

Portland Area HIV Services Planning Council

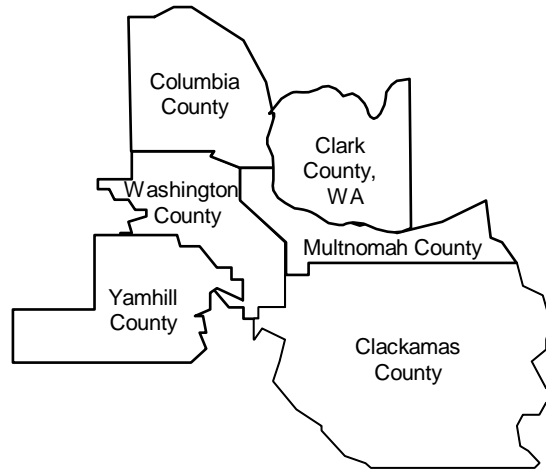
Five Year Comprehensive Care Plan

2005-2010



Portland Area HIV Services Planning Council

Five Year Comprehensive Care Plan 2005-2010



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

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

Approved December 7, 2005
Title I, Ryan White CARE Act
Portland Area HIV Services Planning Council
Portland, Oregon

Portland Area HIV Services Planning Council
Five Year Comprehensive Care Plan
2005-2010

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Portland Area HIV Services Planning Council

Advocacy and planning for people affected by HIV in the Portland metro area
Ryan White CARE Act, Title 1



December 29, 2005

LCDR Beth A. Henson, MA, MSW, LICSW
Senior Public Health Analyst, Western Services Branch
Health Resources and Services Administration
HIV AIDS Bureau, Division of Service Systems
5600 Fishers Lane, Room 7A-42
Rockville, MD 20857

Dear Ms. Henson,

On behalf of the Portland Area HIV Services Planning Council, we are pleased to express our support for the Portland Area EMA HIV Planning Council 2005-2010 Comprehensive Plan and to provide the following assurances:

1. The Vision, Mission, Values, Goals, and Objectives identified in the Plan were formulated by the Comprehensive Plan Task Force and approved by the Planning Council. The Objectives, Strategies and Measurements were developed by the Council and approved over the course of two regularly scheduled meetings.
2. Stakeholders including Service providers, consumers of Title 1 services and other interested community members were consulted via public survey, and public testimony opportunities were available throughout the creation of the Plan. Agendas and Council minutes detailing the planning process were, and continue to be, available to the public. Grantee input was sought and Grantee staff participated in development of the Strategies and Measurements for the plan.
3. Council representatives served on the Statewide Coordinated Statement of Need working group and actively participated in the creation of the drafts for the final document. Despite the challenges presented by different due dates, the State and the EMA worked together to create a draft SCSN, themes of which are reflected in this Comprehensive Plan.

The Council continuously works to improve the systems, tools and policies that are necessary to work together, as a diverse community of many voices, to improve access to a comprehensive continuum of high quality, community-based primary care and support services. We, along with our community partners, look forward to meeting the challenges of the coming years.

Sincerely,

Cherrell Edwards, Co-Chair
Portland Area HIV Services Planning Council

John Motter, Co-Chair
Portland Area HIV Services Planning Council

3653 SE 34th Ave. ♦ Portland, OR 97202-3034
phone: (503) 988-3030 x25703
fax: (503) 988-3035
email: hivcouncil@co.multnomah.or.us
web: <http://www.hivportland.org>

**Portland Area HIV Services Planning Council
Five Year Comprehensive Care Plan 2005-2010
Contributors**

Council Co-Chairs

John Motter Cherrell Edwards

Comprehensive Plan Task Force

Maria Kosmetados	Ryan Stephens
Mark Loveless	John Motter
Erin Kelleher	Cherrell Edwards
Guy Michelson	Linda Jaramillo
Tamara Brauchler	Kalissa Canyon-Scopes

Portland Area HIV Services Planning Council

Tom Cherry	Rick Stoller
Muthoni Ehmann	Vic Fox
Alison Frye	Bill Hancock
David Heal	Geri Johnson
Jason Hardaway	Darryl! Moch
Debbie Parrish	Carol Camfield
Greg Fowler	Erin Kelleher
Robert Johnson	Mark Loveless
Loreen Nichols	Dawn Martin
Guy Michelson	Deffo Mebrat
David Sheriff	John Motter
Cherrell Edwards	Maria Kosmetatos

Planning Council Staff

Terry Bonnett
Marisa McLaughlin
Kalissa Canyon-Scopes

Multnomah County Health Department

Jodi Davich Margie Robinson
Graham Harriman Loreen Nichols
Bonnie Kostecky Elizabeth Fosterman

Consumers, Providers and Community Members

Introduction

The Portland Area EMA consists of six counties (Yamhill, Multnomah, Columbia, Washington, Clackamas in Oregon and Clark County in Washington) The Portland Area HIV Planning Council, in partnership with the Title I Program of the Multnomah County Health Department works to create, implement and monitor a quality continuum of care for the Portland Area Eligible Metropolitan Area. The Planning Council has responsibility for needs assessment, service continuum planning and for the allocation of service dollars to general service categories. The Multnomah County Health Department procures services and monitors the quality of the services provided in the continuum.

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

Comprehensive Planning is an opportunity to plan for the future. The pending Reauthorization of the Ryan White Care Act makes this planning effort more difficult than usual. The Comprehensive Plan for 2005-2010 reflects the Council's deeply held values and shared belief in the importance of health care planning that reflects and solicits input from the communities most affected.

The Comprehensive Plan is organized into four sections:

Section I: Current System of Care

- A. Description of the Portland Eligible Metropolitan Area
- B. Epidemiological Profile
- C. Description of the Local, Regional and State Responses to the Epidemic
- D. Assessment of Need
- E. Description of the Current Continuum of Care
- F. Barriers to Care

Section II: Where Do We Want to Go?

Section III: Goals and Objectives

Section IV: Detailed Work Plan

Executive Summary:

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

3,665 persons living with HIV/AIDS (PLWH/A) reside in the six-county EMA. Although HIV increasingly affects women in the EMA, 87.9% of PLWH/A in the EMA are men. 69.1% of PLWH/A are men who have sex with men (MSM). African Americans in the EMA are disproportionately impacted by HIV, accounting for 2.8% of the population, but comprising 8.7% of PLWH/A. Hispanics are 9% of the population, and make up 8.2% of PLWH/A. Native Americans account for 0.9% of the population, and make up 1.1% of PLWH/A. PLWH/A in the EMA have high rates of substance abuse (36.9%) and mental illness (58.6%). 10.9% of PLWH/A report injection drug (non MSM) use as a risk factor. PLWH/A experience high rates of homelessness (16.7%) and they are overwhelmingly low income (75.7% below 100% FPL). These clients are often the most isolated from primary medical care and support services. It is difficult and costly to find and link clients who have these complicating conditions with services.

The foundation for the Portland Area HIV Services Planning Council's Comprehensive Plan is the Council's Vision, Mission and Values statement:

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

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

VALUES:

- We value a culture that supports the independence and dignity of all persons living with HIV/AIDS.
- We value and support individual involvement and choice in all areas of service.
- We value creative approaches, and coordination and collaboration among individuals, agencies, and communities.
- We value the wide range of diversity among us and services that are specific and relevant.
- We value a priorities and allocation process in which decisions are made based on documented need.
- We value a care system that actively seeks the input of those out-of-care as a means to broaden access to services.
- We value a system that integrates prevention strategies into the continuum of care.

GOALS FOR 2005-2010:

- 1) To assure access to a linked system of health care built on a foundation that includes support services and peer participation that promotes and maintains quality care.
- 2) To assure adequate resources which maximize the capacity of the HIV Health Care System.
- 3) To claim the Council's leadership role, authority, and influence in assuring an HIV Health Care system that is inclusive, collaborative, and has adequate resources.
- 4) To develop and lead a broad and inclusive network of public and private organizations that ensures a responsive, flexible system of care and prevention with and for PLWH.

The draft 2006 Statewide Coordinated Statement of Need document identifies challenges to the delivery of prevention and care services. These challenges include a strained safety net; increased poverty among PLWH/A; and increased prevalence of co-morbidities including STDs, Hepatitis C, substance abuse, and mental health issues. Compartmentalized health systems and funding stream as well as differing philosophies between agencies and professional disciplines provide additional challenges to a shared framework for HIV prevention and care.

The strategies outlined in the Comprehensive Plan attempt to address these challenges as they exist in the Portland Area EMA. Major themes reflected in the strategies are:

- Continued reliance on data for planning and allocation decisions;
- Using and understanding of the chronic care model for quality improvement and understanding of best practices in health system planning;
- Integration of public and private systems serving PLWH/A in our EMA in support of a more unified system of care;
- Importance of community participation in the planning and evaluation of health care; and
- Cooperation and collaborative efforts among providers, planners, and funding sources in an environment of increasing need and decreasing resources.

Throughout the planning process, gaps were identified in our local continuum of care; some of these reflect the difficulties of collaboration across public and private systems, across disciplines, across prevention and care. Health Care dollars are stretched and the insurance system is becoming more complex and inconsistent for all persons living with chronic and acute illnesses. Identifying and reaching people who are not in care continues to be a challenge, and preventing the spread of HIV is an ongoing concern.

Thoughtful participation by affected-community in the design and implementation of a useable care system is a unique feature of Ryan White Title 1 Care Act legislation. Successful delivery strategies to bring "out of care" and "hard to reach" populations into care must be built in consultation with members of those communities. The Portland Area HIV Services Planning Council is committed to improved coordination with the larger safety net system, continued

research and education for improved planning and continued relationship building with partners in the service delivery system. Council members live and work in this community, and are affected by the opportunities and the failings of the safety net system in the EMA. The Council is passionate about services for PLWH, for ourselves, for our family and friends and for the community that we live in. This plan outlines the Planning Council's roles and responsibilities, identifies service delivery gaps and barriers, and outlines what the Council plans to do about those gaps in the coming years. The Comprehensive Plan also identifies what the Council plans to achieve and how that achievement will be measured.

**Portland Area HIV Services Planning Council
Five Year Comprehensive Care Plan
2005-2010**

I. Current System of Care

A. Description of the Portland Eligible Metropolitan Area

General demographics of the EMA The Portland Eligible Metropolitan Area (EMA) encompasses over 5,000 square miles, spans two states, and includes: five Oregon counties, Clackamas, Columbia, Multnomah, Washington, and Yamhill; and Clark County in Washington State. The 2004 population estimate for the EMA is 2,040,550. 2004 population estimates show 79.8% of the EMA population is White (not Hispanic), 5.5% Asian/Pacific Islander, 2.8% African American, 2.6% biracial, and less than 1% Native American. Hispanics are the fastest growing ethnic group in the EMA, accounting for 9% of the EMA population. 40.2% of all people of color, including 67% of all African Americans in the EMA live in Multnomah County.

Demographics of the HIV/AIDS populations There are 3,665 PLWH/A living in the EMA. Although HIV increasingly affects women in the EMA, 87.9% of PLWH/A in the EMA are men. 69.1% of PLWH/A are men who have sex with men (MSM). African Americans in the EMA are disproportionately impacted by HIV, accounting for 2.8% of the population, but comprising 8.7% of PLWH/A. Hispanics are 9% of the population, and make up 8.2% of PLWH/A. Native Americans account for 0.9% of the population, and make up 1.1% of PLWH/A. PLWH/A in the EMA have high rates of substance abuse (36.9%) and mental illness (58.6%). 10.9% of PLWH/A report injection drug (non MSM) use as a risk factor. PLWH/A experience high rates of homelessness (16.7%) and they are overwhelmingly low income (75.7% below 100% FPL). These clients are often the most isolated from primary medical care and support services. It is difficult and costly to find and link clients who have these complicating conditions with services.

Geography of the EMA with regard to communities affected by HIV/AIDS and the location of HIV/AIDS services in relation to those communities An estimated 73.3% of PLWH/A are in Multnomah County; followed by 10.2% in Clark County, 8.6% in Washington County, 6.0% in Clackamas County, 1.3% in Yamhill County, and .6% in Columbia County. For the most part, PLWH/A travel to Portland to access a well-established health care and social services system. A highly accessible public transportation system serves most PLWH/A in the EMA. The two Title I medical providers are the Multnomah County Health Department HIV Health Services Center and the Oregon Health & Science University HIV Clinic. These clinics have a long history of collaboration due to their common mission of serving as a safety net for uninsured and low-income PLWH/A. Combined, the clinics serve over 1,100 PLWH/A per year. Many PLWH/A who qualify for the Oregon Health Plan (Medicaid) or other health insurance receive medical services through the private sector. Access points for other HIV primary care, case management, and support services are distributed throughout the EMA.

Brief description of the continuum of care offered in the EMA HIV counseling, testing and referral services are provided at public and private health care sites throughout the EMA, including projects that focus on reaching high-risk populations. Primary care services include

medical care, medications, dental care, substance abuse treatment, mental health therapy, residential and hospice care, and complementary health care. Support services include case management, outreach, housing, health insurance, food, transportation and psychosocial support. These support services help clients meet basic needs and promote retention in medical care and adherence to treatment. Primary care and support services are provided through a combination of public and private health systems and community agencies in the EMA.

B. Epidemiological Profile

B1. HIV/AIDS Epidemiology

Summary of AIDS Incidence, AIDS Prevalence and HIV (non AIDS) Prevalence Data by Demographic Group and Exposure Category The following Table 1 shows AIDS incidence (01/01/03 to 12/31/04), AIDS prevalence (as of 12/31/04), HIV (non-AIDS) prevalence (as of 12/31/04) and combined AIDS and HIV (non-AIDS) prevalence using CDC generated AIDS data and Oregon and Washington HARS data. In 2003, the EMA stopped using the CDC midpoint estimate for HIV (non AIDS) prevalence and began using Oregon and Washington HARS data instead. HIV prevalence trends through 2002 will be presented using past CDC HIV midpoint estimates; 2003 and 2004 HIV prevalence data is based on Oregon and Washington HARS.

