

# 2010 STD/HIV/Hepatitis C Program Annual Report

Multnomah County Health Department

November 2011



## **Acknowledgements**

Special thanks to the partners who contribute to our efforts to reduce the impact of STDs, HIV, and Hepatitis C and support the health and quality of life of our clients and communities:

- Our staff of community health workers, health educators, clinicians, disease intervention specialists, administrative support, managers, research analysts, and social workers;
- Our community members living with HIV/AIDS, Hepatitis C or STDs who take care of themselves and others, and their partners, friends, and families who give them support;
- Our multiple collaborative partners: non-profit organizations, health care systems and clinics, local and state public health departments, community coalitions and advisory boards.

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## How to Read and Use this Report

### What is the purpose of this report?

This report provides an overview of the STD and HIV/AIDS epidemics in Multnomah County and the Portland metropolitan area and services provided by the Multnomah County Health Department (MCHD) STD/HIV/Hepatitis C (HCV) Program and when applicable, collaborative partners. Data from multiple sources are utilized to create a broader understanding of the types and outcomes of HIV and STD services delivered in the Portland metropolitan area. This report provides the means through which the program can: identify commonalities in program indicators, goals and initiatives; use a singular tool for program planning and development; and identify what is needed to bridge gaps in data collection and evaluation. We intend for this report to inform communities, provide better access to information and establish accountability and transparency with our partners.

### How is this report organized?

The report begins in Section 1 with an overview of the STD/HIV/Hepatitis C epidemics in Multnomah County, and the HIV/AIDS epidemic in the Portland Transitional Grant Area (TGA) - a six-county area covered by Ryan White Part A federal grant funds including Multnomah, Clackamas, Columbia, Washington, Yamhill Counties in Oregon and Clark County, WA. Sections 2-6 describe the services we offer, the clients we serve, and utilization in 2010. Each section also focuses on the outcomes and performance measures for services delivered in 2010. Section 7 provides information on internal and external collaborations, including community partnerships.

### What time period is reported?

Data are presented from the most recent time period available. For the Multnomah County STD/HIV/HCV epidemics, we report data through December 31, 2010. Data related to the HIV epidemic in the Portland metropolitan Transitional Grant Area (TGA) are through December 31, 2009. Client, service utilization, and outcomes data are reported for calendar year 2010.

### What kinds of data are used?

The epidemiologic overview provides case rates (number of reported infections per 100,000 residents for a specified period of time) for STD/HIV/HCV. To help stabilize rates and observe time trends when there are a small number of events, rates are aggregated into rolling averages, using three-year or five-year intervals. By creating rolling rates, trends can be more easily identified. HIV prevalence data is presented as percentages to allow for comparisons across demographic groups. Service utilization data are presented in numbers and percentages.

## Introduction

In the United States, public health professionals have identified 10 “Essential Services of Public Health”. These define the core of the STD/HIV/Hepatitis C program’s efforts. This program has some part in providing these services to help achieve the Multnomah County Health Department (MCHD) vision of Healthy People in Healthy Communities.

The essential services are:

1. **Monitor** health status to identify community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate, and empower** people about health issues.
4. **Mobilize** community partnerships to identify and solve health problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. **Assure** a competent public health and personal healthcare workforce.
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.

Our role in these essential services is reflected in our mission: “To prevent the transmission of sexually transmitted diseases (STDs), HIV, and Hepatitis C (HCV) and reduce the impact of disease acquisition and drug-related harm on individuals and communities by: *promoting policies that positively impact physical and sexual health; implementing effective, population-based public health interventions; prioritizing populations that experience the greatest disparities; and engaging in collaborative community partnerships and planning*”.

The STD/HIV/HCV program employs a variety of individual, group, and community-level strategies targeted to those persons at highest risk for acquiring and/or transmitting STDs, HIV and viral hepatitis. HIV, STDs and HCV account for almost 80 percent of all reportable diseases in Multnomah County. Each year, through our program and in collaboration with community partnerships:

- ✓ 5,000 clients get screened and/or treated for sexually transmitted infections;
- ✓ 9,000 HIV tests are performed in the community;
- ✓ Over one million used syringes are taken off city streets;
- ✓ 2,500 people living with HIV/AIDS get medically necessary HIV care services; and
- ✓ Epidemiological information is collected and analyzed on over 4,000 cases of chlamydia, gonorrhea, syphilis, and HIV that occur among our county residents.

The STD/HIV/HCV program prevents and treats diseases that jeopardize the health and independence of all county residents. Multnomah County HIV and syphilis infection rates are the lowest among large West Coast cities, due in part to these program efforts. Preventing these communicable diseases not only creates healthier communities, it is a cost-effective effort. Each prevented Hepatitis C case saves about \$100,000<sup>1</sup>, while each prevented HIV case saves about \$385,000 over a lifetime<sup>2</sup>.

Delayed STD and HIV treatment increases disease transmission and costly chronic medical conditions such as AIDS, liver disease and infertility. Untreated STDs can cause poor maternal and child health, including infected babies, miscarriages, and tubal pregnancy. In particular, untreated HIV can lead to poor health, the inability to work or maintain stable housing, and poverty. This program's emphasis on community prevention, outreach, early diagnosis and treatment reduces disease transmission and the likelihood of devastating long-term outcomes.

However, several challenges still remain. These diseases continue to disproportionately affect racial, ethnic and sexual minority communities. Rates of gonorrhea, HIV and chlamydia are disproportionately high in the Black/African American community. The majority of new syphilis and HIV cases were among gay, bisexual, and other men who have sex with men (MSM). This program continues to address health inequities in our community and provides all populations with needed services, ensuring early access to care, preventing disease spread and reducing costs.

Although the services provided by the STD/HIV/HCV program are varied and complex, they are bound by a set of core values: science, community, and social justice. It is our goal to provide high-quality services that make an impact on the STD, HIV, and HCV epidemics and the communities we serve. We hope the following document will be valuable for local agencies, community groups, and providers in the planning of services and activities. Please feel free to use this report for grant writing and program planning. It is our belief that the sharing of information serves to strengthen our relationships and, ultimately, helps to provide services more effectively to our clients and communities.



**Kim Toevs, MPH**  
**MCHD STD/HIV/HCV Program Manager**

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<sup>1</sup> The C. Everett Coop Institute, Associated Health Care Costs – United States, Dartmouth College, 2010 available at <http://www.epidemic.org/theFacts/theEpidemic/USHealthCareCosts>.

<sup>2</sup> Schackman, B. et al., The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States, *Medical Care*, 44:11, Nov. 2006.

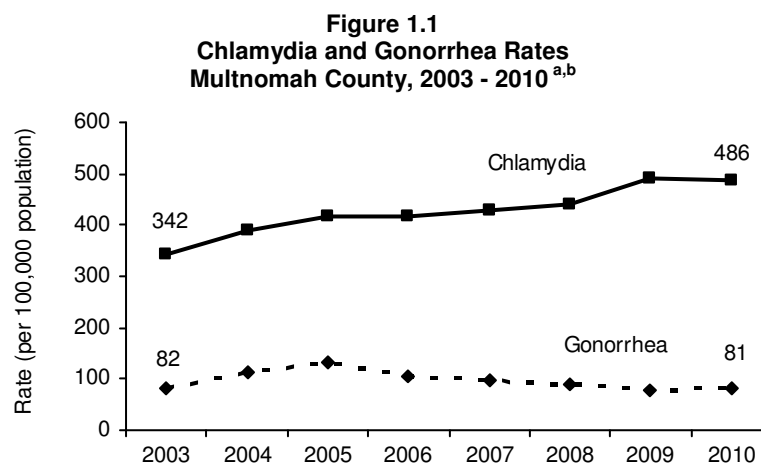
# 1

## Rates of STDs, HIV, and Hepatitis C

The following section provides an epidemiological overview of chlamydia, gonorrhea, syphilis, Hepatitis C, and HIV infections in Multnomah County, as well as a description of the HIV epidemic and HIV co-morbidities in the Portland metropolitan area. All Oregon physicians, other health care providers, and laboratories are required by law to report certain diseases and conditions, such as HIV, chlamydia, gonorrhea, and syphilis, to local health departments. All Oregon local health departments are required to investigate cases of notifiable diseases and pathogens. The Multnomah County Disease Investigation System data were used in the following sections.

### A. Chlamydia and Gonorrhea

Chlamydia is the most frequently reported sexually transmitted disease in Multnomah County (Figure 1.1). In 2010 the rate of chlamydia was 486 per 100,000 residents. Individuals who have unprotected sex, multiple sex partners, and sexual intercourse with an infected person are at high-risk for chlamydia infection. The Oregon Department of Human Services reports that three-fourths of infected women and half of infected men have no symptoms to alert them to seek early care. Rates presented here are likely underestimates of the actual rate of chlamydia infection because most people with chlamydia are unaware of their infections. National data show chlamydia incidence to be stable or decreasing.<sup>3</sup> Gonorrhea rates have declined slightly since 2005. The rate of gonorrhea was 81 per 100,000 residents in 2010.

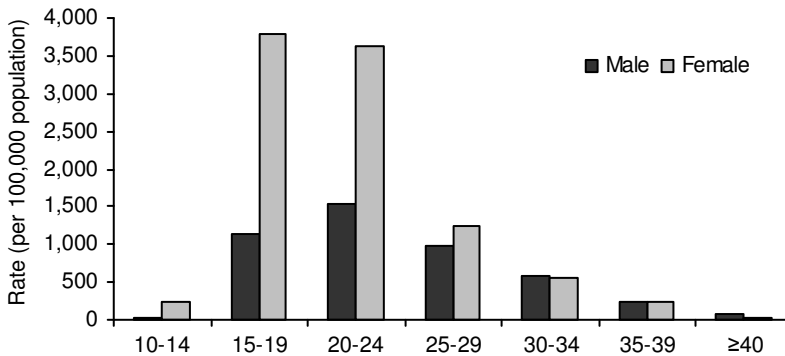


<sup>a</sup>Multnomah County analysis of DIS surveillance data 2003-2010, reported numbers may not match official DHS numbers; <sup>b</sup>Population estimates from the PSU Population Research Center.

Reflecting national rates, Multnomah County females ages 15-24 years had the highest rate of chlamydia in 2008 (Figure 1.2). Higher rates among females may be due to more screening among females than males.

<sup>3</sup> Satterwhite et al. Chlamydia Prevalence Among Women and Men Entering the National Job Training Program: United States, 2003-2007. *Sex Transm Dis* 2010;37(2):63-37

**Figure 1.2**  
**Chlamydia Rates by Age and Gender**  
**Multnomah County, 2010<sup>a,b</sup>**



<sup>a</sup>Multnomah County analysis of DIS surveillance data 2003-2010, reported numbers may not match official DHS numbers; <sup>b</sup>Population estimates from the PSU Population Research Center, 2010 calculated using the same population numbers as 2009.

Reported gonorrhea rates were highest among males ages 20-24, followed by females ages 15-19 (Figure 1.3). Gonorrhea rates were higher for males than females in every age category with the exception of youth under age 19.

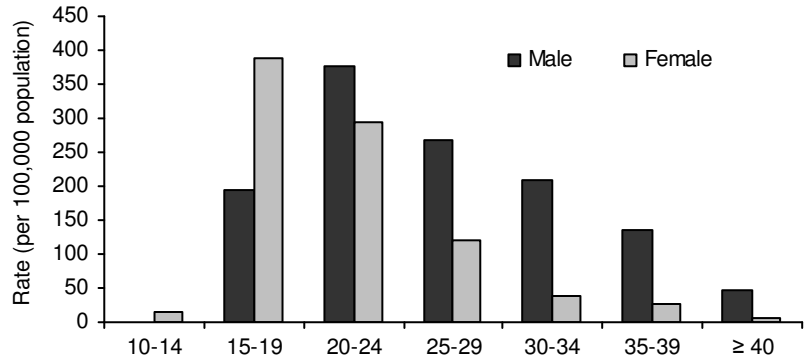
Gonorrhea and chlamydia rates in Multnomah County and nationally have been consistently higher among Blacks/African Americans than other racial and ethnic

groups (Figure 1.4). In 2010, the gonorrhea rate among Black/African American was six times higher than the White non-Hispanic rate. Due to increasing chlamydia case numbers and decreasing funding, the quality of case information for chlamydia is not high enough to accurately calculate subgroup disparities for 2010. Currently, local and state public health departments are developing different data collection approaches to regain adequate accuracy with limited staff time.

MCHD is addressing the disparities in gonorrhea and chlamydia in Blacks/African Americans through the STD/HIV/HCV Program's African American Sexual Health Program, or

AASHEP. AASHEP's primary goal is to eliminate African American/African immigrant sexual health disparities. One way AASHEP accomplishes this is through community outreach and education to increase STD/HIV awareness, access to care, and changes to systems and structures which contribute to health disparities in and among local Black/African-American communities. AASHEP projects include: the knowsexpdx campaign; a faith-based initiative, including the Balm In Gilead community breakfast; participating in various community events, such as screening House Parties (developed on the DEBI-based Sista-to-Sista intervention, SiHLE (Sistering, Informing, Healing, Living, and Empowering), a multi-session, small group, culturally-based skills training intervention to reduce risky sex behavior among African-American/African immigrant

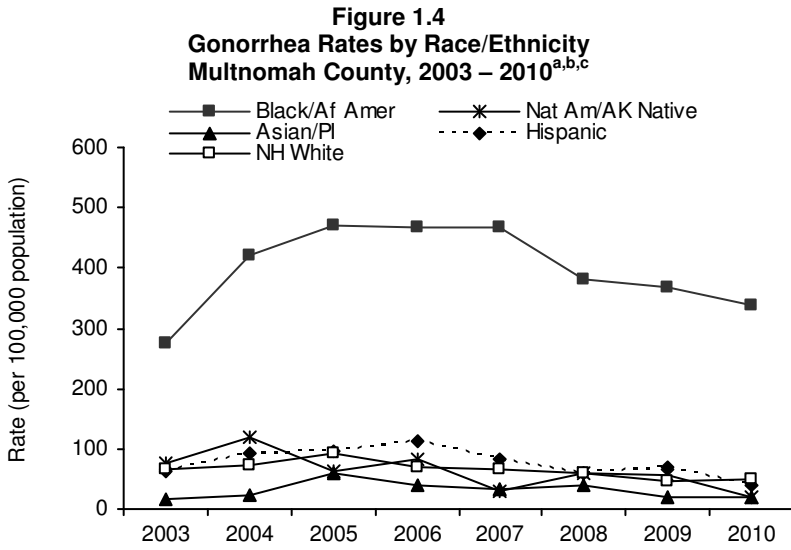
**Figure 1.3**  
**Gonorrhea Rates by Age and Gender**  
**Multnomah County, 2010<sup>a,b</sup>**



<sup>a</sup>Multnomah County analysis of DIS surveillance data 2003-2010, reported numbers may not match official DHS numbers; <sup>b</sup>Population estimates from the PSU Population Research Center, 2010 calculated using the same population numbers as 2009.

adolescent females; & MARS (Male Advocates for Responsible Sexuality), an evidenced-based curriculum teaching sexual responsibility to young African American/African immigrant males in Multnomah County. AASHEP continues to participate in collaborative partnerships with community organizations and coalitions such as the African American AIDS Awareness Action Alliance (A6) to plan community-

wide STD/HIV awareness activities; Healthy Birth Initiatives (HBI) by providing education & support to the clients they serve & Human Solutions, where clients receive STD/HIV/sexual health education. In 2010, (July 1-December 31, 2010) AASHEP staff participated in 58 events, making 1,820 contacts.



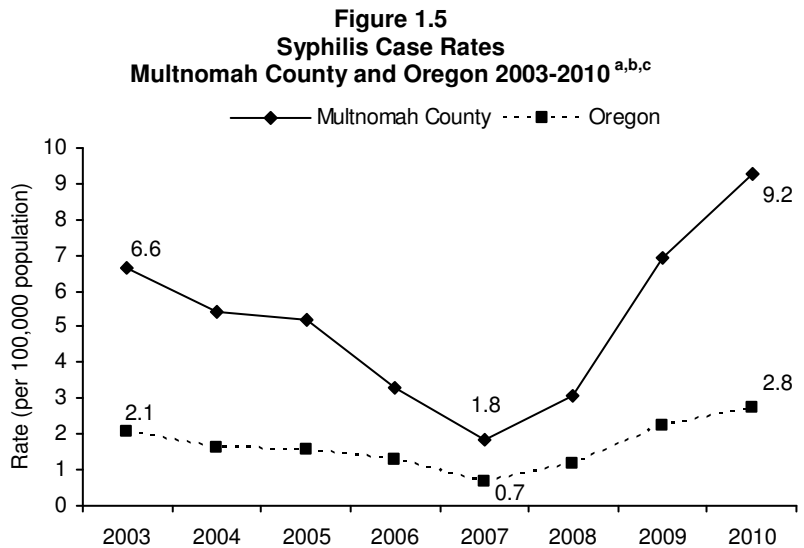
<sup>a</sup>Multnomah County analysis of DIS surveillance data 2003-2010, reported numbers may not match official DHS numbers; <sup>b</sup>Population numbers calculated using the National Center for Health Statistics Bridged Estimates, 2010 calculated using the same population numbers as 2009; <sup>c</sup>NH White = Non-Hispanic White.

