, PLWH/A ex-offenders reported a 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. Adequate discharge planning as these patients leave the corrections system is also a large service gap.

Those Part A agencies whose clients include recently incarcerated PLWH/A have found that:

- Having the same medical provider following infected individuals in the state corrections system as in their primary HIV clinic eases the transition to continued care upon release.
- Peer mentors are an effective means of engaging recently incarcerated PLWH/A into recovery, mental health counseling, and/or medical appointments, where appropriate, during the transition out of incarceration.
- With an increase in clients coming from federal corrections programs, “felony friendly” housing that is also clean and sober can be difficult to find and/or maneuver. This special population faces additional barriers and requires increased attention and facilitation while transitioning out of corrections.

# 3

## Patterns of Client Service Utilization

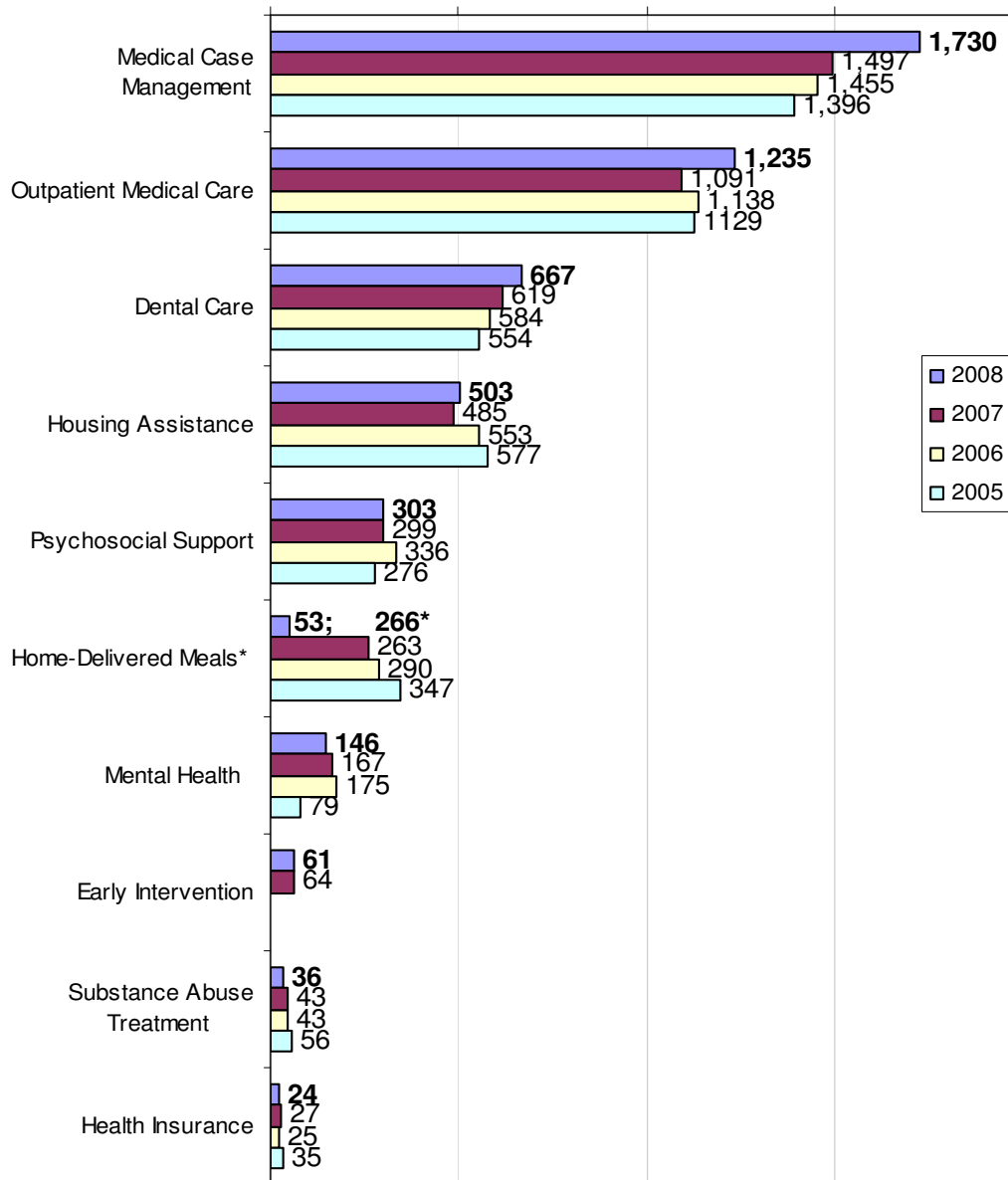
Ryan White Part A funds support a continuum of care services to help clients achieve positive medical outcomes. As such, examining patterns of client utilization of Part A-funded services provides insight on client needs and ability to access different services within this continuum. *Important to note is that the Part A-funded continuum of care does not represent a closed system of care.* Though some clients may only access services from one Part A-funded provider, this does not mean they don't access other care providers or services. Providers not funded by Part A are not accounted for in this report.

### ***Client Service Access***

In 2008, 94.9% of all clients received at least one HIV core service from Part A-funded providers. The percentage of all clients that have received at least one core services has increased since 2005 (90.4%). Core services include outpatient medical care, health insurance, dental, mental health therapy, substance abuse treatment, medical case management, and early intervention services. Approximately 28% of all clients received at least one support service from a Part A-funded provider, a decrease from 2006 (40%). Support services include housing (assistance and related services), psychosocial support, and food/home-delivered meals. There were changes to support services between FY 06-07 and FY 07-08, including the elimination of certain types of services, most likely accounting for the decrease in the percentage of clients receiving support services. A higher percentage of clients receiving support services were female (20.7%), persons of color (32.2%), poor ( $\leq$ 100% FPL; 80.7%), and lack permanently housing (28.7%) than those receiving core services only. Clients accessing support services were also more likely to have some form of public health insurance (49.2%) and have an HIV risk factor other than MSM (53.5%). Clients accessing support services were also more likely to access services from more than one Part A-funded provider during 2008 (77.2%) than their counterparts (34.5%). Approximately 23% of all clients received both core and support services, also a decrease from 2006 (31%).

In 2008, ten agencies were funded to provide 24 program areas across ten different service categories. The following graph displays the number of clients receiving each Part A-funded service over the last four years. Overall, the number of clients per service category has remained relatively consistent, with notable increases or decreases in a few areas. From 2007 to 2008, the number of clients receiving medical care, medical case management and dental care has increased. The number of clients receiving housing services increased slightly last year, while the number of clients receiving mental health and substance abuse treatment services has decreased slightly over the last few years.

**Figure 3.1 Number of Clients Served Across Part A-Funded Services**



\*The home-delivered meal category used to include congregate meals/food services, in addition to home-delivered meals. In 2008, meals served at agencies were incorporated in psychosocial support services. If these services remained within the food/home-delivered meals category, the total number of clients served in 2008 would be 266.

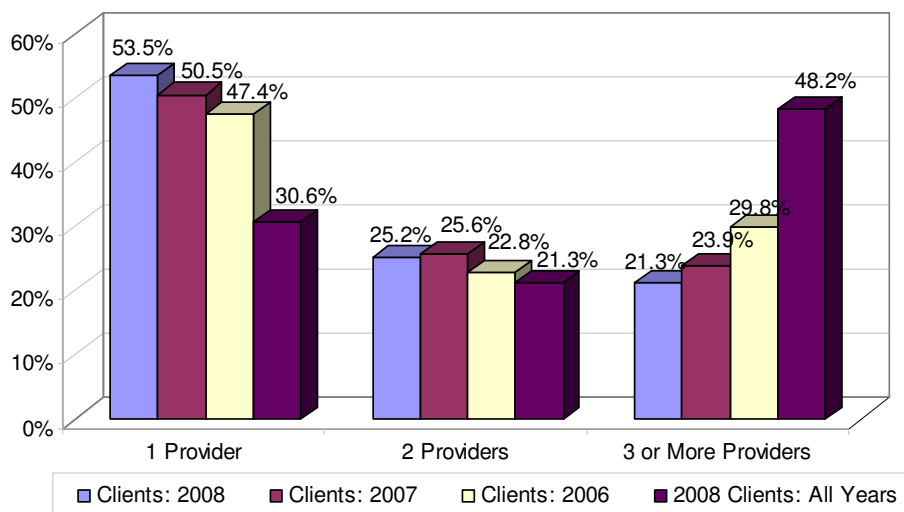
More information by service category on client service utilization, service goals, and funds allocated and spent during the 2008-09 fiscal year can be found in “Overview of Clients and Services by Service Category” below.

***Client Utilization by Number of Service Providers***

The following section answers the question: “Are clients receiving service from more than one Part A-funded provider?”. This examines how many providers a client accesses to receive the range of services needed.

In 2008, 53.5% of clients received services from one Part A-funded provider, while approximately 8% of clients received services from four or more. The following graph displays Part A clients served in different years by the number of providers accessed. Over the last three years, a higher percentage of clients have been accessing services from only one Part A provider within a year, while a lower percentage of clients have been accessing services from three or more providers. Though the majority of 2008 clients have accessed only one Part A-funded provider in the past year, when examining the number of providers 2008 clients have seen over the past several years, it is clear that clients will access a larger range of Part A services from more providers over time.

**Figure 3.2 Part A Clients by Number of Providers**



A subset of clients receiving services from three or more providers in 2008 was examined to better characterize a more “high Part A utilizing” population. A higher percentage of clients accessing three or more providers had acuity scores greater than 29 (48.3%) compared to those who accessed less than 3 providers (32.6%). A higher percentage of these clients were non-permanently housed (24.5%), and poor (79.9%; under <100% FPL) than those accessing less than three providers (14.5% and 62.0% respectively). About one out of four of these clients (23.4%) had IDU or MSM/IDU risk. Additionally, clients accessing three or more providers were more likely to be PLWH/A of color (35.5%) in comparison to those who accessed less than 3 providers (25.6%). No differences were observed in the number of providers accessed by gender.

### **Overview of Clients and Services by Service Category**

The following section provides an overview of the 10 Part A-funded services. Each of the service category descriptions contains a service definition, a summary of key facts and issues, including a brief overview of client demographics and characteristics, and a description of service utilization and cost in FY 08-09. When available, a brief description of service outcomes for the fiscal year is also included; however, service category outcomes are discussed further in-depth in Chapter 4.