TABLE 1: AIDS INCIDENCE, AIDS PREVALENCE, HIV (NON AIDS) PREVALENCE, AND HIV/AIDS PREVALENCE

	AIDS Incidence: 01/01/03 to 12/31/04		AIDS Prevalence as of 12/31/04		HIV (non AIDS) Prevalence as of 12/31/04		HIV/AIDS Prevalence as of 12/31/04	
Demographic Group/Exposure Category	<i>AIDS incidence is defined as the number of <u>new</u> AIDS cases diagnosed during the period specified. Data Source: CDC</i>		<i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified. Data Source: CDC</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (non AIDS) as of the date specified. Data Source: OR and WA HARS</i>		<i>HIV/AIDS Prevalence is defined as the estimated number of diagnosed people living with HIV (including AIDS) as of the date specified.</i>	
Race/Ethnicity	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total
White, not Hispanic	279	72.8%	1608	79.9%	1333	80.7%	2,941	80.2%
Black, not Hispanic	37	9.7%	163	8.1%	157	9.5%	320	8.7%
Hispanic	44	11.5%	178	8.8%	122	7.4%	300	8.2%
Asian/Pacific Islander	10	2.6%	34	1.7%	18	1.1%	52	1.4%
American Indian/Alaska Native	10	2.6%	26	1.3%	13	0.8%	39	1.1%
Multi- Race	3	0.8%	4	0.2%	3	0.2%	7	0.2%
Unknown	0	0.0%	0	0.0%	6	0.4%	6	0.2%
Total	383	100.0%	2013	100.0%	1652	100.0%	3,665	100.0%

TABLE 1: AIDS INCIDENCE, AIDS PREVALENCE, HIV (NON AIDS) PREVALENCE, AND HIV/AIDS PREVALENCE (CONT'D)

	AIDS Incidence: 01/01/03 to 12/31/04		AIDS Prevalence as of 12/31/04		HIV (non AIDS) Prevalence as of 12/31/04		HIV/AIDS Prevalence as of 12/31/04	
Demographic Group/Exposure Category	<i>AIDS incidence is defined as the number of <u>new</u> AIDS cases diagnosed during the period specified. Data Source: CDC</i>		<i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified. Data Source: CDC</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (non AIDS) as of the date specified. Data Source: OR and WA HARS</i>		<i>HIV/AIDS Prevalence is defined as the estimated number of diagnosed people living with HIV (including AIDS) as of the date specified.</i>	
Gender	#	% of Total	#	% of Total	#	% of Total	#	% of Total
Male	340	88.8%	1821	90.5%	1400	84.8%	3,221	87.9%
Female	43	11.2%	192	9.5%	252	15.2%	444	12.1%
Not Specified	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	383	100.0%	2013	100.0%	1652	100.0%	3,665	100.0%
Age at Diagnosis (Years)	#	% of Total	#	% of Total	#	% of Total	#	% of Total
<13 years	0	0.0%	2	0.1%	15	0.9%	17	0.5%
13 - 19 years	1	0.3%	2	0.1%	17	1.0%	19	0.5%
20 - 44 years	266	69.5%	1087	54.0%	1,091	66.0%	2,178	59.4%
45+ years	116	30.3%	922	45.8%	529	32.0%	1,451	39.6%
Not Specified	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	383	100.0%	2013	100.0%	1652	100.0%	3,665	100.0%

TABLE I: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NON AIDS) PREVALENCE (CONT'D)

Demographic Group/ Exposure Category	AIDS Incidence: 01/01/03 to 12/31/04		AIDS Prevalence as of 12/31/04		HIV (non AIDS) Prevalence as of 12/31/04		HIV/AIDS Prevalence as of 12/31/04	
	<i>AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified.</i>		<i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (non AIDS) as of the date specified.</i>		<i>HIV/AIDS Prevalence is defined as the estimated number of diagnosed people living with HIV (including AIDS) as of the date specified.</i>	
<i>Adult/Adolescent AIDS</i> <i>Exposure Category</i>	#	% of Total	#	% of Total	#	% of Total	#	% of Total
Men who have sex with men	242	63.2%	1352	67.3%	1,162	71.2%	2,514	69.1%
Injection drug users	55	14.4%	237	11.8%	161	9.9%	398	10.9%
Men who have sex with men and inject drugs	31	8.1%	183	9.1%	114	7.0%	297	8.2%
Heterosexuals	52	13.6%	208	10.4%	178	10.9%	386	10.6%
Other/Hemophilia/blood transfusion	3	0.8%	29	1.4%	16	1.0%	45	1.2%
Risk not reported or identified	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	383	100.0%	2009	100.0%	1,631	100.0%	3,640	100.0%
<i>Pediatric AIDS Exposure Categories</i>	#	% of Total	#	% of Total	#	% of Total	#	% of Total
Mother with/at risk for HIV infection	0	0.0%	2	50.0%	21	100.0%	23	92.0%
Other/Hemophilia/blood transfusion	0	0.0%	2	50.0%	0	0.0%	2	8.0%
Risk not reported or identified	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	0	0.0%	4	100.0%	21	100.0%	25	100.0%

B2. Narrative Description of the Current HIV/AIDS Prevalence in the EMA

HIV/AIDS cases by demographic characteristics and exposure category The primary data sources for HIV and AIDS prevalence and incidence includes Oregon and Washington HARS and CDC estimates. Population estimates are based on the 2004 American Population Survey. As of 12/31/04, 3,665 individuals were estimated as living in the Portland EMA diagnosed with AIDS (2,013) or living with HIV (1,652). 383 new AIDS cases were reported during the past two years (2003 and 2004), a 2.1% increase over the previous two-year reporting period (2002 and 2003). Although HIV is still primarily a disease of men in the EMA, the proportion of new HIV-positive cases in women is increasing. HIV counseling and testing data for 2004 for the EMA indicate that women accounted for 14.7% of all new positive tests, a 100% increase from 1999. While women account for 9.5% of all living AIDS cases reported through 12/31/04, they account for 11.2% of new AIDS cases reported in the last two years, and make up 15.2% of those living with HIV (non-AIDS) for this same time period.

African Americans account for 8.1% of all reported living AIDS cases (through 12/31/04), but make up 9.7% of new AIDS cases, and 9.5% of persons living with HIV (non-AIDS). Hispanics account for 8.8% of all reported living AIDS cases, but make up 11.5% of new AIDS cases and 7.4% of those living with HIV (non-AIDS). 2004 EMA HIV counseling and testing data indicate that 10.1% of new HIV-positive tests were in African Americans, and 14% were in Hispanics. Whites continue to be the largest racial group affected by HIV and AIDS, accounting for 79.9% of all reported living AIDS cases (through 12/31/04), making up 72.8% of new AIDS cases, and 80.7% of persons living with HIV (non-AIDS). Combined, Asians, Pacific Islanders, Native Americans, and Alaska Natives account for 3.2% of all reported living AIDS cases (through 12/31/04), 6% of new AIDS cases, and 2.5% of persons living with HIV (non-AIDS).

The majority of all cases continue to be in men who have sex with men (MSM). MSM account for 67.3% of all living AIDS cases (through 12/31/04), 63.2% of new AIDS cases, and 71.2% of those living with HIV (non-AIDS). IDUs (excludes MSM/IDU) account for 11.8% of living AIDS cases (through 12/31/04), 14.4% of new AIDS cases, and 9.9% of persons living with HIV (non-AIDS). MSM/IDU account for 9.1% of living AIDS cases (through 12/31/04), 8.1% of new AIDS cases, and 7.0% of persons living with HIV (non-AIDS). Heterosexual contact accounts for 10.4% of all living AIDS cases, 13.6% of new AIDS cases, and 10.9% of persons living with HIV (non-AIDS). Risk factor data is only available for public sector HIV testing, and therefore it is difficult to draw firm conclusions. The data on new HIV-positive tests for 2004 show 58.2% MSM, 9.2% IDU, and 18.4% Heterosexual.

HIV in the EMA continues to primarily impact adults. Persons under age 20 make up only 0.2% of all living AIDS cases (through 12/31/04). Only one new AIDS case was reported for persons under age 20 in 2004. As of 12/31/04, 1% of the HIV (non AIDS) population was children under the age of 20. Persons ages 20-44 account for 54.0% of all living AIDS cases (through 12/31/04), 69.5% of new AIDS cases, and 66.0% of those living with HIV (non-AIDS). The EMA's PLWH/A are aging. Persons ages 45+ years account for 45.8% of all living AIDS cases, 30.3% of all new AIDS cases, and 32.0% of those living with HIV (non-AIDS).

Shifts in the Epidemic Over Time Table 1 compares percent change in AIDS prevalence, AIDS incidence, HIV prevalence and number of HIV positive test to give a picture of the changes in

the HIV epidemic in the EMA since 1999. AIDS prevalence data reflect where the AIDS epidemic has been over the past six years. AIDS incidence, HIV prevalence and testing results suggest where the epidemic is going. The numbers for Asian/Pacific Islander, American Indian and Alaska Native are too small to be statistically significant and are not included.

Table 2: Percentage Change in Demographic and Risk Categories from 1999 to 2004

Populations	AIDS Incidence	AIDS Prevalence	HIV (Non AIDS) Prevalence	Positive HIV Tests
<i>Race/Ethnicity, Gender and Age at Diagnosis</i>				
White, not Hispanic	-8.6%	-5.4%	4.8%	-2.0%
Black, not Hispanic	3.8%	11.7%	-28.2%	-42.8%
Hispanic	24.3%	30.5%	0.0%	43.5%
Male	-2.6%	-2.0%	-1.0%	-7.4%
Female	32.4%	21.3%	3.6%	66.1%
13 - 19 years	200.0%	200.0%	200.0%	96.8%
20 - 44 years	-12.0%	-22.1%	-18.9%	-2.9%
45+ years	33.0%	34.6%	48.7%	-8.1%
<i>Major Adult AIDS Exposure Category</i>				
Men who have sex with men (MSM)	1.4%	-3.4%	17.0%	-16.7%
Injection drug users	4.7%	-1.7%	-41.9%	16.5%
MSM and inject drugs	-32.2%	-4.2%	-22.9%	-21.1%
Heterosexuals	16.6%	10.7%	-19.7%	168.0%

AIDS Incidence Over the past six years, AIDS incidence among PLWA is affecting more women, African Americans, Hispanics, youth under 20 years, adults over 45 years, injection drug users and heterosexuals. Fewer cases involve men who have sex with men and inject drugs, persons between the ages of 20 and 44 years, men in general, and White (not Hispanic) persons. **AIDS Prevalence** In general, AIDS prevalence mirrors shifts in AIDS incidence. However, there has been an overall decrease in percent of PLWA whose risks are MSM and IDU. **HIV (non AIDS) Prevalence** Over the past six years, there has been a slight drop in HIV (non AIDS) prevalence among men, and Hispanics have not experienced a significant change in HIV (non AIDS) prevalence. Although there has been a significant decrease in HIV (non AIDS) prevalence in the African American community, unfortunately African Americans are still affected with HIV (non AIDS) at a rate almost three times their proportion in the EMA population. The overall percent of HIV (non AIDS) prevalence among injection drug users has declined; however, IDU as a risk factor has increased in the past 18 months. **New HIV Positive Test Results** Over the past six years, a greater proportion of persons testing positive are women, youth, Hispanics and injection drug users.

Disproportionate impact of HIV/AIDS on certain populations in comparison to the impact on the general population The following table shows the population of the Portland EMA by race and gender, and compares the general population to the PLWH/A population. In the Portland EMA, HIV has disproportionately impacted African Americans. African Americans

account for only 2.7% of the population of the EMA but make up 8.7% of PLWH/A—three times higher. The proportion of Hispanics PLWH/A (8.2%) is slightly less than the proportion of Hispanics in the general population (9.0%). Native Americans account for less than 1% of the population of the EMA and make up 1.1% of PLWH/A. While the HIV epidemic increasingly impacts women in the EMA, the majority of PLWH/A continue to be men.

Table 3: Comparison Select Demographic Information

Category	Total EMA Population ¹		People Living with HIV (including AIDS)		People Living with AIDS		People living with HIV (Non AIDS)	
Totals	2,040,550		3,665		2,013		1,652	
Race/Ethnicity								
White, not Hispanic	1,628,389	79.8%	2,941	80.2%	1608	79.9%	1333	80.7%
Black, not Hispanic	54,616	2.7%	320	8.7%	163	8.1%	157	9.5%
Hispanic	183,789	9.0%	300	8.2%	178	8.8%	122	7.4%
Asian/Pacific Islander	105,830	5.2%	52	1.4%	34	1.7%	18	1.1%
American Indian/Alaska Native	17,737	0.9%	39	1.1%	26	1.3%	13	0.8%
Multi- Race	50,189	2.5%	7	0.2%	4	0.2%	3	0.2%
Unknown	0	0.0%	6	0.2%	0	0.0%	6	0.4%
Gender								
Male	1,015,437	49.8%	3,221	87.9%	1,862	91.1%	1,378	86.30%
Female	1,025,113	50.2%	444	12.1%	183	8.9%	218	13.70%

2002 Census Racial/Ethnic Estimates applied to 2004 PSU Population Estimates¹

The number of living AIDS cases has grown at a higher rate than the growth in general population during this same period of time. AIDS prevalence increased from 1,619 cases in 1999 to 2,013 cases in 2004. From 1999 to 2004 the EMA general population grew 10.9%, while the number of people living with AIDS grew 24.3%, almost two and a half times the general population growth. Due to a change in HIV prevalence estimation methods during 2003, it is not possible to compare 2004 HIV prevalence data to 1999. With antiretroviral therapies, HIV+ individuals do not rapidly progress to AIDS. Over the past five years, the number of reported annual AIDS deaths has leveled off at an average of 60 per year. The increase in the number of new HIV+ individuals, in combination with the increasing number of individuals living with AIDS, indicates that the HIV and AIDS epidemic is continuing to grow. This is a turnabout from the trend of continued decline in new AIDS cases in the late 1990's.

Summary of Co-Morbidities that Affect Cost and Complexity of Providing Care The following table provides prevalence data on primary co-morbidities, poverty, insurance status and Medicaid coverage for the general population and PLWH/A in the Portland EMA, as well as data sources and dates. Quantitative data from multiple sources have been used to describe co-morbid conditions and poverty and insurance status. Where the number of cases varied across the data sources, a mid-point reference was taken as the best estimate of the co-morbidity for the particular condition. Population data is based on 2000 Census, 2004 Portland State University Population Estimates, and 2003 Washington State Data Book.

Table 4: 2004 Co-Morbidity, Poverty, Insurance Status and Medicaid Coverage

Co-morbidity	General Population Prevalence: # / %	PLWH/A Population Prevalence: # / %
Tuberculosis ^{1,2}	70 persons (.004%)	38 persons (.01%)
All STDs (including Syphilis) ^{3,4}	6,796 persons age 20-44 (.53%)	476 persons (13%)
Syphilis ^{1,2}	47 persons in 2004 (.002%)	28 persons in 2004 (.8%)
Injecting Drug Users (IDU) & Other Substance Abuse ^{3,5,6}	IDU: 20,406 persons (1%) Other Substance Abuse 179,568 persons (17.7%)	IDU: 695 persons (18.9%) Other Substance Abuse 1,096 persons (29.9%)
Homelessness ^{3,5,7,8}	36,360 persons (1.8%)	612 persons (16.7%)
Severe Chronic Mental Illness ^{9,10}	163,244 persons (8.0%)	674 persons (18.4%)
All Mental Illness ^{3,5,9,10}	418,313 persons (20.5%)	2,144 persons (58.5%)
Dual Diagnosis of Substance Abuse & Mental Illness ^{3,5}	Not available	1,012 individuals in 2004 27.6% of population
Hepatitis C ¹¹	36,730 persons (1.8%)	910 persons (25%)
No Health Insurance ^{5,12, 13}	336,691 persons (16.5%)	557 persons (15.2%)
Poverty ^{5,12,14,15}	300% of FPL 912,126 persons (44.7%) 100% of FPL 277,515 persons (13.6%)	300% of FPL 3,606 persons (98.4%) 100% of FPL 2,774 persons (75.7%)
Medicaid Coverage ¹²	216,149 persons (10.8%)	1,164 persons (31.8%)
¹ Oregon Health Division (OHD), 2004. ² Clark County Health Department (CCHD), 2004. ³ 2002 Survey for People Living with HIV and AIDS in Oregon, 2003. ⁴ OHD, 2003 Oregon STD Annual Report. ⁵ Partnership Project & Clark County Case Management Database, 2004. ⁶ Oregon Office of Alcohol and Drug Abuse County Databooks, 2002. ⁷ U.S. Conference of Mayors Report, 2004. ⁸ Clackamas Community Development, 2003-2005 Consolidated Plan. ⁹ American Psychiatric Association, July 2002. ¹⁰ SAMHSA: Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003. ¹¹ CDC Data. ¹² MCHD EPIC, 2004. ¹³ 2004 Oregon Population Survey. ¹⁴ Washington Dept. of Social & Health Services, 2004. ¹⁵ Oregon Office of Medical Assistance Programs, 2004.		