**B. Syphilis**

In the United States, syphilis infections are increasing – particularly among gay, bisexual and other MSM. Syphilis is easy to cure in its early stages but may be difficult to diagnose. Left untreated, syphilis can lead to serious, long-term health effects, such as dementia, blindness, and even death.

Following a syphilis outbreak affecting West Coast cities, rates dropped steadily between 2003 and 2007 (Figure 1.5). In mid-2008, Multnomah County STD/HIV/HCV Program

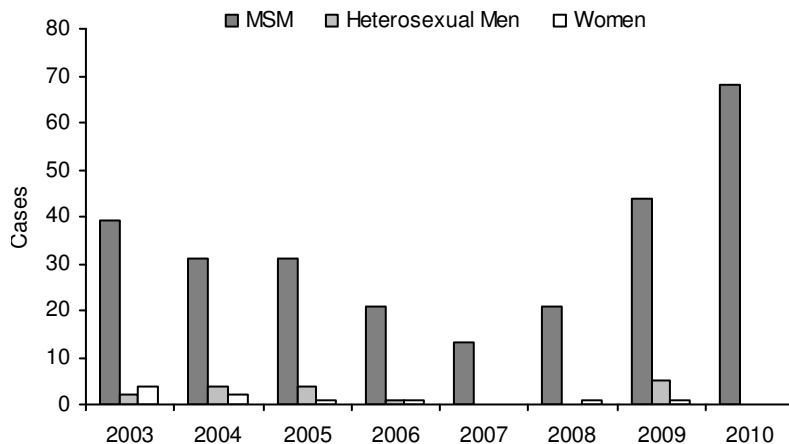
identified another syphilis outbreak, primarily affecting gay, bisexual, and other MSM, especially those living with HIV. As a result of this outbreak, rates rose from 1.8 cases per 100,000 residents in 2007 to 9.2 cases per 100,000 residents in 2010.



<sup>a</sup>Multnomah County analysis of DIS surveillance data 2003-2010, reported numbers may not match official DHS numbers; <sup>b</sup>Population estimates from the PSU Population Research Center; <sup>c</sup>Early syphilis includes Primary, Secondary, and Early Latent diagnoses.

Syphilis infections in Multnomah County between 2003 and 2010 have been reported among men significantly more than women, with the majority of these cases occurring among gay, bisexual, and other MSM (Figure 1.6). In 2010, almost 90% of syphilis cases were among MSM, of whom more than 50% were co-infected with HIV. This is significant because syphilis increases the likelihood of sexual transmission of HIV.

**Figure 1.6**  
**Syphilis Cases by Sex and Sexual Orientation**  
**Multnomah County, 2003-2010<sup>a,b,c</sup>**



<sup>a</sup>Multnomah county analysis of DIS surveillance data 2003-2010, reported numbers may not match official DHS numbers; <sup>b</sup>Men Who Have Sex with Men (MSM) is defined here as any male who self identifies as having sex with men; MSM are self identified through the interview process and may not accurately reflect true MSM morbidity; <sup>c</sup>Early syphilis includes Primary, Secondary, and Early Latent diagnoses.

Multnomah County's STD/HIV/HCV Program is responding to the current outbreak and preventing new cases by increasing awareness about syphilis among community members and healthcare providers, specifically those involved in HIV care. To coordinate and lead these efforts, the Syphilis Elimination Workgroup was formed. The goal of the Syphilis Elimination Workgroup is to prevent new cases of syphilis by increasing awareness about the disease among health care providers and community

members. The group meets regularly to monitor the latest case data reports, tailor messaging to providers and issue briefs for the community, and create educational materials including flyers, posters, ads, and testing coupons.

### **C. Hepatitis C**

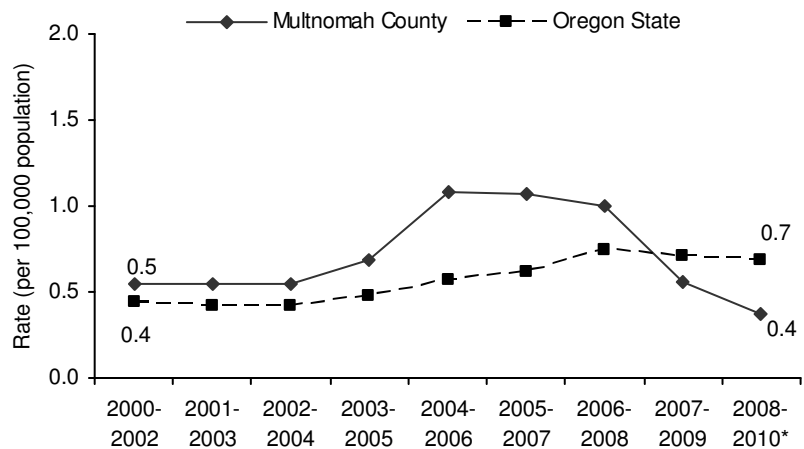
The Centers for Disease Control and Prevention estimates that Hepatitis C (HCV) is the most common blood borne infection in the United States and that most cases of HCV remain undetected. There is no vaccine for HCV. Since people with acute HCV frequently do not exhibit symptoms, cases go undetected unless chronic liver disease is present or the infection is detected through blood screening for other purposes. The highest infection rates are found among injection drug users and people with hemophilia who received transfusions or clotting factor concentrates prior to 1987. Routine testing for HCV is recommended for injection drug users, people living with HIV, people with a blood transfusion or organ transplant prior to 1992, people who received clotting factors made before 1987, children born to HCV positive women, and health care workers and emergency medical staff *after* exposure to HCV positive blood.

Chronic HCV became a reportable disease in Oregon in July of 2005. Multnomah County has had voluntary laboratory reporting since 2001. The MCHD Communicable Disease Program maintains a registry of these reports. The registry has identified over

10,000 individuals in Multnomah County who have tested positive for the HCV virus. About 20% of people with chronic infection have continuing liver inflammation which can cause disabling symptoms including cirrhosis of the liver. A significant percent of people with cirrhosis develop liver failure or liver cancer. Illness, deaths, and health care costs due to HCV disease are expected to increase over the next 20 years.

The number of new acute cases has steadily decreased since 2008 (Figure 1.7). The rate of new acute HCV was less than 1 per 100,000 in Multnomah County and in Oregon in the period 2008-2010.

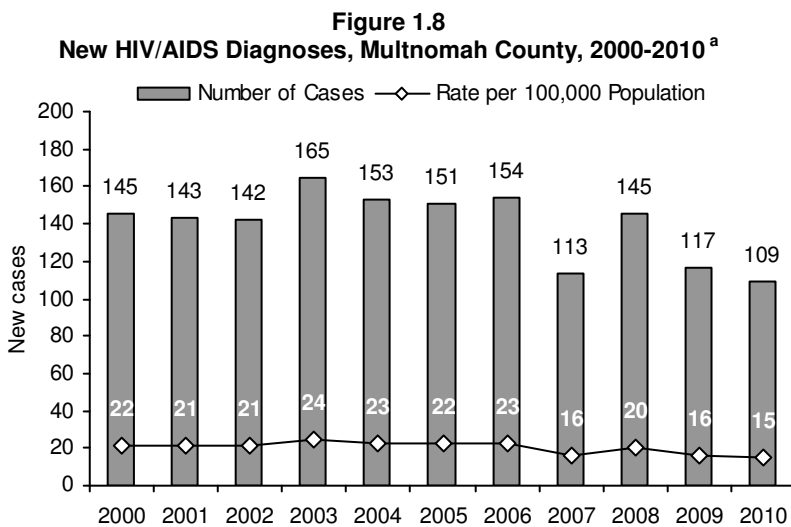
**Figure 1.7**  
**Acute Hepatitis C Rates,**  
**Multnomah County and Oregon, 2000-2010<sup>a</sup>**



<sup>a</sup>Source: Oregon Dept. of Human Services, Acute and Communicable Disease.

**D. HIV/AIDS – Incidence in Multnomah County**

HIV transmission occurs via sexual contact with someone infected, sharing needles or syringes contaminated with HIV and being exposed to the virus before or during birth or



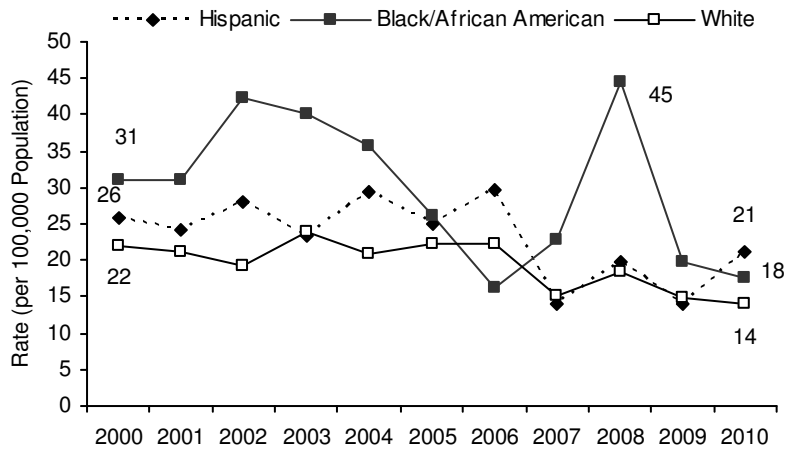
<sup>a</sup>Source: Oregon Dept. of Human Services, HIV/STD/TB Program.

through breastfeeding. The main risk behaviors associated with HIV infection are having unprotected sex with a person of positive or unknown HIV status and sharing needles or syringes. Latex condoms used consistently and correctly are highly effective in preventing the transmission of HIV. Using brand-new syringes and other injection-related materials (or not injecting) are important strategies in preventing

HIV/AIDS.

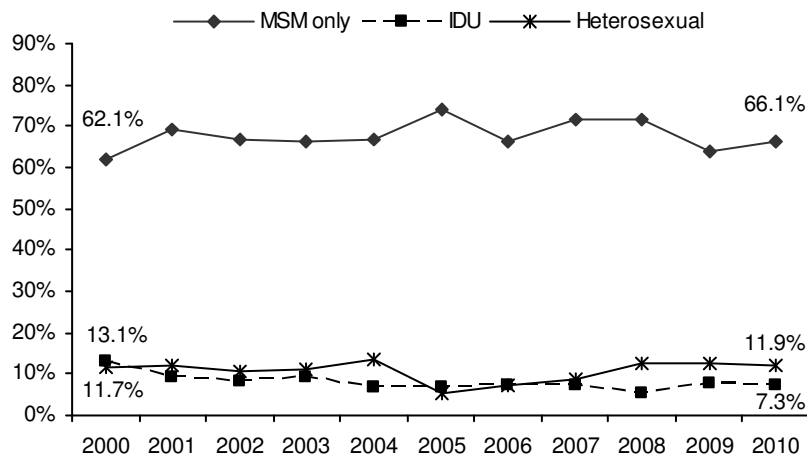
The rate of new HIV/AIDS diagnoses has remained relatively steady in Multnomah County. There were 109 HIV/AIDS diagnoses during 2010 (Figure 1.8). New HIV/AIDS diagnoses rates were higher among Blacks/African Americans in the early 2000s and declined in 2005 and 2006 (Figure 1.9). The rate increased in 2007 and 2008 but has subsequently declined. Rates can fluctuate due to the small number of cases diagnosed each year among this population. Gay, bisexual, and other MSM comprise the greatest percent of new HIV/AIDS diagnoses (Figure 1.10) and continues to be the community most affected by HIV/AIDS in Multnomah County.

**Figure 1.9**  
**New HIV/AIDS Diagnoses by Race/Ethnicity**  
**Multnomah County, 2000-2010<sup>a</sup>**



<sup>a</sup>Source: Oregon Dept. of Human Services, HIV/STD/TB Program.

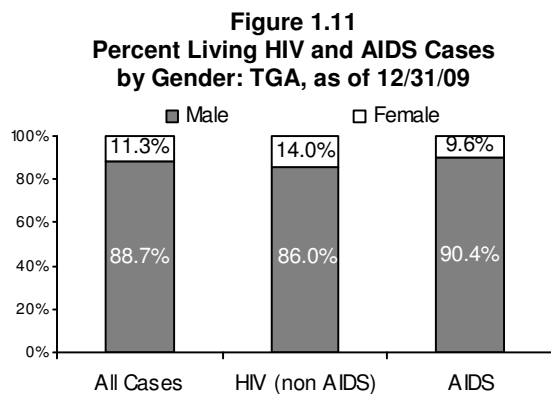
**Figure 1.10**  
**Percent of New HIV/AIDS Diagnoses by Risk Factor**  
**Multnomah County, 2000-2010<sup>a</sup>**



<sup>a</sup>Source: Oregon Dept. of Human Services, HIV/STD/TB Program.

**E. HIV/AIDS – Prevalence in the Portland Metropolitan Area**

Prevalence represents the number of cases of a disease in a given population at a point in time. The Ryan White Part A federal grant funds are grant monies given to Transitional Grant Areas (TGAs) to provide services for low-income persons living with HIV/AIDS (PLWH/A). The Portland TGA serves PLWH/A from 6 counties comprising the Portland metropolitan area - Clackamas, Columbia, Multnomah, Washington, Yamhill, and Clark County in Washington state. As such, each year we examine HIV prevalence in the 6-county area.



The highest concentration of HIV/AIDS cases in Oregon is in the Portland metropolitan area, with the majority of cases located in Multnomah County. At the end of 2009, approximately 4,000 people were estimated to be living with HIV/AIDS in the TGA (n=4,074).

Of the 4,074 prevalent cases of HIV/AIDS in the TGA, an estimated 2,536 persons have had an AIDS diagnosis and 1,538 persons are living with HIV (non-AIDS). cases and 258 new HIV (non-AIDS) cases

Two hundred and ninety eight new AIDS were reported during the past two years (January 1, 2008 through December 31, 2009). Although HIV mostly affects men, 14.3% of HIV cases and 13.4% of AIDS cases diagnosed from Jan 2008 – Dec 2009 occurred in women. As of December 31, 2009, women accounted for 14% of all persons in the TGA living with HIV (non-AIDS) and 9.6% of all persons living with AIDS (Figure 1.11).

**Figure 1.12**  
**HIV/AIDS Cases, by Race/Ethnicity TGA, as of 12/31/09**

Race/Ethnicity	Percent
White, not Hispanic	78.5%
Hispanic/Latino	9.7%
Black/African American	8.1%
Asian	1.8%
American Indian/Alaskan Native	0.9%
Multiracial	0.6%
Native Hawaiian/Pacific Islander	0.3%
Unknown race/ethnicity	0.1%

Figure 1.12 shows the distribution of HIV/AIDS cases by race/ethnicity in the six-county area. HIV/AIDS has had a

**Figure 1.13**  
**HIV/AIDS Cases, by Risk Category and Gender TGA, as of 12/31/09**

Risk category	Male	Female
MSM	75.2%	-
MSM/IDU	8.9%	-
IDU	6.8%	21.6%
Heterosexual	2.9%	62.9%
Other <sup>a</sup>	6.1%	15.5%

<sup>a</sup>Includes cases with unknown risk, and transmission from mother to child or via blood transfusion.

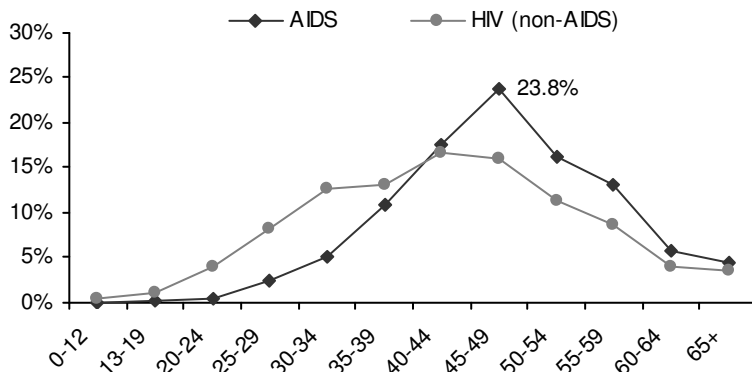
disproportionately high impact on Blacks/African Americans in the TGA. Blacks/African Americans account for only 2.8% of the population of the TGA but make up 8.1% of PLWH/A – almost three times higher. The prevalence rate among other racial/ethnic groups is fairly proportionate to the TGA population. The impact of HIV/AIDS is even more pronounced among female PLWH/A of

color. Approximately 39% of all women living with HIV/AIDS in the TGA are racial/ethnic minorities.

Gay, bisexual, and other MSM comprise the greatest percentage of PLWH/A in the Portland metro area, and continues to be the community most affected. This specific population accounted for 71.5% of all living adult HIV/AIDS cases with a known risk factor, followed by those with heterosexual risk (10.2%), intravenous drug use risk (IDU; 9.1%), and MSM/IDU (8.5%). Reported risk varies substantially by gender (Figure 1.13). Heterosexual contact was the predominant risk category for adult females with a known risk factor (73.9%).

The TGA's PLWH/A population is aging. At the end of 2009, persons aged 50 and older accounted for 35.1% of all PLWH/A in the TGA, and an additional 20.9% of PLWH/A are aged 45-49 (Figure 1.14). Older PLWH/A represent a greater proportion of AIDS cases; 63.3% of AIDS cases are among individuals 45 years of age or older, compared to 43.8% of HIV cases. Persons aged 25-44 account for 36.0% of all PLWA, 50.5% of PLWH, and 56.0% of new AIDS cases.