## **Outpatient Medical Care**

**Service Definition:** Provision of primary and HIV medical care at specialty clinics that follow national standards of care for the treatment of HIV. Care includes diagnosis and treatment of physical and mental health conditions, medication management and adherence counseling, medical care coordination, and referral to other specialty providers and linkage to case management services.

### **Key Facts and Issues:**

- Outpatient medical providers saw 144 more Part A clients in FY 08-09 than the previous year.
- 249 clients received 659 uninsured medical visits in FY 08-09, an average of 2.6 uninsured visits per client. About 1 in 5 medical care clients (21.4%) were uninsured at some point during the year, a decrease from FY 07-08 (28.7%). The number of uninsured clients and visits also decreased from FY 07-08 (314 clients; 1,012 uninsured visits), though the average number of uninsured visits per client is only slightly lower (3.2 visits per client). This decrease may be an indication that clients have access to more coverage (e.g. CAREAssist expansion).
- The percentage of clients who are *underinsured* increased from 29.8% in 2004 to 65.5% in 2008 at one clinic. *Underinsurance* is defined as any insurance reimbursement which is less than half the amount of the highest reimbursement rate for a given service. In FY 08-09, there was an average of 9 underinsured visits per underinsured client. Part A funds also offset the growing cost of these visits and allow medical clinics to provide wrap-around services for clients, such as pharmacy and care coordination services despite being limited by insurance coverage.
- Women (16.0%), racial/ethnic minorities (31.0%), and youth (3.8%) were served in equal or greater proportion to their representation in the HIV/AIDS epidemic. A lower percentage of clients were 50+ years of age (20.8%).
- 74.3% of clients had incomes  $\leq$ 100% FPL and 54.1% had private insurance (mainly through OMIP), a higher percentage than clients not receiving these Part A-funded medical services.
- 92.6% have maintained or improved CD4 counts to above 200 cells/ul; 92.1% of clients who were diagnosed with HIV at their first visit did not progress to AIDS by their last visit.
- HIV group medical visits have been implemented this year at one clinic and will continue to improve service access and availability to clients. Group medical visits provide shared health messages for PLHW/A and allow for greater discussion and Q&A among groups of patients. After the group visit each patient sees the provider individually where they are able to discuss issues unique to their care. The addition of an HIV specialty pharmacist to the staff has also enhanced targeted, HIV-specific care at one medical provider.
- One clinic this year also tried several ways to address their no-show rate, including reminder phone calls, providing written explanations of appointment cancellation policy, and allowing clients most likely to no-show the opportunity to come in any day and be seen on a stand-by basis instead of making an appointment. This freed more appointment slots and has given hard to serve clients more options to stay engaged in care.

**Service Utilization and Cost:** In FY 08-09, 1,235 clients were eligible to receive Part A-funded medical care services, an increase from 1,091 eligible clients in FY 07-08. The average number of uninsured visits per client has consistently decreased over the last four years (FY 05-06: 5 uninsured visits). Additionally, 571 clients received 5,288 underinsured visits, an average of 9 visits per client. 278 clients received 1,409 care coordination visits to support client engagement in medical care. *This service category met >100% of the contract goals.*

A total of \$677,388 was allocated to outpatient medical care (FY 07-08: \$650,000). By the end of the year, 100.0% of funds were utilized.

## **Health Insurance**

**Service Definition:** Health insurance funds pay for health insurance premiums, co-pays and deductibles for clients who live in the TGA. In FY 08-09, Part A funds in this category are only being utilized for Clark County, Washington residents. CareAssist through Part B provides similar services for Oregon TGA clients.

### **Key Facts and Issues:**

- Though only 24 clients were served in FY 08-09, these services ensure the gaps in the Washington State health insurance programs are filled.
- 21% of clients were female, 21% were racial/ethnic minorities, and 25% were 50 years of age or older. As Part A funded health insurance applies to such a small number of clients, these proportions are comparable to their representation in the epidemic.
- 17% lacked permanent housing and 75% were at or below 100% FPL, comparable to other Part A clients.
- By the end of FY 08-09, 50% of health insurance clients were engaged in medical care in the last 6 months, while 85% of clients did not have any lapse in coverage during the year.
- This year, Washington State Department of Social and Health Services discontinued the practice of meeting eligible clients' spend down costs<sup>5</sup>. As a result, clients now have to cover their own medication and medical costs up to their spend down amount before they can be eligible for Medicaid. While the provider is investigating possible solutions to assist clients with this, more clients may be uninsured in the coming year.

**Service Utilization and Cost:** In FY 08-09, 24 Clark County clients received health insurance assistance, similar to FY 07-08 (n=27). These clients received a total of 31 insurance premium payments and 69 medical visit co-payments. *This service category met >100% of the contract goals.*

In FY 08-09, a total of \$31,410 was allocated to health insurance services (FY 07-08: \$19,654). By the end of the year, 80.6% of funds were utilized.

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<sup>5</sup> A spend down is similar to a deductible in a conventional insurance plan. For certain clients with income over the automatic eligibility for Medicaid, clients must meet a specific spend down amount first before becoming eligible for Medicaid in some states like WA.

## **Mental Health**

**Service Definition:** Mental health assessment and individual/couple/family counseling on-site or at-home, group counseling, crisis intervention, and medication management for PLWH/A. Mental health services are delivered by mental health professionals (psychiatrists, psychiatric nurse practitioners, licensed social workers, or licensed professional counselors). Recruitment into mental health and substance abuse treatment services by peer mentors is also funded through a joint mental health and substance abuse treatment project.

### **Key Facts and Issues:**

- In FY 08-09, 146 clients received Part A-funded mental health services, a decrease of 21 clients from last year. These clients received close to 1,200 hours of mental health assessment, counseling, medication management, and/or group therapy, as well as 659 encounters with peer mentors. This is 225 less hours of therapy than in FY 07-08.
- Though the Part A cost per client per year increased in FY 08-09 (\$825) from FY 07-08 (\$733), mental health parity legislation related to health insurance plans continues to result in less reliance on Part A funds to fill coverage gaps. Peer mentor programs are not reimbursable though, and remain funded by Part A.
- Women (22.6%), racial/ethnic minorities (22.7%) and those with IDU or MSM/IDU risk factor (29.7%) were served in greater or comparable proportion to their representation in the epidemic; clients from outside Multnomah County (21.2%) were served in lower proportion.
- 78.3% of clients had incomes =<100% FPL, a higher percentage than Part A clients not receiving these mental health services.
- The percentage of clients with stable or improved functioning by the end of the year, as indicated by the OQ-45, a scientifically reliable measurement tool for tracking psychotherapy and behavioral treatment progress, increased from 82% in FY 06-07 to 92% in FY 08-09.
- The largest mental health provider increased their ability to target dually diagnosis mental health/substance abuse clients this year through the development of an internal database with this subgroup in order to improve the assessment and referral process for these clients.
- A peer mentor engagement program served 55 clients in FY 08-09. The peer mentor model continues to be a successful means of engaging clients into active mental health or substance abuse treatment; 71% of clients in this program successfully engaged in treatment in FY 08-09, an increase from FY 07-08 (61%).
- This program reports that the effectiveness of peer mentors appears to be due to the wealth of life experience they bring to individual conversations, allowing them to translate complex treatment information into lay terms in a non-threatening, culturally competent, egalitarian manner.

**Service Utilization and Cost:** In FY 08-09, 146 clients received mental health services (>100% of contract goal). Clients received 55 hours of assessment; 683 hours of individual, couple and/or family counseling and 17 hours medication management (98% of contract goal altogether); and 443 hours of group mental health client contact (63% of contract goal). 225 fewer hours were billed to Part A in FY 08-09 than in FY 07-08. 55 clients (72% of contract goal) received 659 encounters with peer mentor staff to support mental health/substance abuse treatment engagement.

A total of \$124,855 was allocated to mental health services in FY 08-09 (FY 07-08: \$123,481). By the end of the year, 96.5% of mental health therapy funds were utilized. The Part A cost for mental health services averaged \$825 in FY 08-09 (\$733 in FY 07-08). \$29,600 was reallocated away from mental health services during FY 08-09 due to decreased Part A need and utilization.

## **Dental Care**

**Service Definition:** Comprehensive dental care provided by practitioners who treat HIV positive patients. Services include diagnostic, preventive and restorative care, oral surgery and emergency care resulting from pain and infection. Crown and bridge procedures are also provided, with some limitations.

### **Key Facts and Issues:**

- In FY 08-09, Part A-funded dental providers saw 48 more clients than in FY 07-08. Though the number of clients receiving dental services increases each year, the average number of visits per client decreased this year.
- Racial/ethnic minorities (23.1%), women (9.3%), clients 50+ years of age (33.6%), and clients from outside Multnomah County (28.9%) were served in equal or greater proportion to their representation in the epidemic.
- 63.7% of clients had incomes =<100% FPL, a lower percentage than Part A clients not receiving these dental services.
- The average Part A cost per client per year has continually decreased since FY 05-06 (\$597) to FY 08-09 (\$422). Part F provides some reimbursement; however, there was a lower reimbursement rate from Part F for uncompensated dental services last year than in the past.
- 62% of clients had at least one preventive visit in FY 08-09, comparable to FY 07-08 (63%). The percentage of clients that received emergency care but did *not* receive preventive care decreased this year (47%) from last year (53%).
- The main provider of dental care in the TGA reported increasing numbers of new clients with various acuity levels. In particular, the Hispanic population served by the primary dental clinic is at its highest level to date.
- Dental providers have faced challenges in spreading accurate information about services to the target population. They have worked to overcome this challenge by developing materials to be distributed to area providers and community members.
- A series of significant funding cuts to the main TGA dental clinic this year greatly affected the ability to provide care. However, the provider has survived a near closure and is in the process of rebuilding its staff. They have been able to re-open every Saturday and have added dentists, hygienists, denturists and dental assistants to the staff.