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

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

The following chart summarizes the Title I funding in the context of local, regional and state resources. The funds support the continuum of care as described in Section E.

Table 5: Summary of Public Funding

	Outpatient Medical Care	Other Primary Care Services	ADAP/ Health Insurance	Community-Based Support Services	Inpatient Medical Care	Prevention with Positives	TOTAL
Title I	650,000	533,699	30,000	1,597,970	0	0	2,811,669
Other Federal	2,352,984	608,021	3,346,758	1,457,807	2,577,719	506,629	10,849,918
State	0	0	296,013	600,200	706,406	31,694	1,634,313
City/County	470,651	0	5,635	79,293	0	0	555,579
TOTAL	3,473,635	1,141,720	3,678,406	3,735,270	3,284,125	538,323	15,851,479

Section E provided a detailed description of the continuum of care that reflects the overall response to the epidemic.

D. Assessment of Need

D.1 Unmet need estimate The most recent estimate of unmet need for primary medical care in the Portland Eligible Metropolitan Area (EMA) is based on a framework provided by Mosaica and the Health Resources & Services Administration (HRSA) that was adapted by a local work group. Members of the ongoing State/EMA workgroup include representatives of the Title I grantee, EMA Planning Council, Title II/ADAP, and Title III HIV clinic along with public health research and surveillance staff. Findings in the Unmet Need Framework are disseminated through work group representatives and through presentations to State and EMA planning groups. A summary of the 2004 Unmet Need Framework for the Portland follows.

Table 6. 2004 Portland EMA Unmet Need Framework

Population Sizes	Value	Data Source
A. Number of person living with AIDS (PLWA) aware for the period of 01/01/04 – 12/31/04	2,063	HARS (OR & WA) ¹
A1 Adjusted number of living PLWA in 2004	2,074	A/ proportion captured ²
A. Number of person living with HIV(PLWH)/non-AIDS aware for the period of 01/01/04 – 12/31/04	1,241	HARS (OR & WA) ¹
B1 Adjusted number of living PLWH in 2004	1,641	B/ proportion captured ²
PLHA Care Patterns	Value	Data Source
C. Number of PLWA who received the specified HIV primary medical care services in 2004	1,070	HARS and TRIO ³
C1. Adjusted PLWA Met Need by proportion of cases with only non-reportable results	1,586	C/ proportion of cases reportable ⁴
PLWH Care Patterns	Value	Data Source
D. Number of PLWH who received the specified HIV primary medical care services in 2004	685	HARS and TRIO ³

D1. Adjusted PLWH Met Need by proportion of cases with only non-reportable results	886		D/ proportion of cases reportable ⁴
Calculated Results	Value	Percent	Calculation
E. Number of PLWA who did not receive primary medical services	488	24%	Value: A1-C1 Percent E/A1
F. Number of PLWH who did not receive primary medical services	755	46%	Value: B1-D1 Percent: F/B1
G. Number of PLWH/A who did not receive primary medical services	1,243	33%	Value: E+F Percent: G/(A1+B1)

¹. Unmet Need in the EMA was estimated separately for Clark County and added to the estimated number of PLWH/A from the other five Oregon counties making up the Portland EMA. The HIV/AIDS Reporting Systems (HARS) in Oregon and Washington were used to estimate the number of PLWH/A. HARS data was extracted July 2005. ² Oregon HIV(nonAIDS) data was assumed to capture 74.6% of all PLWH (aware) and 100% of PLWA (aware) based on a comparison between cases in HARS and those in the CAREAssist database (Oregon's ADAP program). Washington data was assumed to capture 85% of PLWH(aware) and 95% of PLWA(aware) in 2004 based on a 'code performance evaluation study'. These adjustments were applied to each subgroup. There were no differences by sex, race, or age group when comparing CAREAssist clients who had been reported versus those who had not been reported. ³. 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. ⁴. Met Need was adjusted upwardly based on an estimate from two EMA HIV clinics of the proportion of patients with CD4 or viral load tests in 2004 who had only reportable CD4 and viral load results: 0.0.6745 for AIDS and 0.7729 for HIV(nonAIDS).

Population estimates Cases were defined as persons with HIV or AIDS (PLWHA), aged ≥ 13 years, living within the six-county Portland EMA and aware of their infection. The number of cases was calculated by taking the number of cases reported to Oregon and Washington (Clark County only) HIV/AIDS Reporting Systems (HARS) as living as of December 31, 2004 divided by the estimated sensitivity, or completeness of reporting, of HIV and AIDS. Oregon data was assumed to capture 74.6% of all PLWH (aware) and 100% of PLWA (aware) based on a comparison between cases in HARS and those in the Oregon CAREAssist (ADAP) database. Washington data was assumed to capture 85% of PLWH (aware) and 95% of PLWA (aware) based on a "code performance evaluation study". These adjustments were applied to each subgroup. There was no difference by sex, race, or age group when comparing CAREAssist clients who had been reported to those who had not been reported.

Estimates of people in care The work group defined cases with Met Need as people who received at least one viral load or CD4 test during 2004. ART was not included in the definition of Met Need because: (a) it is data not collected through the HIV/AIDS surveillance system, (b) patients typically have CD4/viral load testing if they are prescribed ART, and (c) the Met Need adjustment described here takes into account patients who have non-reportable lab results. Both Oregon and Washington do not require reporting of undetectable viral loads or CD4 counts ≥ 200 cells/mm³. As a result, Met Need was estimated by first determining the number of cases in HARS with at least one reported CD4 or viral load during 2004 and then upwardly adjusting this number to account for cases with testing that would not have been reported to the surveillance system (i.e. undetectable viral load or CD4 ≥ 200 ($\geq 14\%$)). This upward adjustment was accomplished by soliciting clinical testing data from two large local HIV clinics on the proportion of cases where at least one CD4 count or viral load was done and at least one detectable viral load or CD4 counts < 200 ($< 14\%$) was obtained. We used these empiric

proportions to adjust our initial estimates of Met Need. Because the rates of undetectable tests differed significantly by whether or not individuals had progressed to AIDS, Met Need was estimated separately for PLHW and PLWA cases. The two clinics that provided empiric testing data served over 1,100 patients during 2004. These sample patient populations did not differ significantly by race, age, sex or risk group from all cases reported in the Portland EMA.

Estimates of unmet need Unmet Need was calculated by subtracting the number of persons with Met Need from the estimated number of HIV (non-AIDS) and AIDS cases.

Estimation methods Several limitations of the estimation methods described above require mention. The actual number of living PLWHA (aware) was not known but rather was estimated from reported living cases and estimates of completeness of case reporting. Neither Oregon nor Washington's HIV/AIDS surveillance systems collect results of CD4 counts ≥ 200 cells/mm³ or viral load tests that are undetectable. Therefore, we estimated the proportions of persons receiving these tests using estimates from two large clinics. To the extent that these sites (serving just under a third of all EMA patients) are not representative of all clinical sites, these estimates may be flawed. Our approach also assumed that net migration of PLWH and PLWA in and out of the EMA was zero. However, net migration is unknown. Finally, the estimate of Unmet Need was neither adjusted for those that died in 2004 nor for those who were diagnosed in 2004. However, a retrospective look at Unmet Need in 2003 showed that Unmet Need was unchanged by adjusting for those who died or were diagnosed in 2003, that is, the change in the estimate of Unmet Need was less than five percent.

Assessment of unmet need 46% (755 of 1,641) of PLWH and 24% of PLWA (488 of 2,074) in the EMA did not receive CD4 or viral load testing in 2004. Subgroup analyses were not performed when subgroup denominators were less than 100, but the percentage of PLWH and PLWA with Unmet Need remained quite high across gender, age, and risk groups.

Demographics and location of persons who know their HIV status and are not in care

PLWH in the 30-44 yr. age group had 47% Unmet Need versus those in the 45 year and older age group who had 34% Unmet Need. This difference was not as pronounced and was only somewhat suggestive among all PLWH/A (33% Unmet Need for 30-44 yrs olds; 28% Unmet Need for those 45 yrs and older). Unmet Need appeared to be higher among males with HIV (47%) than among females with HIV (42%). There also appeared to be a difference between whites with HIV (47%) and non-whites (40%). Unmet Need among MSM with HIV was 47% and was 18% among MSM with AIDS. Additional subgroup analysis will be included in the full Unmet Need report. The majority of persons who know their HIV status and are not in care reside in Multnomah County, Oregon and Clark County, Washington.

Service needs, gaps and barriers to care In 2001, the EMA completed the study, "Barriers to Care: HIV-Positive People Not Receiving Health Care for Their HIV Disease". This study used structured interviews, provider surveys, analysis of Oregon Medicaid data and data from a HIV primary care site to estimate the number of out-of-care PLWH/A and to identify their barriers to care. The study estimated that 9-11% of PLWH/A in the EMA were out of care. This study confirmed previous findings that co-morbidities such as substance abuse and mental illness, along with homelessness, lack of case management services, and conflicted provider

relationships play a large role in preventing PLWH/A from remaining in care for their HIV disease. PLWH/A in the EMA continue to have high rates of substance abuse (29.9%), mental illness (58.5%) and homelessness (16.7%). Preliminary data from a study of our CareLink outreach program identified the most significant service needs among outreach clients as dental care, housing, financial assistance, transportation, and case management.

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

Over the past two years, the Planning Council and HIV Care Services staff have been involved in developing the Unmet Need Framework in partnership with the State. The Planning Council has reviewed and taken into consideration Unmet Need Framework findings as part of the decision making for the priorities and allocation process. The Framework results highlighted the need for targeted outreach to the newly diagnosed and out-of-care PLWH/A. An emphasis on reaching the out-of-care and keeping PLWH/A in quality care is woven into all aspects of all Title I funded services.

D2. HIV medical care needs, core and support service needs

Several factors have converged to create serious service delivery challenges that require the support of HIV/AIDS emergency funds for the Portland EMA. These include the continued increase in AIDS and HIV prevalence, the disproportionate impact of HIV/AIDS on emerging populations in the EMA, high levels of co-morbidities among PLWH/A, the increased need for HIV-related services, and the prolonged economic downturn in the EMA.

Continued increase in HIV and AIDS cases and prevalence. According to CDC estimates, 383 new AIDS cases were reported for the EMA in 2003 and 2004. During this same period, Oregon and Washington HARS shows that 294 new HIV (non AIDS) cases were reported. Together this represents an average of 338 new HIV (including AIDS) cases each year, creating an increase in PLWH/A who need access to primary care and essential support services to manage their HIV disease. As a result of new treatments, PLWH (non-AIDS) do not progress as rapidly to AIDS and PLWH/A are living longer, with a corresponding long-term need for primary care and essential support services. In contrast, a small but growing number of PLWA in the EMA are reaching end-stage, often as a result of complications related to co-infection with HCV. The severity of illness adds service needs such as increased hospitalizations, respite care, home delivered meals, and hospice services. There has been a 21% increase in HIV positive test results from 127 positive tests in 1999 to an average of 142 per year in 2003 and 2004. Since 1999, the annual number of AIDS deaths has increased over 60%. The trend of increased annual newly reported AIDS cases, AIDS deaths and persons living with AIDS that the EMA has experienced in the past three years is expected to continue in the coming grant year.

Emerging populations. The HIV/AIDS epidemic has affected persons in all sex, age and racial/ethnic groups and all counties in the EMA. This effect, however, has not been the same for all groups. In the beginning of the epidemic, White MSM were the predominate population affected. Although White MSM are still disproportionately affected, recent trends show a shift in the epidemic toward Hispanics, African Americans, and women. AIDS case rates and newly diagnosed HIV infections are much higher among African Americans and Hispanics. HIV disproportionately impacts African Americans in the EMA who account for 2.7% of the

population, but make up 11.2% of HIV (non AIDS) incidence for the period of 1/1/2003 – 12/31/04 and 9.7% of AIDS incidence for the same period of time. Hispanics are 9% of the population, but also make up 11.2% of HIV (non AIDS) incidence for and 11.5% of AIDS incidence for the period of 1/1/2003 – 12/31/04. While women accounted for 9.5% of all living AIDS cases in 2004, HIV (non AIDS) prevalence in 2004 for women was 15.2%, a 12.6% increase since 2002.

High levels of co-morbidities among PLWH/A. The 5.6% increase in gonococcal infections in 2003 compared to 2002 is associated with additional cases among White MSM of all ages. The largest number of MSM in Oregon reside in the EMA. In 2003, 75% of the statewide reported male gonorrhea cases were interviewed; of the 449 males interviewed, 262 (58%) of those cases were MSM. The majority (96%) of these MSM were white and 90% lived in the Portland Tri-County area. Gonorrhea infections among MSM increased twelve percent in 2003 when compared to the previous year; 262 cases in 2003 compared to 234 cases in 2002. The percentage of MSM with gonorrhea compared to non-MSM has increased since 1999 when 30% of gonorrhea cases were MSM to 2003 when 58% of the cases were MSM. In 2002, 43% of early syphilis cases were attributed to MSM. This rate increased to 66% in 2003. These increasing rates of syphilis indicate a higher incidence of unprotected sex and therefore an increased risk of HIV infection. This is further substantiated by the *We're Listening: 2002 Survey for People Living with HIV and AIDS in Oregon* report which indicates that 13% of its respondents had been diagnosed with an STD in the past year.

PLWH/A in the EMA have high rates of substance abuse (30%, excluding injection drug use) and mental illness (59%). 19% of PLWH/A report injection drug use as a risk factor. Twenty five percent of PLWH/A are co-infected with Hepatitis C. PLWH/A experience high rates of homelessness (17%) and are overwhelmingly poor (76% below 100% FPL). Chronic substance abuse, particularly methamphetamine use, creates additional medical problems, malnutrition, serious dental decay and infections, and the exacerbation of HIV symptoms—all of which accelerates the progression of HIV disease. Some research shows that multiple attempts at changing addictive behaviors may be needed before ongoing recovery is attained. This cycle can burn out options for PLWH/A with substance abuse problems, as periodic attempts to “get my life together” with a flurry of visits to case managers, re-application to insurance programs, new medical and lab appointments and renewed commitment to medication regimens can fall apart when substance abuse resumes. This cycle can have serious consequences for future care options as appointments are not kept, regimens are started and not followed, and insurance programs are allowed to lapse. Some providers may have a “no show” policy that makes return to care difficult, and many insurance programs have waiting periods for re-application.