**Figure 1.14**  
Percent of HIV and AIDS Cases, by Age  
TGA, as of 12/31/09

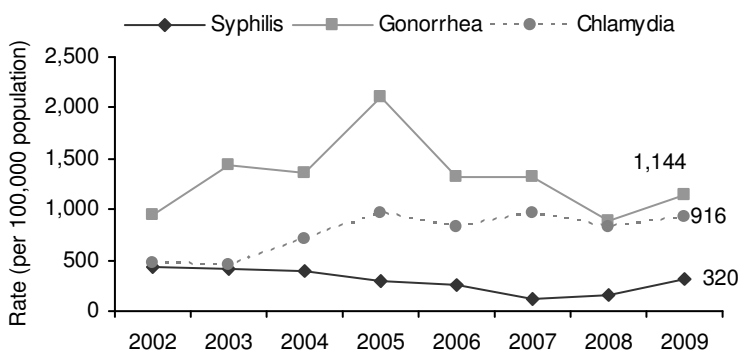


Approximately 69% of all PLWH/A in the TGA live in Multnomah County, followed by Washington County (11.9%), Clark County (10.4%), Clackamas County (7.2%), Yamhill County (1.1%), and Columbia County (0.7%).

**F. HIV/AIDS Co-morbidities**

Figure 1.15 depicts the rates of syphilis, gonorrhea, and chlamydia cases among male PLWH/A in Oregon from 2002 through 2009. After peaking in 2005 at 2,100 per 100,000, the rate of gonorrhea among HIV positive males decreased to 1,144 per 100,000 in 2009. In contrast, the rate of chlamydia has decreased slightly over the same time period, from 971 per 100,000 in 2005 down to 915 per 100,000 in 2009 among male PLWH/A.

**Figure 1.15**  
Rate of Sexually Transmitted Diseases  
Among Males with HIV/AIDS  
Oregon 2002-2009



As shown in Figure 1.5, the syphilis infection rate in

Multnomah County increased from 6.9 per 100,000 in 2009 to 9.2 per 100,000 in 2010.

While these increasing and decreasing trends in co-morbidity incidence mirror those in the general population, overall the rates are much higher among PLWH/A. Table 1.1 illustrates this disparity in co-infection between the general population and PLWH/A in the Portland TGA (Multnomah, Columbia, Clackamas, Yamhill, Washington, and Clark Counties), with respect to incidence of syphilis, gonorrhea, and tuberculosis.

Quantitative data from multiple sources have been used to describe co-morbid conditions. 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 2009 Census Estimates, 2009 Portland State University Population Estimates, and 2009 Washington State Office of Financial Management.

**Table 1.1 Incidence of Syphilis, Gonorrhea, and TB in Portland TGA and Co-Morbidity among PLWH/A, 2009**

<b>Co-morbidity (among persons aged 13+)</b>	<b>General Population Incidence: # new cases/100,000 persons</b>	<b>PLWH/A Population Incidence: # new cases/100,000 persons</b>
Syphilis <sup>a</sup> <b>Number of cases:</b> <b>2009 rate:</b>	70 cases 4.8/100,000	14 cases 320.4/100,000 PLWH/A
Gonorrhea <sup>a</sup> <b>Number of cases:</b> <b>2009 rate:</b>	822 cases 45.2/100,000	44 cases 1,211.1/100,000 PLWH/A
Tuberculosis <sup>a,b</sup> <b>Number of cases:</b> <b>2009 rate:</b>	72 cases 3.3/100,000	2002-2009 average case rate: 120.0/100,000 PLWHA

<sup>a</sup> Oregon Health Division, 2009. <sup>b</sup> Clark County Health Department, 2009.

When compared to the general population in the TGA, rates of syphilis and gonorrhea are 67 and 27 times higher, respectively, among PLWH/A. This population is also disproportionately impacted by additional co-morbidities including tuberculosis, HCV, and mental health/substance abuse diagnoses when compared to the general population.

## 2

## Clinic-Based STD Screening and Treatment

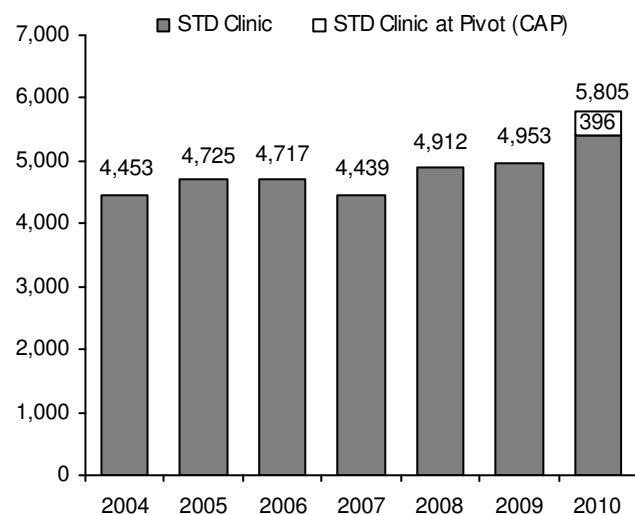
STD clinic staff provide high quality, accessible medical services as an essential element in the prevention of STDs. Staff evaluate and treat infected patients and partners, provide confidential HIV testing, risk reduction counseling, and Hepatitis A and B vaccinations to individuals regardless of ability to pay. When indicated, evaluation and treatment of vaginitis, genital herpes, and other non-reportable STDs is provided, as well as HPV vaccination and HCV counseling and testing. Test results are available in-person and/or by phone in most cases. The clinic is a regional training site for those seeking to improve STD evaluation/treatment skills.

The screening, identification, and treatment of STDs are critical to preventing and treating STD infections. The Centers for Disease Control and Prevention (CDC) STD treatment guidelines state that “the prevention and control of STDs are based on the following five major strategies: 1) education and counseling of persons at risk on ways to avoid STDs through changes in sexual behaviors; 2) identification of asymptotically infected persons and of symptomatic persons unlikely to seek diagnostic and treatment services; 3) effective diagnosis and treatment of infected persons; 4) evaluation, treatment, and counseling of sex partners of persons who are infected with an STD; and 5) pre-exposure vaccination of persons at risk for any vaccine-preventable STD”.<sup>4</sup> The STD clinic uses these treatment guidelines as a resource for clinical care while also considering the context of the local epidemic and the individual.

### A. STD Screening: Clients

In 2010, a total of 5,805 clients received services at the STD Clinic, including STD screening and treatment offered by the program at Pivot starting in July 2010. Pivot is a part of Cascade AIDS Project (CAP), and is a space dedicated to the physical, personal, and social health of gay/bi/trans men. The mission of Pivot is to create a space where community members come together and build a stronger, healthier community free of stigma and shame. Services include testing for chlamydia, gonorrhea, syphilis, HIV, and a physical exam and treatment, when indicated. This service has increased collaboration with CAP and provided an opportunity for the program to provide culturally specific care in a

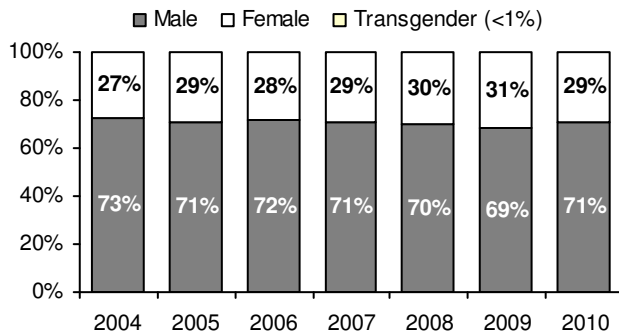
**Figure 2.1**  
Number of STD Clinic Clients, 2004-2010



<sup>4</sup> CDC. Sexually Transmitted Diseases Treatment Guidelines. August 2006. Available at <http://www.cdc.gov/std/treatment/2006/rr5511.pdf>.

community space. For more information about Pivot, see their website at [www.pivotpdx.org](http://www.pivotpdx.org). Outside In (OI) had previously partnered with CAP to provide clinical STD services at this site. Figure 2.1 shows that 396 clients received services at Pivot and 5,409 clients received services at the STD Clinic.

**Figure 2.2**  
**STD Clients by Gender, 2004-2010**



Seven out of ten clients seen at the STD Clinic in 2010 were male (71%). Women have had more access to low cost STD services that are integrated into family planning programs throughout Multnomah County, possibly explaining why a lower percentage of STD clients were female (Figure 2.2).

Hispanic (13.6%), (Figure 2.3). The percentage of clients by race/ethnicity has remained stable. The percentage of Black/African American and Hispanic clients seen at the STD clinic exceeds their proportion in the general Multnomah County population (Black/African American 5.4%, Hispanic 10.9%, Census 2010).

**Figure 2.3**  
**STD Clients by Race/Ethnicity, 2010**

Race/Ethnicity	Percent
White, not Hispanic	63.7%
Hispanic/Latino	13.6%
Black/African American	17.7%
Asian/Native Hawaiian/Pacific Islander	3.8%
American Indian/Alaskan Native	1.2%

In 2010, about two out of five STD clinic clients were 25 – 35 years of age (40.9%; Figure 2.4). Youths 15 – 24 years of age comprised the second largest proportion of clients seen at the STD clinic (29.3%). Similar to race/ethnicity, the percentage of STD clients by age has remained stable.

**Figure 2.4**  
**STD Clients by Age, 2010**

Age	Percent
0 - 14	0.0%
15 - 19	6.7%
20 - 24	22.6%
25 - 35	40.9%
36 - 45	16.7%
45+	13.1%

Individuals testing for STDs are asked to report the gender of their sexual partners to better identify sexual risk around STD transmission and to identify disparities in specific communities. The majority of female clients seen at the STD clinic in 2010 identified having male sex partners (91%). Among male clients seen at the STD clinic, one in four clients (27%) identified having male sex partners (MSM), while 67% identified as having only female sex partners. Similar to other demographics, these percentages

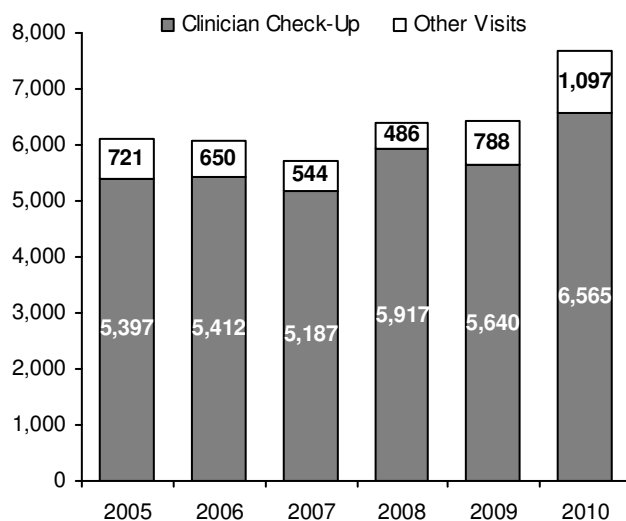
have remained stable over the last six years.

**B. STD Screening: Services**

The STD clinic provides services through five basic types of visits: a full check-up, “Just Checking,” vaccine-only, results-only and treatment-only visits. In a full check-up, a clinician performs a physical exam and any relevant STD screening tests. People with symptoms of infection, or who have a known exposure, receive treatment. In 2009, the

STD clinic began providing “Just Checking” visits. These visits are provided by trained counselors for clients who do not have any STD symptoms and do not require a physical exam, but would like to be tested for gonorrhea, chlamydia, syphilis or HIV. A “vaccine-only” visit includes HPV vaccines for uninsured women and men 18 and under, and Hepatitis A & B vaccines to people who meet specific risk criteria. Vaccine-only visits were discontinued in April, 2011. A “results-only” visit occurs when clients come in only to receive their test results. A “treatment-only” visit is a visit provided by a Disease Intervention Specialist (DIS) with support from a Mid-Level Provider, to treat a client diagnosed with chlamydia or gonorrhea or to treat a client that has been exposed to either but had not yet received treatment.

**Figure 2.5**  
Number of STD Visits by Visit Type, 2005-2010



In 2010, 5,805 individuals had 7,662 visits at the STD clinic. The STD clinic has averaged over 6,000 visits each year over the last three years (Figure 2.5). Over the past five years, full clinician check-ups accounted for the majority of visits, including 86% of all visits in 2010.

In April 2010, the STD clinic began participating in a national NIH-funded study called Project Aware. The project tested the effectiveness of client-centered prevention counseling provided with HIV rapid testing (same day results) by measuring the incidence of STDs and self-reported sexual risk

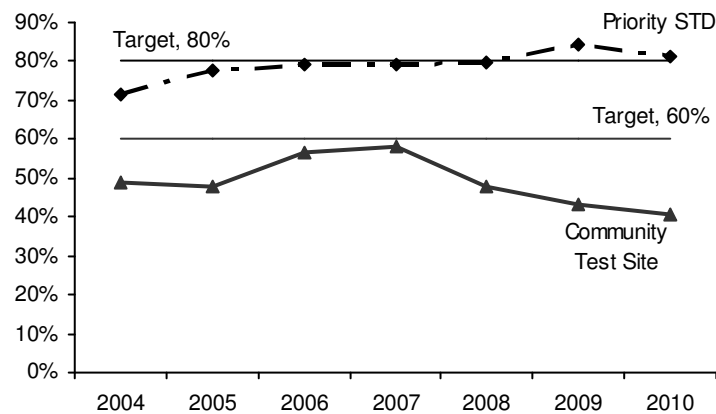
behaviors after 6 months. The study evaluation will also examine the cost-effectiveness of this intervention. Local partners included Oregon Health and Science University (OHSU) and the Council of Drug Abuse (CODA). Additional study sites included STD clinics in Miami, Jacksonville FL, Columbia SC, Washington, DC, Pittsburgh, Seattle, San Francisco, and Los Angeles. The study was completed in May 2011 and results are expected in 2012.

### **C. STD Screening: Performance and Outcomes**

Access to high quality medical services is an essential element in the prevention and treatment of STDs. There are two measures that examine the STD Clinic performance: slot utilization as a measure of clinic efficiency and client satisfaction with the services provided.

The percentage of priority visit slots utilized reached the target goal in 2008 and continued to meet the goal in 2009 and 2010 (Figure 2.6). The percentage of community HIV test site slots utilized has been decreasing since 2007 (57.9%; 2010: 40.6%), and is below the program target goal of 60%.

**Figure 2.6**  
**Percent of Visit Slot Utilization**  
**Priority STD Clinic Visits and Community Test Site, 2004-2010**

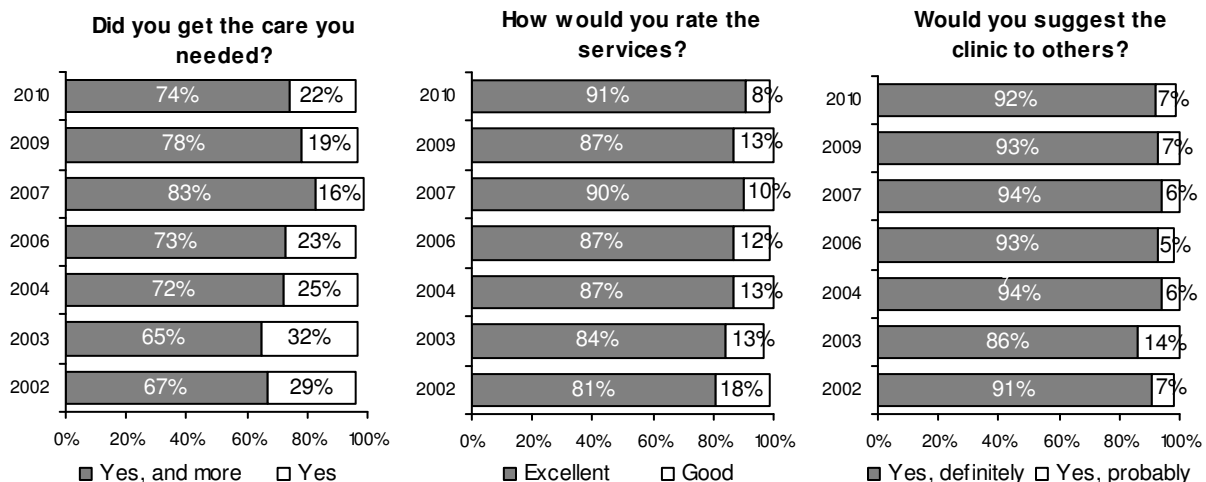


**D. STD Screening: Client Satisfaction**

The STD Clinic regularly surveys its clients as part of its quality management program. Patients are recruited by office staff to fill out the self-administered survey as they check out from their visit. Patients are offered the choice of a variety of snack items as incentive to complete the survey. In 2010, a total of 330 surveys were completed from a total eligible group of approximately 477 patients who were seen in the STD Prevention program during survey administration, resulting in a 69% response rate. The majority of respondents were male, almost half were between 18 and 29 years of age, and slightly over one-third had some college education.

Respondents reported high levels of satisfaction with the services provided. With some variation, client satisfaction with their visit has remained high throughout the years that the survey has been given (Figure 2.7). Approximately all clients responded that they got the care that they needed, rated services received as “excellent” or “good”, and responded that they would suggest the clinic to others.