**Service Utilization and Cost:** In FY 08-09, a total of 667 clients received 2,578 dental care visits from Part A-funded dental providers. This averaged 4 visits per client per year, a lower average number of visits than seen in the last 3 years (5 visits per client per year). *This service category met >100% of the contract goals.*

A total of \$285,353 was allocated to dental care services in FY 08-09 (FY 07-08: \$274,749). By the end of the year, 98.7% of funds were spent. Part A reimbursement rates are set at 80% of usual fees. The average Part A cost per client per year was \$422 (as compared to \$443 in FY 07-08; \$543 in FY 06-07 and \$597 in FY 05-06). \$35,668 was reallocated to dental services during FY 08-09; traditionally, a larger amount of funds have been available to reallocate to dental care services than in FY 08-09.

## **Outpatient Substance Abuse Treatment**

**Service Definition:** Assessment, individual and group counseling, as well as engagement coordination in outpatient treatment for clients in alcohol and drug-free housing. Recruitment into mental health and substance abuse treatment services by peer mentors are also funded through a joint mental health and substance abuse funding effort.

### **Key Facts and Issues:**

- In FY 08-09, a total of 36 clients received outpatient substance abuse treatment. The average number of treatment hours per client decreased in FY 08-09 (8.6 hours) from FY 07-08 (20.5 hours).
- The average Part A cost per client per year increased in FY 08-09 (\$894) from in FY 07-08 (\$813).
- Racial/ethnic minorities comprised 28% of all clients and women 11%, comparable to their representation in the epidemic. The majority of clients were between 25 – 44 years of age (56%). A high percentage of clients had IDU or MSM/IDU as their primary risk factor (50%).
- 47% of clients were unstably housed, a higher percentage than Part A clients not receiving these services. The majority of substance abuse treatment clients though were in time-limited alcohol and drug (A&D) free housing. The majority of clients were poor (= <100% FPL; 89%). A high percentage of clients (53%) accessed services from 4 or more Part A providers.
- Slightly more than half of clients (54%) at service termination had successfully completed treatment in FY 08-09, a decrease from FY 07-08 (64%).
- Providers of substance abuse treatment have reported that:
  - A large number of LGBT methamphetamine users this year were seen this year, in addition to an increase of clients with multiple chronic issues such as HIV and Hepatitis C.
  - Continued substance abstinence and stable housing after treatment this year was due in part to networking and “wraparound” services within the agency, as well as working with other providers in areas of substance abuse and mental health.

**Service Utilization and Cost:** A total of 36 clients received substance abuse treatment in FY 08-09 (84% of contract goals). Of these, 7 clients received 60 hours of treatment (35% of contract goals), averaging 8.6 hours per client per year (FY 07-08 average: 20.5 hours). Of these 36 clients, 29 clients residing in alcohol and drug free housing received 791 client contacts of substance abuse treatment engagement services (79% of contract goals). This averages 27 client contacts per client by the end of the year (FY 07-08 average: 31 contacts).

A total of \$37,125 was allocated to outpatient substance abuse services (FY 07-08: \$37,574). By the end of the year, 86.6% of funds were spent. The average Part A cost per client per year for treatment services in FY 08-09 was \$894, a higher average than in FY 07-08 (\$813). \$5,000 was reallocated away from outpatient substance abuse services during FY 08-09.

## **Medical Case Management**

**Service Definition:** Assessment, coordination of services and linkages to services inside and outside the Ryan White system of care. All clients receive primary medical case management services which include treatment adherence assessment, health insurance maintenance, and coordinating timely access to appropriate levels of medical and supportive services, through ongoing client assessment. Specialty case management services are also offered in conjunction with primary case management services; this includes nursing case management, intensive case management for high acuity Latino and African and African American clients, and services for clients living in transitional housing units to ensure they are able to maintain housing, thereby impacting their ability to maintain medical care and medication adherence.

### **Key Facts and Issues:**

- 1,730 clients received medical case management services in FY 08-09, averaging 8.1 hours per client per year. For the last four years, case management client load has consistently increased.
- 36.3% of case management clients required intensive case management (acuity score 29+) in FY 08-09, a decrease since FY 05-06 (55.2%). Female clients and clients with IDU as primary risk factor had higher acuity scores.
- Women (16.5%), racial/ethnic minorities (31.8%), youth (3.4%), and clients from outside Multnomah County (33.3%) were served in equal or greater proportion to their representation in the epidemic. A higher percentage of clients had heterosexual (22.4%) risk exposure; a lower percentage was 50+ years of age (23.5%).
- 92.1% of case management clients had health insurance coverage by the end of FY 08-09; 91.3% were engaged in medical care.
- This year, 14 groups/workshops, such as HIV 101, were offered by case management providers; 13 clients completed the Positive Self-Management Program (PSMP).
- Medical case managers in the TGA have reported that increasingly clients are accessing services further along in disease progression.
- In addition to reporting an increasing clientele of women and younger MSM, this year case managers reported an increase in safety concerns by clients and the living situations they are in. Due to the economic downturn and continued instability that occurred this year, there is a concern that this will only increase during the next year.

**Service Utilization and Cost:** In FY 08-09, 1,730 clients received Part A-funded medical case management services (*>100% of contract goal*), an increase of 233 clients. Clients received a total of 13,965 hours of service (face-to-face and other; *>100% of contract goals*), an average of 8.1 hours per client. In the first year of the new Minority AIDS Initiative (MAI) program, 33 clients also received 386 hours of MAI medical case management services, averaging 11.7 hours per client (*39% of contract goals*).

A total of \$895,120 was allocated to medical case management (FY 07-08: \$852,400). By the end of the year, 100.0% of funds were utilized. The average Part A cost per client per year (not including MAI clients) was \$517 (FY 07-08 average cost: \$569; FY 06-07: \$581). \$10,000 was reallocated to medical case management services during FY 08-09 to support a new medication adherence program.

## **Early Intervention Services (EIS)**

**Service Definition:** Counseling to individuals with respect to HIV/AIDS, testing, and referrals to medical care and treatment and mental health and substance abuse treatment services, as appropriate, to newly diagnosed individuals and persons who have fallen out of care.

### **Key Facts and Issues:**

- The EIS program began in July 2007, and has focused on PLWH/A who are out of care and the newly diagnosed, many of whom come into care later in their disease progression with a variety of cofactors including mental health and substance abuse issues.
- 61 clients received EIS in FY 08-09, averaging 10 contacts per client per year.
- Women (35%), racial/ethnic minorities (38%), youth (6%), and clients from outside Multnomah County (33%) were served in equal or greater proportion to their representation in the HIV/AIDS epidemic. A higher percentage of clients also had IDU (25%) or heterosexual (23%) risk exposure.
- 88% of clients had incomes  $\leq$ 100% FPL, 46% were unstably housed, and 24% were uninsured, a higher percentage than Part A clients not receiving EIS.
- 75% of EIS clients had seen a medical provider in the last 6 months by the end of FY 08-09, an increase from FY 07-08 (57%). Three out of four EIS clients also engaged in case management services.
- Providers of early intervention services have reported that obtaining referrals for clients out of care for 6 months or longer was a challenge this year, as medical sites gather this information differently. The establishment of a referral system with Medical Case Management for those out of care for more than 6 months has been difficult.
- In view of the incarceration of several EIS clients during their program participation, providers report the importance of continuing to work with these clients while they are incarcerated to prepare for their release and ensure they are receiving adequate care.

**Service Utilization and Cost:** EIS staff provided a total of 611 contacts ( $>100\%$  of contract goal) to 61 clients in FY 08-09 ( $62\%$  of contract goals). This averages 10 contacts per client per year. The majority of these clients had been diagnosed with HIV over one year prior to receiving EIS ( $n=45$ ), while 16 clients needing services had been newly diagnosed in the past year. Of the 61 clients, 47 clients needed assistance engaging in medical care or both medical care and mental health or substance abuse treatment. 14 clients needed assistance engaging in mental health or substance abuse treatment services alone. Emphasis is placed on finding clients who need assistance engaging in medical care.

A total of \$143,120 was allocated to EIS in FY 08-09 (\$95,300 was allocated to EIS for 8 months of FY 07-08). By the end of the year, 98.6% of funds were utilized. The average Part A cost per client for EIS was \$2,314 in FY 08-09 (FY 07-08: \$1,449). \$7,000 was reallocated away from early intervention services during FY 08-09.

## **Housing Services**

**Service Definition:** Emergency rental assistance (ERA) and transitional housing assistance to PLWH/A and their families. Eviction prevention, information and referral, education, and housing case work enable clients to access and remain in transitional and permanent housing. Alcohol/drug-free housing is also provided for PLWH/A while enrolled in outpatient substance abuse treatment.

### **Key Facts and Issues:**

- 503 clients received housing services in FY 08-09, a slight increase from FY 07-08.
- Ryan White funds continue to support a mix of both direct housing assistance to clients and support services which are able to leverage housing units from other funding resources (see Appendix A for other resource amounts).
- Women (19.1%), racial/ethnic minorities (32.3%), youth (5.2%), and clients from outside Multnomah County (29.7%) were served in equal or greater proportion to their representation in the epidemic; a higher percentage of clients also had IDU or MSM/IDU (26.4%) risk exposure or heterosexual (23.5%) risk. Clients 50+ years of age (21.6%) were served in lower proportion.
- 81.3% of clients had incomes =<100% FPL and 28.8% were unstably housed, a higher percentage than Part A clients not receiving these housing services.
- 84% of housing clients were engaged in medical care and medical case management services in FY 08-09. 88% of Ready-to-Rent graduates, 94% of clients who had received ERA, and 92% of clients receiving rental subsidies in FY 08-09 had stable housing at the year's end.
- Housing service providers have reported a high need for emergency rental assistance for move-in costs or eviction prevention, with several clients having to pick between paying rent and paying utilities.
- The largest housing service provider agency implemented a flexible, walk-in meeting schedule model this year to better utilize staff time and ensure all clients are seen. As a result, no clients were turned away, and since meetings were not scheduled, staff did not have issues with "no shows".