Problems affecting the general population, such as poverty, homelessness, substance abuse, and mental illness have much higher rates among PLWH/A. Table 5: 2004 Co-Morbidity, Poverty, Insurance Status and Medicaid Coverage on page 21 shows that, when compared to the general population, PLWH/A in the EMA are five times more likely to be below 100% of poverty; almost ten times more likely to be homeless; and more than twice as likely to be substance abusers and to suffer from mental illness. It is particularly difficult for medical providers to maintain quality care for PLWH/A who are homeless or in unstable housing. Ever changing contact information for this group makes follow up by providers extremely difficult.

Increased need for HIV-related services. The sheer number of clients who need services has increased as new cases are identified and PLWH/A are living longer. In addition, the EMA is making an intensive outreach effort to identify and enroll out-of-care clients in primary medical care. The *We're Listening* needs assessment reported that 15% of PLWH/A in the care system were unable to meet all their primary medical care needs — an estimated 637 for the EMA. *We're Listening* identified the top five most needed services and the percent unmet need (gap) in the availability of those services as: dental care (39% gap); case management (25% gap); drug reimbursement (16% gap); outpatient medical care (15% gap); and health insurance (14% gap). Other Title I service priorities with an unmet need of more than 20% included housing, mental health counseling, food/meals, and complementary health care. The report identified the top barriers to PLWH/A as: personal finances, service availability, waiting times for appointments and services, lack of client information about system resources, and transportation.

Using the CDC estimates of persons who are infected but unaware of their HIV status, there are approximately 873 to 1,357 additional PLWH/A in the EMA who do not know their status. Based on the 2004 Unmet Need Framework, 1,243 PLWH/A know their status in the EMA but are out of care. As additional cases are identified, the system of care will be further taxed.

Continued economic downturn and high cost of living. The economy in the EMA has taken a hard hit over the past four years, affecting the ability of low-income PLWH/A to make ends meet. The Oregon Employment Department determined that Oregon was in an economic recession from late 2001 through much of 2004. Oregon's median income dropped nearly 10% between 2000 and 2004. For over four years, Oregon's unemployment rate has been one of the highest in the nation. The unemployment rate in the Portland EMA is 6.5% as of September 2005. This compares to 5.1% nationwide. Clark County, Washington, parallels the Oregon experience with an August 2005 unemployment rate of 7.6%. According to the *We're Listening* needs assessment, 54% of PLWH/A are unemployed and looking for work. Recent and projected increases in home energy costs, high automobile fuel costs and housing costs also contribute to financial hardship. Northwest Natural Gas received a 15% increase in the rate for residential customers; the Portland Metropolitan area average price for a gallon of gasoline has increased 37% from a year ago; and housing prices continue to rise. The Portland area's median home price jumped 19.4% since August 2004. Applying the federal guideline of spending a maximum of 30% of gross household income on rent, an individual would need an annual income of \$25,760 to afford the \$644 Fair Market Rent for a one-bedroom apartment. In 2004, an estimated 76% of PLWH/A in the Portland EMA had incomes below the poverty line (\$9,310), far below the Fair Market Rent guidelines. The safety net system of health and social services is very fragile as program after program experienced drastic cuts during the past four years. These cuts reflect the reduced State and Local revenues that resulted from the poor economy.

Estimated level of service gaps among PLWH in the EMA Oregon Health Services issued *We're Listening: 2002 Survey for People Living with HIV and AIDS* in October 2003. This is the most recent and comprehensive assessment of service gaps. This report was considered by the HIV Planning Council as part of the prioritization and allocation process. This report includes findings related to service needs, gaps and barriers of PLWH/A. Respondents were asked to

examine a list of 24 service areas and indicate whether they needed the service in the past year and, if so, whether they received the service all of the time, some of the time, or none of the time. For this analysis, there was a ‘service gap’ if someone needed a service but *never* received it or if they only received it *some of the time*. Respondents were also asked, “*What, if anything, made it difficult to get this service?*”

The following table summarizes service needs and service gaps for the top fourteen service needs. The service gaps are presented in two ways: as a percent of the total population (“population perspective”) or as a percent within the smaller group who report needing the service (“service perspective”). Both perspectives are important because they shed light on different issues. The population perspective looks at gaps in relation to how many in the total population are affected. The service perspective looks at the relative difficulty in receiving a particular service, i.e. the gap among only those people who needed the particular service.

Table 7: Service Needs and Gaps

Service Need Category (most needed to least needed)	Service Gap: % of total population estimated to face gap	Service Gap: % of those needing service who faced a gap
Outpatient Medical Care	15%	16%
Health Insurance	14%	17%
Case Manager	25%	29%
Dental Care	39%	50%
Drug Reimbursement	16%	23%
Groceries or Meals	27%	53%
Emergency Rent/Utilities Paid	28%	57%
Mental Health Counseling	20%	44%
Help With Housing	24%	52%
Transportation	19%	45%
Alternative Care	22%	59%
Nutritional Counseling	15%	41%
Counseling- Support Group	16%	43%
Help With Legal Affairs	21%	70%

In summary, from the population perspective (the number of people reporting a gap in the total population), the services with the highest gaps included dental care (39%), emergency rent/utilities (28%), groceries or meals (27%), case manager (25%), and help with housing (24%). From the service perspective (the percent of those reporting a gap in the group needing the service), the services with the highest gaps included help with legal affairs (70%), alternative care (59%), emergency rent/ utilities (57%), groceries or meals (53%), and help with housing (52%). EMA respondents were more likely to report a gap for emergency rent/utilities and case management, while non-EMA respondents were more likely to report a gap for alternative care. Five barriers to accessing services were most frequently mentioned by respondents, and these barriers impacted multiple service areas: personal finances, service availability, waiting times for appointments and services, lack of client information about system resources, and transportation.

See Section F for additional discussion of the needs and barriers of special populations.

E. Description of the Current Continuum of Care

The EMA's Established Continuum of HIV/AIDS Care The EMA's Continuum of Care goals are: informed public support through community education and advocacy; knowledge of serostatus for persons at risk; maintenance of negative status; early access to clinical and support services to maintain the best possible quality of life for PLWH/A; and prevention to stop HIV transmission. Title I currently serves 2,082 unduplicated clients, 57% of all PLWH/A in the EMA. Planning Council guidance directs that services be provided to historically underserved populations, including women, children, youth, and racial and ethnic minorities at least in proportion to their representation in the HIV/AIDS prevalence.

- Early intervention services (EIS)/counseling and testing, and prevention. Publicly-funded outreach, counseling, testing and referral services focus on reaching high-risk populations, including men who have sex with men, racial and ethnic minorities, substance abusers, youth, and women. Locations include health department community testing sites and STD clinics, correctional facilities, drug treatment agencies, and high-risk community settings. Rapid testing methods are used at many community test sites. Health departments are implementing enhanced follow-up procedures with newly diagnosed PLWH/A to ensure early linkage with primary medical care. The lead HIV case management agency in the EMA, the Partnership Project, provides a prevention-funded intensive behavioral change counseling program, Supporting Healthy Options for Prevention, for HIV-positive and HIV-negative individuals who engage in high risk behaviors. Health Department work groups are developing and implementing action plans to address racial/ethnic health disparities and disparities in sexually transmitted diseases among men who have sex with men in the Portland metropolitan area.
- Primary Care. In the continuum, primary care services include medical care, medications, dental care, substance abuse treatment, mental health therapy, hospice care, and complementary health care. Services are provided through a combination of public and private health systems and community-based agencies. PLWH/A with private or Medicaid insurance coverage access care through their designated health care providers. Veterans can access a range of primary care services through two VA medical clinics. In Oregon, clients with incomes below 200% of FPL who have insurance can receive help paying for premiums, medication co-pays, and deductibles through the state's ADAP/Health Insurance Program, called CAREAssist. The program also covers the full cost of medications on the ADAP formulary for uninsured clients. All clients with incomes over 100% FPL pay a cost-share. Clark County clients are covered by Washington State programs first; those who are not eligible can enroll in a Title I-funded insurance continuation program. For uninsured clients and clients with limited coverage, Ryan White programs provide a safety net, including two HIV specialty medical clinics, the HIV Health Services Center at Multnomah County Health Department and the HIV Clinic at Oregon Health & Science University (OHSU). These two clinics serve more than 1,100 PLWH/A. Other Title I-funded primary care services include two community dental clinics; three community-based mental health providers; three substance abuse treatment agencies; and three complementary health care programs.

- Access Services – Outreach and Case Management. Outreach services target African American and Latino PLWH/A through the Title I Minority AIDS Initiative grant. Another Title I outreach program focuses on other hard-to-reach PLWH/A who are reluctant to seek services or experience barriers to ongoing care, e.g., substance abuse and/or mental illness, criminal history, and homelessness. Outreach services are coordinated with Prevention outreach programs sponsored by local health departments to reduce duplication of services. HIV case management in the EMA is coordinated with the major medical health systems and funded by both mainstream and Title I resources.
- Support Services. Support services in the EMA promote retention in medical care and assist clients in meeting basic needs. These services are provided through a combination of public agencies and private community-based organizations. The Portland EMA *HIV/AIDS Resource Guide* lists over 150 agencies that provide a wide range of social services. Community providers offer HIV-specific services including permanent alcohol and drug-free housing at the Rosewood Apartments; housing with supportive services for clients with mental illness; two residential care centers; the Neighborhood Housing and Care Program which combines stable housing with in-home primary care and social work services; Esther’s Pantry and Martha’s Pantry emergency food programs; a Kid’s Connection program to help HIV-affected children and their families access services; and a Working Choices program to help PLWH/A manage their return to work. Title I-funded support services address gaps in the mainstream systems. Transportation services for clients in outlying communities in the EMA, and those who have difficulty using public transportation enable clients to attend primary care and case management appointments. Housing education, emergency rent assistance and transitional housing services are coordinated with HOPWA and with services offered through Housing Authorities. The Title I home-delivered meal program, Daily Bread Express, serves clients who are homebound. Title I psychosocial support programs help clients build and sustain personal support systems through support groups, one-to-one problem-solving sessions, and assistance with activities of daily living at two day centers.

Mechanisms within the EMA that enable newly infected, underserved, hard-to reach individuals and/or disproportionately impacted communities of color to access and remain in primary medical care The EMA’s HIV service system is designed to link clients with primary care and sustain participation in primary care over time. By contract, all Title I-funded providers must screen new clients for access to a medical provider and health insurance. New clients without a provider are referred to a Title I-funded clinic as an immediate source of care and into case management for long-term planning. Case management and medical care providers conduct eligibility screening for public programs (e.g., Oregon Health Plan, CAREAssist) to give clients access to the full range of primary care services covered by insurance. All Title I funded case management and medical providers have referral relationships with agencies that serve as points of entry for clients needing HIV services, including hospital systems/emergency rooms, drug treatment and mental health agencies, agencies serving at risk youth, counseling and testing and STD clinics, and agencies serving the homeless.

The primary medical care system has changed in response to the service needs of emerging and underserved populations. The HIV Health Services Center (HHSC) and the HIV Clinic at OHSU have referral relationships with the EMA outreach programs described below. The HHSC

works with homeless youth programs to encourage new young HIV-positive clients to engage in care. HHSC providers meet regularly with county medical staff working in the jails to case conference on treatment plans for HIV-positive inmates. The HIV Clinic at OHSU provides direct HIV medical care to inmates at two state corrections facilities and a drug rehabilitation center. Support is also provided for transitioning inmates who are released from jail into care in their home communities. The HHSC has integrated on-site mental health and substance abuse counseling into a “one-stop” service model. The HHSC is the largest provider of HIV care for African refugee women in the EMA. This is a highly isolated and stigmatized community in which confidentiality and use of interpreters is critical to ongoing care. A HHSC staff person serves as a liaison to the two agencies that receive these women, Catholic Charities and the Multnomah County Refugee Screening Program. Both the HHSC and OHSU have strengthened medical adherence support for their clients through on-site pharmacy services. Complementary health care programs also help clients deal with the side effects of treatment which in turn promotes adherence to drug regimens.

The support services system has also implemented programs that respond to the needs of emerging and underserved populations. Psychosocial support services offer stability for a marginalized population that leads to more consistent participation in care. A drop-in day center serves PLWH/A who have difficulty dealing with activities of daily living, many of whom are homeless or living in temporary housing. The center provides regular meals, a program of supportive activities, and a place for clients to meet with social service providers. Another center provides services for women and their families, including child care while women are participating in support groups and other center activities.

The housing program includes education programs for clients with a history of homelessness, substance abuse and other challenging life situations. Landlords give special consideration to Ready-to-Rent class graduates. The Positive Directions Program workshops cover tenant education, employment, health, budgeting and parenting. The Housing program has established specialized housing for clients with substance abuse problems and for families affected by HIV, including refugee families who are new to the area.

Coordination with Other CARE Act Programs. The Council identifies service gaps and makes allocation decisions based on data about consumer-identified needs, service capacity, and service utilization. The resources provided by other CARE Act funded programs are essential in maintaining a comprehensive continuum of care. Title II: Oregon and Washington allocate Title II funds on a statewide “parity” funding formula that considers both Title I and Title II service funding. Based on this formula, the EMA has not been eligible for Oregon Title II funding for the past four years. Clark County receives a small Title II award from the State of Washington. Title I and II funds in Clark County are combined to support a comprehensive case management program. ADAP funds a comprehensive HIV drug formulary for PLWH/A. Oregon and Washington also use ADAP funds to pay insurance premiums. Additionally, Oregon ADAP covers co-pays and deductibles. ADAP staff provide program updates to the Council, and Council members participate in the ADAP Advisory Group. Two years ago, Title I reallocated funds to the State ADAP Program to help deal with a significant budget shortfall. Last year, the ADAP Program stabilized and no longer needed Title I funds, so these resources were reallocated to address other gaps in primary care services. Currently, Title I funds health

insurance to address a small gap in access to insurance in Clark County. This ensures that Clark County clients receive health insurance services at a level comparable to clients living in the five Oregon counties of the EMA.

Title III: The Multnomah County Health Department has the EMA's only Title III clinic, the HIV Health Services Center (HHSC). This clinic provides the full range of primary care services. These services are supported by multiple funding streams. Title I and Title III funds work together to bridge the gap in access to medical care for uninsured clients and to offer services not covered by other resources. Oregon Health and Science University (OHSU) is in the second year of a Title III capacity building grant to create a quality improvement (QI) program and clinical data system. Title I staff participate in QI committees for both OHSU and the HHSC to facilitate use of common approaches to service standards and outcomes.

AETC: Multnomah County's HHSC has been the AETC clinical training site for a five state region since 1999. The Research and Education Group, a non-profit agency that coordinates community-based HIV clinical trials in Oregon and Clark County, recruits providers for AETC training conducted at the HIV Health Services Center.