**Figure 2.7**  
**STD Clinic Client Satisfaction**



Respondents were asked, “If there was one thing you could change about this clinic what would it be?” Fifty-six percent of clients answered this question. Thirty-three percent of the clients surveyed responded with nothing, can’t think of anything, or not a thing. Of those who made specific comments, 13% offered positive comments about the clinic and 53% made suggestions or critical comments. Of the suggestions or critical comments, the largest group were critical comments about the wait time, the physical space of the clinic and amenities offered, and staff interactions.

## 3

## Testing

HIV testing services are provided in clinics as well as community-based settings such as county jails, alcohol and drug treatment programs, local bars, and at community events. Confidential and anonymous HIV testing options are available at most sites. Risk reduction counseling and referrals to services, such as STD screening, are a standard part of service provision. Test results are available in-person and/or by phone in most cases. In addition, targeted outreach engages those at risk for or living with STDs, HIV, and HCV, who are not otherwise being served. Services aim to increase awareness and improve access to prevention and care services through client-centered counseling and referrals.

This model of HIV counseling, testing and referral services is a cornerstone of national HIV prevention. The CDC recommends routine HIV screening of adults, adolescents, and pregnant women in health care settings in the United States.<sup>5</sup> Additionally, targeted testing of populations at high risk for HIV infection based on local epidemiologic data is still a recommended strategy for prevention, particularly in low incidence states like Oregon. CDC's Advancing HIV Prevention (AHP) Initiative includes recommendations to "use new models for diagnosing HIV infections outside medical settings. The use of rapid HIV tests can increase access to early diagnosis and referral for treatment and prevention services." The AHP Initiative also supports use of rapid testing for high risk individuals in non-clinical settings such as short-stay correctional facilities, bars, parks, and shelters.<sup>6</sup>

### **A. Testing: Clients**

Data on testing performed by the program is available by test, not by individual. As such, it may contain duplication of individuals who tested multiple times during the year. In 2010, the majority of tests were among males (72%, Figure 3.1), a proportion that has remained steady across the years. Overall, about two-thirds of those tested were White (66%), 14% were Black/African Americans and 12% were among Hispanic/Latino. Blacks/African Americans were tested at a rate exceeding their proportion in the general population of Multnomah County (14% of MCHD tests vs. 6% of the county population). Almost half (44%, n=2,878) were between the ages of 20-29 at the time of the test, followed by clients between 30-39 years old (26%).

Individuals testing for HIV are asked to report their risk factors in order to identify the most probable mode of transmission, in the event of a positive test. Categories include men who have sex with men (MSM); injection drug users (IDU); individuals who are both MSM and IDU; individuals with a sex or needle-sharing partner who is HIV positive; individuals with a partner at risk; individuals who have sex for money/drugs/survival; and low or no risk. The proportions of testers by risk differ notably between testing sites. Within sites, the proportion of each risk category is relatively unchanged each year.

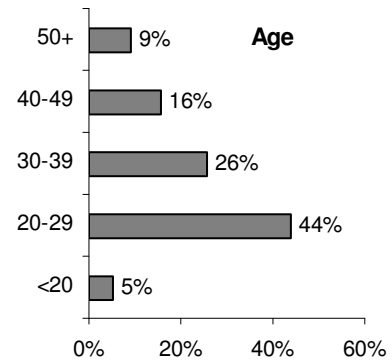
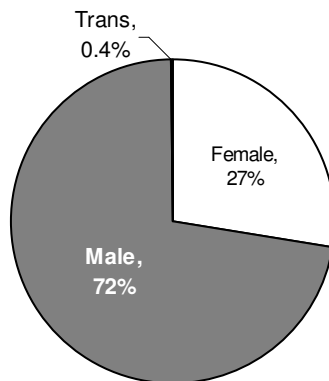
<sup>5</sup> CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care settings. September 2006. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>. Accessed 9/7/07.

<sup>6</sup> CDC. Recommendations for HIV testing in high risk populations. January 2006. <http://www.cdc.gov/hiv/resources/reports/hiv3rddecade/chapter5.htm>. Accessed 11/21/08.

Among all individuals tested in 2010, just over a quarter (27%) self-reported MSM, the largest proportion of any risk factor. About three-fourths of those tested at the STD clinic (73%) report low or no risk. Among high risk testers across all sites, a majority (65%) reported MSM. The sites where the greatest proportion of those tested were MSM included the Downtown Counseling and Test Site (CTS), Northeast CTS, bar testing, and testing done by STD Clinic staff at Cascade AIDS Project (CAP). Almost all tests conducted through bar outreach alone in 2010 were among MSM (88%). While fewer than 10% (9.1%) of all tested in 2010 were IDU or MSM/IDU, 43% of those tested in corrections and 65% of those tested at Hooper Detoxification Center identified IDU as their primary risk factor. When combined with MSM/IDU, IDU make up 11% of all tested: 48% of those tested in corrections and 69% of those in drug treatment. The variation in predominant risk factors by site demonstrates how each testing venue serves a unique sub-population and illustrates the value in providing a variety of site locations for all individuals seeking to test for HIV.

**Figure 3.1**  
**CTS Clients by Race/Ethnicity, Gender, and Age**  
**2010**

Race/Ethnicity	Number	Percent
White, not Hispanic	4,255	66%
Black/African American	922	14%
Hispanic/Latino	798	12%
Asian	188	3%
Multiracial	188	3%
American Indian/Alaskan Native	59	1%
Native Hawaiian/Pacific Islander	42	1%



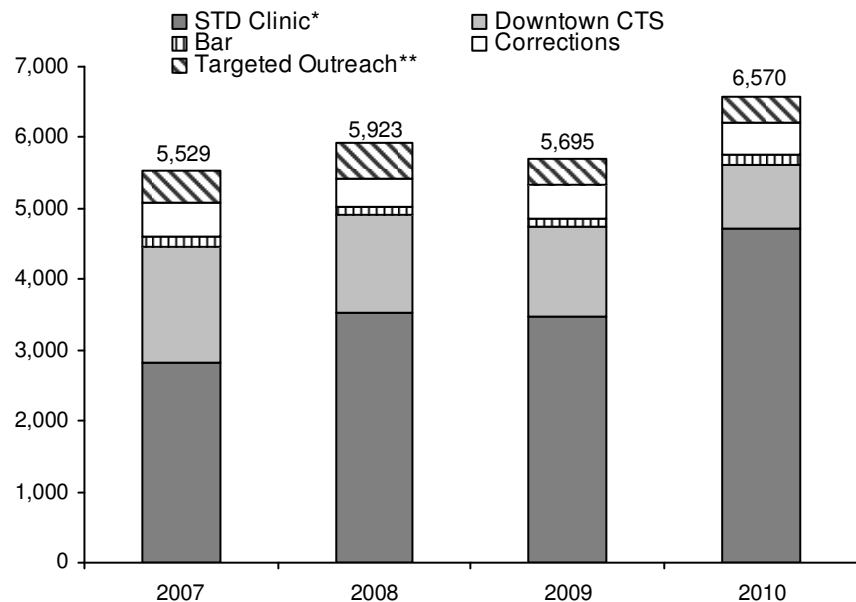
**B. Testing: Services**

The number of HIV tests performed remains fairly steady each year. In 2010, staff performed 6,570 tests for HIV, a 15% increase from 2009 (Figure 3.2). The majority of tests occurred at the STD Clinic (n=4,335, 66%). Another 5.6% were done by STD Clinic staff at CAP’s Pivot site (n=369), for a total of 4,704 tests done through the STD Clinic (72% of total). The second most frequently utilized testing venue was Downtown Community Test Site (CTS) at 14% (n=902); the proportion of tests conducted at this site decreased almost 30% from 2009 (n=1,275) despite the overall increase in tests. An additional 171 tests were done at the Northeast CTS site, for a total of 16.3% of the tests done at one of the two CTS sites. The remaining tests were divided between corrections and targeted outreach events (respectively: n=444, 7%; n=360, 5%). There is a wide range in the number of hours that testing is conducted at each site per week: 2.5 hours at NE CTS and Hooper, 7 hours by STD staff at CAP, 24 hours at the Downtown CTS site, and 38 hours at the STD Clinic. In addition, the number of staff and amount of staff time invested differs across sites – including travel, preparation and set-up time.

In addition to direct testing services, staff also conduct outreach and recruitment to testing in jails, streets, public sex environments, and through local businesses and social service agencies.

This targeted outreach engages those at risk for, or living with, STDs, HIV, and HCV who are not otherwise being served. Services aim to increase awareness and improve access to prevention and care services through client-centered counseling and referrals. Staff made 1,354 street-based outreach encounters in 2010, distributing condoms, educational material, HIV test coupons, referral and resource lists to high risk individuals throughout the Portland Metropolitan area.

**Figure 3.2**  
**Number of HIV Tests Performed by Site and Year**  
**2007-2010**



\*2010 data includes testing done by STD Clinic staff at CAP (n=369).

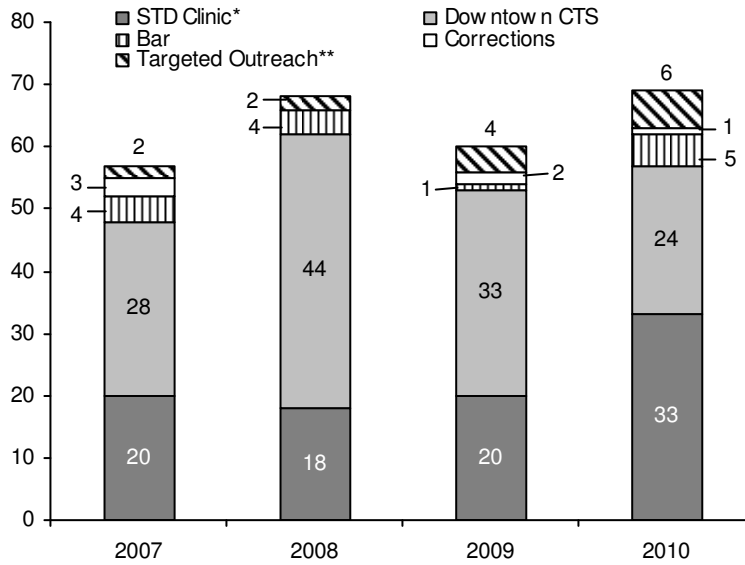
\*\*Targeted outreach includes tests performed at NE CTS, community testing events, and Hooper Detox.

**C. Testing: Performance and Outcomes**

Each year, combined testing efforts of the STD/HIV/HCV program identify approximately half of all reported cases of HIV/AIDS in Multnomah County. The total number of HIV positive tests identified through Multnomah County testing venues has varied across the years, from 89 in 2005 to 50 in 2006, and 69 in 2010. Prior to 2010, the largest number of HIV positive tests consistently occurred at the Downtown CTS site. In 2010, more positive tests were identified at the STD Clinic than any other site (Figure 3.3).

Figure 3.4 illustrates the total positivity rate and the new positivity rate from 2007-2010. The positivity rate is calculated by dividing the number of positive tests identified by the total number of tests performed. The new positivity rate excludes individuals who have previously tested positive. The positivity rate remained at 1.1% in 2010. Likewise, individuals who had previously tested positive make up about 15-20% of positives each year, so the rate of “new positivity” is slightly below the overall positivity rate every year, ranging from 1.3% in 2005 to 0.9% in 2010. Among the new HIV cases in Multnomah County 2010, over half were tested at an MCHD testing site.

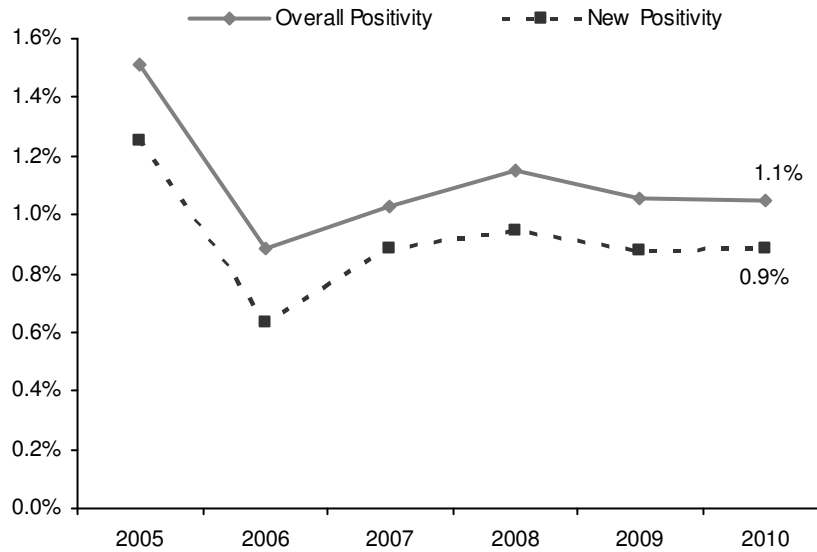
**Figure 3.3**  
**Number of HIV Positive Tests Identified by Site and Year**  
**2007-2010**



\*In 2010, STD Clinic data includes three positive tests done by STD Clinic staff at Cascade AIDS Project.

\*\*Targeted outreach includes tests performed at NE CTS, community testing events, and Hooper Detox.

**Figure 3.4**  
**Total Positivity and New Positivity Rates by Year**  
**2007-2010**



### **D. Hepatitis C Health Education and Testing:**

The program conducts group educational sessions and presentations on HCV prevention at multiple venues targeting those at highest risk for infection (injection drug users). Weekly classes are offered at the Multnomah County Inverness Jail and Hooper Detoxification Center (a 54-bed medical detoxification program). Once a month, the same classes are conducted in Spanish at the jail, as well. Staff offer voluntary testing for HCV after each class session. The purpose of the class is to increase knowledge of HCV transmission and introduce drug and sexual risk reduction. When clients agree to test for HCV, staff also facilitate follow up for test results at the STD clinic after release from jail or detox - increasing their opportunity for linkage to care.

Staff also conducted HCV testing at the Downtown and Northeast Community Test Sites, the STD clinic, and occasionally at other community events. Table 3.1 contains the number of HCV tests performed at each site, by result.

**Table 3.1 Hepatitis C Testing by Site, January - December 2010<sup>a</sup>**

Test Result	STD (n=194)		CTS (n=191) <sup>b</sup>		Corrections Outreach (n=171)		Total (n=556)	
	n	%	n	%	n	%	n	%
<b>Non-reactive</b>	123	63.4	100	52.4	89	52.0	312	56.1
<b>Reactive</b>	28	14.4	51	26.7	42	24.6	121	21.8
<b>Equivocal<sup>c</sup></b>	41	21.1	39	20.4	39	22.8	119	21.4
<b>Missing</b>	2	1.0	1	0.5	1	0.6	4	0.7

<sup>a</sup>HCV test data for 2010 were obtained from Quest Diagnostics; <sup>b</sup>Includes testing from both the downtown and NE CTS sites, as well as a small amount of testing done at bars, Pride, Hooper Detoxification Center, and other community events; <sup>c</sup> Equivocal results were "Reactive," but had a signal to cut-off ratio was between 1 and 7.99; in order to be considered Reactive, the signal to cut-off ratio had to be 8 or more.

For individuals living with HCV, a free, one-time education class, *Living Well with Hepatitis C* is offered four times throughout the year. In 2010, 18 participants completed the class and most were from Multnomah County (n=14).

## 4

## Disease Intervention Services

Disease intervention and partner services include an array of services offered to persons with HIV and other sexually transmitted diseases and their sexual or needle-sharing partners. These services also include the collection of surveillance and epidemiology data for reportable STD cases among residents of Multnomah County. Staff receive reports of all positive cases of reportable STDs from health care providers and laboratories. Staff investigate all HIV, syphilis, and gonorrhea cases, and priority chlamydia cases as resources allow. Staff then interview patients from identified priority populations, assure they have received treatment, and assist in making sure sex and/or needle-sharing partners are notified about possible exposure and are offered evaluation and treatment at no cost. These services improve individual and community health by identifying infected persons, confidentially notifying partners of possible exposure, and providing infected persons and partners a range of medical, prevention, and psychosocial services including risk reduction counseling, testing for HIV and other types of STDs (syphilis, gonorrhea, and chlamydia), HCV screening, and referrals or linkage to services.

In addition, disease intervention specialists offer early intervention services (EIS) to any individual who is newly diagnosed with HIV/AIDS to ensure that they are engaged in medical services to treat their HIV disease. These services also connect clients with resources for medical insurance, housing, substance abuse and mental health treatment and other supportive services that help maintain their health. In addition, staff are able to identify clients who may be diagnosed with a different STD, but who are also HIV positive. If these clients are not receiving care for their HIV disease, resources and reconnection with HIV medical care and support services are provided. The program has increased our overall ability to re-engage with clients who may have fallen out of care or who may be unaware of support services available. See the HIV Care Services section of Chapter 6 for more information on EIS clients and service outcomes.

