Contents

Section I: Introduction

Executive Summary of Integrated Plan and SCSN

Oregon's 2027-2031 Integrated Plan and Statewide Coordinated Statement of Need (SCSN) represent the synthesis of information gathered from community planning, ongoing needs assessment, public comment, and town hall/listening sessions. Since 2012, Oregon has had an integrated statewide planning group, the End HIV/STI Oregon Statewide Planning Group (OSPG), which takes a syndemic approach to address all parts of the status-neutral continuum. The Part A Planning Council (PC) provides planning guidance to the Portland metropolitan Transitional Grant Area. This Integrated Plan and SCSN is a joint submission of Oregon's HIV Prevention Program, Ryan White Part A Program, and Ryan White Part B Program, and its development was guided by the OSPG and PC.

The key strategies from our previous 2022-2026 plan and branded End HIV Oregon Initiative were updated for the current 2027-2031 Plan. The goals and objectives outlined here also align with the Oregon Health Authority's Strategic Plan and Oregon's State Health Improvement Plan 2025-2029. End HIV Oregon's four key pillars are:

- Diagnosis
- Prevention
- Treatment
- Response

Oregon's goals and objectives are written with our vision of ending new HIV and STI diagnoses and ensuring that all people with infections receive high-quality treatment and supportive services. Oregon's plan focuses on people and communities disproportionately impacted by HIV and STI, and those with limited access to care.

Approach

Oregon used a broad, iterative planning process to update our 2022-2026 Integrated Plan, engaging the community to identify priorities, modify strategies, and approve the final documents. The key strategies from our previous plan and branded End HIV/STI Oregon Initiative (testing, prevention, treatment, and response) were carried over to the current 2027-2031 Plan; the objectives were reviewed and modified, as needed; and the activities were updated. All data in the needs assessment and situational analysis were reviewed and updated. Oregon is not an EHE jurisdiction.

Documents submitted to meet requirements

The following documents are included in this submission:

- The Statewide Coordinated Statement of Need
- Oregon 2027-2031 Integrated Plan
- Integrated Planning Submission Checklist (Appendix 1)
- Oregon Needs Assessment Inventory (Appendix 2)
- Summary of Findings from Community Town Halls, 2026 (Appendix 3)
- Oregon HIV Prevention, Care & Treatment Resource Inventory (Appendix 4)

Hyperlinks are included for all references that can be accessed online.

Section II: Community Engagement and Jurisdictional Planning Process

Jurisdictional Planning Process

Oregon uses a broad, iterative planning process to develop our Integrated Plans, engaging the community to identify priorities, develop strategies, and approve the final documents.

Specifically, data were synthesized from more than 40 existing data sources (see Needs Assessment Inventory, Appendix 2) and additional primary data were collected from under-represented voices, including people living with HIV (PLWH). Primary means of collecting data included ongoing surveys, focus groups, and engagement of planning bodies, as well as the following opportunities held in 2026:

- Four online Town Hall-style listening sessions that gathered feedback from Part A providers, Part B providers, English-speaking PLWH, and Spanish-speaking PLWH.
- In-person focus groups with consumers receiving services in Part A.

Additional groups and individuals were engaged on specific portions of the plan; for example, the Statewide PrEP/PEP Advisory Group gave input on the portions of the plan related to PrEP and PEP and helped develop those goals and objectives. Individual and group meetings with key community partners (e.g., grantees, subrecipients, community-based organizations (CBOs), partners representing priority populations) to discuss needs and priorities were ongoing throughout 2025-2026.

Community members were recruited through planning groups, direct invitation, listservs, and agency partners to provide detailed feedback on the entire Integrated Plan, especially high-level priorities, goals and objectives. Additional information about service priorities was gathered through the following opportunities:

All stages of planning included representation from people and communities disproportionately impacted by HIV and STI, and people with limited access to care. See below for more details.

Groups involved in the process

Interests Represented	Represented on Planning Group(s)	Additional Means of Engagement
Health department staff*	X	Gathered input from HIV/STI Statewide Services program staff
Community- based organizations serving populations affected by HIV/HIV services providers*	X	Part A and B provider town halls
People living with HIV*	X	Oregon HIV Medical Monitoring Project Part A Client Experience Survey Town Hall listening sessions with English and Spanish-speaking PLWH

		Engaged a minimum of 33% unaligned consumers on the Part A Planning Council Engaged consumers in leadership and in 30% of membership on OSPG
Populations at risk or with HIV representing priority populations	X	Chime In surveys (National HIV Behavioral Health Survey), formative assessments, and data debrief community meetings Statewide PrEP/PEP Advisory Group Familias en Acción Cafecito discussions
Behavioral or social scientists	X	
Epidemiologists	X	Gathered data for cluster response
HIV clinical care providers including (RWHAP Part C and D)*	X	Ongoing input through AETC engagement
STD clinics and programs	X	Gathered input from HIV/STI Statewide Services program staff
Non-elected community leaders including faith community members and business/labor representatives*	X	Sexual health workgroups at Black churches led by African American AIDS Awareness & Action Alliance (A6)
Community health care center representatives including FQHCs*	X	AETC survey of FQHC providers
Substance use treatment providers*	X	
Hospital planning agencies and health care planning agencies*	X	
Intervention specialists	X	
Academic institutions	X	
Mental health providers*	X	
Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility*	X	Feedback from staff in the OCEAN Housing Program for PLWH newly released from jail or prison
Law enforcement, correctional facilities, juvenile justice	X	Received input from OCEAN staff (housing program for PLWH exiting corrections)
Social services providers including housing and homeless services representatives*	X	Coordination with Part A and Part B HOPWA programs Part A participation on local housing care continuum advisory boards Representatives from Central City Concern and other social services on planning groups
Local, regional, and school-based clinics; healthcare facilities; clinicians; and other medical providers	X	AETC survey of FQHC providers