RWCA Dental Programs: The Oregon Health and Science University (OHSU) School of Public Dental Health participates in the Part F Dental Reimbursement program at their community-based Russell Street Dental Clinic. OHSU also just renewed a five year Dental Community Partnership Grant. This grant funds HIV clinical rotations for dental students, general practice residents, and dental hygiene students. The clinical rotations expand access to services for PLWHA/A at the clinic and increase access in the community as these oral health professionals establish their practices. OHSU coordinates client outreach activities in the grant with the two largest contractors delivering Title I primary care and support services. Title I contributes dental care funding to help fill the gap in resources for the majority of PLWH/A without dental insurance.

SPNS grants: Multnomah County has two grants – the final year of a multi-year grant to evaluate the Title I CareLink outreach program at Cascade AIDS Project and a new grant to replicate the OPTIONS Prevention with Positives intervention at two primary medical care clinic sites, the HHSC and OHSU. OHSU has a new SPNS grant to evaluate two models of care for opioid treatment (buprenorphine and substance abuse counseling)–treatment integrated with primary medical care at OHSU and HHSC clinics and treatment delivered at a stand-alone treatment program. The Council receives reports on these grants to inform planning processes.

Ryan White Title 1 Planning Council Service Category Priorities

Table 8. Summary of Priority Services to be Funded in FY 2006

Service Category	2005 Priority	2006 Priority	2005 Allocation (per grant award)	2006 Allocation Request	Percent Change from 2005 to 2006	Percent of 2006 Allocation Request
Tier One						
Outpatient Medical Care	1	1	\$650,000	\$690,000	6.2%	21.5%
Health Insurance	2	2	\$30,000	\$40,000	33.3%	1.2%
Drug Reimbursement	3	2	\$0	\$0	0.0%	0.0%
Mental Health Therapy	7	3	\$125,946	\$126,000	0.0%	3.9%
Dental Care	5	4	\$230,000	\$250,000	8.7%	7.8%
Substance Abuse Tx	8	5	\$81,814	\$83,000	1.4%	2.6%
Case Management	4	6	\$762,592	\$772,600	1.3%	24.1%
Housing Assistance	6a	7	\$282,677	\$282,700	0.0%	8.8%
Housing-Related Svcs	6b	8	\$95,245	\$96,250	1.1%	3.0%
Tier Two						
Psychosocial Support	9	9	\$147,156	\$157,200	6.8%	4.9%
Outreach (including MAI)	10	10	\$185,314	\$185,300	0.0%	5.8%
Transportation	12	11	\$5,756	\$5,985	4.0%	0.2%
Complementary Care	11	12	\$95,939	\$96,000	0.1%	3.0%
Food-Group/Home-Delivered Meals	15	13	\$119,230	\$119,300	0.1%	3.7%
Residential Care	13	-	\$0	\$0	0.0%	0.0%
Early Intervention Svcs	14	-	\$0	\$0	0.0%	0.0%
SUBTOTALS			\$2,811,669	\$2,904,335		90.6%
Non-Service Priorities						
Planning Council Support	16	14	\$274,498	\$270,167	-1.6%	8.4%
Program Support	17	15	\$25,000	\$30,000	20.0%	0.9%
GRAND TOTALS			\$3,111,167	\$3,204,502	3.0%	100.0%

F. Barriers to Care

The Portland EMA faces a major challenge in implementing a system of care that reaches all affected populations across our community. The Portland EMA encompasses six counties in two states, covers more than 5,000 square miles, and centers on a large metropolitan area surrounding the City of Portland. Multnomah, the most populated county in the EMA, has approximately 73% of the persons living with HIV/AIDS in the EMA, and the remaining 27% are dispersed throughout the five outlying counties. Residents in the six counties travel to Portland to varying degrees in order to access a well-established health care and social services system. The majority of PLWH/A in need of HIV services are generally well served by the care system.

However, the EMA includes small and diverse communities of PLWH/A that are difficult to reach through mainstream providers and systems.

The EMA’s Hispanics (8.2% of PLWH/A) and African Americans (8.7% of PLWH/A), are a small, but increasing proportion of those living with HIV/AIDS in the EMA. The majority of African American PLWH/A live in Multnomah County. Hispanic PLWH/A are more dispersed throughout the six counties. The demands of the service system are complex within these populations where issues of discrimination, fear, lack of community acceptance of the disease and of alternative lifestyles create barriers. The 2002 Rapid Assessment, Response and Evaluation of the HIV Epidemic in the African American Community in the EMA (RARE) study, funded by the Ryan White HIV Planning Council, found that many African American MSM were uncomfortable disclosing their HIV-positive serostatus to family members and reported that their homosexuality makes it nearly impossible to rely on family members, church or community for support. Hispanic PLWH/A in rural areas also reported a reluctance to be open about their sexuality for fear of rejection.

The *2001 Latino PLWH: Service Needs and Barriers to Care* identified strong cultural and language barriers that prevent many Hispanic PLWH/A from accessing care. The Bureau of Citizenship and Immigration Services reports that Oregon is ranked 16th in the nation for the number of illegal aliens. Approximately 10% of Oregon’s Hispanic population is undocumented. An estimated 77% of the Hispanic PLWH/A in the EMA are undocumented—this is 2% of the total PLWH/A population. Employment for Hispanics in Oregon is often seasonal and part-time. Unstable employment and a transient lifestyle make it more difficult to connect with needed services. In addition, many undocumented Hispanics are fearful of deportation if they seek assistance; therefore, intensive outreach and advocacy is needed to bring them into the health care system. Undocumented PLWH/A are usually uninsured, resulting in limited care options.

As a risk group, injection drug users (includes MSM/IDU) represent about 18.9% of persons living with AIDS in the EMA and 17% of persons living with HIV in the EMA. Substance abuse is a significant co-morbid condition for PLWH/A in the EMA. Dual/multiple diagnosis clients place extraordinary demands on providers throughout our service system. Intensive case management and other support systems are required to engage and maintain in care persons with a substance abuse diagnosis. Service options become particularly challenging and costly for PLWH/A who remain active substance abusers.

The HIV Planning Council has identified the following populations with special needs and barriers to care: youth (13-24 years); injecting drug users (IDU); men of color who have sex with men; White/Anglo men who have sex with men; women of child-bearing age (13 yrs and older); and persons with mental illness. The following table summarizes data about these six populations.

Table 9: Summary of EMA Population Estimates

Portland EMA Special Populations	<u>Estimated</u> number of persons in general population and PLWH/A	<u>Estimated</u> HIV (including AIDS) prevalence rates in the EMA
1. Youth, 13-24 years	334,365 Total EMA 87 PLWH/A	16.3% General Population 2.4% PLWH/A Population

Portland EMA Special Populations	Estimated number of persons in general population and PLWH/A	Estimated HIV (including AIDS) prevalence rates in the EMA
2. Injecting drug users	20,406 Total EMA 695 PLWH/A	1.2% General Population 18.9% PLWH/A Population
3. Men of color who have sex with men	7,578 Total EMA 556 PLWH/A	7.3% General Population 15.2% PLWH/A Population
4. White/Anglo men who have sex with men	29,938 Total EMA 2,255 PLWH/A	7.5% General Population 61.5% PLWH/A Population
5. Women of child-bearing age	482,711 Total EMA 257 PLWH/A	0.05% General Population 7.0% PLWH/A Population
6. Persons with mental illness	418,313 Total EMA 2,134 PLWH/A	0.05% General Population 58.2% PLWH/A Population

Youth ages 13-24 years make up 16.3% of the EMA's total population, and are distributed evenly across the EMA. Youth 13-24 comprise 2.4 % of the estimated HIV/AIDS cases in the Portland EMA. Youth need comprehensive HIV/AIDS primary care and support services within a well-managed continuum of care. This includes accessible primary care providers who have specialized knowledge of HIV, as well as coordinated access to specialists for treatment of HIV related illnesses and common co-morbidities such as mental disorders, substance abuse, and co-infection with hepatitis or STD. Access to primary care is a significant issue for youth because they are less likely to have health insurance, have high poverty rates, and they are likely to deny or minimize the severity of their HIV disease.

Youth require psychosocial support services, referral services, emergency financial assistance, outpatient substance abuse treatment, and housing. Youth particularly need targeted outreach and high quality case management to link them to primary care and social support services and maintain them in care. They are also more reliant on social support services, since issues of poverty, hunger, and lack of affordable housing are magnified in this population. 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. Support services directed to youth should be delivered through multi-service agencies that youth perceive as safe and accessible and that they see as appropriate to their particular needs. Youth need to receive gender and culturally appropriate HIV prevention and early intervention messages where they hang out.

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

Injection drug users who are in primary medical care require high levels of case monitoring and service coordination to reduce the interference of their drug use with HIV treatment. Injection drug use is associated with higher levels of adverse health effects related to substance abuse, and with higher risk for progression of HIV disease. Available substance abuse treatment methods are relatively ineffective for this population. As both co-morbidities are life-threatening chronic conditions, access to appropriate services must be assured for extended periods of time, and treatment must be adjusted to varying levels of acuity over time. IDUs require expedited access

to detoxification and other substance abuse treatment services, as their readiness to engage in treatment may change dramatically over time. Persons in this population require primary treatment by specialists who understand the dynamics of both illnesses and who are prepared to deal with their potential interactions, such as co-infection with all forms of Hepatitis, other infections related to unhygienic injection practices, and interactions between illegal drugs and HIV medications. These drug interactions may create an increased mortality risk for IDUs who are receiving certain antiviral medications. IDUs experience higher rates of mental disorders than the general population, complicating treatment of both substance abuse and HIV disease. For active IDUs, drug use adversely affects their ability to follow scheduled medical treatment and to adhere to HIV treatment regimens.

Intensive case management is needed to stabilize members of the IDU population and maintain them in care; however, support services may be ineffective for this population unless they are specialized to deliver substance abuse treatment along with other support. IDUs who continue to use have a higher rate of incarceration than other PLWH/A, with each episode of incarceration having the potential to interrupt their treatment for HIV disease. *2002 Survey for People Living with HIV and AIDS in Oregon* recommends that service providers conduct behavioral interventions with PLWH/A who continue to inject drugs and share needles and ensure that PLWH/A who inject drugs have access to clean, sterile needles through needle exchange programs and pharmacies. The EMA's HIV Prevention Program has been a leader statewide in implementing behavioral interventions with IDUs and operating a needle exchange program.

Men of color who have sex with men (MCSM) comprise 15% of PLWH/A in the Portland EMA. 7.3% of all MCSM are HIV positive, a rate similar to White MSM. MCSM need comprehensive HIV/AIDS primary care and support services within a well-managed continuum of care. This includes accessible primary care providers who have specialized knowledge of HIV, as well as coordinated access to specialists for treatment of HIV related illnesses, and common co-morbidities such as mental disorders, substance abuse, and co-infection with hepatitis or STD. For MCSM, the intensity of primary medical care and social support services must be able to vary over the course of the disease, so flexible client-centered case management is necessary. This population may include a large group of long-term HIV survivors, because the epidemic spread most quickly and widely in its initial stages among men who have sex with men and intravenous drug users. Long-term survivors require more diverse and individualized antiviral regimens. They also experience more HIV breakthroughs and opportunistic diseases; they are more likely to require hospitalization, supported housing, and hospice care.

Recent studies have also indicated resurgence in new infections among MCSM. This is borne out by HIV surveillance data in Oregon, which show new infections among Hispanics at 14%, and African Americans at 10% in the Portland EMA—both of these rates are higher than these groups' respective percent of the general population. Newly infected MCSM are more likely to present with resistant strains of HIV than those who were diagnosed earlier in the epidemic. While all MSM require high quality care, this is particularly critical for MCSM, because historic barriers to health care access are still present in communities of color. The *2002 Survey for People Living with HIV and AIDS in Oregon* identified language and culture as potential barriers to care. All services for MCSM must be gender and culturally appropriate.

White MSM (including White MSM/IDU) are the largest population (2,514 persons) affected with HIV in the EMA. 7.5% of all White MSM in the EMA are HIV positive. As with all populations, White MSM need comprehensive HIV/AIDS primary care and support services within a well-managed continuum of care. This includes accessible primary care providers who have specialized knowledge of HIV, as well as coordinated access to specialists for treatment of HIV related illnesses and common co-morbidities such as mental disorders, substance abuse, and co-infection with hepatitis or STD. For MSM, the intensity of primary medical care and social support services need to change over the course of the disease, so flexible client-centered case coordination is necessary. This population contains a group of long-term HIV survivors, because the epidemic spread most quickly and widely in its initial stages among White men who have sex with men and intravenous drug users. Long-term survivors require more diverse and individualized antiviral regimens, as they are more likely to experience resistance to, and serious side effects from, available medications. Recent studies have also indicated resurgence in new infections among younger men who have sex with men. While all MSM require high quality case management to link them with the entire array of primary care and social support services and to maintain them in care, this is particularly important for younger MSM, because they need to develop stable relationships with health care providers that last for a long period of time.

Women of childbearing age (13 years and older) are distributed throughout the EMA. Women in the EMA have lower incomes on average than men. Women of childbearing age are 12% of PLWH/A in the Portland EMA. Women need comprehensive HIV/AIDS primary care and support services within a well-managed continuum of care. This includes accessible primary care providers who have specialized knowledge of HIV and women's health, as well as coordinated access to specialists for treatment of HIV related illnesses and common co-morbidities such as mental disorders, substance abuse, and co-infection with hepatitis or STD. According to *We're Listening: 2002 Survey for People Living with HIV and AIDS in Oregon*, access to primary care is a significant issue for women PLWH/A because they are less likely to have health insurance, have higher poverty rates, and are likely to forego their own health care needs in favor of children and other family members for whom they care. This study also reported proportionately higher needs by women for psychosocial support services, referral services, emergency financial assistance, outpatient substance abuse treatment, and child care. *We're Listening* also indicates that women were more likely to need emergency rent/utilities and housing assistance. Barriers to addressing these issues were most often related to system capacity issues such as appointment/service wait times and lack of knowledge about services.

Women require case management to link them with the primary care and social support services and maintain them in care. They are more reliant on social support services than other PLWH/A, since issues of poverty, hunger, and lack of affordable housing are magnified as they apply to family units. Women who depend on employment to support themselves and their families are more likely to lack adequate transportation and childcare than other subpopulations of PLWH/A in the Portland EMA. Psychosocial support services directed to female PLWH/A should be delivered through multi-service agencies that women perceive as accessible and designed to meet their particular needs. Women need to receive HIV prevention and early intervention messages in conjunction with their HIV care, and in places where they congregate. All services for female PLWH/A must be gender and culturally appropriate, and childcare should be available to female PLWH/A while they are receiving other services.

Mental illness affects 58% of PLWH/A in the EMA. PLWH/A with mental illness who are in primary medical care require high levels of case monitoring and service coordination to reduce the interference of their psychiatric disorders with HIV medical treatment. Mental disorder is associated with higher levels of substance abuse, and with higher risk for progression of their HIV related symptoms. As both co-morbidities are chronic conditions, access to appropriate services must be assured for extended periods of time, and treatment must be adjusted to varying levels of acuity over time. PLWH/A with mental disorders require expedited access to crisis intervention services, as their vulnerability to the effects of psychiatric disorders may increase periodically.