**Service Utilization and Cost:** *HOUSING ASSISTANCE:* 180 clients received housing assistance services by the end of the year (98% of contract goal). 28 clients (households) were in supportive housing units funded by Part A (>100% of contract goal). Part A provided 81 housing rental months for these clients, an average of 2.9 months per client per year (FY 07-08: 4.1 months). Additionally, 43 clients in Housing Authority of Portland (HAP) housing units received 90.25 hours of housing case work funded by Part A. 186 clients received emergency rental assistance payments (>100% of contract goals). *HOUSING-RELATED SERVICES:* 295 clients received housing-related services by the end of the year (98% of contract goal). 69 clients attended housing education and workshops (67% of contract goal). 86 clients received eviction prevention services (>100% of contract goals). 203 clients attended housing planning meetings for an assessment and assistance in identifying strategies to maintain stable housing (70% of contract goal). *ALCOHOL & DRUG FREE HOUSING:* 29 substance abuse treatment clients (>100% of contract goal) lived in alcohol and drug-free housing for a total of 87 client occupancy months (83% of contract goals), while enrolled in outpatient treatment. This averages 3.0 months per client by the end of the year (FY 07-08 average: 3.1 months).

A total of \$361,535 was allocated to housing services in FY 08-09 (FY 07-08: \$332,657), of which alcohol & drug free housing comprises \$40,990. By the end of the year, 98.8% of funds were spent. \$24,000 was reallocated to housing services during FY 08-09.

## ***Psychosocial Support***

***Service Definition:*** Psychosocial support programs provide emotional, social and practical support to clients through day drop-in centers, congregate meals and peer support. Psychosocial services are targeted for women, youth and children and historically underserved populations – clients who are homeless, clients with multiple diagnoses, and racial and ethnic minorities.

### ***Key Facts and Issues:***

- A total of 303 clients received psychosocial support service in FY 08-09, consistent with FY 07-08 (299 clients). The average number of visits per client in FY 08-09 to the multi-service center and women’s/children’s center was slightly higher than in FY 07-08.
- Women (27.4%), racial/ethnic minorities (33.7%), youth (6.0%) and were served in equal or greater proportion to their representation in the epidemic; 25.4% of clients were 50+ years of age. A higher percentage of clients had IDU or MSM/IDU (32.8%) risk exposure or heterosexual (30.6%) risk exposure.
- Some clients from outside Multnomah County (12.9%) received psychosocial services, though planning guidance does not require geographic proportionality due to the service centers being located in Portland.
- 82.9% of clients had incomes =<100% FPL and 33.8% were unstably housed, a higher percentage than Part A clients not receiving these psychosocial support services.
- 87% of psychosocial clients were maintaining regular medical care, similar to FY 07-08 (86%). 94% of clients responded that these services helped them deal with their disease. Close to two-thirds of clients (65%) responded that psychosocial support providers talk to them “always” or “often” about seeing a medical provider.
- Providers of psychosocial support services reported that clients usually engage in services at stressful points in their lives, and many who have found stability do not continue to attend groups and services on a regular basis.
  - Clients accessing psychosocial support commonly report needing services during times when they are feeling socially isolated or alone in their struggle to get their needs met.
- One psychosocial support provider reported an increase in attendance at congregate meals, and an overall increase in social activity with clients staying longer and engaging with others.

### ***Service Utilization and Cost:***

A total of 303 clients received psychosocial support services in FY 08-09 (FY 07-08: 299 clients). Of these, 232 clients made 7,035 visits to the multi-service center, averaging 30.3 visits per client per year (FY 07-08 average: 29 visits). 213 of these clients accessed a total of 7,892 congregate meals, an average of 3 meals a month. In addition, 72 clients made 897 visits to the women and children’s multi-service centers, averaging 12.5 visits per client per year (FY 07-08 average: 10 visits). *Service providers met 100% of the contract goals.*

A total of \$158,022 was allocated to psychosocial support services in FY 08-09 (FY 07-08: \$149,168 for similar services). By the end of the year, 100.0% of funds were utilized. The Part A cost for psychosocial services averaged \$522 in FY 08-09 (FY 07-08 average: \$499).

## **Home-Delivered Meals**

**Service Definition:** This service provides medically necessary home-delivered meals.

### **Key Facts and Issues:**

- In FY 08-09, 53 clients received 10,164 home-delivered meals, an increase in meals from FY 07-08.
- Women (15%) and racial/ethnic minorities (20%) were served in proportion to their representation in the epidemic in the home-delivered meal program; a higher percentage of clients receiving home-delivered meals were 50+ years of age (53%) than seen in the epidemic, most likely a result of clients being later in disease progression. A lower percentage of clients were from outside Multnomah County (15%).
- 89% of home-delivered meal clients maintain regular medical care.
- The average cost per meal decreased in FY 08-09 (\$4.02) from FY 07-08 (\$5.21 per meal).
- This year, the home-delivered meals program has added monthly supplemental groceries to the clients that requested this service. These groceries are paid for from non-Ryan White funds.
- Providers have aggressively sought other funding sources for these services.

### **Service Utilization and Cost:**

By the end of FY 08-09, a total of 53 clients (85% of contract goals) received 10,164 home delivered meals (>100% of contract goals). This averages 16 meals per client per month (FY 07-08 average: 14 meals).

A total of \$40,858 was allocated to food/home-delivered meal services in FY 08-09 (FY 07-08: \$43,031 and FY 06-07: \$54,031). By the end of the fiscal year, 100.0% of funds were used. The average Part A cost per meal was \$4.02 (FY 07-08: \$5.21 per meal; FY 06-07: \$4.62 per meal).

# 4

## Quality Management

HIV Care Services aims to support an accessible continuum of high quality care in which people living with HIV/AIDS take a pro-active approach to managing their health. The purpose of the TGA's Quality Management Program is to improve the quality of services and ultimately the health outcomes for PLWH/A by ensuring that: 1) Part A services adhere to TGA standards of care, Public Health Service (PHS) guidelines and established clinical practice; 2) strategies for improving medical care include links to support services that enhance access to care and adherence to treatment regimens; 3) epidemiological, clinical and client utilization data are used to evaluate and address trends in the TGA; and 4) sharing timely and accurate data among stakeholders provides for transparency and accountability in the design and implementation of high quality programs to serve PLWH/A.

### Outcomes

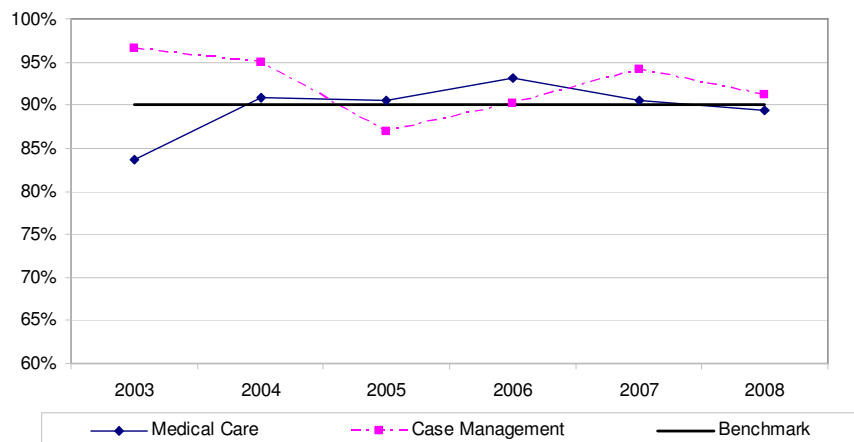
Epidemiological and service utilization data have been presented in Chapters 1 – 3; the following chapter will focus on the outcomes for clients receiving Part A-funded services. Additionally, results of the Part A client satisfaction survey are included at the end of this chapter.

### Client Maintenance in Medical Care

As Ryan White funds emphasize a medical model of care and a care system which supports engagement and retention in medical care, client maintenance in medical care is an expected provider outcome. In the past two years, the TGA definition for clients receiving ongoing medical care changed from client connection to a medical provider to a more specific measure of clients having had an HIV primary medical care visit in the last 6 months. Medical care providers continue to monitor whether clients have been lost-to-care. As medical providers and medical case managers have direct access to client medical charts, when possible these data are used first and triangulated with data from providers who use less rigorous data collection methods, such as client self-report.

The chart to the right illustrates client maintenance in medical care for clients receiving medical and medical case management services, both of which have been around or above set targets (90%) for at least the last three years. Additionally, within HRSA HAB HIV Core Performance Measures for Adults/Adolescents, medical visit maintenance performance is defined as the percentage of clients who had two or more medical visits at least 3 months apart in an HIV care setting during the measurement year. Approximately 80% of active Part A clients receiving medical or medical case management services in FY 08-09 met this criterion for medical visit maintenance.

Figure 4.1 Client Maintenance in Medical Care, Medical & MCM



## Service Specific Outcomes

Part A service providers also report on a range of service specific outcomes to monitor the quality and effectiveness of the services provided to clients.

### Outpatient Medical Care

Outpatient medical care providers report on two main outcomes: client health maintenance (as measured by clients' CD4 test results and recently viral load), and clients receiving care according to public health standards (PHS) clinical guidelines (e.g. PPD tests, syphilis and Hepatitis C screening, etc.).

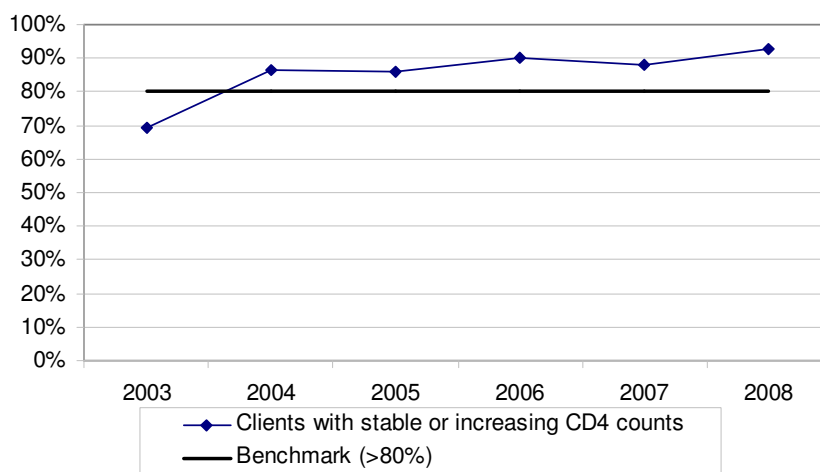
The chart to the right illustrates client health maintenance over the last five years in terms of client CD4 count results. The percentage of clients with stable or increasing CD4 counts (>200 cells/ $\mu$ l) has been increasing since 2003.