Medicaid/Medicare partners	X	Ongoing and ad hoc discussions with Medicaid and Medicare partners about billing for HIV/STI services and other issues relevant to End HIV Oregon priorities
Latine community members	X	Familias en Acción-led Cafecito with community leaders
African American community members	X	Five community focus groups conducted by the African American AIDS Awareness Action Alliance (A6)
Pacific Islander community members	X	
American Indian/Alaska Native community members	X	Northwest Portland Area Indian Health Board conducted needs assessment the nine federally recognized tribes in Oregon and with NARA NW, the Urban Indian Health Program. Part A engaged urban Native leadership, with an ongoing focus on addressing disparities
Gay, bisexual, and other men who have sex with men (MSM – also referred to as MMSC)	X	Chime In survey (2017)
People who inject drugs (PWID)	X	Chime In survey and formative assessments (2018, 2022, 2024)
Long-term survivors	X	Oregon HIV Medical Monitoring Project (MMP) Participation in Town Hall listening sessions
Youth	X	Oregon Youth Risk Behavior Survey
Community members unaligned or unaffiliated with agencies currently funded through HRSA and/or CDC	X	Town Hall listening sessions
Community- and faith-based organizations, including civic and social groups	X	Sexual health workgroups at Black churches led by African American AIDS Awareness & Action Alliance (A6)
Professional associations		Ongoing engagement with the Board of Pharmacy
Local businesses		Participate in formative research for MSM cycle of Chime In (gay bars, bookstores, bathhouse) and Portland area engagement of businesses in strategic prevention approaches
Existing community advisory boards	X	MMP, Chime In, CAREAssist Advisory Boards
Community members resulting from new outreach efforts	X	Input from newly funded Public Health Modernization CBOs, new OSPG members drawn from community-at-large

Role of RWHAP Part A Planning Council

This Integrated Plan was developed jointly by partners and service providers from Parts A and B. Specifically, the RWHAP Part A Planning Council participated in plan development in the following ways:

- Presentations at RWHAP Part A Planning Council meetings
- Meetings between Part A and Part B staff

- Participation by RWHAP Part A Planning Council members on the Statewide Planning Group – for example, the Statewide Planning Group Community Co-Chair is on the Part A Planning Council. This ensures coordination and communication during the planning process
- Extensive analysis by PLWH of data and conversation with expert panelists who work in the HIV field during monthly Planning Council meetings, regular subcommittees, and additional community engagements.
- Specific invitations issued to Part A Planning Council members, including members of the BIPOC Data Review Committee, to review and comment on the planning document via *Google Docs*
- Signed Letter of Concurrence from Part A Planning Council

Role of planning bodies and other entities

Since 2012, Oregon has had an integrated statewide planning group, which takes a syndemic approach to address all parts of the status-neutral continuum. The mission of this group, the End HIV/STI Oregon Statewide Planning Group (OSPG), is to regularly identify strengths, needs, gaps, and service priorities, resulting in a comprehensive plan that will support people in Oregon living with, affected by, or at risk for HIV/STI. OSPG includes members representing all Ryan White service areas, diverse geographic regions of the state, and a variety of disciplines. Approximately 30% of the voting membership of OSPG are PLWH. PLWH and persons from communities with higher vulnerability to HIV and limited access to healthcare are prioritized for OSPG membership.

The Part A HIV Planning Council (PC) is dedicated to improving the quality of life for those infected and/or affected by HIV/AIDS, and to ensuring that members of our community play lead roles in planning and assessment of HIV resources. The Part A HIV Planning Council, a 30-member community involvement group, is a decision-making body that plans and evaluates the delivery of medical and social services in Clackamas, Columbia, Multnomah, Yamhill, Washington, and Clark Counties. The Planning Council accomplishes this by deciding how Part A federal funds will be spent by setting priorities and allocating funds to programs serving people living with or affected by HIV/AIDS in the urban/suburban region where about 2/3rds of the PLWH reside in Oregon. The PC actively involves the community in assessing PLWH healthcare and social service needs. The council is composed of diverse individuals including service providers, public health representatives and currently includes nearly 50% membership of people living with HIV/AIDS.

Oregon Health Authority staff, as the Part B grantee, were responsible for coordinating the planning process, including needs assessment, planning meetings, developing feedback mechanisms, and writing and submitting the final document.

Multnomah County Health Department staff, as the Part A grantee, were responsible for ensuring full participation of Part A Planning Council members, assisting with needs assessment, developing goals and objectives, and reviewing and providing feedback on the document. Multnomah County facilitates and supports deep ongoing community engagement, particularly through an active Planning Council. While the co-governance process with PLWH is time-intensive and complex, it is essential to ensuring innovations, meaningful evaluation of the

service network, and bringing to life the Denver Principles commitment to "nothing about us without us."