Persons in this population require primary treatment by specialists who understand the dynamics of both illnesses, and who are prepared to deal with their potential interactions. Mental disorders can adversely affect the ability of PLWH/A to follow scheduled medical treatment, and to adhere to HIV treatment. Episodes of psychosis, depression, and suicidal ideation may place PLWH/A with mental disorders in situations where they are temporarily unable to make good health care decisions. In such cases, the mental health system is often unable to respond quickly to the person's need for additional surveillance, more intensive mental health services, or protective custody. Under such circumstances, primary medical care and support services essential to maintaining health can be lost by PLWH/A with mental disorders. Intensive case management and client advocacy services are needed to stabilize members of this population and maintain them in care. PLWH/A with mental disorders are more likely to experience unemployment, homelessness, poverty, and incarceration than the general population, indicating that social support services are highly needed by this population to allow them to remain in medical care. Social support services, especially housing and nutrition programs may be ineffective for this population unless delivered in conjunction with treatment for mental disorders. People with mental disorders have a higher rate of incarceration than other PLWH/A, with each episode of incarceration having the potential to interrupt their treatment for HIV disease. Mentally ill people are also more likely to become victims of theft and interpersonal violence. Mentally ill PLWH/A need frequent and consistent messages concerning prevention of HIV transmission through unsafe sex or substance abuse. Mental health services must be designed and delivered in a manner that is culturally appropriate for ethnic and sexual minority populations.

II. *Where Do We Want To Go?*

The HIV Planning Council is committed to continuing its collaborative efforts with the Grantee and service providers to work toward a system of care which:

- Ensures the availability and adequacy of critical HIV-related local core services within the EMA (primary medical care that is consistent with Public Health Service Treatment Guidelines; HIV-related medications, mental health treatment, substance abuse treatment, oral health, and case management);
- Eliminates disparities in access to services and related support services among disproportionately affected sub-populations and historically underserved communities;
- Specifies strategies for identifying individuals who know their HIV status but are not in care, informing them about available treatment and services, and assisting them in the use of those services; and
- Addresses the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system.

The draft 2006 Statewide Coordinated Statement of Need document identifies challenges to the delivery of prevention and care services. These challenges include a strained safety net; increased poverty among PLWH/A; and increased prevalence of co-morbidities including STDs, Hepatitis C, substance abuse, and mental health issues. Compartmentalized health systems and funding stream as well as differing philosophies between agencies and professional disciplines provide additional challenges to a shared framework for HIV prevention and care. Focusing on these four guiding principles will help to meet current and future service delivery challenges.

III: Goals and Objectives

The main goals and objectives of the Comprehensive Plan are as follows:

- 1) To assure access to a linked system of health care built on a foundation that includes support services and peer participation that promotes and maintains quality care.**
 - Eliminate disparities in access to services and related support services among disproportionately affected sub-populations and historically underserved communities.
 - Ensure the availability and adequacy of critical HIV-related core services within the EMA.
 - Increase peer participation in the delivery of, and ensure that clients will have input into, Ryan White funded systems.
 - Promote and maintain quality care through understanding and application of the Chronic Care Model.

- 2) Assure adequate resources that maximize the capacity of the HIV Health Care system.**
 - Assure adequate resources within the local HIV Health Care System.
 - Maximize the capacity of the HIV Health Care system to address the primary health care and treatment needs of those who know their HIV status but are not in care, as well as the needs of those currently in the HIV/AIDS care system.
 - Implement strategies to identify and provide information about available services to individuals who know their HIV status but are not in care.

- 3) To claim the Council's leadership role, authority, and influence in assuring an HIV Health Care system that is inclusive, collaborative and has adequate resources.**
 - Planning Council understands breadth of its role and exercises leadership within that role.
 - Support a HIV Health Care system that is inclusive and collaborative.

- 4) To develop and lead a broad and inclusive network of public and private organizations that ensures a responsive, flexible system of care and prevention with and for PLWH.**
 - Participate in a broad inclusive network of private and public organizations.
 - Build relationships with HIV prevention programs.
 - Build relationships with substance abuse prevention and treatment programs.

Beyond the annual strategies that will be implemented each year, The Council has elected to adopt several additional strategies in order to meet our goals and objectives. The following narrative describes the annual strategies (short-term) and additional strategies (long-term) that are outlined in the work-plan detailed in Section 4.

Goal 1: To assure access to a linked system of health care built on a foundation that includes support services and peer participation that promotes and maintains quality care.

Annual Strategies Each year, Council will assess information from various sources in their efforts to *facilitate the elimination of disparities* in accessing HIV services. This process will include: 1) holding community forums to identify knowledge gaps and service needs in specific underserved populations; 2) updating needs assessment tools for cultural appropriateness and inclusion; and 3) evaluating Minority AIDS Initiative (MAI) expenditures, in combination with African American and Latino PLWH service gaps, to guarantee that MAI funds are appropriately targeted. In order to *ensure the availability and adequacy of critical HIV-related core services*, the Council will systematically review timely data (including, but not limited to, HIV/AIDS service data, epidemiological and EMA unmet need reports, fiscal information, and current insurance issues) to develop Priority and Allocation Reports. In addition, each year the Council will examine the continuum of care in the EMA, and invite public testimony for the prioritization and allocation process, so that the Priority and Allocation reports adequately reflect priority principles and planning directions. Ryan White Title I funds will be rapidly and appropriately allocated annually by using all of the above information. The Council will maintain 33% or above representation by unaligned consumers of Ryan White services to *guarantee that clients will have input* into Ryan White funded systems.

Additional Strategies

Year 1: 2005-06: To further ensure the availability and adequacy of critical HIV-related core services within the EMA, the Council plans to 1) Adopt a “hold harmless” approach to funding for core services, and 2) deliver standardized training on Resource Allocation and Planning to all Council members. In addition, Council staff and the Grantee will work collaboratively to develop a training curriculum to educate all Council members on the Chronic Care Model as a first step towards the Council’s efforts to promote this model and maintain quality care in the Portland EMA.

Year 2: 2006-07: By the second year of this plan, the Council will assess the trainings provided on Resource Allocation and Planning during Year 1, to better identify gaps in members’ understanding of these processes. Ongoing Chronic Care Model training will be provided, focusing on patient self-management. The Council will support ongoing training of leaders in the Chronic Care Model, and will work collaboratively with the Grantee to disseminate such trainings to providers. In addition, an inventory of available public and private HIV care networks will be conducted to develop a basic HIV “toolbox” which will include information on service eligibility, accessibility and availability. The “toolbox” will be distributed among substance abuse, mental health and other providers in the larger care system. During Year 2, an inventory report outlining existing general health care disparities data in the Portland EMA will be presented to the Council as an initial step towards better understanding and eliminating disparities in access to services.

Year 3: 2007-2008: During Year 3, the Council will continue its support to the Grantee’s ongoing efforts to train providers in, and integrate the Chronic Care Model in HIV care service delivery. Quality improvement measures will be developed for the Council planning process, and

utilized to measure this model's progression. The HIV "toolbox" created during Year 2 for stakeholders, will also be distributed to first-access service points throughout the EMA. A second inventory assessing disparities in HIV health care will be completed, utilizing the techniques in the prior year's inventory report on health care disparities. Information from both inventories will provide a clear analysis on disparities affecting HIV-positive populations. Results from these inventories will be presented to the Council, and will be used by the Council during priority setting and resource and allocation processes.

Year 4: 2008-2009: During Year 4, the Council will continue its support of the Grantee's efforts towards implementing patient self-management as a component of the Chronic Care Model, and will assess any increases in consumer participation as a result of such programs. In addition, the Council and Grantee will develop integrated quality improvement tools and will begin measuring any changes or improvements in HIV healthcare disparities in the Portland EMA. Data from such measures will be used during the planning and resource allocation process and findings will be reflected in Council Service Category Guidance where appropriate.

Year 5: 2009-2010: The Council will continue to support the Grantee's efforts to integrate the Chronic Care Model, with focus on patient self-management, and assess any additional outcomes in this effort.

Goal 2: To assure adequate resources that maximize the capacity of the HIV Health Care system.

Annual Strategies Each year, the Resource Allocation Report will be developed and presented to Council for review to *assure adequate resources within the local HIV Health Care System*. This report will reflect timely information, based on an ongoing review of funding principles, updated allocations assumptions and decision making criteria. Funding decisions will be based on multiple data sources, including, but not limited to: service utilization data, needs assessments, cost analysis, key informant interviews, and public testimony. The Council will invite County Board of Commissioners representatives to a minimum of three council meetings a year to foster communication and collaborations. Similarly, the Co-Chairs and Administrator will meet with the Multnomah County Chair representative twice yearly and report on these discussions to the Council. The Council will work with the Grantee to identify and disseminate information about any additional possible funding sources to Ryan White providers. In order to *maximize the capacity of the HIV Health Care system* to address PLWH/A needs, Service Category Guidance will be reviewed and updated annually through an Ad Hoc Committee.

Additional Strategies

Year 1: 2005-06: The Council and the Grantee will research strategies to integrate peer advocates in early support programs as part of a central approach to identify and provide information to HIV-positive individuals who know their status, but are not yet in care.

Year 2: 2006-07: During Year 2, Service Category Guidance advocating a strong peer component in early support programs will be written to continue the development of peer involvement in helping HIV-positive individuals access early care. In addition, Council and

Grantee will plan a networking meeting between Mental Health and Substance Abuse agencies in Oregon and Southwest Washington to begin facilitating a dialogue between providers, in an effort to maximize the capacity of the HIV Health Care system in addressing the needs of PLWH/A.

Year 3: 2007-2008: During the third year of the plan, the Council will develop an “unmet need network” with HIV providers and other social service agencies to generate ideas and recommendations on decreasing unmet HIV care services needs in the EMA.

Year 4: 2008-2009: During Year 4, the Council will utilize the recommendations of the “unmet need network” group to develop strategies to address unmet needs in the EMA. Outcome measures will also be developed and applied to assess successful application of Council’s strategies to address unmet service needs. In addition, best practices among existing Peer Mentoring programs will be researched and presented to Council members, complementing earlier work done on early support programs with peer components.

Goal 3: To claim the Council’s leadership role, authority, and influence in assuring an HIV Health Care system that is inclusive, collaborative, and has adequate resources.

Annual Strategies The Council will engage in several activities each year to *ensure a consistent understanding of the role and leadership potential* among all Council members and to *support an inclusive and collaborative HIV Health Care system*. In the first quarter of each year, a Council Retreat will be held for the joint purposes of receiving training in committee roles and responsibilities and reviewing and renewing sub-committee work plans. A New Member Orientation will be held for all new members on basic Council functions. For returning members, the Council will assess on a continuing basis other training needs. A public relations strategy will be developed by the Membership/Community Relations Committee to ensure that the Council maintains full membership with representatives in all mandated slots throughout the year. This strategy will be presented to and approved by the Executive Committee. Committee Chair nominations and appointments will be also made during the first quarter of each planning year. In the second quarter, the Planning Committee and any additional, interested Council members will be trained on the priority setting process. The grant award will be reviewed, and allocation adjustments made as needed. The Council will participate in the IGA agreement with Clark County to ensure the agreement is current and signed. Current Minority AIDS funding will be reviewed to guarantee appropriate expenditure of funds. Key informant interviews will be conducted during this quarter to identify current service gaps in HIV/AIDS care within the EMA. In the third quarter, the Co-chair and Committee Chair evaluation will be performed and results given to Council co-chairs. Comprehensive plan progress will be evaluated and feedback presented to Council. By the fourth quarter of each year, all committees will review their work plans and identify areas of improvement, in a continuing effort to produce more efficient and productive work plans. An Evaluation of the Administrative Mechanism will be conducted by the Council and a report produced for the Grantee to include in grant application. In order to measure the progress made during Council and sub-committee meetings, meeting evaluations will be completed and analyzed each quarter to examine improvements made and address ongoing issues. In addition to the work identified above, the Council will continue to identify and prioritize new networks/groups for collaborations (see Goal 2 for examples). Members of

the public will also have the opportunity to attend any Council or Sub-Committee meeting and offer testimony, while community forums will be held as needed to inform knowledge gaps identified by Council.

Additional Strategies

Year 1: 2005-06: A Memorandum of Understanding (MOU) between the Council and Health Department will be drafted, signed and distributed to all Council members to ensure an understanding of the breadth of Council's role.

Year 2: 2006-07: During Year 2, as a component of supporting an inclusive and collaborative HIV Health Care system, the Council will conduct a review of the current continuum of care to facilitate better understanding of its strengths and weaknesses.

Year 3: 2007-2008: During Year 3, the Council and Grantee will use the continuum of care review conducted in Year 2 to identify quality improvement measures to formally evaluate the current continuum. In addition, a consumer and provider survey will be conducted in an ongoing effort to identify, prioritize, and address service gaps in the EMA.

Year 4: 2008-2009: The MOU between the Council and the Health Department will be reviewed. Based on the prior identification and prioritization of service gaps, Council will seek additional resources outside of the Ryan White Care Act to address gaps. Council will also adapt its understanding of the continuum of care based on prior years' review and evaluation efforts.

Goal 4: To develop and lead a broad and inclusive network of public and private organizations that ensures a responsive, flexible system of care and prevention with and for PLWH.

Annual Strategies To realize the above goal, the Comprehensive Plan includes strategies to develop relationships with a broad network of service providers, while also focusing specifically on strengthening collaborations with HIV prevention and substance abuse treatment programs. In a direct effort *to build relationships with HIV prevention programs*, the Council's prevention knowledge gaps will be identified and addressed yearly. The Council will also collaborate on an ongoing basis with Prevention Planning Groups to identify prevention data sources for use in Priority and Allocation reports, and best practices for Council planning purposes. In addition, beginning in Year 2, Council and Grantee will work to engage health departments in each county in the EMA, and approach political leaders in outlying counties to seek support *in creating a broad-based network for care and prevention for PLWH/A*.

Additional Strategies

Year 1: 2005-06: In order to develop a broad and inclusive network in the system of care and prevention with and for PLWH/A, annual key informant presentations will include substance abuse providers the first year.

Year 2: 2006-07: During Year 2, the Council and the Grantee will start identifying and working collaboratively with non-HIV agencies, clinics, and health departments in each county throughout the EMA, including rural areas, to engage a broader network of service providers. The Council will also get recommendations from Oregon and Washington State on best prevention practices, using the CDC list of “DEBI’s” as criteria for evidence-based prevention interventions, and integration of such practices into service delivery. In addition, the Council will identify knowledge gaps among Council members on mental health/substance abuse prevention and treatment and develop a strategy for better Council understanding of these services areas. The Council will continue working with the AIDS Housing Systems Service Integration group to facilitate housing and case management programs that increase client participation in substance abuse treatment.