Three additional medical outcome measures were included in 2007 to assess service quality, transmission risk and client health maintenance. Approximately

85% of clients receiving medical care from a Part A funded provider had at least two CD4 tests at least 3 months apart during 2008, an increase from 2007 (75.4%). However, there appeared to be a decrease in the percentage of clients who had an undetectable last viral load test (< 400 copies; 65%) in 2008 from 2007 (71%). The percentage of clients who had an HIV diagnosis at their first visit who did not progress to AIDS by their last visit also showed a slight decrease in 2008 (92.1%) from 2007 (97.4%), though still approximately at the medical program's target goal (93%).

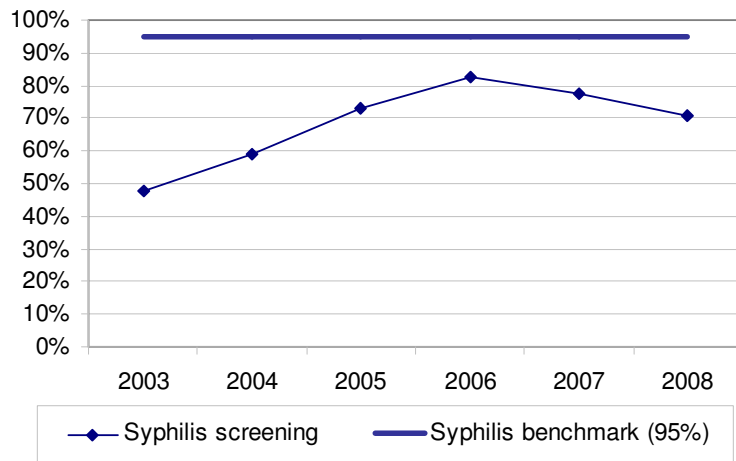
Additional measures are used to assess service quality and whether clients are receiving care according to PHS clinical guidelines for HIV treatment. The following charts show the percentage of clients receiving syphilis screening, a PPD test for tuberculosis, and among women, a pelvic exam and Pap test. The target benchmarks set for these outcomes are indicative of the outcomes for clinics in the top 25% percentile of a national quality effort (HIVQual) in 2007. However, HIVQual results were based on clients who have engaged in medical care in the first 6 month period and the second 6 month period of a year, while Part A medical client outcomes were based on all clients receiving at least one medical care visit in a specific year.

Figure 4.2 Medical Care Client Outcomes, CD4

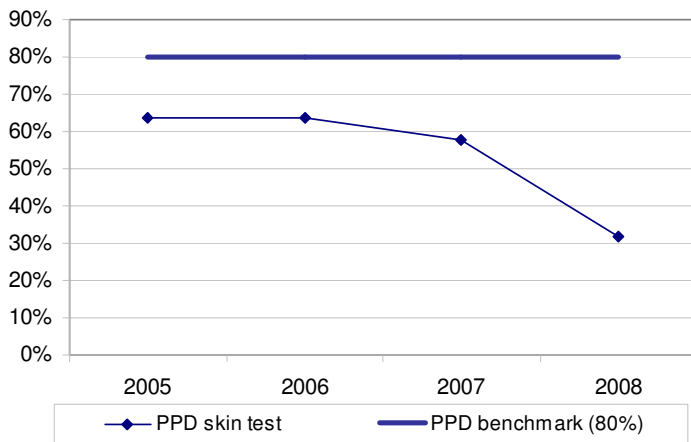


Because many STDs are asymptomatic, clinical guidelines recommend that routine screening of curable STDs (syphilis, gonorrhea, and chlamydia) is performed yearly for all sexually active individuals. The percentage of all clients (not just those who are sexually active as these data are not collected on a routine basis) receiving syphilis screening has increased over the last five years, though showing decreases in 2007 and 2008.

**Figure 4.3 Medical Care Client Outcomes, Syphilis Screening**



**Figure 4.4 Medical Care Client Outcomes, PPD**

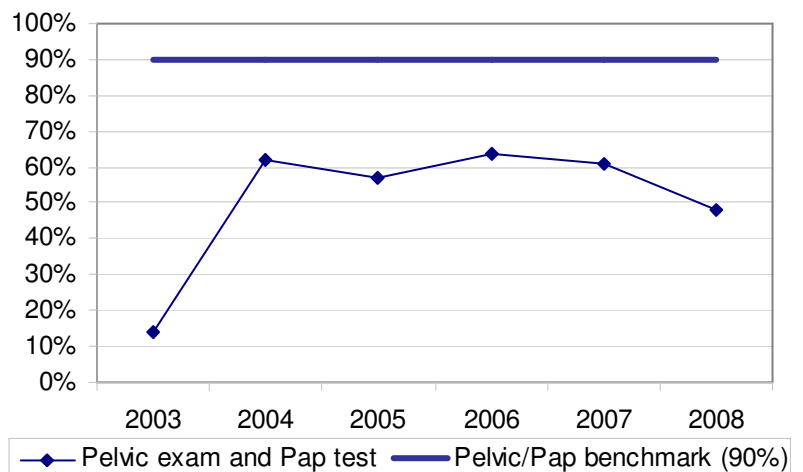


PHS guidelines also indicate that when HIV infection is first recognized, a patient should receive a tuberculin skin test. Repeated testing should also be considered for clients who have had a negative skin test, but who have subsequently experienced an increase in CD4 cell count and therefore may have restored sufficient immunocompetence to mount a positive response. The percentage of clients receiving a PPD tuberculin skin test among those for whom it was clinically indicated has decreased substantially since 2006. One provider has reported switching to a quantiferon gold assay, rather than PPD as their tuberculin screening test. The number of clients obtaining this assay is not reflected yet in these

outcomes, and may account for why the percentage of clients receiving PPD's has been decreasing, as clients would not receive both screening tests.

For women, pelvic examination should be conducted at least annually, and more frequently among women with a history of abnormal Pap smears, unsafe sexual practices, exposure to STDs, or development of gynecologic signs or symptoms. The percentage of women receiving a pelvic exam and Pap test has decreased since 2006. Data accuracy may have been an issue with this indicator in 2003, and may continue to be an issue, as some women receive pelvic exams/Pap tests outside of their primary HIV medical provider clinic.

**Figure 4.5 Medical Care Client Outcomes, Pelvic/Pap**



### Medical Case Management

Case management providers report on two main outcomes: clients lost to follow-up and clients with health insurance at the end of the contract year. Helping clients obtain and retain health insurance is an important component of case management and is fundamental to assisting clients with medical care maintenance and lowering costs to the medical system. The percentage of clients with health insurance at the end of the contract year has remained stable in the last four years and above the target goals set. The percentage of clients lost to follow-up, which has successfully remained <5% for the last 4 years, increased in 2008. This is due in part to a change in the criterion for lost to follow-up in 2008, which now also includes clients that are not responding to one or more phone calls by case managers, in addition to clients who are confirmed as lost to follow-up.

Figure 4.6 MCM Client Outcomes, Health Insurance

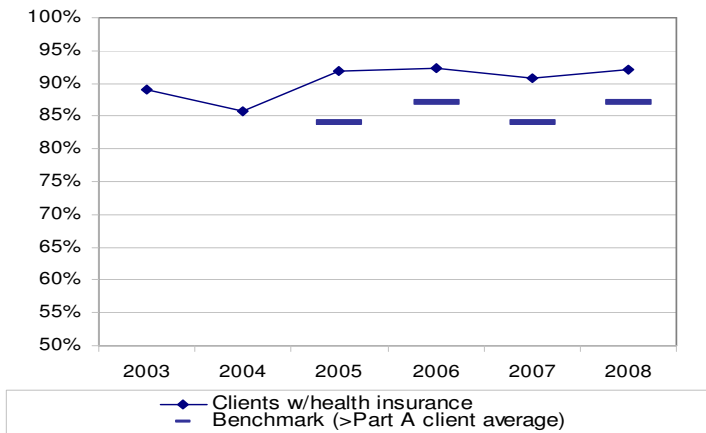
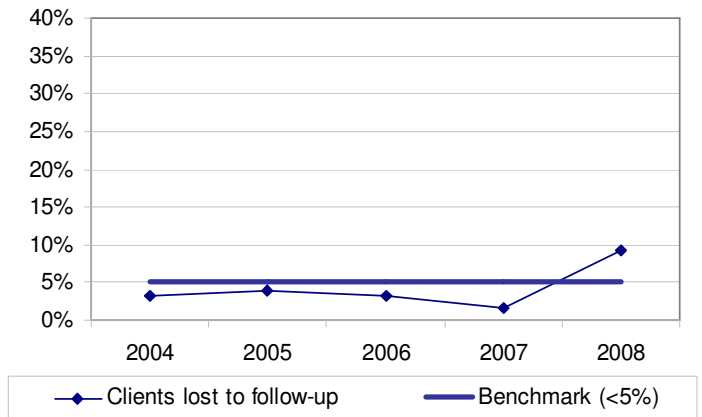


Figure 4.7 MCM Client Outcomes, Lost to Follow-up



### Dental Care

Dental providers report on two main outcomes: preventive care with all clients and preventive care with clients initially seeking emergency care. Maintaining regular preventive care visits is a crucial component in sustaining good oral health and preventing infection that could challenge the immune system. Of the Part A dental clients seen in 2008, close to two out of three clients (62%) had received at least one preventive dental care visit. By comparison, 47% of Multnomah County Health Department dental service clients received preventive services. In 2008, there was a decrease in the percentage of clients who received emergency dental care but who did not receive preventive care, closer to the set target.