Both entities were responsible for providing a Letter of Concurrence on the final documents from their respective planning bodies.

Collaboration between RWHAP Parts A-D and Part F

Representatives from RWHAP Parts A-F are active participants in OSPG and the Part A Planning Council.

Engagement of people with HIV

People living with HIV were involved in all stages of the process, including needs assessment, priority setting, development of goals and objectives, and implementation, monitoring, evaluation, and quality improvement.

Needs assessment:

- Oregon has participated in the HIV Medical Monitoring Project since 2007. MMP data are used to gain a deeper understanding of health-related experiences and needs of PLWH in Oregon. The project collects data from PLWH to provide a wide array of locally and nationally representative estimates of behaviors and clinical outcomes of persons in care for HIV; describe health-related behaviors; determine accessibility and use of prevention and support services; increase knowledge of the care and treatment provided; and examine differences by geographic area, patient characteristics, and access to social determinants of health. MMP includes PLWH who participate in RWHAP-funded services and those who do not.
- Oregon regularly surveys PLWH participating in RWHAP programs, such as CAREAssist (Oregon's AIDS Drug Assistance Program), Parts A and B case management, and the Oregon Housing in Opportunities Program (OHOP), and uses those data to understand PLWH needs, as well as to improve programs. We also conduct periodic special evaluation studies to better understand specific needs, such as PLWH needs around pharmacy access or viral suppression support.
- Part A conducted the bi-annual Client Experiences Survey in 2023 and focus groups in early 2024. Results are used to help identify priorities and service gaps and inform quality management efforts.
- PLWH participated in meetings, surveys, focus groups, and community town halls.

Priority setting; development of goals/objectives; and implementation, monitoring, evaluation, and QI processes:

- In Winter 2026, Oregon conducted two Town Hall style listening sessions with PLWH (one in English, one in Spanish) to identify their service priorities, gaps, and suggestions for improvement.

- PLWH are active participants in the Part A Planning Council (PC) and OSPG, where many of these activities take place; both groups include PLWH in leadership positions, including as co-chair and on Operations and Planning Committees. The Part A Planning Council goes through the HRSA-mandated Priority Setting & Resource Allocation (PSRA), Evaluation of Administrative Mechanism, and grant application/renewal process each year, and supports the implementation of a Client Experiences Survey every two years. The PC also engages in Contingency Planning, Reallocation, and a BIPOC Data Review Committee and QI processes, as needed (e.g., for improving the PSRA process). All of these tasks inform and include needs assessment and identification of priorities. Additional PLWH leadership and engagement opportunities are available through participation in the CAREAssist (Oregon's ADAP) Client Advisory Group and the HIV Medical Monitoring Program Client Advisory Group.

- Direct invitations were made to PLWH through Ryan White Programs, community-based organizations, and social media to review the draft plan and provide input on goals, objectives, and priorities during the public comment period.

Key priorities

The following priorities were identified from four key types of current primary data: PLWH Town Halls, Provider Town Halls, planning group feedback (PSRA info from the PC and survey data from OSPG), and supplementary surveillance studies (HIV Medical Monitoring Project for PLWH services and Chime In for HIV prevention services) and are supported by epidemiological data:

Services for PLWH:

- Mental health and substance use support and treatment
- Medical case management
- Housing
- Linkage to care for people newly diagnosed with HIV

Prevention:

- Integrated HIV/STI testing
- Services for people who use drugs
- Strategies to increase HIV/STI awareness
- PrEP/PEP access

Brief Results Gathered from Specific Primary Data Sources –

Priorities Identified in Client Town Halls

Two Town Hall-style, online focus groups were conducted with PLWH in Oregon in March 2026. One group was held in English (attended by 23 people) and one in Spanish (attended by 6 people). Participants were asked to endorse their top three service category priorities from a list of core medical services and supportive services. Participants identified the

following priorities (there were no differences between English and Spanish-speaking groups):

Core Medical Services:
- Medical Case Management
- Mental Health
- Outpatient/Ambulatory Medical Services

Supportive Services:
- Housing
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals

Priorities Identified in Provider Town Halls
Two townhall-style, online focus groups were conducted with Ryan White providers in Oregon February and March 2026. One group was held with Part A providers (n= 9 participants) and one was held with Part B providers (n= 7 participants). Two additional participants who could not attend the live sessions provided feedback via a survey (one from each Region). Participants were asked to endorse their top three service priorities for PLWH from a list of core medical services and supportive services. Participants identified the following priorities (differences between Part A and B groups are noted):

Core Medical Services:
- Early Intervention Services (the only RWHAP category that includes HIV testing and linkage to care)
- Medical Case Management
- Mental Health (prioritized by Part A)
- Outpatient/Ambulatory Medical Services (prioritized by Part B)

Supportive Services:
- Housing
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Medical Transportation (prioritized by Part B at same ranking as EFA)

Priorities Identified by Planning Groups: Part A/Priority Setting and Resource Allocation
The Part A Planning Council conducts the federally mandated Priority Setting and Resource Allocation (PSRA) process each year. The Planning Council's service category priorities for Grant Year 25-26. were:
- Mental Health
- Medical Case Management
- Housing