Year 3: 2007-2008: By Year 3, an ongoing quarterly electronic newsletter will be developed and disseminated. At least three regular Ryan White Title I informational presentations a year encouraging more inclusive organizational networks will be made to city and county officials in the EMA. The Council and the Grantee will continue their relationships with prevention providers and will develop Guidance that supports the integration of prevention into care services. Effective substance abuse prevention strategies will be researched, presented to the Council, and integrated into Service Category Guidance. The Council will identify and create an assessment tool to address issues related to substance abuse and connection to primary medical care. The Council will use information gathered from the AIDS Housing Systems Services Integration group during Year 2 to develop Guidance reflecting Council support for service integration methods connecting clients to housing, mental health services, and substance abuse treatment.

Year 4: 2008-2009: Finally, to increase coordination of substance abuse/prevention services available in HIV care, the Council will identify best practices for identifying and referring clients to substance abuse programs through communications with local drug abuse treatment programs. These best practices will be shared with public through the Council website.

SECTION IV: *DETAILED WORK PLAN*

Implementation of the Comprehensive Plan will be monitored and evaluated throughout the grant year and formally evaluated on an annual basis. Strategies will be incorporated into existing work plans for each Council sub-committee. The Executive Committee of the Council will continue to monitor work plan progress at their monthly meeting. The Evaluation Committee will complete an annual formal review of Council progress toward goals and objectives, and will recommend any changes or updates needed. The Annual report will include their findings and be presented to the Council in October of each year. The Planning Council Administrator will provide project and fiscal oversight and support for implementation, monitoring, and evaluation activities. Updates to the plan will be discussed and decided at the Council annual retreat in September. The Planning and Resource Allocation committees will continue to monitor changes in the epidemic, in service needs and provider capacity that may affect strategies in the plan. The Administrator will continue to keep track of legislative, regulatory and other changes in the health service system that may affect activities in the plan and will work closely with the Grantee to coordinate implementation efforts. A detailed work plan follows.

Goal #1: To assure access to a linked system of health care built on a foundation that includes support services and peer participation that promotes and maintains quality care.

Goal 1 Objective #1: Eliminate disparities in access to services and related support services among disproportionately affected sub-populations and historically underserved communities				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Conduct community forums to identify access issues and service gaps for target PLWH populations.	<ul style="list-style-type: none"> Schedule forums and recruit participants. Develop culturally competent questions to be addressed at forums. Analyze forum findings. 	Quarter 2 Annually or As Needed	<ul style="list-style-type: none"> Planning Committee Resource Allocations Committee Membership/CR Committee 	<ul style="list-style-type: none"> Findings of focus groups understood and incorporated into service planning and delivery.
Update and conduct ongoing annual needs assessment.	<ul style="list-style-type: none"> Review needs assessment tools for cultural appropriateness and appropriate racial group inclusion. Implement need assessment activities. 	Quarter 2 Annually	<ul style="list-style-type: none"> Evaluation Committee Planning Committee 	<ul style="list-style-type: none"> Needs Assessment updated regularly for completeness.
Approve annual Minority AIDS Initiative (MAI) funding allocation.	<ul style="list-style-type: none"> Review previous expenditures of MAI funds. Identify service gaps for African American and Latino PLWH in the EMA. Present funding recommendations to Council. 	Annually	<ul style="list-style-type: none"> Resource Allocations Committee 	<ul style="list-style-type: none"> MAI funds targeted appropriately.
Understand disparities in health access for Core Services for the general and HIV populations in the EMA.	<ul style="list-style-type: none"> Collect, review and compare data and reports related to health care disparities for the general and HIV populations in the EMA. Prepare a summary report of health disparities. 	June 2007 through July 2008	<ul style="list-style-type: none"> Council Staff Evaluation Committee PDES and/or PSU Consultants Grantee 	<ul style="list-style-type: none"> Data driven information is used during the priority setting and resource and allocation processes. Report analyzing health disparities in general population vs. HIV specific

Goal 1 Objective #1: Eliminate disparities in access to services and related support services among disproportionately affected sub-populations and historically underserved communities				
Strategy	Activities	Timeline	Responsible Parties	Measurement
	<ul style="list-style-type: none"> Recommend target health disparities to be addressed through the Ryan White CARE system 			<p>population presented to Planning Council.</p> <ul style="list-style-type: none"> Prioritization of health disparities to be addressed through the Ryan White CARE system
Develop outcome measures for tracking improvement in health disparities related to access and service utilization.	<ul style="list-style-type: none"> Define desired outcome measures. Integrate quality improvement methods from Chronic Care Model. 	August 2008 through August 2009	<ul style="list-style-type: none"> Evaluation Committee Council Staff Grantee Service Category Guidance Planning Committee Resource Allocation Committee 	<ul style="list-style-type: none"> Outcome measures identified and applied to planning and resource allocation process, included in Guidance to the Grantee where appropriate.

Goal 1 Objective #2: Ensure the availability and adequacy of critical HIV-related core services within the EMA				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Compile current data needed to support annual service delivery planning.	<ul style="list-style-type: none"> Review prior year's Priority and Allocation reports. Identify information gaps. Assess current data. Identify strategy for collecting additional data. 	Quarter 1 Annually	<ul style="list-style-type: none"> Planning Committee Resource Allocation Committee Evaluation Committee 	<ul style="list-style-type: none"> Annual Priority and Allocation report outlines assessment, data gaps and efforts made to insure decision making is data driven.

Goal 1 Objective #2: Ensure the availability and adequacy of critical HIV-related core services within the EMA				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Use current data to inform program and system planning and service delivery.	<ul style="list-style-type: none"> • Compile, review and analyze updated HIV/AIDS services data, needs data, risk trends, insurance coverage, co-morbidities, etc. • Review trends in EMA epidemiology. • Review special reports, including SCSN. • Present data summaries to full Planning Council and various committees. 	Quarter 1 Annually	<ul style="list-style-type: none"> • Planning Committee • Evaluation Committee • Resource Allocation Committee • Planning Council Committee 	<ul style="list-style-type: none"> • Priority and Allocation reports show appropriate data used for decision making.
Reallocation of funds to reflect current needs and service utilization.	<ul style="list-style-type: none"> • Review data on unspent funds. • Request information on reason for underutilization of funds. • Evaluate need for continuation of funds or reallocation to different category. 	Quarter 1 Ongoing	<ul style="list-style-type: none"> • Resource Allocation Committee • Grantee • Council Staff 	<ul style="list-style-type: none"> • Council reallocates funds rapidly and consistently with appropriate use of data.
Annual Priorities and Allocations Report presented to Council for approval.	<ul style="list-style-type: none"> • Continuum of Care reviewed and service categories prioritized. • Existing and emerging needs in the EMA identified. • Council's impact on serving ethnic and cultural communities assessed. • Public testimony is presented from consumer, provider, 	Quarter 3 Annually	<ul style="list-style-type: none"> • Planning Committee • Council Staff • Executive Committee 	<ul style="list-style-type: none"> • Council decision making reflects understanding of priorities and service environment. • Final report reflects Council and Public testimony input.

Goal 1 Objective #2: Ensure the availability and adequacy of critical HIV-related core services within the EMA				
Strategy	Activities	Timeline	Responsible Parties	Measurement
	and community perspectives.			
Maintain and/or expand resources for core services.	<ul style="list-style-type: none"> Analyze service needs and utilization data in the context of the available funding streams. As appropriate, adopt a “hold harmless” approach to allocations for core services. 	Annually	<ul style="list-style-type: none"> Membership/CR Committee Planning Council Resource Allocation Committee 	<ul style="list-style-type: none"> At a minimum, core services are held at flat funding as adjusted for inflation.
Provide resource allocation and planning training to Council members.	<ul style="list-style-type: none"> Training provided at Council meeting prior to annual Priority setting. Training assessment and evaluation tools developed and implemented. 	May 2006 and June 2007	<ul style="list-style-type: none"> Membership/CR Committee Planning Committee Resource Allocation Committee Council Staff Evaluation Committee 	<ul style="list-style-type: none"> Training held in early Spring Evaluation of training identifies how training affected members’ understanding of allocation decisions made.
Understand the capacity of non-Title I funded core service providers.	<ul style="list-style-type: none"> Inventory of public and private HIV care networks and capacity. 	June 2007	<ul style="list-style-type: none"> Evaluation Committee Planning Committee Grantee 	<ul style="list-style-type: none"> Yearly inventory report Updated as needed in subsequent years
Create HIV information and referral materials for stakeholders in the larger health care and social service community.	<ul style="list-style-type: none"> Work with Grantee to update and disseminate Ryan White information and referral materials. 	June 2007 and July 2008	<ul style="list-style-type: none"> Grantee Evaluation Committee Council Staff 	<ul style="list-style-type: none"> Information and referral materials distributed to first-access points throughout EMA

Goal 1 Objective #3 Increase peer participation in the delivery of, and ensure that clients will have input into, Ryan White funded systems.				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Maintain Council representation and reflective-ness.	<ul style="list-style-type: none"> • Maintain membership recruitment efforts. • Web site content updated. 	Annually	<ul style="list-style-type: none"> • Membership/CR Committee • Co-Chairs • Council Staff 	<ul style="list-style-type: none"> • Council maintains 33% or above representation by unaligned consumers of Ryan White services.

Goal 1 Objective #4 Promote and maintain quality care through understanding and application of the Chronic Care Model				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Promote the Chronic Care Model as the theoretical/functional framework for HIV care services delivery.	<ul style="list-style-type: none"> • Train Council on Chronic Care Model. • Work with Grantee to support implementation of Chronic Care Model training for providers. • Utilize quality improvement process from Chronic Care Model in planning processes. 	05/06 06/07 07/08	<ul style="list-style-type: none"> • Grantee • AETC • Executive Committee • Council Staff • Title II • Planning Committee • Membership/CR Committee • Evaluation Committee 	<ul style="list-style-type: none"> • Training done. • Allocations and priorities reflect support of self management trainings • Grantee report on training plan for providers. • Quality improvement measures applied to Council planning process.

Goal #2: To assure adequate resources that maximize the capacity of the HIV Health Care system.

Goal 2 Objective #1: Assure adequate resources within the local HIV Health Care System				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Review previous funding principles, allocations assumptions, and decision making criteria.	<ul style="list-style-type: none"> • Establish funding principles • Update allocation decision making matrix 	Quarter 1 Annually	<ul style="list-style-type: none"> • Resource Allocation Committee 	<ul style="list-style-type: none"> • Resource Allocation Report reflects continuing improvements in principles used and continuing use of data to drive allocation decisions.
Allocation Decisions are based on appropriate data sources.	<ul style="list-style-type: none"> • Use multiple data sources for decision making including service utilization; cost analysis; key informant and community focus group presentations; needs assessment, etc. 	Quarter 3 Annually	<ul style="list-style-type: none"> • Evaluation Committee • Planning Committee • Council Staff • Resource Allocation Committee • Membership/CR Committee 	<ul style="list-style-type: none"> • Allocation minutes reflect use of data in funding decisions.
Resource Allocation Report presented to Council.	<ul style="list-style-type: none"> • Determine funding allocations based on priorities report and recommendations. • Present report to Planning Council for review. • Produce report with public testimony input considered. 	Quarter 4 Annually	<ul style="list-style-type: none"> • Resource Allocation Committee • Council Staff 	<ul style="list-style-type: none"> • Planning Council discussion of report reflects understanding of funding principles and decision making criteria used.
Council fosters closer collaboration with designated representative of the Multnomah County Board of Commissioners representative.	<ul style="list-style-type: none"> • Identify three Council meetings per year where attendance by representative is most important for improved understanding of resource gaps in HIV service system. • Invite representative to three Council meetings per year. • Co-Chairs and Administrator 	2005-2010 all years	<ul style="list-style-type: none"> • Co-Chairs • Executive Committee • Council Staff 	<ul style="list-style-type: none"> • Increased communication between Council and Board of Commissioners.

Goal 2 Objective #1: Assure adequate resources within the local HIV Health Care System				
Strategy	Activities	Timeline	Responsible Parties	Measurement
	meet with Multnomah County Chair's representative at least twice yearly.			
Council provides encouragement and support for providers seeking funding sources outside of Ryan White.	<ul style="list-style-type: none"> Work with Grantee to identify and forward information about possible funding sources to Ryan White providers. 	Ongoing	<ul style="list-style-type: none"> Council Staff Grantee Planning Council 	<ul style="list-style-type: none"> Grant opportunities forwarded to Ryan White providers.

Goal 2 Objective #2: Maximize the capacity of the HIV Health Care system to address the primary health care and treatment needs of those who know their HIV status but are not in care as well as the needs of those currently in the HIV/AIDS care system				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Service Category Guidance reviewed and updated.	<ul style="list-style-type: none"> Guidance collected throughout Planning and Allocation process. Ad Hoc Committee formed to review and improve service category guidance. 	Q4 Annually	<ul style="list-style-type: none"> Resource Allocations Committee Planning Committee Grantee 	<ul style="list-style-type: none"> Service Category Guidance reflects the intent of the Council.
Create "Unmet Need" taskforce to focus reducing barriers of out-of-care PLWH.	<ul style="list-style-type: none"> Recruit task force members. Develop task force charter. Schedule & facilitate meetings. Develop plans, including outcome measures, to address barriers experience by out-of-care PLWH. Update plan annually. 	07/08 08/09	<ul style="list-style-type: none"> Council Staff Council members 	<ul style="list-style-type: none"> Task force formed. Plan developed and approved by Council.

Goal 2 Objective #3: Implement strategies to identify and provide information about available services to individuals who know their HIV status but are not in care				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Support development of early support program with strong peer component.	<ul style="list-style-type: none"> • Develop service category Guidance that supports peer component in early support strategies. • Research peer led early support strategies for best practices and present to Planning Committee. • Modify guidance as needed to reflect best practices. 	05/06 06/07	<ul style="list-style-type: none"> • Evaluation Committee • Council Staff • Care Services • Planning Committee 	<ul style="list-style-type: none"> • 06/07 Service Category Guidance supports peer involvement in early support strategies.

Goal #3: To claim the Council’s leadership role, authority, and influence in assuring an HIV Health Care system that is inclusive, collaborative, and has adequate resources.