Figure 4.8 Dental Client Outcomes, Preventive Visit

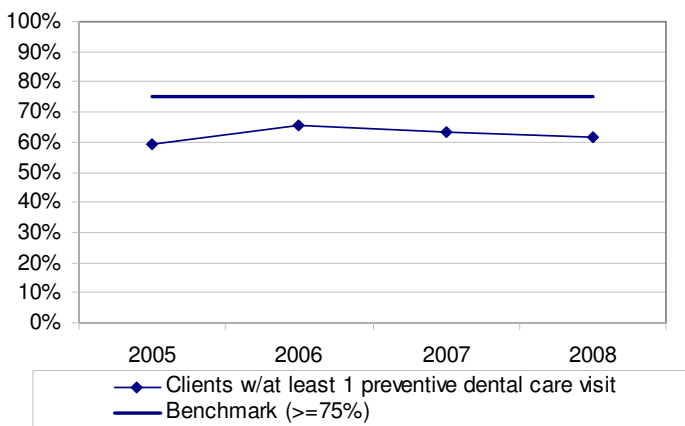
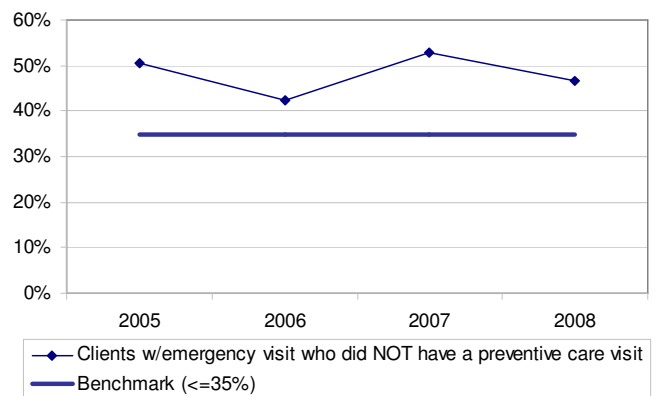


Figure 4.9 Dental Client Outcomes, ER/Preventive Visit

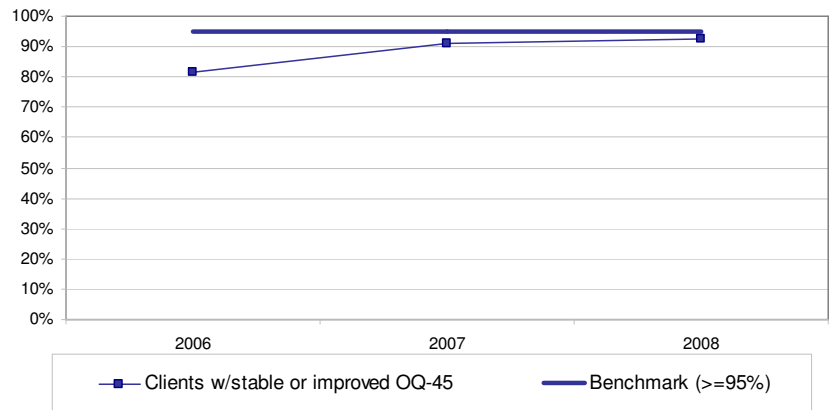


### ***Mental Health***

Mental health providers report on one main outcome: stable or improved level of functioning. Beginning in 2006, stable or improved functioning was measured using the OQ-45. The OQ-45 has been demonstrated as reliable and valid and is widely used in mental health service settings.<sup>6</sup> Comparisons are made between first and last scale rating that are administered at least 90 days apart. The percentage of clients with stable or improved functioning as indicated by the OQ-45 increased from 81.8% in 2006 to 92.4% in 2008 (see graph below), close to the target set

at 95%. Additional analysis showed that close to one out of three clients (29.4%) had symptom scores that were indicators of overall distress. Among those clients with elevated symptom scores, 93% showed significant improvement by their last OQ-45 score. Additionally, 92% of clients with stable OQ-45 scores were able to maintain these scores during the contract year.

**Figure 4.10 Mental Health Client Outcomes**



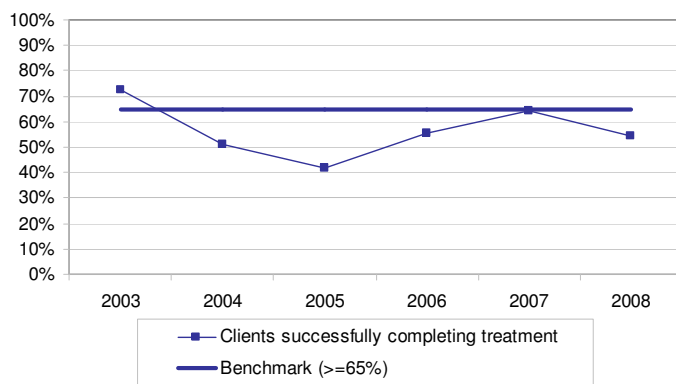
### ***Substance Abuse Treatment***

Substance abuse treatment providers have traditionally reported on one main outcome: successful completion of substance abuse treatment. Over one out of two clients (54.2%) had successfully completed treatment at service termination. This outcome has substantially improved since 2005, though it decreased in 2008 (see chart below). In comparison, in Multnomah County services, 60%

of substance abuse treatment clients successfully complete treatment, while the nationwide average is 51%.

Additionally, a new measure was added in 2007 to assess the efficacy of a new peer mentor program in engaging clients into mental health or substance abuse treatment; 71% of clients engaged in substance abuse treatment, while 72% engaged in mental health services. This is an increase from 61% of clients in the peer program engaging in those services in 2007.

**Figure 4.11 Substance Abuse Treatment Client Outcomes**



### ***Health Insurance Services***

Health insurance providers report on two main outcomes: client engagement in medical care and insurance coverage lapse during the year. By the end of 2008, 50% of health insurance clients were engaged in medical care, while 85% of clients avoided any lapse in coverage during the year.

<sup>6</sup> Lambert, M.J., Burlingame, G.M., Umphress, V., Hansen, N.G., Vermeersch, D.A., Clouse, G. C., & Yanchar, S.C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy*, 3(4), 249-258.

### ***Early Intervention Services***

Early intervention providers report on three main outcomes: client engagement in case management/medical care, clients lost to follow-up, and how long it takes clients to graduate from these services. This was the second year since this early intervention program began and reported on outcomes. Three out of four clients (75%) had seen a medical provider in the last 6 months, an increase from 2007 (57%); 75% of clients were also engaged with a case manager, a decrease from 2007 (89%). Close to 17% of clients were lost to follow-up, an increase from 2007 (9.4%). Clients that were newly diagnosed with HIV took an average of 106 days to graduate from program (37.8 days in 2007), while clients who were previously diagnosed took an average of 132 days (113 days in 2007).

### ***Housing***

Housing providers report on several outcomes: client maintenance in stable housing, establishment of client housing plans, client maintenance in medical care and medical case management, client access and maintenance of health insurance, and client access and maintenance of income source. Establishment of these specific outcomes occurred in 2008 in efforts to better coordinate housing outcomes with US Department of Housing and Urban Development (HUD), Oregon State, and the Housing Authority of Portland (HAP). Part A funds emergency rental assistance, ready-to-rent classes, and housing assistance programs that provide rental subsidies for transitional housing and housing case work for clients. Emergency rental assistance makes it possible for clients to cover the upfront costs associated with moving into permanent housing, and prevents those with short-term financial issues from being evicted. Approximately 94% clients remained in permanent housing at the end of the program year after receiving emergency rental assistance. Less than 1 out of 4 of these clients (23%) were clients who had received emergency rental assistance the previous year. At the end of the program year, approximately 9 out of 10 clients remained in permanent housing after successful graduation from ready-to-rent classes (88%) and among those who received supportive housing (92%). Across all three programs, all housing clients (100%) had an established housing plan for maintaining ongoing stable housing. Approximately 84% of housing clients were maintained in medical care and medical case management, while 85% had accessed and/or maintained health insurance. More than one in two (58%) housing clients successfully accessed and/or maintained qualification for sources of income (e.g. income-producing job, benefits, financial support, etc.).

### ***Psychosocial Support and Food***

Psychosocial support and food providers reported on three new outcomes in 2008: client engagement in medical care, client engagement in case management, and clients reporting that services help them deal with their HIV disease. Psychosocial support providers also report on one additional outcome: support for medical care engagement. Close to 90% of all psychosocial support (87%) and food clients (89%) had seen an HIV medical provider within the last 6 months at the time of their last service visit; 89% of both psychosocial support and food clients were also connected to a case manager. Approximately 94% of psychosocial support clients reported that these services helped them deal with their HIV disease; surveys with food service clients did not produce a high enough response rate to report on this outcome in 2008. Close to two out of three clients (65%) reported that psychosocial services providers talked to them “always” or “often” about seeing a medical provider.

## **Client Satisfaction Survey Results**

The Ryan White Part A Program regularly surveys its clients as part of its quality management program. In 2008, client satisfaction survey data were collected through a short, self-administered, anonymous questionnaire at the 10 agencies receiving Part A funds for services. The questionnaire posed 14 close-ended questions about client demographics and satisfaction with services provided by the distributing agency. Two open-ended questions asked respondents to describe in their own words what they would improve about the service agency and any other comments they wanted to share about the agency or its services. Survey results are based on 629 completed surveys of 1549 distributed to clients who visited agencies during their survey distribution period (40%).

### **Demographic Characteristics of Respondents**

A majority of respondents self-identified as white (69%), male (82%) and residents of Multnomah County (66%). Respondents were about evenly split between the 25 - 44 year and 45 and older age groups; only 3% of respondents were 24 years old or younger. Ninety-three percent of respondents completed the survey in English; 7% completed it in Spanish (Table 1).

**Table 4.1: Demographic Characteristics of Part A Survey Respondents**

<b>DEMOGRAPHIC CHARACTERISTIC</b>	<b>Percent*</b>	<b>Number</b>
<i>Age Group: (n=609)</i>		
24 and under	3	16
25-44	49	298
45 and older	48	295
<i>Gender: (n=622)</i>		
Male	82	513
Female	16	100
Transgender	1	9
<i>Race/Ethnicity: (n=629)</i>		
White	69	435
Black/African American	11	67
Latino	12	75
All Others	8	52
<i>County of Residence: (n=629)</i>		
Clackamas	6	38
Columbia	<1	3
Clark (in Washington State)	9	59
Multnomah	66	413
Washington	12	77
Yamhill	1	6
All Other	5	33
<i>Survey Language: (n=629)</i>		
English	93	584
Spanish	7	45

\*Percentages may not equal 100% because of rounding

Because this was an opt-in survey distributed to clients who visited Part A agencies during the survey distribution period, we don't know if clients who completed the survey differed from those who declined. However, respondent distributions by gender, age, and race/ethnicity are similar to proportions of Part A clients overall, indicating that little or no systematic bias occurred.<sup>7</sup>

***Client Satisfaction with Part A Services***

Respondents answered a series of questions about their satisfaction with the services they received from the agency distributing the questionnaire. Some clients receive services at more than one agency and, thus, had more than one opportunity to provide feedback. Six percent of clients said they had filled out the survey at another agency and 4% said they didn't know if they had previously completed it. Therefore, up to 10% of respondents may have answered the satisfaction questions more than once, but their answers pertained to the services provided at different agencies. Taken as a whole, these data reasonably reflect satisfaction with the overall services provided by Part A-funded agencies. In addition, there were no significant differences by age, gender, or race/ethnicity between those who had completed the survey more than once and those who had not, so demographic comparisons should not be skewed by the small number of respondents who provided more than one response.