The FY 26-27 priorities are:

- Outpatient/Ambulatory Medical Services
- Mental Health
- Medical Case Management

The group also voted to add a fourth priority: Medical Transportation for those who cannot access Ride to Care and other insurance-specific community resources. Medical Transportation services have been implemented in the 26-27 grant year, with special emphasis on addressing needs for PLWH living further from urban/suburban centers and those with disabilities in the TGA

Priorities Identified by Planning Groups: OSPG Survey
The OSPG was asked to identify their top priorities over the next five years in three areas: testing and prevention, treatment, and response. The following priorities were endorsed by more than 50% of respondents:

- HIV/STI/Viral Hepatitis testing in health care and community settings
- Access to prevention services for people who use drugs
- Better systems to ensure rapid linkage to care for people newly diagnosed with HIV
- Expanded access to mental health and substance use resources for PLWH
- Increased HIV/STI awareness
- PEP/PrEP access

Priorities Identified through the HIV Medical Monitoring Project (MMP) (Statewide, PLWH):

The following unmet needs were identified using MMP survey data. Current data (2021-2023) are compared to previous time periods (2018-2020 and 2015-2017) to identify notable increases. Increases are noted in **bold type**.

- Overall: 47% of respondents identified at least 1 unmet need: (vs. 43% and 50%)
- Highest priority areas:
    - 20% reported unmet need for dental services (vs. 20% and 20%)
    - 14% reported unmet need for mental health services increased (**vs. 9% and 11%)**
    - 12% reported unmet need for HIV peer support increased (**vs. 10% and 9%)**

Priorities Identified through Chime In (Portland-area, people at risk for HIV):

- HIV/STI awareness among people who inject drugs (PWID) and low-income heterosexual people:

    - Self-perceived risk of acquiring HIV was low among PWID (2025) and low-income heterosexual people (2019), despite high prevalence of drug use and condomless sex, including some transactional sex.
    - PrEP awareness is low among both groups and PrEP use is nearly non-existent.

- Continued access to sterile syringes, especially through syringe services programs:
    - Two-thirds of PWID reported injecting at least daily; most reported using safer injection practices when sterile syringes were available.
    - About 75% received sterile syringes through an SSP. Only 17% received syringes from a pharmacy and 5% from a doctor's office.

Updates to other strategic plans

Oregon is not an Ending the HIV Epidemic (EHE) jurisdiction. Based on community input, we branded our 2017-2021 Integrated Plan as the End HIV/STI Oregon Initiative, a shared venture of statewide community partners and the Oregon Health Authority. We view our 2027-2031 plan as an update to our first End HIV Oregon plan – a process that is iterative – and will continue to use the End HIV Oregon brand for external communications about the plan (e.g., annual reports to the community, which are released every year on World AIDS Day; information provided on the End HIV Oregon website).

Section III. Contributing Data Sets and Assessments

Data Sharing & Use

Oregon collects, analyzes, and reviews a wide range of data on an ongoing basis, including surveillance, program evaluation, administrative, and needs assessment data. A full list of data sources/Needs Assessment Inventory is available in Appendix 2.

OHA maintains data sharing agreements with the following entities for the following purposes:

- Local public health authorities for the purpose of disease reporting and follow-up. Communicable disease data, including HIV and other reportable STI, is collected via the Oregon Public Health Epidemiologic Users System (ORPHEUS).
- Various health systems (e.g., Kaiser, Oregon Health & Sciences University (OHSU), Providence Health Systems) for collecting medical record data for patients living with HIV who are participating in the HIV Medical Monitoring Project.
- Northwest Portland Area Indian Health Board, Tribal Epi Center, and individual tribal nations for formalizing how OHA will work with tribal partners on outbreak response and for defining parameters for a data linkage between HIV surveillance and the tribal registry.
- Regional CBO partners/Part B subrecipients (HIV Alliance, Eastern Oregon Center for Independent Living) and Part A grantee (Multnomah County Health Department) for sharing data through CAREWare and conducting matches to share viral load data and ensure continuity of client care.
- OHA Health Analytics for access to the All Payer All Claims dataset and Hospital Discharge Dataset to conduct special studies, including frequency and predictors of HIV/STI testing and PrEP usage and characteristics of individuals diagnosed with HIV in inpatient settings.
- U.S. Department of Health & Human Services for routine matching of Oregon's HIV/AIDS case registry to the National Death Index and for reporting individual-level HIV testing data (Evaluation Web).

Multnomah County Health Department maintains data sharing agreements with the following entities for the following purposes:

- OHA data use agreements for:
    - HSSS and HGAP maintain front-end ORPHEUS surveillance database access, entry, and use for newly diagnosed PLWH care coordination and HIV surveillance data analytics.
    - CAREAssist (Oregon ADAP) data use and import into CAREWare for RW client insurance, FPL and eligibility coordination and analytics.
    - DataMart contract, which includes access to a back-end shared server of ORPHEUS data tables. Data use agreements maintained between Multnomah, Washington, and Clackamas local public health authorities for surveillance laboratory data import into CAREWare for RWHAP client care coordination purposes and TGA RWHAP linkage to care, unmet need, and viral load analysis.
- Organized Health Care Agreement (OCHA) across TGA RWHAP funded agencies for data sharing within CAREWare and for CAREWare data import from local

provider specific medical, case management and housing data systems (e.g., EPIC, Service Point) for purposes of cross-RWHAP provider client care coordination and client services and outcomes analysis, including disparities seen by client characteristics.