Disease intervention and partner services play an important role in the prevention and control of STDs and HIV. The CDC recommends that all persons diagnosed with HIV and early syphilis receive partner services. The CDC also recommends disease intervention and partner services for individuals diagnosed with gonorrhea and chlamydia who are determined to be high-priority cases. The CDC recognizes that the ability “to identify infected persons, notify their partners of their possible exposure, and provide infected persons and their partners a range of medical, prevention, and psychosocial services can have positive results including 1) positive behavior changes and reduced infectiousness; 2) decreased STD/HIV transmission; and 3) reduced STD/HIV incidence and improved public health”.<sup>7</sup>

### **A. DIS: Cases**

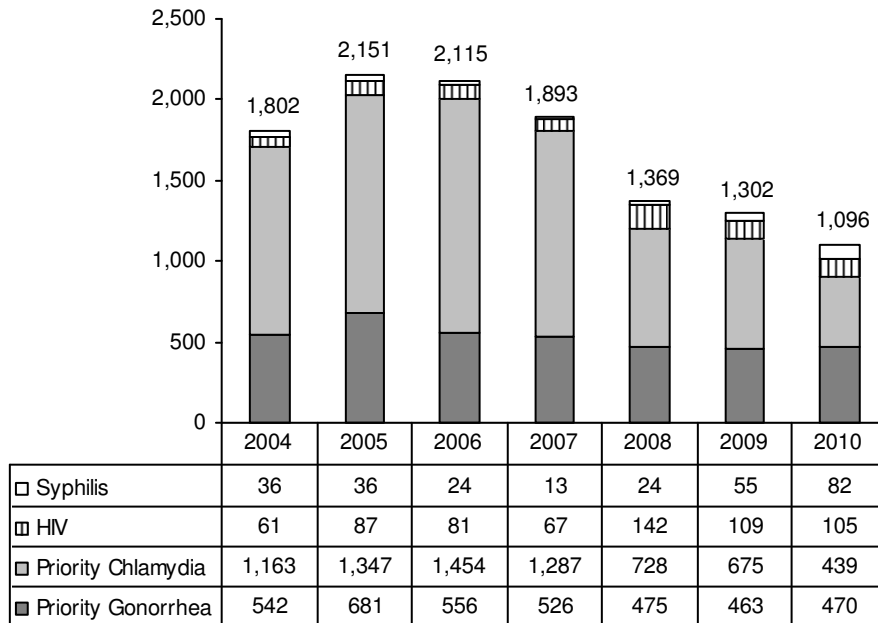
In 2010, 1,096 cases of HIV, syphilis, priority gonorrhea, and priority chlamydia were investigated by disease intervention specialists (DIS). The number of total cases investigated has consistently decreased since 2005, with investigation of priority

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<sup>7</sup> CDC. Recommendations for Partner Services Programs for HIV Infection, syphilis, gonorrhea, and chlamydial infection. November 2008. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm>.

chlamydia cases accounting for the majority of the decrease (Figure 4.1). In the last four years, several programmatic changes have influenced the number of cases investigated. Beginning in 2007, all HIV cases newly diagnosed at any site in Multnomah County were referred to MCHD for disease investigation. This more than doubled the number of HIV cases investigated between 2007 and 2008. Additionally, a recent surge in syphilis cases has quadrupled the number of syphilis cases investigated

**Figure 4.1**  
Number of DIS Cases Investigated  
2004-2010



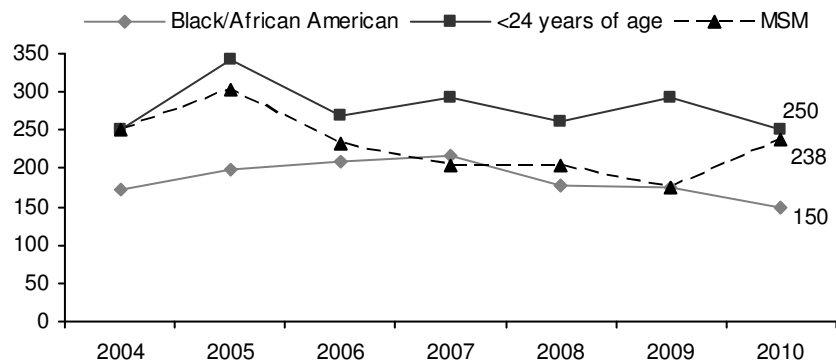
between 2007 and 2010. Due to the severity of disease consequences, HIV and syphilis case investigation and priority gonorrhea investigation are prioritized over chlamydia case investigation. Due to budget restrictions, fewer staff have been available, which has contributed to the lower number of priority chlamydia cases investigated. In general, HIV and syphilis case investigation and partner services are

more time consuming than gonorrhea and chlamydia cases.

Priority gonorrhea cases investigated are based on local disease epidemiology. With the majority of cases occurring among youths, and the disparities gonorrhea rates among the Black/African American and MSM communities, these populations are prioritized for case investigation (Figure 4.2).

The number of gonorrhea cases investigated among MSM declined between 2005 and 2009, reflecting fewer MSM cases identified during those years. In 2010, more MSM cases were identified and consequently investigated.

**Figure 4.2**  
Number of Priority Gonorrhea Cases Investigated  
2004-2010

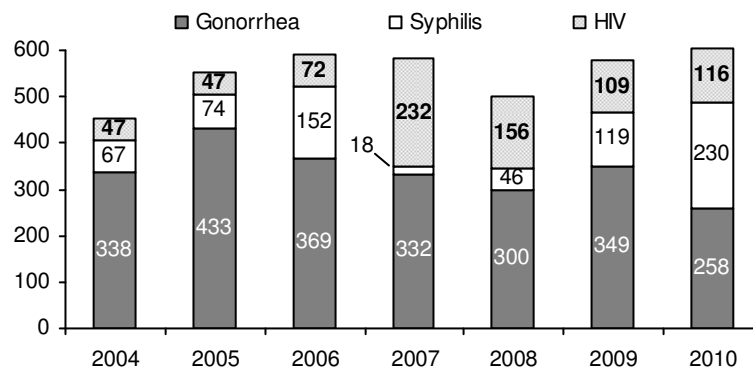


**B. DIS: Services**

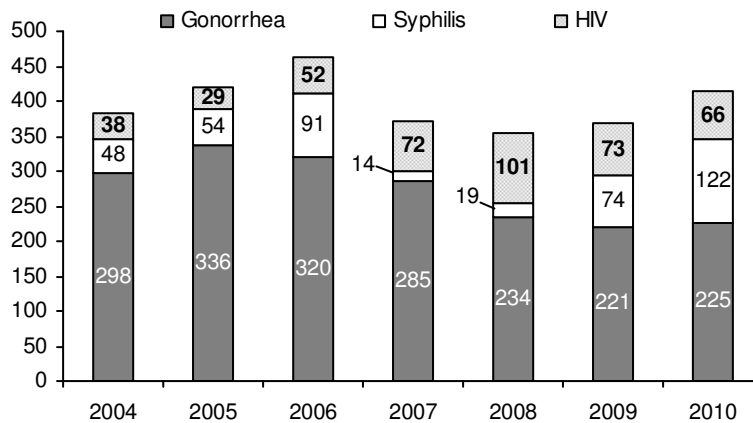
In 2010, 604 partners were elicited from people diagnosed with HIV, syphilis, and/or gonorrhea (Figure 4.3). Over 500 partners per year have been elicited through DIS work since 2005. Though the partners elicited from priority gonorrhea cases represented the largest single group, an increasing percentage were from HIV and syphilis cases. Partners elicited from HIV and syphilis comprised approximately one in five partner contacts (21.8%) in 2005, but close to three in five contacts (57.3%) in 2010. Changes in the way HIV is reported and investigated and the recent syphilis outbreak may be responsible for this increase in partner contacts (see section above).

In 2010, 413 partners were brought in for examination and treatment. Some partners may not have been brought to exam if they had already been treated for that STD or lived outside of Multnomah County. The percentage of partners brought to exam in 2010 is reflective of partners elicited by STD (Figures 4.3 and 4.4).

**Figure 4.3  
Number of Partners Elicited through DIS Work  
2004-2010**



**Figure 4.4  
Number of Partners Brought in for Exam by STD  
2004-2010**

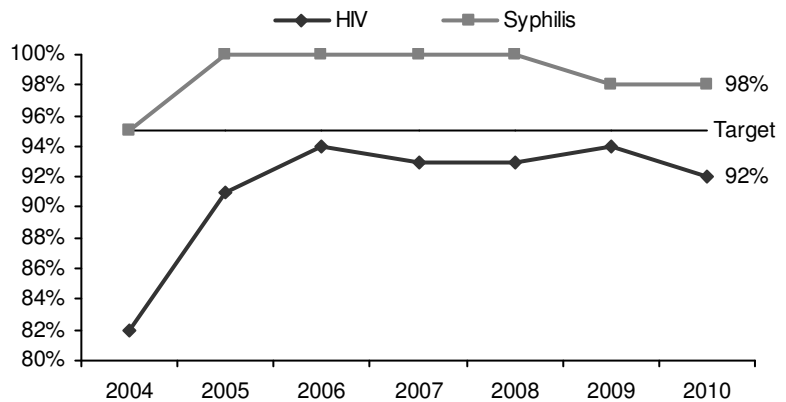


**C. DIS: Performance and Outcomes**

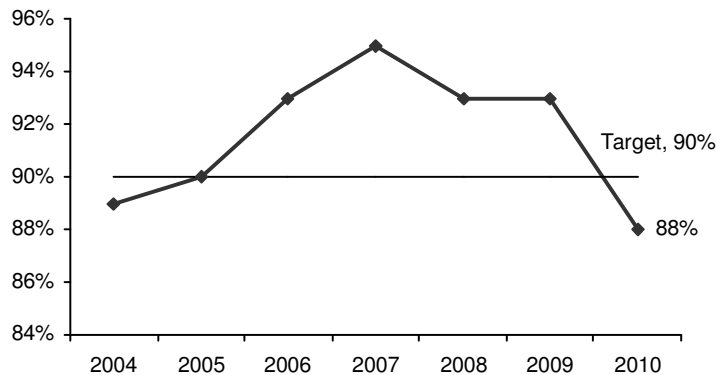
Disease intervention and partner services play a key role in identifying new cases of HIV and STDs and in stopping the further transmission of these diseases. There are two main measures that examine the disease intervention and partner service performance: the ability to follow-up on all newly diagnosed cases (percent of cases interviewed) and the ability to bring partners of cases in for examination and treatment (brought to exam index).

The percentage of syphilis cases interviewed has increased since 2004 (Figure 4.5), and has remained consistently over the 95% program target. Historically, the percent of HIV cases interviewed has been slightly under target (94% in 2009), and fell slightly to 92% in 2010.

**Figure 4.5**  
Percentage of HIV and Syphilis Cases Interviewed



**Figure 4.6**  
Percentage of Gonorrhea Cases Interviewed

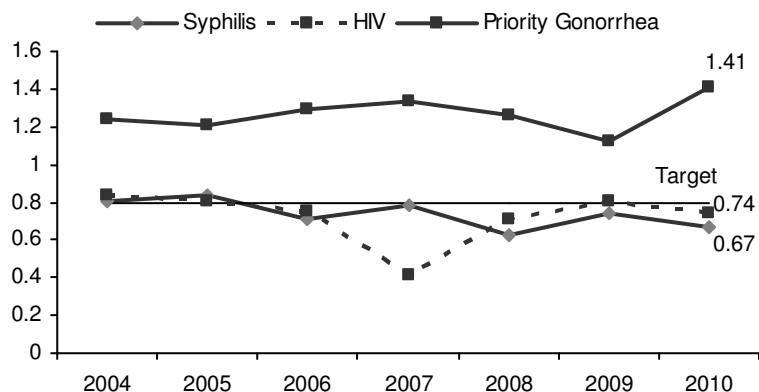


The percentage of gonorrhea cases interviewed increased after 2004, fell slightly in 2008 and then decreased below target to 88% in 2010 (Figure 4.6). Although staff interviewed more cases in 2010 than 2009, the percentage decreased because there were more cases of gonorrhea overall in 2010. In addition, there were

DIS staffing shortages at various times during the year.

The brought-to-exam index is calculated by dividing the total number of partners brought to exam by the total number of partners elicited. Partners that had been previously treated or who were outside Multnomah County jurisdiction are not included in this calculation (and as a result, the index may be greater than 1). In 2010, the priority gonorrhea brought-to-exam index was higher than the

**Figure 4.7**  
Partners Brought-to-Exam Index



program target of 0.8 (Figure 4.7). The brought-to-exam index for priority gonorrhea contacts has been consistently above program target over the last six years, while the index for syphilis has been below target since 2005. The brought-to-exam index for HIV decreased slightly in 2010 (0.74) from a low seen in 2007 (.41).

# 5

## Syringe Exchange and Disposal

Syringe exchange and disposal provides new, sterile syringes in exchange for used ones, along with wound care and safer sex supplies to reduce the spread of HIV, HCV and other blood-borne infections among injection drug users and the larger community<sup>8</sup>. Staff provides risk reduction counseling including and referrals to medical care, housing, STD treatment, mental health counseling, alcohol and drug treatment, and opiate overdose prevention.

In Multnomah County, injection drug use is one of the leading causes of HIV infection. Many people who inject drugs either cannot access drug treatment, are not ready to stop injecting drugs, or relapse after a period of abstaining from drugs. Given this reality, many government agencies and community-based organizations have recommended that single-use of sterile syringes is an important strategy to reduce the spread of HIV, HCV and other blood-borne infections. Some of these organizations include: the U.S. Public Health Service, the Institute of Medicine of the National Academy of Sciences, the U.S. Prevention Services Task Force, Centers for Disease Control and Prevention, the National Research Council, the National Commission on AIDS, the American Medical Association, and many others.<sup>9</sup>

### **A. Syringe Exchange: Clients**

The Multnomah County HIV Prevention Program provides syringe exchange services every weekday through an outreach van at 3 locations throughout the area, and one indoor exchange site in Northeast Portland. Van stops include sites in outer Southeast Portland (Gresham), close-in Southeast, and the busy 82<sup>nd</sup> Ave area. Service at a fourth van stop in Old Town was discontinued as of July 2009 due to rapid decline in utilization at this location, possibly a result of neighborhood gentrification and increased policing of the area.

Until July 2011, clients were not asked for any identifying information to use syringe exchange services. While staff counted the number of visits to sites and recorded basic demographic information on each client visit, it was not possible to monitor the number of unique clients served. Starting in July 2011, staff implemented a system of creating unique identification codes for clients, consisting of a combination of initials and partial date of birth. Clients now use these ID codes every time they return to exchange. As a result, the program can monitor changes in unduplicated client population more accurately. Clients may refuse to create an identification code, though very few have done so between July and September 2011. Because this report involves data through 2010 and the ID code system had not yet been created, the syringe exchange data presented here represents duplication of data – i.e., clients who returned more than once throughout the year were counted more than once with respect to gender, age, and race.

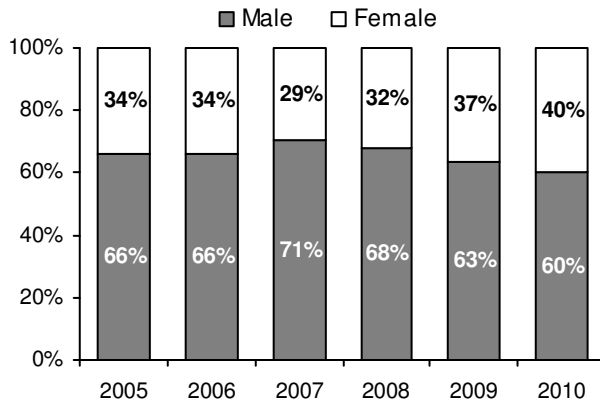
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<sup>8</sup> Academy for Educational Development (AED). A Comprehensive Approach: Preventing Blood-Borne Infections Among Injection Drug Users. Washington (DC): AED; December 2000. Funding provided under Centers for Disease Control and Prevention contract number 200-97-0605.

<sup>9</sup> Centers for Disease Control and Prevention. (1999) *HIV Prevention and Access to Sterile Syringes*. Washington (DC): Prevention among Injection Drug Users. [http://www.cdc.gov/idu/pubs/hiv\\_prev\\_acc.htm](http://www.cdc.gov/idu/pubs/hiv_prev_acc.htm)

In 2010, there were 3,518 encounters or visits to all four exchange sites, with clients bringing in about 815,000 syringes. In general, the majority of clients served by the syringe exchange program were white males between the ages of 30-54. The ratio of women to men has fluctuated slightly over the past five years, but women are typically involved in just over one third of all encounters (n=1,391, 40% in 2010, Figure 5.1). SE 82<sup>nd</sup> consistently serves the highest proportion of women, at just under half of the visits

**Figure 5.1**  
Syringe Exchange Clients by Gender and Year  
2005-2010

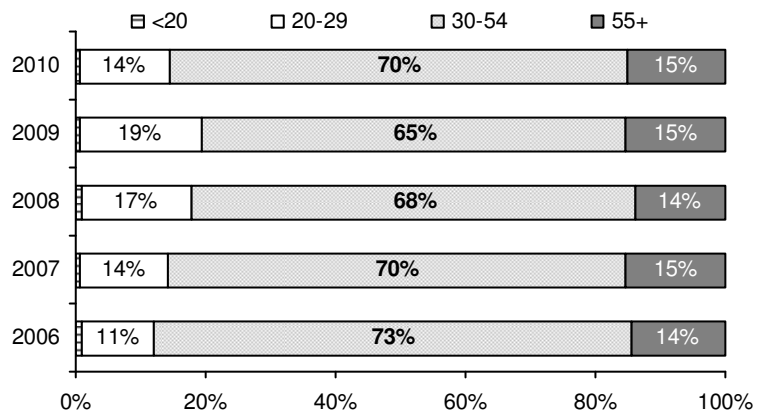


by women (44%). On Friday nights, this site is shared with a local organization that holds a weekly dinner for women affected by the sex industry, substance abuse, and homelessness, which may account for the greater representation of female clients during this shift.