***Number of Client Contacts with Part A-Funded Agencies***

Clients reported a fairly even distribution of visits to Part A-funded agencies in the past 12 months, ranging from 1 or 2 to more than 13 visits; the highest proportion of clients (27%) reported 13 or more past-year visits (Table 2).

***Client Ratings of Overall Quality and Impact of Services***

Almost 3 in 4 clients (73%) rated the quality of Part A services as 'excellent' and another 23% rated the quality as 'good'. A handful of clients (4%) ranked quality of service as 'fair' (3%) or poor (1%) (Table 2).

Likewise, most clients (82%) said that the services they received 'helped a great deal' in dealing with their HIV disease; another 15% said services helped 'somewhat' (Table 2).

**Table 4.2 Client Contacts, Quality Ratings, and Perceptions of Service Impact**

<b>QUESTION</b>	<b>Percent*</b>	<b>Number</b>
<i>How many contacts have you had with this agency in the past 12 months (include today's visit)? (n=601)</i>		
1 -2	<b>19</b>	<b>111</b>
3 -4	<b>19</b>	<b>111</b>
5 - 6	<b>16</b>	<b>99</b>
7-12	<b>19</b>	<b>115</b>
13+	<b>27</b>	<b>165</b>
<i>How would you rate the quality of services you have been receiving? (n=597)</i>		
Excellent	<b>73</b>	<b>437</b>
Good	<b>23</b>	<b>140</b>
Fair	<b>3</b>	<b>15</b>
Poor	<b>1</b>	<b>8</b>

<sup>7</sup> According to Part A's latest client services data report, published July 2008, overall client demographics for 2310 clients using Part A services were as follows: 85% men, 15% women, <1% trans; 5% under 24 years, 52% 24-44 years, 44% 45 and older; 71% white, 11% Black/African American, 13% Latino, 6% All Other.

<i>Have the services you received here helped you deal with your disease?</i> (n=596)		
Yes, they helped a great deal	82	490
Yes, they helped somewhat	15	89
No, they really didn't help	2	11
No, they made things worse	1	6

\*Percentages may not equal 100% because of rounding.

### ***Support for Medical Care Engagement***

Because Ryan White services are intended to help people with HIV disease access medical care and remain in treatment, we asked respondents how often agency staff talked with them about seeing their medical provider. Just under half of respondents said that agency staff always talk about seeing their medical provider; another 25% said staff often talk with them (Table 3). The remainder of clients reported that staff broach the topic sometimes (17%) or never (10%). Because these responses refer to services provided at the whole spectrum of Part A agencies, which include HIV medical care, dental care, case management, and a range of support services, it is difficult to interpret this item<sup>8</sup>. There were no significant differences between respondents surveyed at agencies providing core medical services compared to those surveyed at agencies providing support services. Depending on the agency's mission, it may not be feasible for staff to always talk with their clients about seeing their medical provider. On the other hand, for consistent messaging, it would be desirable for all agency staff, particularly those providing core medical services, to address the topic of medical care with their clients often (if not always).

**Table 4.3 Conversations between Staff and Clients about Seeing Medical Provider**

<b>QUESTION</b>	<b>Percent*</b>	<b>Number</b>
<i>How often do staff talk to you about seeing your medical provider?</i> (n=575)		
Always	49	279
Often	25	142
Sometimes	17	99
Never	10	55

### ***Client Satisfaction with Five Specific Aspects of Part A Services***

Most clients reported being satisfied with five specific 'customer service' aspects of Part A service delivery; the average score across all five items was 3.8, with 4.0 being the highest possible rating. Almost 2 in 3 clients (63%) reported the highest level of satisfaction across all five items. Responses varied across items, with the fewest clients reporting satisfaction with the promptness of service delivery (73%) and the most reporting satisfaction with the level of respect and care given to clients (84%). The highest proportion of clients (87%) said that services are always provided with appropriate privacy (Table 4).

**Table 4.4 Client Satisfaction with Five Aspects of Service Delivery**

<b>QUESTION</b>	<b>Percent*</b>	<b>Number</b>
<i>Promptness of staff in responding to your request</i> (n=600)		
Satisfied	73	437
Mostly satisfied	23	140
Mostly dissatisfied	3	15
Dissatisfied	1	8

<sup>8</sup> Fewer clients answered this item compared to other satisfaction items, so they may have had a hard time interpreting it also.

<i>Ability of staff to listen and understand your problems (n=595)</i>		
Satisfied	75	447
Mostly satisfied	22	129
Mostly dissatisfied	3	15
Dissatisfied	1	4
<i>Professional knowledge and competence of staff (n=601)</i>		
Satisfied	79	477
Mostly satisfied	17	102
Mostly dissatisfied	3	16
Dissatisfied	1	6
<i>Respect and care given to you as an individual (n=594)</i>		
Satisfied	84	499
Mostly satisfied	14	81
Mostly dissatisfied	1	8
Dissatisfied	1	6
<i>How often services were provided with appropriate privacy (n=598)</i>		
Always	87	518
Often	10	58
Sometimes	3	19
Never	1	3

\*Percentages may not equal 100% because of rounding.

### ***Reports of Poor Treatment by Agency Staff***

Respondents were asked if they ever felt they had been treated poorly at Part-A funded agencies because of demographic factors like race, age, gender, or sexual orientation; characteristics like drug use, immigration status, or ability to speak English; or other reasons. Five percent of clients (n=30) reported that they did feel they had been treated poorly by agency staff. The most common reasons clients cited for their poor treatment were sexual orientation (n=10) and drug use (n=10). Other perceived reasons for poor treatment included race (n=6), age (n=6), and gender (n=5). One person each cited immigration status and difficulty speaking English as reasons. Fifteen people cited a range of “other” perceived reasons for poor treatment, including issues like criminal history (n=2), religion (n=1), socioeconomic status (n=1), and personal issues like “envy” (n=1) and “bad hygiene” (n=1).

Confidential information about clients’ reports of poor treatment by agency staff was given to administrators for follow up at each agency receiving such a report.

### ***Responses to Open-ended Questions***

Respondents were given the opportunity to provide open-ended responses to one statement and one questions about the Part A services they received:

- If you could improve one thing about this agency’s services, it would be...
- Do you have any other comments about this agency or its services?

### ***Client Ideas about Improving Services***

Fifty percent of respondents (n=315) provided a response to the question: “If you could change one thing about this agency’s services, [what] it would be?” Responses fell into four broad categories, including increasing the amount and type of services available (n=55), improving access to services (n=53), making improvements to facilities (n=14), and improving customer service (n=12).

The largest number of clients reported that they would like to see more services available through funded agencies, including practical and medical support services (n=42), emotional support services

(n=11), and services that crossed over both categories (n=2). Practical medical and support services included dental care (n=15), transportation (n=12), preventive/complementary care (n=7), help with short-term housing and utilities (n=5), and grocery gift cards (n=3):

*Money for dental emergencies is really needed but also preventative dental care. I have not been able to see a dentist in over TEN YEARS!*

*Reinstate a bus pass program...Maybe [have] a truck that could be loaned in housing emergencies.*

*Connect newly infected or those having a difficult time with having HIV/AIDS with those infected who would like to give them emotional support. Start a peer advocacy program.*

Another large group of clients (n=53) made suggestions related to improving access to agency services. Ideas about improved access mostly related to improving a perceived lack of appropriate staffing (n=40) (e.g. long wait times on hold or between calls, staff not available when needed, too few staff, long wait times for appointments), but also included increasing agency hours (n=7), advertising or information about services (n=4), and assistance for people with disabilities (n=2):

*It seems there isn't enough staff to deal with the demand.*

*Educate me as to what this agency has to offer. Not much outreach or information regarding this subject. Other state agencies seem better at this.*

*Expand hours/days of service for better access (Sat AM)*

Fourteen clients requested improvement to facilities, including improving general facility conditions (n=10) (e.g. cleanliness, size of meeting spaces) and developing pharmacy services exclusively for people with HIV (n=4):

*More spaces for growth. There's plenty of work to be done; there's just not enough space.*

*Cleaner! Especially the waiting room, it smells. I always feel I'm going to catch something going there.*

*Have a pharmacy for HIV patients only.*

Finally, twelve people made suggestions related to improved customer service, including staff friendliness, sensitivity to client confidentiality, and professional knowledge:

*Return phone calls within 24 hours.*

*Not having to ask [HIV-related information] at front desk with people waiting right behind me. No light music to muffle voices, you can hear a pin drop...This was for the purpose of Ryan White forms, but still. It does not matter in terms of confidentiality.*

### ***Additional Client Comments***

Thirty-eight percent of clients (n=240) provided other open-ended comments about Part A agencies or services. Of those, nearly all of the comments provided thanks to agency staff or statements of gratitude for available services (n=214):

*I'm very grateful that [this agency] is here for me and everyone else it serves.*

*This agency has been exceptional in aiding me with getting my life together.*

*My deepest thanks to your staff.*

*Everyone is very friendly and nonjudgmental; it makes for a very relaxing and pleasant visit.*

*All I can say is my treatment team is fantastic and I would most likely be deceased without them. Even the receptionists are cool and always on top of things.*

The remaining comments reiterated the same themes identified in the previous question, such as the need to increase specific services (e.g. dental services, support groups) or improve customer service. Open-ended comments were provided to agency staff for consideration in their quality improvement efforts.

### ***Differences in Satisfaction across Client Characteristics***

Analyses were performed to assess differences in satisfaction with overall quality of Part A services, perceived helpfulness of program participation in dealing with HIV disease, and satisfaction across the five customer service items. In several areas, clients with different characteristics were combined into more general subgroups because of low respondent numbers.