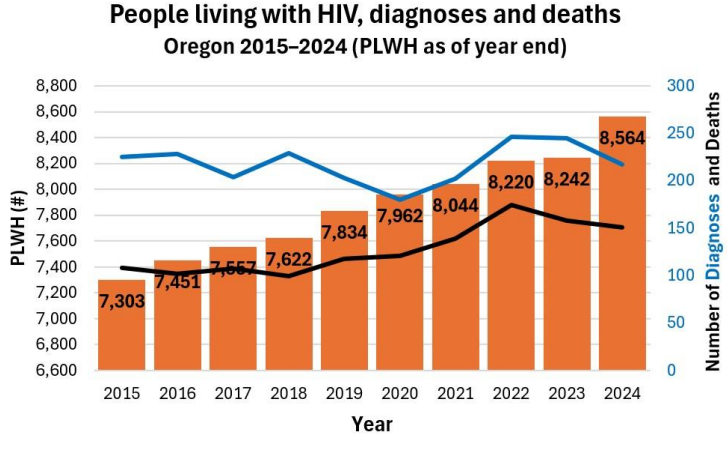
- Washington State Department of Health data-sharing agreement which allows for a one-time yearly import of data from the state surveillance database (PROVIDE) into CAREWare. The import includes demographic data and lab results for active Part A clients who may move through the TGA across Oregon and Washington state lines for access to services and residence.

Epidemiologic Snapshot

Oregon has developed user-friendly data dashboards that summarize key aspects of the HIV epidemic in Oregon. The dashboards are a digital version of the 2024 Epidemiological Profile. Readers are encouraged to visit the dashboards for more detailed information, graphic representations, and the ability to query specific characteristics of interest and time periods. Key facts from the Epi Profile are presented below.

Current Data

The number of people living with HIV (PLWH) continues to increase in Oregon. The number increased from 7,303 in 2015 to 8,564 as of 12/31/2024. This was an increase of 181.7/100,000 residents in 2015 to 200.5/100,000 in 2024. Trends of new HIV diagnoses and deaths were disrupted in 2020, with an increased number of diagnoses in 2022–2023. This disruption in trend made it difficult to statistically model and measure changes by demographic. However, Oregon observed an increase in mortality due to overdose and an increase in HIV diagnoses related to drug use, notably among women and in rural and frontier zip codes.



Key Descriptors

HIV Prevalence

From 1981 to 2024, 11,769 Oregon residents were diagnosed with HIV; in 2024, 8,564 people were living with diagnosed HIV in Oregon. We estimate that another 1,135 people in Oregon are living with HIV but are unaware of their status.

- Residence: 66% of PLWH reside in the five-county Portland metropolitan region (the TGA) compared to about 47% of all Oregonians.
- Sex: 87% of PLWH in Oregon were male; 13% were female.[1]
- Age: Median age for PLWH in Oregon was 53 years for males and 51 years for females. The prevalence of HIV was greatest among persons 55-59 years (472.0 PLWH/100,000 residents). Overall, 56.6% of people living with HIV were 50 years or older. More than two-thirds of PLWH in Oregon (71%) were long-term survivors (diagnosed for 10 years or more).
- Race/ethnicity: Some communities have disproportionate impacts of HIV prevalence. Prevalence among Black/African American residents (841.2/100,000) was four times higher than for white residents (189.2/100,000), the largest group of PLWH in Oregon at 72%. Prevalence of HIV was 221.2/100,000 among Hispanic/Latine residents, 186.2/100,000 among American Indian/Alaska Native residents, 165.3/100,000 among Native Hawaiian/Pacific Islander residents, and lowest among Asian residents at 90.2/100,000.
- Socioeconomic Characteristics: (2021-2023 MMP data)
    - Education: 7% of MMP participants had less than a high school diploma, 25% were high school graduates, 36% had some college, and 32% had a bachelor's degree or higher.
    - Food Insecurity: In 2021–2023, 13% of MMP participants reported past-year food insecurity, similar to the statewide estimate of Oregon households experiencing food insecurity during this period.
    - Poverty: 27% lived in households at or below the poverty threshold, a decrease from 36% in 2018-2020.
    - Houselessness: 6.5% experienced houselessness in the previous 12 months, down from 9% between 2018-2020. (Oregon frequently ranks in the top three or four states for homelessness per capita.)
- Behavioral Health Characteristics: (2021-2023 MMP data)
    - Reported injection and non-injection drug use in the past 12 months continues to rise. Sixty-three percent of MMP clients reported any drug use in the past 12 months in 2021-2023, compared to 36% in 2015-2017 and 46% in 2018-2020. This is consistent with trends in other regions in the US, in which fatal overdose was a major contributor to mortality among PWH and, in some regions, including the Pacific Northwest, exceeded HIV-related mortality.

[1] All references to male or female in this document refer to assigned sex at birth.