Most of the clients (70%) in 2010 were between the ages of 30-54, with the number of 20-29 year old clients decreasing 5% in the last year (Figure 5.2). The Yeon site serves the highest proportion of clients age 20-29, followed by SE 6<sup>th</sup>. The SE 6<sup>th</sup> site also serves the highest proportion of individuals less

than 20 years of age. Clients must be age 18 and older to legally exchange syringes. Among the 20 encounters involving clients under 20 years old in 2010, 40% did not involve syringe exchange. Instead, those clients visited sites for other materials only, such as condoms and referral information.

**Figure 5.2**  
Syringe Exchange Clients by Age Category and Year  
2006-2010



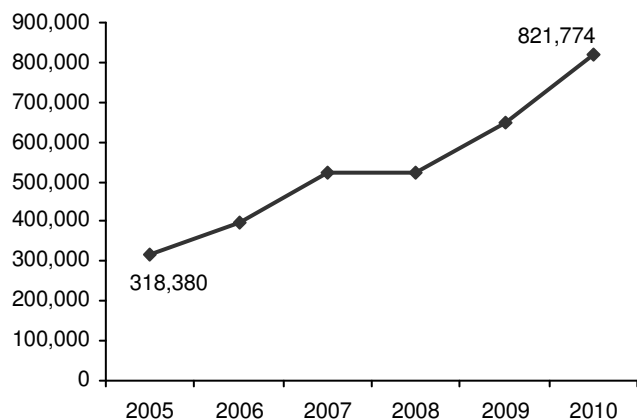
Racial and ethnic diversity of clients varies by site. Overall, the proportion of encounters involving Black/African American clients decreased from a peak of 19% in 2008 down to 9% in 2010. The majority of these encounters occurred at the NE site (83%) in 2010, though most encounters at all sites involved white clients (over 79% of all encounters in 2010).

**B. Syringe Exchange: Services**

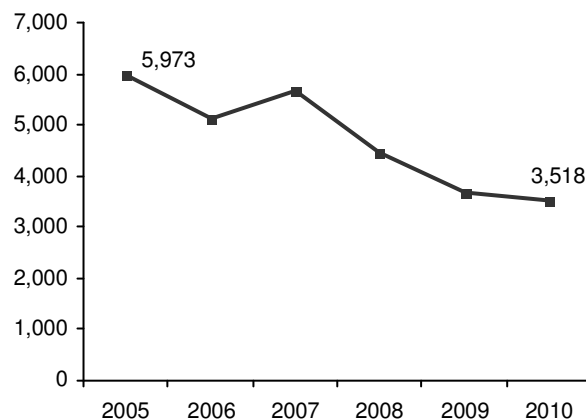
The number of syringes exchanged has more than doubled since 2005, increasing 162% from 318,380 in 2005 to 821,774 in 2010 (Figure 5.3). At the same time, the total number of visits to needle exchange sites has decreased by 41% from 5,973 in 2005 to 3,518 in 2010 (Figure 5.4). As a result, the average number of syringes exchanged per

encounter was 344% higher in 2010 than in 2005 – from 52 syringes to 231 per encounter (Figure 5.5). One possible explanation might be that clients are exchanging on behalf of larger networks than before, acting as “secondary exchangers.” Figure 5.6 shows that secondary exchange has become increasingly common, with over half of all encounters in 2010 involving exchange for at least one other person.

**Figure 5.3**  
Number of Syringes Exchanged, by Year  
2005-2010

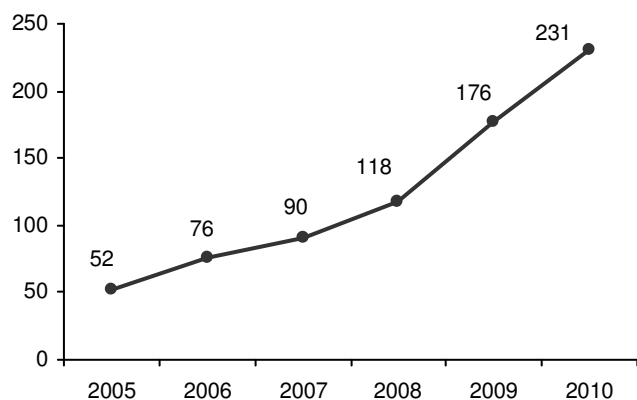


**Figure 5.4**  
Number of Syringe Exchange Encounters, by Year  
2005-2010

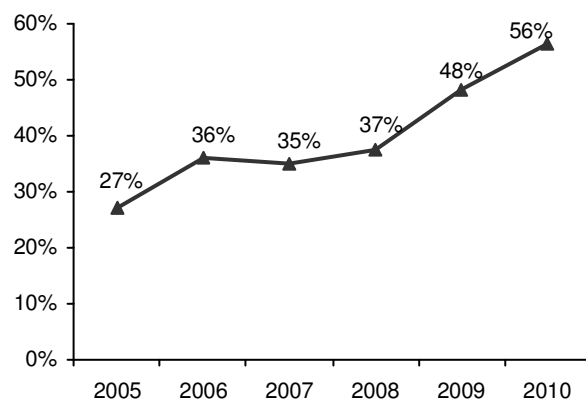


In order to have the greatest public health impact among clients served by the program, syringe exchange incorporates harm reduction education, the Stages of Change model, and motivational interviewing to appropriately gauge where a client is in terms of their willingness and ability to change. By utilizing these models and techniques, syringe exchange staff are able to address a variety of issues that are connected to injection drug use including HIV, viral hepatitis, sexually transmitted diseases, health care, housing, domestic violence, drug treatment, support for families, and mental health. In 2010, the most frequent referrals included drug treatment, information on other needle exchange sites and schedules, abscess and wound care, and HIV counseling and testing.

**Figure 5.5**  
Average Number of Syringes per Encounter, by Year  
2005-2010



**Figure 5.6**  
Percent of Exchange Encounters with  
Secondary Exchangers, 2005 - 2010



In addition to direct syringe exchange service provision, MCHD contracts with Outside In (OI) to provide additional hours of service and reach a broader spectrum of injection drug users. In 2010, OI had over 11 times as many encounters as MCHD exchange sites (Table 5.1). Conversely, MCHD exchanged approximately 235,000 more syringes.

**Table 5.1 Syringe Exchange Utilization at Outside In (OI), 2008-10**

	2008	2009	2010
Exchange encounters	27,465	31,973	39,882
Syringes Collected	460,017	523,194	576,808
Syringes Distributed	478,697	541,094	586,343
% Returned	96.1%	96.7%	98.4%
Secondary Exchangers (number and percent of total encounters)	2,473 (9.0%)	2,770 (8.7%)	3,154 (7.9%)

That OI had so many more encounters, but exchanged less syringes than MCHD is partly explained by programmatic and client differences in each program. The OI syringe exchange is open 30 hours per week, compared to 10.5

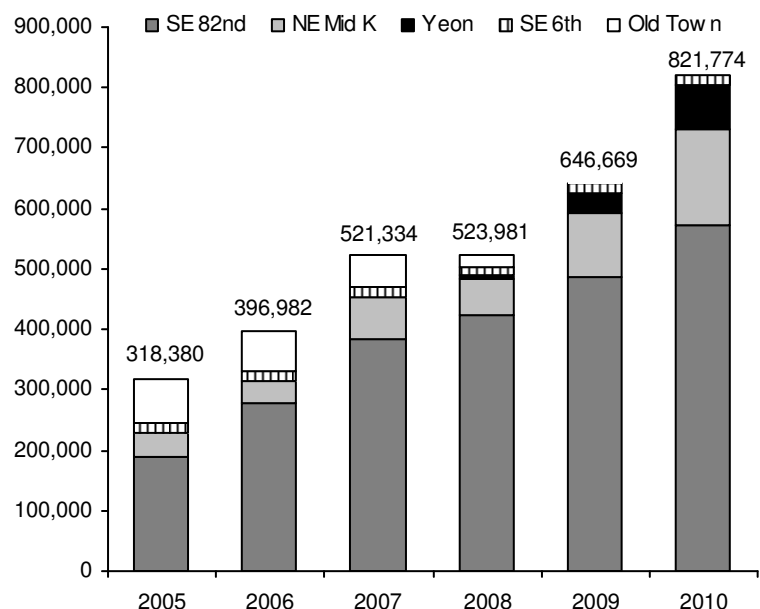
hours per week across all four MCHD sites. There is no maximum number of syringes that clients can exchange at MCHD sites, while OI had a 50 syringe maximum limit (and at one point, a 30 syringe limit) in 2010. MCHD sites also serve a much greater proportion of secondary exchangers who bring in a high volume of syringes, but come less frequently to exchange. In 2010, 57% of the visits to MCHD syringe exchange sites were by secondary exchangers, compared to 8% at OI. Together, the programs exchanged almost 1.4 million syringes in 2010.

**C. Syringe Exchange: Performance and Outcomes**

The syringe exchange program uses a “minimum” model of exchange whereby a number of syringes (3 on weekdays, 5 on weekends) are provided regardless of whether any used syringes were brought in (for individuals bringing in syringes, exchange is one-for-one with no maximum). Ensuring access to clean syringes in this manner is an established harm reduction best-practice recommendation for syringe exchange programs.<sup>10</sup>

Syringe return rate compares the number of syringes distributed to the number of syringes collected at all sites. The program has exceeded the 90% target every year, including 2010 (99.1%). The SE 82<sup>nd</sup> site has typically had the highest return rate among the

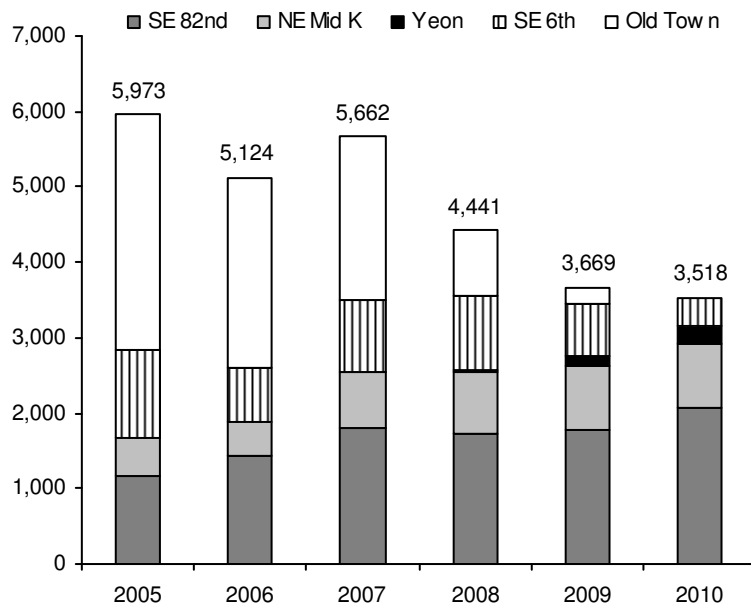
**Figure 5.7  
Number of Syringes Exchanged, by Site and Year  
2005-2010**



<sup>10</sup> Strike, et al. (2006). *Ontario Needle Exchange Programs: Best Practice Recommendations*. Accessed May 6, 2010 from [http://www.harmreduction.org/downloads/ontario\\_bestpractices.pdf](http://www.harmreduction.org/downloads/ontario_bestpractices.pdf)

sites, possibly due to the large quantities of used syringes this site receives in excess of new syringes given out. In 2010, the Northeast site had the highest return rate, at 100.7%. During the same year, the SE 6<sup>th</sup> site had the lowest return rate, at 91.8%.

**Figure 5.8**  
Number of Syringe Exchange Encounters, by Site and Year  
2005-2010



The SE 82<sup>nd</sup> site exchanges the greatest volume of syringes each year, and accounted for 69% of the total number of syringes exchanged in 2010 (Figure 5.7).<sup>11</sup> While SE 82<sup>nd</sup> continues to increase in syringe volume (16% increase from 2009 to 2010), syringes exchanged at the Yeon and NE sites increased even more (103% and 55%, respectively). The number of visits to the SE 82<sup>nd</sup> site was stable between 2007 and 2009, with 1,700 - 1,800 per year, but increased 16% to 2,071 visits in 2010 (Figure 5.8). This site has continued to serve a high percentage of secondary

exchangers (between 60-65% per year since 2005). See Figure 5.6 for more information on secondary exchangers.

Since 2007, the NE site has had the second highest number of encounters and syringes collected (after SE 82<sup>nd</sup>), increasing 84% in syringe volume from 2008 to 2009 and another 55% from 2009 to 2010. Encounters at this site also appear to involve an increasing number of syringes, from 70 syringes per encounter in 2008 to 194 syringes per encounter in 2010.

While Yeon had the third highest exchange volume (70,715 syringes), it had the fewest encounters (247). As a result, this site had the highest rate of syringes per encounter after at 286. In 2010, the Yeon site also had the highest rate of secondary exchangers (81% of encounters). The SE 82<sup>nd</sup> was next highest, at 272 syringes per encounter.

The Old Town syringe exchange site was terminated in July 2009 because it consistently experienced the largest decreases in both syringes and encounters each year. Among the sites operating in 2010, the SE 6<sup>th</sup> and Ankeny site has the fewest encounters and syringes (360 and 16,851, respectively).

<sup>11</sup> Service data represents partial 2008 data for Yeon and partial 2009 data for Old Town as these sites were opened and closed, respectively, on July 1, 2008 and July 1, 2009.

### ***D. Syringe Exchange Client Survey***

In December 2010, Outside In and MCHD engaged in a joint effort to survey clients at their syringe exchange sites. Over a two-week period, 437 injection drug users completed the survey. Most surveys were completed at Outside In (84%). The main findings were summarized below:

- The majority of participants resided within Portland city limits, but 21% reported residences outside of Portland in Multnomah County and other counties.
- Most participants had injected heroin in the last three months (88%) and had used more than one type of drug in the last three months (88%). The largest group of participants had used four to five types of drugs in the last three months (33%).
- Among heroin users, 43% said they were hooked on prescription-type opiates before they began using heroin. This number is slightly higher than was recently reported in Seattle and San Diego (R. Pollini, personal communication).<sup>12</sup> In general, heroin users who were hooked on prescription-type opiates first were younger than other heroin users, and had started injecting more recently than other heroin users.
- Over half of participants reported that they had injected outdoors in the last three months. The majority had injected in a hurry in the last three months (78%).
- Almost half of participants had overdosed in their lifetime, and 18% had an opiate-related overdose in the last year. Participants under 26 were significantly more likely to have overdosed in the last year.
- More than half had come to the syringe exchange without any syringes to exchange in the last year. Many clients said they had no syringes because they had thrown them away (25%).
- Younger participants were more likely to live outside of Portland, use four or more types of drugs, and see others overdose.

The high number of newer, younger heroin users who reported that they were first hooked on prescription-type opiates may account for some of the recent increase in client encounters at syringe exchange sites. Given national and local upward trends in prescription opiate abuse, the transition to injection heroin use may continue rising.

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<sup>12</sup> Banta-Green CJ, Jackson TR, Albert DH, Hanrahan M, Taylor M, Freng S, Ohta J, Soukup M, Miller G, Smith R, Forbes A, Haruff R, Reid S, Finney E. Recent drug abuse trends in the Seattle-King County area: 2009. Seattle: Alcohol & Drug Abuse Institute, University of Washington, June 2010, 19 pp. Accessed online Nov 27 2009 at: [http://depts.washington.edu/adai/pubs/tr/cewg/CEWG\\_Seattle\\_June2010.pdf](http://depts.washington.edu/adai/pubs/tr/cewg/CEWG_Seattle_June2010.pdf).

# 6

## HIV Care Services (Ryan White Part A)

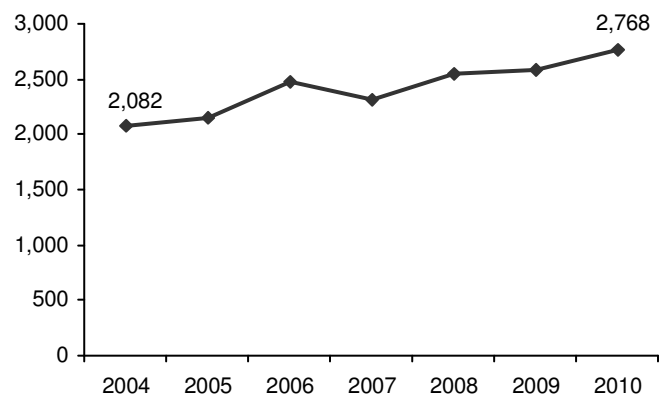
The HIV Care Services program manages the Ryan White Part A federal grant which addresses the unmet health needs of low-income persons living with HIV disease in the Portland metropolitan area. The federal grant-defined Portland metropolitan area consists of five counties in Oregon (Clackamas, Columbia, Multnomah, Washington, and Yamhill) and one in Washington (Clark). Through contracts with eleven organizations, including community-based non-profits, local health departments, and medical centers, clients access primary health care and support services which increase retention in care. Services provided include the *core services* of medical care, health insurance, dental care, mental health and substance abuse treatment, medical case management, and early intervention services. *Support services* offered include housing, psychosocial support services, and food/home delivered meals.