Subgroups were defined by the following characteristics:

- Gender (men vs. women)
- Age (Under 45 vs. 45 and older)
- Race/ethnicity (White, Black/African American, Latino, and all others)

Satisfaction items were defined as follows:

- Overall quality of services (excellent vs. all other)
- Four satisfaction items related to promptness, ability of staff to listen, professional knowledge/competence, and respect and care given (satisfied vs. all other)
- How often services delivered with privacy (always vs. all other)
- Helpfulness in dealing with disease (a great deal vs. all other)

#### *Gender*

There were no reported differences in satisfaction by gender.

#### *Race/Ethnicity*

Fewer Black/African American clients were satisfied with the level of respect and care given to them (73%) compared to white clients (86%), Latinos (82%), and clients of all other races (87%) (p=.049). There were no other reported differences in satisfaction by race/ethnicity.

#### *Age*

Clients age 45 and older were more likely to feel that services 'helped a great deal' in dealing with their HIV disease compared to clients under 45 years (87% vs. 79%, p=.02).

There were no other differences in satisfaction by age group.

**Appendix A: Total Expenditures for Services Directly Funded by Part A**

Table 1. Total Expenditures for Services Directly Funded by Part A and Other Funding Sources Used to Fund These Specific Services

Service Category	Federal		State/County/City	Other Local		TOTAL EXPENDITURES
	Portland TGA Part A Expenditures	All Other Federal Expenditures	State, County and/or City Expenditures	General Operating/Private Grants/Donations	Value of In-Kind (non-cash) Contributions	
Dental Care	\$281,589	\$271,811	\$67,749	\$30,152	0	\$651,300
Early Intervention Services	\$141,130	0	0	0	0	\$141,130
Food Services-Congregate Meals	\$40,857	0	\$14,700	0	0	\$55,557
Food Services-Home-Delivered Meals	\$40,858	\$3,101	\$2,551	0	0	\$46,510
Health Insurance	\$25,328	\$17,478	0	0	0	\$42,806
Housing Services	\$357,169	\$963,995	\$78,787	0	\$34,482	\$1,434,433
Medical Case Management	\$888,120	\$109,570	\$107,364	\$64,126	\$358,766	\$1,527,946
Mental Health Therapy	\$120,453	0	0	\$30,000	0	\$150,453
Outpatient Medical Care	\$677,388	\$1,037,287	\$1,562,981	\$500	0	\$3,278,156
Psychosocial Support Services	\$117,165	\$24,000	0	\$57,100	0	\$198,265
Substance Abuse Treatment	\$35,163	0	0	\$5,000	0	\$40,163
<b>TOTAL</b>	<b>\$2,725,220</b>	<b>\$2,427,242</b>	<b>\$1,834,132</b>	<b>\$186,878</b>	<b>\$393,248</b>	<b>\$7,566,720</b>

**Appendix B: 2008 Clients by Service Category and Demographic Group**

Demographic Category	All Clients	Outpatient Medical Care	Health Insurance	Medical Case Management	Dental Care	Early Intervention Services	Housing Services	Mental Health Therapy	Substance Abuse Treatment	Psychosocial Support Services	Home-Delivered Meals	Estimated HIV/AIDS Prevalence as of 12/31/07
<b>Gender</b>												
Male	84.2%	84.0%	79.2%	83.5%	90.7%	64.7%	80.9%	77.4%	88.9%	72.6%	84.9%	89.0%
Female	15.3%	16.0%	20.8%	16.5%	9.3%	35.3%	19.1%	22.6%	11.1%	27.4%	15.1%	11.0%
Transgender	0.4%											0.0%
<b>Race/Ethnicity</b>												
White	72.1%	69.0%	79.2%	68.2%	76.9%	61.7%	67.7%	77.3%	72.2%	66.3%	80.0%	79.6%
Black/African American	10.3%	11.1%	8.3%	11.5%	6.9%	17.0%	15.4%	9.2%	16.7%	15.8%	2.0%	8.2%
Hispanic	8.6%	8.4%	12.5%	10.1%	6.8%	6.4%	8.5%	6.4%	5.6%	8.8%	6.0%	9.1%
Other (Asian/Pac. Islander, Native American, More than One Race)	9.0%	11.5%	0.0%	10.2%	9.4%	14.9%	8.3%	7.1%	5.6%	9.1%	12.0%	3.1%
<b>Age Group</b>												
<13	0.7%	0.0%	0.0%	0.1%	0.0%	0.0%	1.6%	0.0%	0.0%	2.0%	0.0%	0.3%
13-24	3.4%	3.8%	0.0%	3.3%	1.5%	5.9%	3.6%	0.7%	5.6%	4.0%	1.9%	2.5%
24 - 44 years	50.2%	55.7%	62.5%	54.6%	41.5%	58.8%	54.1%	56.2%	55.6%	46.9%	26.4%	47.1%
45+	45.7%	40.5%	37.5%	42.0%	57.0%	35.3%	40.7%	43.2%	38.9%	47.2%	71.7%	50.1%
<b>County of Residence</b>												
Clackamas	6.2%	6.6%	0.0%	5.5%	7.2%	5.9%	5.4%	2.7%	5.6%	5.0%	0.0%	6.5%
Clark	9.7%	2.3%	83.3%	11.5%	6.4%	9.8%	8.8%	8.2%	13.9%	2.6%	7.5%	10.1%
Columbia	0.6%	.6%	0.0%	0.6%	0.4%	0.0%	0.4%	0.0%	0.0%	0.3%	0.0%	0.6%
Multnomah	69.6%	73.8%	16.7%	66.7%	71.1%	66.7%	70.3%	78.8%	77.8%	87.1%	84.9%	71.3%
Washington	12.3%	14.5%	0.0%	12.8%	12.6%	17.6%	14.0%	10.3%	2.8%	4.3%	5.7%	10.4%
Yamhill	1.5%	1.3%	0.0%	1.5%	1.3%	0.0%	0.2%	0.0%	0.0%	0.7%	1.9%	1.1%

## ***Appendix C: Data Sources***

### ***TOURS***

TOURS (Title One Unduplicated Reporting System) is the client-level data collection system that was designed to extract the providers' data into a centralized system. The front-end data collection system has been built as an MS-Access application that has been installed for provider's needing or wanting to replace their current data collection systems. Simple screens allow entry of all client demographic and service data that are required by Ryan White Part A. In the case of providers who have a singular MS Access data system, TOURS has been linked to the client and service data for extraction in the provider's own client database, but without extracting any client identifying information. In other cases, if the data resides in any proprietary databases, Excel spreadsheets, or multiple databases or sources, and the provider has chosen not to use TOURS as a front-end system, a provider-created extract of data in a standardized format serves as the source of the data export. These extracted data from providers are then imported into TOURS. All data have been cross-checked to CAREAct Data Reports (CADR) and monthly service utilization reports in order to provide some independent confirmation of the client-level data.

All client records were identified by an encrypted Unique Record Number (URN). By generating an URN for all the TGA clients, it was possible to "de-duplicate" the clients reported by each provider and produce an unduplicated client-level data. Once the data were unduplicated, further analysis could be conducted to better describe the population receiving Part A supported services and the type of services clients were receiving.

### ***Monthly Service Expenditure and Quarterly Narrative Reports***

Monthly expenditure and quarterly narrative reports are compiled and submitted by Ryan White Part A providers. These reports cover the grant year – March 1, 2008 – February 28, 2009. In the quarterly narrative reports, providers describe program activities or trends positively or negatively impacting service delivery, Chronic Care Model activities, progress on an annual quality service indicator, and any special service initiatives targeting specific populations.

### ***Outcome Reports***

In late 2003, the Institute of Medicine (IOM) released "Measuring What Matters" to provide Ryan White Care Act grantees with guidance in the area of quality management. As part of the plan to assure quality of care, three sub-strategies were recommended: 1) promoting appropriateness of care; 2) assuring effectiveness of care; and 3) improving patient satisfaction.<sup>9</sup> Each year, Ryan White Part A funded providers report on key indicators to assess their programs impact on the clients that they serve. In 2007, target goals or benchmarks for each indicator were set based off of longitudinal provider performance and other local and national data available.

### ***HIV/AIDS Reporting System (HARS)***

Information on the scope of the HIV/AIDS epidemic in the TGA was compiled mainly from data from HARS. In 1984, Oregon established a public health surveillance system to monitor clinically diagnosed AIDS infections and required physicians to report suspected or confirmed cases. In 1993, laboratories were first required to report test results specific for AIDS. The system was further expanded in late 2001 to require laboratories and physicians to report HIV infections that had not yet progressed to AIDS. Data collected at the time a case is reported permit an estimation of the earliest

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<sup>9</sup> [http://hab.hrsa.gov/reports/report\\_08\\_04.htm](http://hab.hrsa.gov/reports/report_08_04.htm)

data of diagnosis, and a description of clinical status at time diagnosis, most likely mode of infection (risk group), duration of survival, and demographic and social characteristics of cases.<sup>10</sup> Data in this report was collected, analyzed, and reported by the HIV/STD Program in the Office of Disease Prevention.

### ***Client Satisfaction and Needs Assessment Survey***

Previously, Ryan White contractors distributed their own client satisfaction surveys and reported their results to HIV Care Services. Over the past 7 years, standardized surveys have been distributed across service agencies by contracted providers, but the result data entered and analyzed by HIV Care Services. In 2008, Program Design & Evaluation Services (PDES) was responsible for survey coordination and analysis.

The client satisfaction section of the survey used this year was developed in 2008 based loosely on two commonly-used standardized surveys: the CSQ-8<sup>11</sup> and the SSS-30<sup>12</sup>. The needs assessment section of the survey was based on a 2005 evaluation of the needs of PLWH/A receiving case management services in Oregon and Clark County, Washington conducted by PDES. It was modified through discussions with all major contractors and pilot testing with clients at two sites. The survey was translated into Spanish and then made available in either language at all provider sites. Distribution is staggered among the provider agencies so as not to burden clients with filling out surveys from multiple agencies during any given period.

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<sup>10</sup> HIV/STD/TB Program, **HIV/AIDS Epidemiological Profile: 2004**, Oregon Department of Human Services.

<sup>11</sup> An eight-question version of the Client Satisfaction Questionnaire (CSQ-8) was authored by C. Clifford Attkisson.

<sup>12</sup> The Services Satisfaction Scale-30 (SSS-30) was authored by Thomas K. Greenfield and C. Clifford Attkisson.