Goal 3 Objective #1 Planning Council understands breadth of its role and exercises leadership within that role				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Hold Council Annual Retreat	<ul style="list-style-type: none"> • Sub-committee annual work plans evaluated, renewed. • In-service training including committee roles and responsibilities. 	Quarter 1 Annually	<ul style="list-style-type: none"> • Council Staff • Co-Chairs • Membership/CR Committee 	<ul style="list-style-type: none"> • Work plan updated. • Council members demonstrate greater understanding of their roles and responsibilities.
Conduct in-service training for Council members.	<ul style="list-style-type: none"> • Hold New Member Orientation. • Identify Council training needs. • Member training conducted on identified topics. 	Quarter 1 Annually	<ul style="list-style-type: none"> • Membership/CR Committee 	<ul style="list-style-type: none"> • Orientation held for new members with basic Ryan White and Care Act information, Manual with Bylaws, Policies and Procedures, Roberts Rules, Public Meeting Law and Current Care Act provided to

Goal 3 Objective #1 Planning Council understands breadth of its role and exercises leadership within that role				
Strategy	Activities	Timeline	Responsible Parties	Measurement
				new members.
Develop public Relations and Community Relations strategy.	<ul style="list-style-type: none"> • Develop a public relations and communication strategy and present to Executive Committee for approval. 	Quarter 1 Annually	<ul style="list-style-type: none"> • Membership/CR Committee • Executive Committee • Council Staff • Co-Chairs 	<ul style="list-style-type: none"> • Strategy presented and approved by Executive Committee.
Provide training on priority and planning process.	<ul style="list-style-type: none"> • Title 1 Manual Priority Setting Training materials presented. • EMA Specific issues addressed. 	Quarter 2 Annually	<ul style="list-style-type: none"> • Membership/CR Committee • Council Staff 	<ul style="list-style-type: none"> • Training held prior to Priority setting process for Planning Committee members and other interested Council members.
Make Committee Chair nominations and appointments.	<ul style="list-style-type: none"> • Chair and Vice Chair appointed for Evaluation, Planning, Resource Allocation. Co-Chairs appointed for Membership Community Relations. 	Quarter 1 Annually	<ul style="list-style-type: none"> • Membership/CR Committee • Co-Chairs • Executive Committee 	<ul style="list-style-type: none"> • All Committees have appropriate and adequate leadership.
Review grant award.	<ul style="list-style-type: none"> • Allocation adjustments made as needed. • Grant score discussed with Council. 	Quarter 2 Annually	<ul style="list-style-type: none"> • Resource Allocations Committee • Planning Council • Grantee • Council Staff 	<ul style="list-style-type: none"> • Council is responsive to changes in grant award. • Council areas for improvement in next proposal.
Participate in negotiation of Clark County IGA.	<ul style="list-style-type: none"> • Identify and agree to areas of collaboration with Southwest Washington Consortium on HIV and AIDS that are within the purview of the two 	Annually by February	<ul style="list-style-type: none"> • Co-Chairs • Council Staff 	<ul style="list-style-type: none"> • IGA current and signed.

Goal 3 Objective #1 Planning Council understands breadth of its role and exercises leadership within that role				
Strategy	Activities	Timeline	Responsible Parties	Measurement
	bodies.			
Conduct annual evaluation of Co-Chair & Committee Chairs.	<ul style="list-style-type: none"> Evaluation tool developed. Evaluation performed. 	Quarter 3 Annually	<ul style="list-style-type: none"> Membership/CR Committee Executive Committee 	<ul style="list-style-type: none"> Co-Chairs receive evaluation feedback.
Conduct annual review of Comprehensive Plan.	<ul style="list-style-type: none"> Identify areas needing change or updates. Comprehensive Plan progress evaluated 	Quarter 3 Annually	<ul style="list-style-type: none"> Evaluation Committee Planning Council 	<ul style="list-style-type: none"> Assessment presented to Planning Council.
Annual membership recruitment drive.	<ul style="list-style-type: none"> Targeted Recruitment efforts planned and implemented. 	Quarter 4 Annually	<ul style="list-style-type: none"> Membership/CR Committee 	<ul style="list-style-type: none"> Council at full membership with strong committed members.
Council Co-Chairs trained in Facilitative Leadership methods.	<ul style="list-style-type: none"> Coordinate with Health Department to schedule training slots. 	As needed and training available.	<ul style="list-style-type: none"> Council Staff 	<ul style="list-style-type: none"> Meeting evaluations reflect facilitative leadership success. Co-Chairs report understanding of and comfort with leadership role.
Council participates in local and national advocacy networks to increase collaborative efforts between other interested community groups.	<ul style="list-style-type: none"> Identify and prioritize new networks/groups for collaboration. Utilize information technology & list serves. Co-Chairs and Executive Committee will determine appropriate involvement. 	Ongoing	<ul style="list-style-type: none"> Council Staff Executive Committee Co-Chairs 	<ul style="list-style-type: none"> Additional worthwhile collaborations in place.
Recruit for mandated membership slots Assess membership representation of	<ul style="list-style-type: none"> Ongoing assessment of gaps in mandated membership. 	Quarter 1 Annually Quarter 2 Annually	<ul style="list-style-type: none"> Membership/CR Committee Co-Chairs 	<ul style="list-style-type: none"> Council maintains full membership with representatives in all mandated slots.

Goal 3 Objective #1 Planning Council understands breadth of its role and exercises leadership within that role				
Strategy	Activities	Timeline	Responsible Parties	Measurement
EMA epidemic demographics.		Quarter 3 Annually		
Conduct and review meeting evaluations.	<ul style="list-style-type: none"> • Meeting evaluations collected and analyzed quarterly. • Evaluation outcomes and suggestions for improvement provided to committee chairs and to Council Co-Chairs. 	Each Quarter & Annually	<ul style="list-style-type: none"> • Membership/CR • Council Staff • Evaluation Committee • Executive Committee 	<ul style="list-style-type: none"> • Leadership shows continual improvement in subsequent meeting evaluations.
Conduct and submit evaluation of administrative mechanism report submitted to Council.	<ul style="list-style-type: none"> • Ad Hoc committee formed. • Parameters of Evaluation training conducted. • Report produced. 	Quarter 4 Annually	<ul style="list-style-type: none"> • Evaluation Committee • Council Staff 	<ul style="list-style-type: none"> • Evaluation of Administrative Mechanism report presented to Council • Findings included in Grant Proposal.
Make improvements to the next year's Council work plan.	<ul style="list-style-type: none"> • Review work plan • Identify areas of improvement and needed action steps. 	Quarter 4 Annually	<ul style="list-style-type: none"> • All Committees • Council Staff 	<ul style="list-style-type: none"> • Continual improvement in efficient and productive work plans. • Updated plan.
Maintain Council and Health Department MOU	<ul style="list-style-type: none"> • MOU drafted and signed. • Problem solving strategies identified in MOU utilized when needed. 	2005/2006 2008/2009	<ul style="list-style-type: none"> • Executive Committee • Co-Chairs • Grantee • Health Dept Director • Council Staff 	<ul style="list-style-type: none"> • MOU signed, on file in Council Office and each Council member has a copy.

Goal 3 Objective #2: Support a HIV Health Care system that is inclusive and collaborative				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Solicit public testimony as part of planning efforts.	<ul style="list-style-type: none"> Public testimony opportunity provided on every meeting agenda. Special efforts to invite Public Testimony made during Priority Setting and Allocations process. 	All Year	<ul style="list-style-type: none"> Council Staff Planning Council 	<ul style="list-style-type: none"> Members of the public attend Council and Sub-Committee meetings and offer testimony.
Approve Minority AIDS Initiative funding allocation.	<ul style="list-style-type: none"> Assess current use of MAI funding in continuum of care. Address new data received related to MAI funding categories or the funding itself. 	Quarter 2 Annually	<ul style="list-style-type: none"> Resource Allocation Committee Planning Committee Planning Council Grantee 	<ul style="list-style-type: none"> MAI funding used appropriately to best serve intended demographic
Identify service gaps in HIV/AIDS care within the EMA.	<ul style="list-style-type: none"> Key informant interviews Conduct survey including affected populations and service providers. Prioritize gaps. Seek additional resources for gaps outside RWCA system. 	Quarter 2 Annually 07/08 08/09	<ul style="list-style-type: none"> Planning Committee Resource Allocation Committee Evaluation Committee Council Staff Grantee 	<ul style="list-style-type: none"> Improved access to services identified through satisfaction survey and utilization data. Updated gap analysis available to inform priorities and allocation process.
Ensure a quality continuum of care by leveraging RWCA funds with other community resources.	<ul style="list-style-type: none"> Develop shared vision with health care system and social services leaders. Identify opportunities for collaboration. 	07/08	<ul style="list-style-type: none"> Council Staff Planning Council Membership/CR Committee Grantee 	<ul style="list-style-type: none"> Successful meeting with key stakeholders.
Review Continuum of Care.	<ul style="list-style-type: none"> Review current continuum of care. Identify quality improvement measures. Evaluate current continuum. Adapt according to data received. 	06/07 07/08 08/09	<ul style="list-style-type: none"> Planning Committee Grantee Planning Council 	<ul style="list-style-type: none"> Council understands its Continuum of Care and the strengths and weaknesses of it.

Goal 3 Objective #2: Support a HIV Health Care system that is inclusive and collaborative				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Hold Community Forum as needed.	<ul style="list-style-type: none"> Identify information gaps best filled with qualitative data from community forum Plan and implement Forum in targeted demographic 	As Need Identified	<ul style="list-style-type: none"> Evaluation Committee Planning Committee Resource Allocation Committee Council Staff 	<ul style="list-style-type: none"> Forums held and feedback incorporated into decision making process.

Goal #4: To develop and lead a broad and inclusive network of public and private organizations that ensures a responsive, flexible system of care and prevention with and for PLWH.

Goal 4 Objective #1 Participate in a broad inclusive network of private and public organizations				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Keep public officials and policy makers informed about HIV/AIDS epidemic and service issues.	<ul style="list-style-type: none"> Regular Ryan White Title 1 informational presentations to city and county elected officials within the EMA. Electronic newsletter (content from various public and private Service Providers). 	07/08 Ongoing	<ul style="list-style-type: none"> Membership/CR Committee Co-Chairs Council Staff Grantee 	<ul style="list-style-type: none"> At least three Presentations made per year. Council will present to representatives from all Counties in EMA by 2009. Quarterly Electronic Newsletter developed and distributed.
Identify and engage stakeholders throughout the EMA, including the rural counties.	<ul style="list-style-type: none"> Identify non-HIV agencies/clinics. Engage Health Dept. in each county. Ask them to connect us with their network. Approach political leaders in outlying counties to seek their support. 	06/07 Ongoing All Years	<ul style="list-style-type: none"> Membership/CR Committee Co-Chairs Council Staff Grantee 	<ul style="list-style-type: none"> Email list of identified contacts Increased Planning Council participation from outlying counties.

Goal 4 Objective #2 Build relationships with HIV prevention programs				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Identify existing sources of current data on HIV prevention and best practices.	<ul style="list-style-type: none"> • Collaborate with Prevention Planning Groups. • Identify ongoing sources for prevention best practices data. 	Quarter 2 Annually	Prevention Planning Group Planning Resource Allocation Council staff	<ul style="list-style-type: none"> • New sources of prevention information identified and provided for planning purposes.
Determine opportunities to integrate prevention in treatment.	<ul style="list-style-type: none"> • Get recommendations from both Oregon and Washington State agencies for best practices. • Elicit ideas from providers and agencies on grass root integration of best practices. • Support implementation of prevention strategies via guidance. 	06/07 07/08	<ul style="list-style-type: none"> • Evaluation Committee • State DHS • Seattle Title I Planning Council • Guidance Ad Hoc • Grantee • Planning Committee • Resource Allocation Committee 	<ul style="list-style-type: none"> • Use CDC “DEBI” evaluation criteria (grantee as source). • Planning process reflects integration of prevention and care. • Guidance reflects support for integration of prevention and care.

Goal 4 Objective #3: Build relationships with substance abuse prevention and treatment programs				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Assess current coordination of services.	<ul style="list-style-type: none"> • Council representative on Systems Integration project. • Study Clark County model. 	06/07	<ul style="list-style-type: none"> • Evaluation Committee • Planning Committee • Clark County Health Dept • Co-Chairs • Systems Integration group: AIDS Housing Systems Services Integration 	<ul style="list-style-type: none"> • Assessment of current service coordination presented to Council.

Goal 4 Objective #3: Build relationships with substance abuse prevention and treatment programs				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Identify Council's critical knowledge gaps in area of mental health/substance abuse prevention and treatment.	<ul style="list-style-type: none"> Identify knowledge gaps. Organize and conduct key informant presentations. 	05/06 06/07	<ul style="list-style-type: none"> Evaluation Committee Planning Committee 	<ul style="list-style-type: none"> Gaps identified. Strategy to fill knowledge gap in this area created. Annual Key Informant presentations include substance abuse and mental health providers.
Identify areas needing further assessment and/or research for the next funding period.	<ul style="list-style-type: none"> Identify appropriate assessment tool to address critical issues in substance abuse treatment and prevention and connection to primary medical care. 	07/08	<ul style="list-style-type: none"> Evaluation Committee Planning Committee 	<ul style="list-style-type: none"> Assessment tool created. Assessment and research conducted and information used in priorities and allocations process.
Support system integration in housing and case management programs that increases client participation in substance abuse treatment.	<ul style="list-style-type: none"> Link to existing system integration group: AIDS Housing Systems Services Integration. Integrate information from this group into Council planning and evaluation processes. 	06/07 07/08	<ul style="list-style-type: none"> Planning Committee Council Staff Co-Chairs Systems Integration group: AIDS Housing Systems Services Integration 	<ul style="list-style-type: none"> Guidance reflects Council support for service integration methods that connect clients to substance abuse treatment.
Support the integration of effective substance abuse prevention strategies.	<ul style="list-style-type: none"> Research effective substance abuse prevention strategies. 	07/08	<ul style="list-style-type: none"> Council Staff Planning Committee Evaluation Committee Planning Council 	<ul style="list-style-type: none"> Effective strategies report presented to Council. Service Category Guidance reflects Council support for effective prevention and treatment of substance abuse.

Goal 4 Objective #3: Build relationships with substance abuse prevention and treatment programs				
Strategy	Activities	Timeline	Responsible Parties	Measurement
Increase coordination of HIV with substance abuse treatment and prevention services.	<ul style="list-style-type: none"> • Link with well-funded local drug abuse treatment programs. • Identify best practice Tools for identifying potential clients for referral. • Share tools with diverse health care providers through Council electronic newsletter. 	08/09	<ul style="list-style-type: none"> • Evaluation Committee • Council Staff • Ad Hoc Committees (formed with outside experts) 	<ul style="list-style-type: none"> • Tools for identifying substance abuse treatment readiness presented to public through Council website.

Appendix A

Portland Area HIV Services Planning Council Vision, Mission, Values



Portland Area HIV Services Planning Council

VISION:

All persons living with HIV/AIDS in the Portland Area Eligible Metropolitan Area have a right to quality care. (approved May 5, 2005)

MISSION:

Through community partnerships we create opportunities and advocate for access and continuity of a full range of quality care for all persons affected by HIV. (approved May 5, 2005)

VALUES:

- We value a culture that supports the independence and dignity of all persons living with HIV/AIDS.
- We value and support individual involvement and choice in all areas of service.
- We value creative approaches, and coordination and collaboration among individuals, agencies, and communities.
- We value the wide range of diversity among us and services that are specific and relevant.
- We value a priorities and allocation process in which decisions are made based on documented need.
- We value a care system that actively seeks the input of those out-of-care as a means to broaden access to services.
- We value a system that integrates prevention strategies into the continuum of care.
(approved July 6, 2005)

GOALS FOR 2005-2010:

- 1) To assure access to a linked system of health care built on a foundation that includes support services and peer participation that promotes and maintains quality care.
- 2) To assure adequate resources that maximize the capacity of the HIV Health Care system.
- 3) To claim the Council's leadership role, authority, and influence in assuring an HIV Health Care system that is inclusive, collaborative, and has adequate resources.
- 4) To develop and lead a broad and inclusive network of public and private organizations that ensures a responsive, flexible system of care and prevention with and for PLWH.
(approved July 6, 2005)