### A. HIV Care Services: Clients

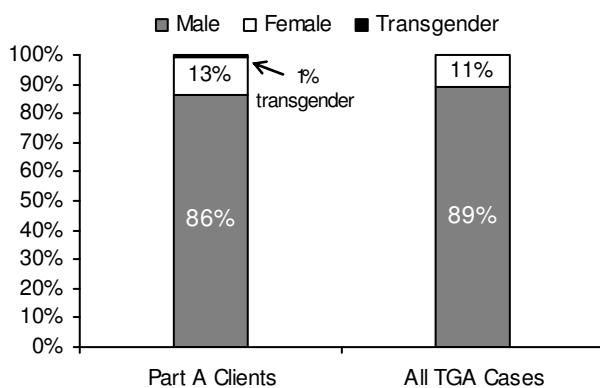
In 2010, 2,768 clients received services through Part A-funded providers – 190 more clients than were served in 2009 (n=2,578). The number of clients receiving Part A-funded services has been gradually increasing over the last several years (Figure 6.1).

Clients receiving Part A-funded services represent approximately two-thirds of all people living with HIV/AIDS (PLWH/A) in the Portland metropolitan area (68%). As a system designed to fill gaps for low-income PLWH/A, the Part A-funded system of care generally over-represents vulnerable and special needs populations. As observed for the past four years, females and racial/ethnic minorities received Part A-funded services in 2010 in greater proportion than their representation in the epidemic (Figures 6.2 and 6.3).

**Figure 6.1**  
Number of Clients who Received Services from Part A-funded Providers, 2004-2010



**Figure 6.2**  
Part A Clients and Overall TGA HIV/AIDS Cases by Gender, 2010



As observed for the past four years, females and racial/ethnic minorities received Part A-funded services in 2010 in greater proportion than their representation in the epidemic (Figures 6.2 and 6.3).

A higher percentage of Part A clients were 45 or older in 2010 (46%), compared to 2005 (38%, Figure 6.4). This shift reflects the overall PLWH/A population in the Portland metropolitan area, which is living longer with HIV.

Part A clients continue to be severely affected by poverty, lack of stable

housing, and reductions in publically-funded insurance and medication programs. Lack of permanent housing has been associated with poorer medical health outcomes and less adherence to HIV medications among PLWH/A. The percent of the population

**Figure 6.3**  
Part A Clients and TGA HIV/AIDS Cases  
by Race/Ethnicity, 2010

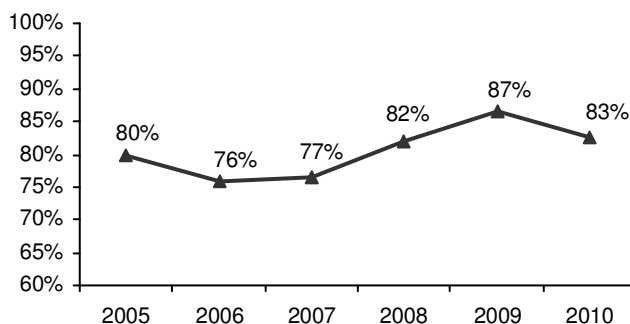
Race/Ethnicity	Part A Clients	All TGA Cases
White	70%	78%
Hispanic/Latino	12%	10%
Black or African-American	11%	8%
American Indian/Alaskan Native	2%	1%
Asian	2%	2%
Multiracial	1%	1%
Unknown	1%	0%
Native Hawaiian	0%	0%

living at or below 100% of the federal poverty level (FPL) is a common measure of poverty, which has also been tied to poorer health outcomes across the general population. Most Part A-funded services are only offered to clients at 200% FPL or below. The type of insurance coverage a client has determines the range of services available to them and has implications on the potential cost to the Ryan White

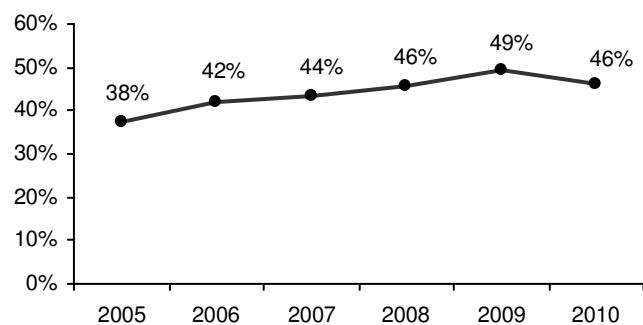
care system. For these reasons, the housing, FPL, and health insurance status of clients provide important insight into ongoing client service needs.

At the end of 2010, close to 83% of clients were permanently housed. 2010 was the first year that the housing rate decreased, after a steady incline since 2006 (Figure 6.5). White and Hispanic clients were more likely to have permanent housing (86% and 83%, respectively) than Black/African American clients (79%) and clients of other racial/ethnic groups (76%).<sup>13</sup> Clients 45 years and older were also more likely to have permanent housing (88%) than those under 25 (75%).

**Figure 6.5**  
Percent of Part A Clients that are Permanently Housed,  
2005-2010



**Figure 6.4**  
Percent of Part A Clients 45+ Years of Age, 2005-2010



In 2010, almost seven in ten clients (66%) had incomes at or below 100% FPL. As seen in the previous four years, female clients were more likely to have incomes below 100% FPL (75%) than males (64%). Black/African American clients (74%) and other clients of color (75%) were more likely to have incomes below 100% FPL than White clients (64%). Clients under 25 years of age (76%) were more likely to have incomes below 100% FPL than clients over 45 (62%).

<sup>13</sup> As the combined proportion of American Indians/Alaskan Natives, Asians, Native Hawaiians/Pacific Islanders, and clients of more than one race was less 6% of the total population served, these racial/ethnic groups have been combined in subgroup analysis.

Almost two in five Part A clients had public health insurance coverage in 2010 (38%), including Medicaid, Medicare, and VA coverage. The percentage of clients with private insurance, which includes the Oregon Medical Insurance Pool (OMIP), has increased over the last five years, while the percentage of clients on Medicaid dropped since 2005. The percentage of clients with no insurance remained at 12%, the same as in 2009. Men and clients under 25 were more likely to have no insurance coverage (13% and 22%, respectively) than females and clients over 45 (9% and 8%, respectively).

### ***B. HIV Care Services: Services***

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

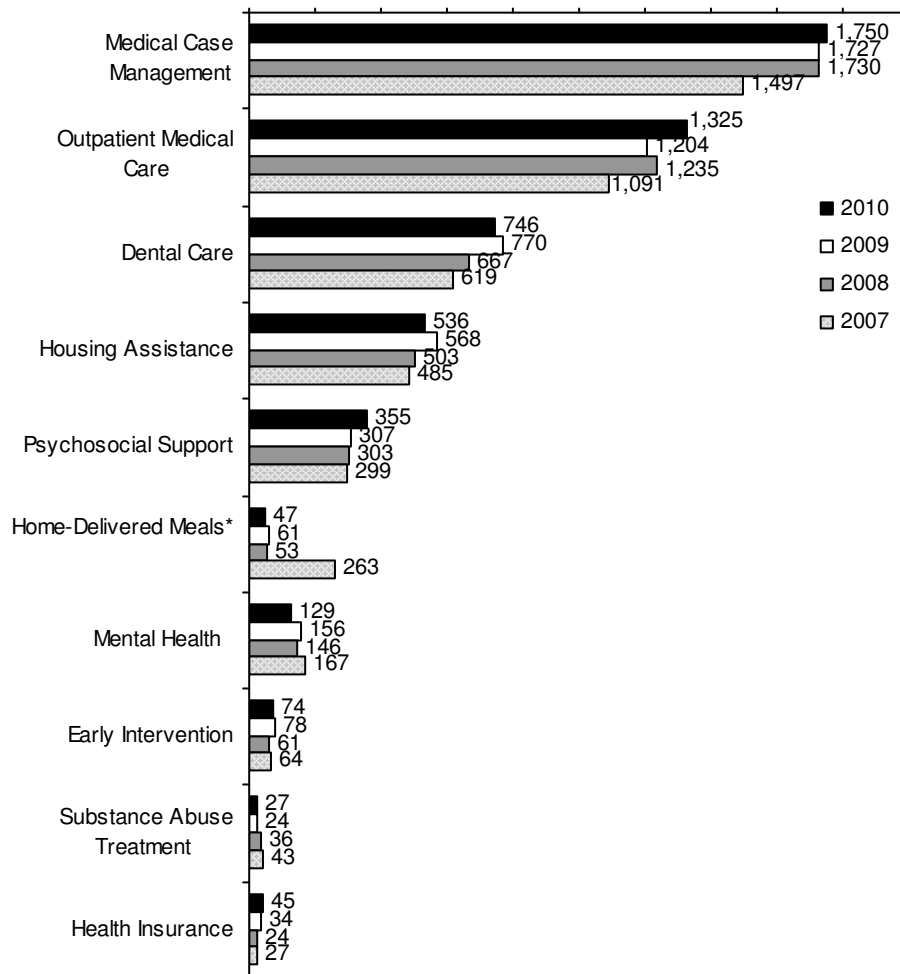
In 2010, 95.2% of all clients received at least one HIV core health care service from Part A-funded providers, such as medical care, health insurance, dental care, mental health and substance abuse treatment, medical case management, and early intervention services. Approximately 29% of all clients received at least one support service from a Part A-funded provider, such as housing, psychosocial support services, and food/home delivered meals. About one in four clients (24.3%) received both core and support services. A higher percentage of clients receiving support services were female (20.1%), PLWH/A of color (32.8%), under 25 years of age (5.5%), poor (= <100%FPL; 77.2%) and non-permanently housed (22.1%). Clients accessing support services were also more likely to have some form of public health insurance (47.7%) and have an HIV risk factor other than MSM (53.9%).

In 2010, 11 contractors were funded to provide 20 programs across ten different service categories. Figure 6.6 displays the number of clients receiving each Part-A funded service over the last four years. Overall, the number of clients per service category has remained relatively consistent, with the exception of some notable increases or decreases in a few areas. From 2009 to 2010, the number of clients receiving outpatient medical care, psychosocial support, substance abuse treatment and health insurance services increased more than 10%. The number of clients receiving home-delivered meals and mental health treatment decreased more than 10%.

More information by service category on client service utilization, service goals, and funds allocated during the 2010-11 fiscal year can be found at the *Portland Area HIV Services Planning Council* website (<http://hivportland.org/>). The Portland HIV Services Planning Council is a 30-member citizen involvement group that annually sets priorities for the allocation of \$3 million in federal funds toward programs serving people living with or affected by HIV/AIDS. The Council plans the delivery of medical and social services in the Portland metropolitan area, involving the community in assessing the

health care and social service needs of PLWH/A. The full Council met regularly in 2010 to review data and decide upon funding priorities and allocations throughout the year.

**Figure 6.6**  
**Number of Clients Per Service Category, 2007-2010**



\*Prior to 2008, the home-delivered meal category included congregate meals/food services, in addition to home-delivered meals. In 2008, congregate meals were incorporated into psychosocial support services.

**C. HIV Care Services: Performance and Outcomes**

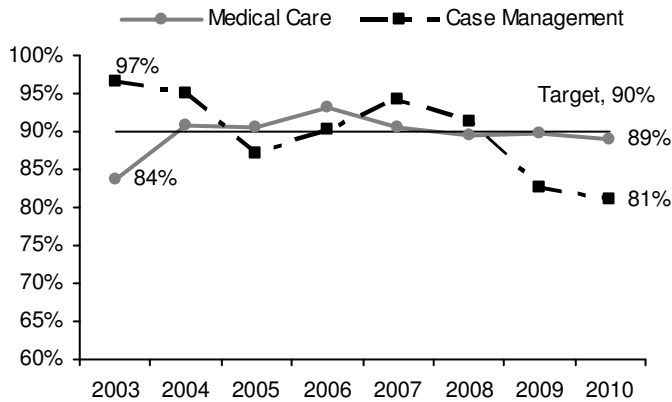
The guiding vision for HIV Care Services is to provide a universally accessible continuum of high quality care in which people living with HIV/AIDS take a pro-active approach to managing their health. The section below highlights some of our core medical services program performance.

**i. Client Maintenance in Medical Care**

As Ryan White funds emphasize a medical model of care and a care system which supports engagement and retention in medical care, client maintenance in medical care is an expected provider outcome. The HIV Care Services program defines maintenance

in medical care as having received a visit with a health care provider within the last 6 months of the contract year. Figure 6.7 illustrates client maintenance in medical care

**Figure 6.7**  
Percent of Clients Maintained in Medical Care, 2003-2010



among clients receiving medical and medical case management services. While medical care outcomes have been around or above set targets (90%) for at least the last six years, only 81% of medical case management clients demonstrated maintenance in medical care in 2010. Declining rates of maintenance may be partly due to clients with lab results (e.g., CD4 and viral load) that consistently indicate they are healthy and that a medical visit is not necessary. In addition, case managers in one

county of the TGA have mentioned that at least one provider there has recommended that clients come in for annual visits only.

**ii. Outpatient Medical Care**

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

Figure 6.8 illustrates client CD4 count results over the last eight years. The percentage of clients with stable or increasing CD4 counts (>200 cells/ $\mu$ l) has been stable and above the target benchmark since 2004. The percentage of clients with an undetectable viral load (<400 copies) at their last test increased 9% in 2010 (80%) - up from 71% in 2009 and 65% in 2008.

**Figure 6.8**  
Clients with Stable or Increasing CD4 Counts, 2003-2010

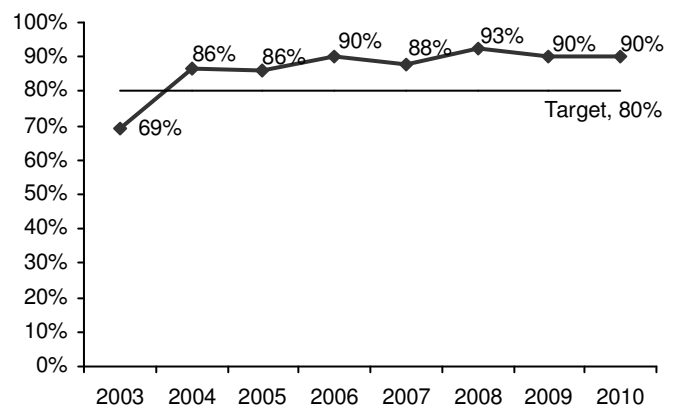
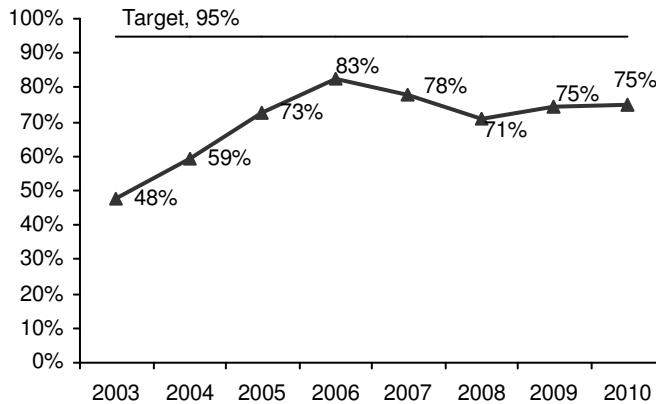


Figure 6.9 shows the percentage of clients receiving syphilis screening, a measure selected because of its relevance across our programs. Because many STDs are asymptomatic, clinical guidelines recommend that routine screening of curable STDs (syphilis, gonorrhea, and chlamydia) is performed yearly for all sexually active individuals. The percentage of all clients (not just those who are sexually active, as these data are not collected on a routine basis) receiving annual syphilis screening has increased since 2003, with 75% of all clients receiving syphilis screening in 2010.

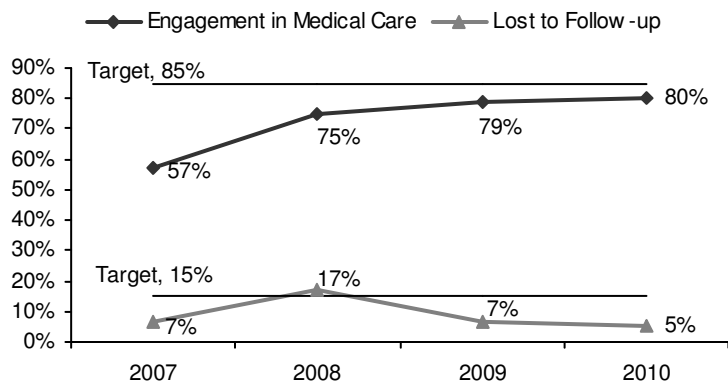
**Figure 6.9**  
Percent of Clients Receiving Syphilis Screening, 2003-2010



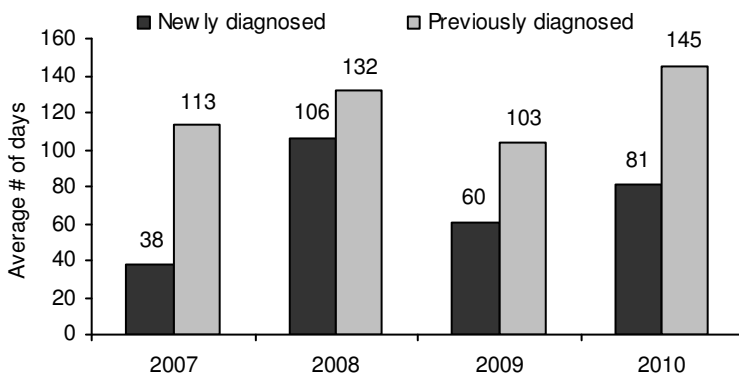
**iii. Early Intervention Services**

Early intervention providers report on three main outcomes: client engagement in medical care, clients lost to follow-up, and how long it takes clients to graduate from these services. 2010 was the fourth year since the early intervention programs began and started reporting on outcomes. Almost eight out of ten EIS clients (80%) were engaged in medical care in 2010, which has been steadily increasing since 2007. Additionally, the percent of clients lost to follow-up has decreased since 2008 (Figure 6.10).