- Binge drinking: Binge drinking is defined as consuming four or more drinks on one occasion for women or five or more drinks for men. Sixteen percent of MMP clients reported binge drinking in the past 30 days in 2021-2023, similar to the state average.
- Current Smoker: Twenty-six percent are current smokers (2021-2023), down from 33% in 2015–2017, but more than double the proportion of Oregon adults who reported current smoking in 2022.
- Mental Health: Twenty-nine percent received mental health counseling or treatment, a decrease from previous years.

HIV Incidence

Oregon is considered a low incidence state for HIV, with an annual average of 218 new HIV diagnoses between 2020-2024, and 217 cases being diagnosed in 2024. Overall, new HIV diagnoses fell during 2015-2020 followed by an increased number of diagnoses during 2022-2023; 2,179 Oregon residents were diagnosed with HIV during 2015-2024.

In 2020, Oregon experienced a record low, with 180 newly diagnosed cases (4.2/100,000). However, these rates were likely artificially low because fewer people received health care during 2020. Moreover, there were large racial and ethnic inequities in new diagnoses. Oregonians who were Black/African American, American Indian/Alaska Natives, Native Hawaiian/Pacific Islander, Multiracial, and Hispanic/Latine had higher than average HIV diagnosis rates, while Oregonians who were White or Asian had lower than average rates.

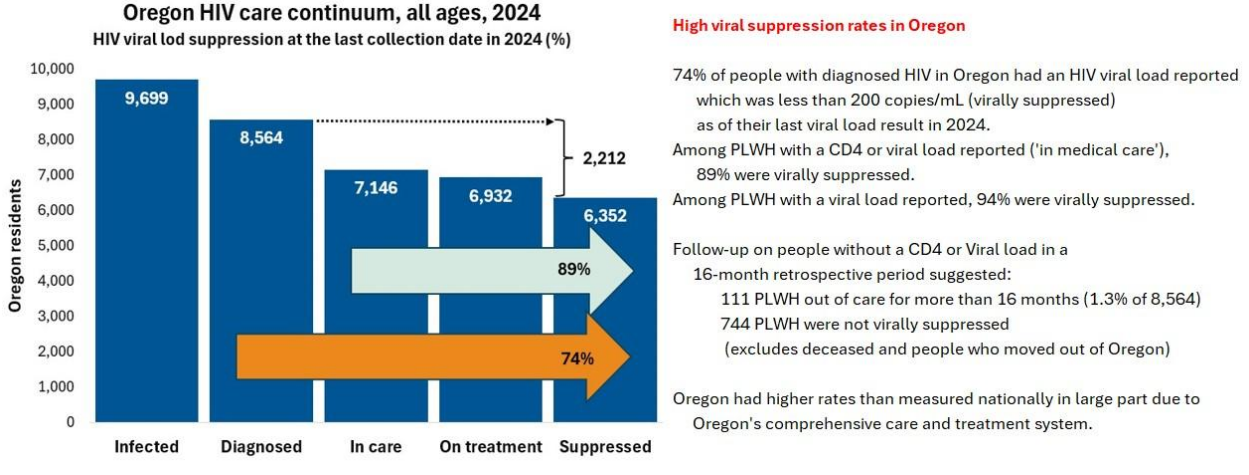
Characteristics of people newly diagnosed with HIV between 2015 to 2024:

- Sex: Rates of diagnosis decreased among males from 9.9 to 8.7 diagnoses per 100,000. The rate of new HIV diagnoses among females remained stable (1.3 to 1.5/100,000).
- Age: The median age at diagnosis was 35.0 years for males and 38.0 years for females in 2024. The average rate over 10 years was highest among people aged 25-34 years.
- Race/ethnicity: Black/African American people during 2015–2024 experienced an average diagnosis rate 4.4 times higher than Oregon overall (22.7/100,000 compared to Oregon 5.2/100,000). Rates among Hispanic/Latine people and white people were 8.5 and 4.2/100,000, respectively. Black/African American females were disproportionately represented among new HIV diagnoses. There were fewer than 10 new diagnoses each year among all other racial and ethnic groups; rates among American Indian/Alaska Natives (7.9/100,000) and Native Hawaiian/Pacific Islanders (11.2/100,000) were higher than the Oregon average. Over 70% of Black Oregonians live in the TGA and the Portland metropolitan area has the 9th largest urban Indian population in the U.S.
- Behavioral characteristics: People who reported male-to-male sexual contact (MMSC) accounted for 66.9% of all new HIV diagnoses 2015–2024 and 77.7% among males. Approximately 1 in 9 reports among males lacked enough information to assign a transmission category. Among females, IDU accounted for 27.1%, sex with males 51.5%, and unknown risk accounted for 21.5%. The proportion of new diagnoses reporting past injection drug use has remained at 22%.

- Geographic region: During 2024, the proportion of new HIV diagnoses among Multnomah County residents decreased from 38.2% to 29.5% (10.9 to 8.0 diagnoses/100,000 residents). New diagnoses in Multnomah, Washington, and Clackamas counties dropped from 8.1 to 5.8 diagnoses/100,000 residents. This decline was offset by an increase outside the Tri-County region from 3.7 to 4.5 diagnoses/100,000 residents. However, multi-year analysis shows the incidence rate began increasing again in the metro region, with an estimated 129 new diagnoses among TGA residents in 2025, of 224 in the entire state. On average, Multnomah County maintains the highest incidence rate in the state with 10.1 new diagnoses/100,000 residents (2019-2023).