**Figure 6.10**  
Medical Care Engagement through EIS Program, 2007-2010



**Figure 6.11**  
Average Number of Days to Graduate from EIS Program, 2007-2010



Clients that were newly diagnosed with HIV took an average of 81 days to graduate from the program (Figure 6.11). Clients graduate once they are engaged in medical care and do not require further assistance. Clients who were previously diagnosed took an average of 145 days.

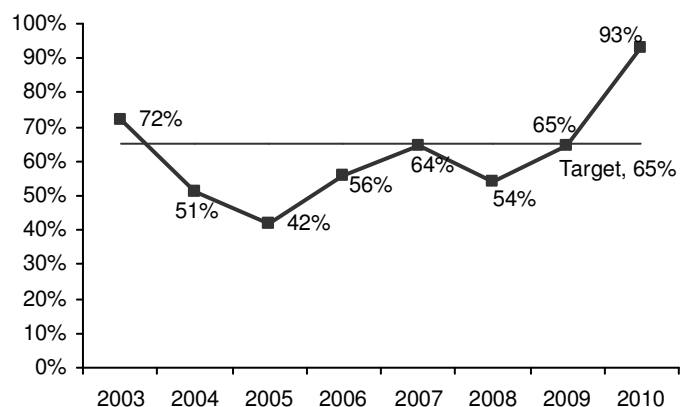
#### iv. Mental Health

Mental health providers report on one main outcome: stable or improved level of functioning. Beginning in 2006, stable or improved functioning was measured using the OQ-45, a reliable and valid questionnaire widely used in mental health service settings.<sup>14</sup> The percentage of clients with stable or improved functioning has been relatively stable for the last four years, though not quite reaching the set target goal of 95%. In 2010, providers switched to a new assessment tool – ACORN (A Collaborative Outcomes Resource Network). Consequently, the amount of OQ-45 data available was insufficient to compare to previous years and results are not included in this report.

#### v. Substance Abuse Treatment

Substance abuse treatment providers have traditionally reported on one main outcome: successful completion of substance abuse treatment. Most clients (93%) successfully completed treatment at service termination (n=15). This outcome has substantially improved since 2005 and is well above the target of 65% (Figure 6.12).

**Figure 6.12**  
Percent of Clients Successfully Completing  
Substance Abuse Treatment, 2003-2010



#### D. HIV Care Services: Client Satisfaction and Needs Assessment

The Ryan White Part A Program annually surveys its clients as part of its quality management program. The questionnaire asked about client demographics, key service needs, the level to which those needs have been met, and satisfaction with services. Surveys were distributed in November and December 2010, through 13 programs at the 8 agencies that deliver these Part A-funded services to people living with HIV: mental health care, early intervention services (EIS), dental care, housing services, delivered meals, outpatient medical care, substance abuse treatment, and psychosocial support. Results of this survey suggest that Oregon's Ryan White Care Act system is doing well in ensuring health care and key support services for many people living with HIV/AIDS (PLWH/A) in Oregon and in Clark County, Washington.

In general, clients reported high rates of satisfaction with agency staff and treatment. Almost all clients (94-95%) responded that they were satisfied or mostly satisfied with staff promptness in responding to requests and returning phone calls, their ability to listen and understand, their professional knowledge and competence, and respect and care given to respondents as individuals. Likewise, 93% said that services were always or often provided with privacy.

<sup>14</sup> Lambert, M.J., Burlingame, G.M., Umphress, V., Hansen, N.G., Vermeersch, D.A., Clouse, G. C., & Yanchar, S.C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy*, 3(4), 249-258.

There were some differences in satisfaction by client subgroups. Clients who had been homeless in the last year were less likely to be satisfied with staff's ability to listen and understand their problems, and the staff's professional knowledge and competence. Clients with depression, anxiety, or other emotional issues were less likely report satisfaction with the promptness, professional knowledge or competence of staff. Clients with substance abuse issues were less likely to report satisfaction with the privacy of services provided.

The primary purpose of the client needs assessment evaluation was to: describe the key HIV service needs of Part A medical case management clients and the extent to which those needs are being met by the current system, and to determine whether service needs and gaps vary by client demographic or other characteristics.

We asked clients to examine a list of 10 service areas, in order to help the Part A program evaluate which services are most needed by people with HIV and if they are able to access those needed services. Clients were asked to indicate whether they needed the service in the past year and if so, whether the service was: easy to get, neither hard nor easy, hard to get, or they were not able to get the service. For this analysis, we say that there was a 'service gap/difficulty' if someone needed a service but *could not get it* or found the service *hard to get*.

The top 5 service gaps among those who identified a need for the service included:

- Financial assistance with housing (21%)
- Dental care (18%)
- Other housing help (e.g. education, counseling, etc.) (14%)
- Mental health therapy/counseling (10%)
- Support services (e.g. support groups, community meals, etc.) (8%)

Reported service needs varied across different client subgroups:

- Clients who had been *homeless in the last year* and clients with *depression, anxiety, or other emotional issues* were more likely to identify needing all services with the exception of health insurance.
- Clients with *substance abuse issues* were more likely to identify needing case management, mental health therapy/counseling, and support services.
- Clients with *no income* were more like to report needing health insurance, dental care, financial assistance for housing, and other housing help.
- Clients from *Multnomah County* were more likely than clients outside Multnomah County to identify needing health insurance, support services, and other housing help.
- Clients who were *incarcerated* in the past three years were more likely to identify needing substance abuse treatment, mental health therapy/counseling, case management, and financial assistance for housing.
- *Younger* clients were more likely to report needing substance abuse treatment and health insurance while *older* clients were more likely to report needing at-home food services.
- *Latino* clients were more likely to report needing health insurance.

- Both *Latino* and *African American* clients were more likely to report needing at-home food services.

HIV Care Services, in coordination with providers and the Planning Council, are in the process of identifying improvement areas based on the findings of this needs assessment survey.

### ***E. HIV Care Services: Community Forums***

The Part A HIV Services Planning Council sets priorities and allocates resources among service categories, based on documented needs and client preferences in the Portland metropolitan area (which includes Multnomah, Clackamas, Columbia, Washington and Yamhill Counties in Oregon and Clark County in Washington). This priority-setting function is a legislative requirement for Part A Planning Councils and is among the most important and challenging responsibilities of planning bodies, especially given the severe need and limited resources in every community.<sup>15</sup>

As part of this priority setting and resource allocation process, community forums were conducted to gather information from consumers in the Portland metropolitan area. The primary goal of these forums was to better understand consumers' experiences regarding the HIV services they receive and whether these services meet their needs.

During April and May 2011, Planning Council members and HIV Care Services staff conducted a series of six community forums in the Portland metropolitan area. The goal for consumer participation was to obtain a sample of individuals with a cross-section of experience in the Ryan White system. With this goal in mind, the forums targeted the following sub-populations: 1) Spanish speaking individuals, 2) Communities of color, 3) Women, 4) Men who have sex with men, 5) Low-income individuals, and 6) Clark County residents. Forum fliers specifically targeted these populations, though any person receiving Ryan White-funded services was welcome to attend. Forums ranged from 60 to 90 minutes in duration, and participants received \$10 Fred Meyer gift cards for their time. Based on the results of the Needs Assessment (see previous section), forum participants were asked about their experiences with housing assistance and dental care. They were also asked how they would prioritize services in the event of budget cuts.

A total of approximately 63 consumers participated across the six forums.<sup>16</sup> Among participants, 68% were male, 30% were female. Almost half of the participants were white (48%), 25% were Latino, 18% were African-American, 3% were Native American/Alaskan Native, 3% were multiracial, and 2% were Asian. The average participant was 46 years old.

Overall, participants at several forums spoke of the need for housing and dental care and these two categories were cited the most often when discussing which services to prioritize during budget cuts. Participants reported barriers to housing that were

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<sup>15</sup> For more information on the priority setting and resource allocation process please visit the following link: [http://web.multco.us/sites/default/files/health/documents/hiv\\_psra.pdf](http://web.multco.us/sites/default/files/health/documents/hiv_psra.pdf)

<sup>16</sup> There were approximately 3-4 individuals who attended more than one forum.

related to eligibility, such as having a criminal history, not having substance abuse problems, or “couch surfing” (as opposed to living on the street). Other participants spoke of long waiting lists or the need for additional types of housing assistance, such as mortgage assistance or more emphasis on permanent housing solutions. (Note: Ryan White grant funding may not be used to pay for permanent housing; the grant restricts use to temporary housing only.)

Participants in four forums reported no barriers to dental care. At the other two forums, participants mentioned long wait times in scheduling dental appointments. Others pointed out that the spectrum of dental services was limited, and that a diseased tooth would likely be removed, rather than restored. Some participants reported confusion related to recent changes in public insurance, and how those changes affected their dental coverage.

Substance abuse treatment was also mentioned as a necessary service. While there was an appreciation for the coordination and referrals that case managers offer, participants also expressed frustration with having multiple case managers who specialize in different services (medical, housing, CAREAssist etc.), instead of having one case manager who could meet all of their needs. When discussing which services they would cut if Ryan White funding decreased, participants at three forums suggested case management and proposed that current services could be streamlined. In addition, participants conveyed that some of their needs may be met through “mainstream” service providers and that there is not always a need for HIV-specific services. Participants at multiple forums reported difficulty in obtaining transportation assistance (e.g. bus passes or tickets).

# 7

## Community Collaborations and Interventions

Central to the STD/HIV/HCV program mission is engaging in collaborative community partnerships and planning. These collaborations across program areas and agencies are aligned by common strategies and goals, while working together to achieve the same program outcomes. It is our belief that the sharing of ideas, information, and joint program planning and development strengthens our relationships with service providers and communities, which ultimately leads to empowered citizens and united efforts to improve health. Additional community collaboration include:

### **A. African American AIDS Awareness Action Alliance (A6)**

A6 is a coalition of community-based organizations, community members, and state and local health departments in the Portland metropolitan area. This collective has partnered collectively for over eight years to increase awareness about the HIV/AIDS disparity among the Portland Black/African American community. Through various outreach methods including targeted education, providing training & resources, erasing stigma, & HIV testing, A6 seeks to engage and empower community members on ways to educate, inform & protect themselves, their families and communities, and to encourage optimal health outcomes. Specific activities include organizing community-level activities to provide education and testing services in honor of the national observance days (National Black HIV/AIDS Awareness Day, National HIV Testing Day, and World AIDS Day); working with youth and adult peer educators to develop strategies that increase awareness and provide training and skill building activities to the community; and supporting local faith-based initiatives such as the annual Balm in Gilead Week of Prayer.

### **B. Latino Sexual Health Coalition/OYE**

The LSHC, now called “Opciones Y Educación” (OYE) was formed in 2009 to fill a gap in sexual health work with Latino communities. Existing programs provide sexual health services and basic education about STDs including HIV. This coalition works to promote more open discussion about sexuality and sexual health, including how homophobia and rigid gender roles can be barriers to healthy sexuality. OYE is also a coalition of community-based organizations, community members, and local health departments in the Portland metropolitan area. During 2010, the coalition participated in five health fairs, distributing materials and engaging people of all ages in conversations about sexuality. Coalition members also held eight workshops in different community settings, ranging from low-income housing, to the MEChA conference (National Movimiento Estudiantil Chicano de Aztlán) for Latino high school students. Current projects include developing workshops for staff at agencies (including faith-based agencies) that serve Latino communities.

### **C. SH4MC**

Sexual Health for Men Coalition (SH4MC) promotes the sexual health of gay, bisexual and other MSM in the Portland metropolitan area and is comprised of representatives from community-based organizations, community members, and state and local health departments in the Portland metro area. The major themes of SH4MC’s work include:

outreach to medical providers to improve cultural competence for working with MSM; consistent messaging on health issues for the community; participating in data analysis, and identifying trends and appropriate responses; internet outreach coordination, including ongoing website development; coordination of services at community events; and support of efforts to influence community norms.

#### ***D. LGBTQ Sexual Health Promotion***

This program partnered with the state health division, the department of education, Cascade AIDS Project, Planned Parenthood, and Portland State University to implement the Working to Institutionalize Sexuality Education grant. Eight school districts around the state were given funding to bring their sexuality education in line with a new state law that requires all schools to provide comprehensive, LGBTQ inclusive sexuality education in grades K-12. Our program offered technical assistance and training to support LGBTQ inclusion. We helped to adapt the My Future, My Choice program, used with sixth graders statewide, for LGBTQ inclusion. We have continued to provide technical assistance to other sexuality education projects and programs to promote LGBTQ inclusion.

#### ***E. LGBTQ Health Coalition of Columbia Willamette***

This coalition formed in 2010 by 7 partnering organizations and community members to address health inequities for the LGBTQ community, working toward an inclusive society where laws, policies, and systems support wellness. The coalition received capacity-building funding to begin community based participatory research to develop a strategic agenda for policy change.

#### ***F. Mpowerment***

Mpowerment (MP) is a community-level, CDC evidence-based intervention, designed and evaluated for young Men who have Sex with Men (MSM). Young gay men who participated in MP significantly decreased their rates of unprotected anal intercourse, the highest sexual risk activity for acquiring and transmitting HIV. MP has been adapted for use with diverse populations and yielded similar results. The MP intervention is run by a core group of 10-15 community members and is supported by paid staff. The core group, along with other volunteers, design and carry out all project activities. MP uses a combination of informal and formal outreach, discussion groups, safe space(s), social opportunities, and social marketing to reach a broad range of community members with HIV prevention, safer sex, and risk reduction messages.<sup>17, 18</sup>

Beginning January 1, 2010, the county contracted with Cascade AIDS Project (CAP) to implement MP and to support, enhance, and expand HIV Counseling, Testing, and Referral Services (HIV CTRS) targeted to sexual and social networks of MSM in the Portland metropolitan area. CAP-funded activities are designed to reduce HIV/AIDS related stigma among MSM communities; build and strengthen MSM community connections through engagement; increase HIV knowledge and risk reduction practices among MSM; create a community norm of positive sexual health; and reduce isolation among MSM individuals. Moreover, MP and CTRS activities are designed to increase

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<sup>17</sup> <http://www.effectiveinterventions.org/go/interventions/mpowerment>

<sup>18</sup> Kegeles, S.M., Hays, R.B., Coates, T.J. (1996). The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men. *American Journal of Public Health*, 86 (8), 1129 – 1136.

the number of HIV-positive MSM who access HIV care, case management, early intervention services, and partner counseling and referral services; increase the number of MSM who know their HIV/STD status; and increase the number of MSM treated for STDs.<sup>19</sup>

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<sup>19</sup> Multnomah County Contract #4600008057

## Glossary of Acronyms and Terms

AASHEP	African American Sexual Health Program
AHP Initiative	Advancing HIV Prevention Initiative, CDC.
AIDS	Acquired Immune Deficiency Syndrome
A6	African American AIDS Awareness Action Alliance
CAP	Cascade AIDS Project
CDC	The Centers for Disease Control and Prevention
CODA	Council of Drug Abuse
CTS	Community Test Site
CTRS	Counseling, Testing and Referral Services
DIS	Disease Investigation Specialist
EIS	Early Intervention Services
FPL	Federal Poverty Level
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIV core services	Medical care, health insurance, dental care, mental health and substance abuse treatment, medical case management, and early intervention services
HIV support services	Housing, psychosocial support services, and food/home delivered meals
HRSA	Health Resources and Services Administration. Part of the US Department of Health and Human Services, which administers the Ryan White Program
IDU	Injection Drug Use
IRB	Institutional Review Board
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
LSHC	Latino Sexual Health Coalition
MARS	Male Advocates for Responsible Sexuality
MCHD	Multnomah County Health Department
MP	Mpowerment program
MSM	Men who have Sex with Men
NIDA	National Institute on Drug Abuse
OHSU	Oregon Health & Sciences University
OMIP	Oregon Medical Insurance Pool
PHS	Public Health Standards
PLWH/A	People living with HIV/AIDS
Ryan White Part A-funds	Administered federally by HRSA, these funds provide emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas (TGA) that are most severely affected by the HIV/AIDS epidemic. The Multnomah County Health Department (MCHD) is the grantee for these funds.
Secondary exchangers	IDUs who distribute syringes to other IDUs
SiHLE	Sistering, Informing, Healing, Living, and Empowering
SH4MC	Sexual Health 4 Men Coalition
STD	Sexually Transmitted Disease
TGA	A six-county area including Multnomah, Clackamas, Columbia, Washington, Yamhill Counties in Oregon and Clark County, WA