HIV Care Continuum

Ensuring people living with HIV are aware of their status, rapidly linked to care, retained in care, and virally suppressed are critical steps to improving health outcomes and ending new HIV transmissions in Oregon. Oregon has a much higher proportion of PLWH in care and virally suppressed than the U.S., but there is still much work to do to ensure the estimated 1,135 people living with HIV but unaware of their status are diagnosed, and that all people living with HIV benefit from high quality care. Furthermore, some people and communities experience disproportionate impacts. Differences in HIV care continuum outcomes by demographic and other characteristics can be explored by visiting Oregon's online HIV Epi Profile 2024 care continuum dashboard; they will also be discussed throughout this Integrated Plan.



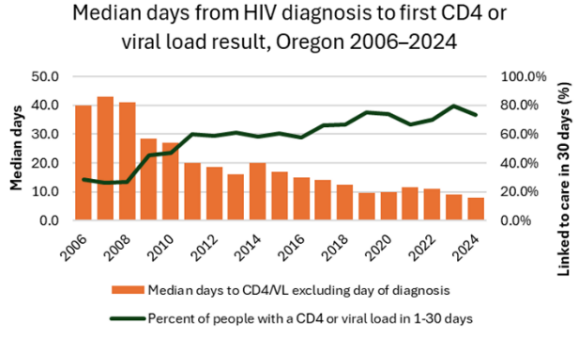
Seventy-four percent (6,352/8,564) of people living with HIV were virally suppressed in 2024. This percentage assumes that people without a reported viral load were not virally suppressed. Of the 6,750 people with a reported viral load in 2024, 94% (6,352) were virally suppressed.

Viral suppression was lower among people:
· 20-29 years of age
· With American Indian/Alaska Native race/ethnicity
· Reporting injection drug use (IDU) who were male

· Reporting male-to-male sexual contact and injection drug use (MMSC/IDU)
· Reporting non-injection drug use
· Reporting sex with a person who injects drugs
· Experiencing houselessness or unstable housing
· Who were residents in rural counties
· Diagnosed with HIV in the hospital
· Reason for testing: Contacted by a partner or County Health Department

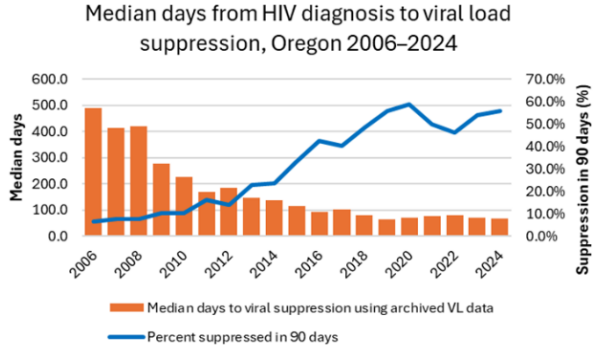
People vulnerable to HIV:

People most vulnerable to HIV can be described by those groups with an increasing incidence but also by care metrics which distinguish those groups least likely to be linked to care within 30 days, achieve viral suppression in 90 days, and/or receive an AIDS diagnosis within 90 days. The proportion of people newly diagnosed with HIV who were linked to care within 30 days has increased over time, from 58% in 2014 to 73% in 2024.



Some communities were less likely to be linked to care within 30 days, including people:
· Reporting injection drug use (IDU) and male
· Diagnosed at HIV screening/referral facilities or at ER/Urgent Care
· Diagnosed outside of Multnomah, Washington, and Clackamas counties
· Who were residents in rural counties
· Experiencing houselessness/unstable housing

The proportion of people achieving viral suppression within 90 days increased from 24% in 2014 to 56% in 2024.



Viral suppression within 90 days tended to be lower among people:
· Reporting Injection Drug Use (IDU or Male-to-male sexual contact and an IDU risk (MMSC/IDU)
· Diagnosed with HIV in the hospital
· Diagnosed outside of Multnomah, Washington, and Clackamas counties
· Who were residents of rural counties
· Experiencing houselessness or unstable housing
· Who had sex with a person who injects drugs (PWID)

We estimate that 1,135 people in Oregon were living with HIV but were unaware of their status. Describing those people diagnosed late in their HIV infection may offer insight into which Oregonians are living with HIV, but do not know their HIV status. The percentage of people newly diagnosed with HIV who developed AIDS within 90 days of their diagnosis (also known as late diagnosis) declined from 33% in 2014 to 26% in 2024.

The percentage of people with late HIV diagnoses was higher among people:
· With Asian race/ethnicity
· Not reporting a transmission risk
· Reporting injection drug use (IDU) who were male
· Diagnosed with HIV in the hospital
· Who were residents in rural and frontier zip codes
· Reason for testing: A medical provider suggested it

HIV CLUSTERS

There were unexpected increases in HIV across Oregon in 2024–2025, particularly in rural and frontier zip code regions. A cluster in Southwest Oregon was driven by drug use and included more females than would have been otherwise expected. HIV molecular cluster analysis in Oregon over the last five years found clusters consistent with these findings.

From 2018-2020, a time-space cluster of new HIV infection was detected in Clackamas, Multnomah, and Washington Counties (the Portland metro area) among people who inject drugs (PWID) and/or people who used any form of methamphetamine. Most cluster cases had no molecular relationships to previous cases. The public health response included activating incident command, development and implementation of an enhanced interview tool, outreach testing, and stakeholder engagement.

When a cluster is identified, partners including staff from OHA, LPHA, the AETC, and CBOs in the affected jurisdictions work together to develop and implement a timely response. For example, a 2025 multi-modal media campaign led by HIV Alliance, in partnership with OHA and multiple LPHAs, reached a significant number of Southwest Oregon residents, with millions of campaign impressions through billboards, radio, digital advertising, and other means. During the three months of the campaign, orders for mail order HIV home test kits nearly doubled and orders for condoms and other sexual health supplies increased by 43%, with particularly high increases in Coos and Klamath counties. Additional social media and digital ads targeting specific communities continued after the main campaign was completed.

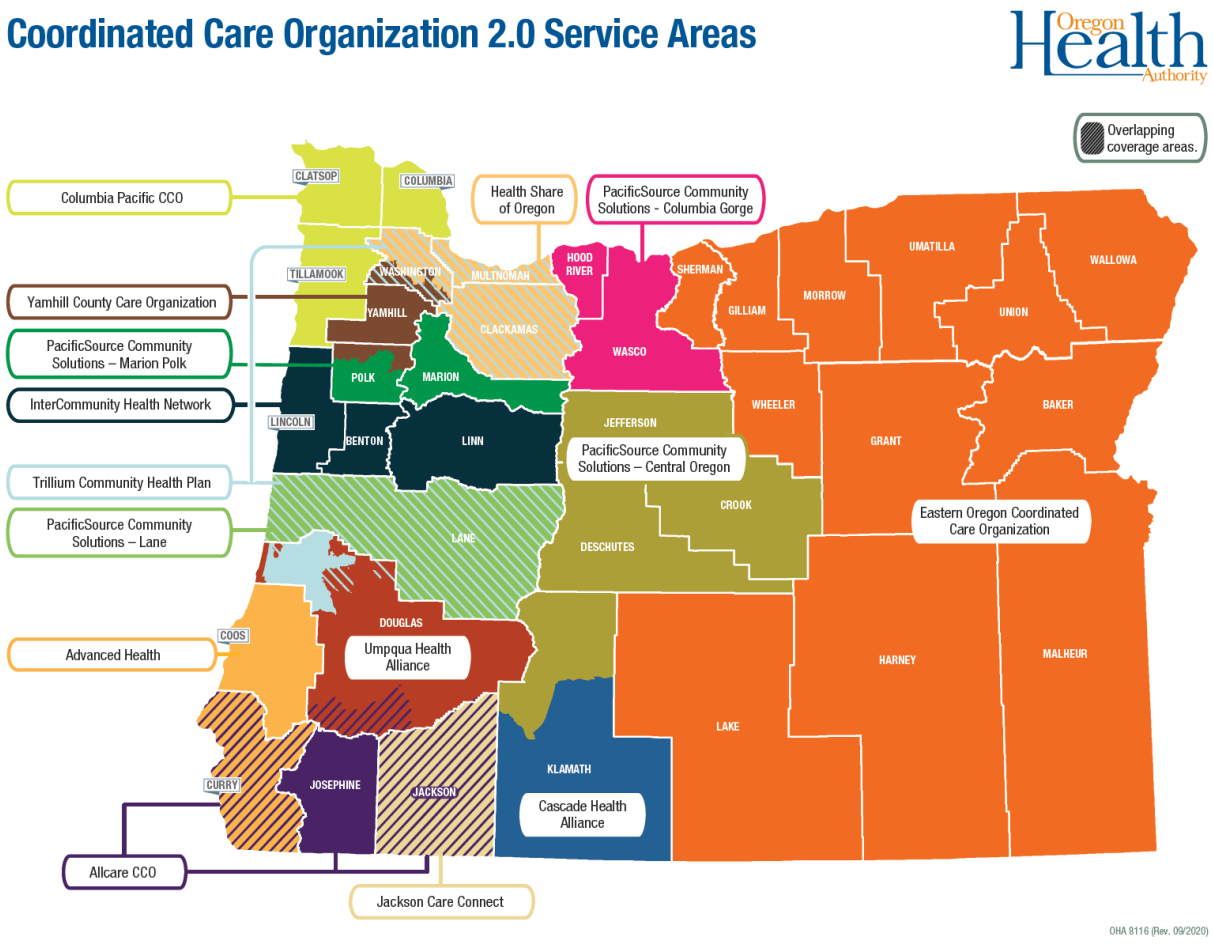
HIV Prevention, Care and Treatment Resource Inventory

Oregon's HIV prevention and care system includes a wide range of funded and leveraged resources and is built on a strong healthcare system, with 97% of Oregonians covered by health insurance. This is an increase of more than 11 percentage points—or more than 400,000 people—since 2011.

Many prevention services, including HIV/STI testing and PrEP, are covered by health insurance, although there is wide variation in co-pays, out-of-pocket costs, and coverage of labs and other ancillary services. HIV and STI treatment is considered an essential health service covered by all plans. CAREAssist pays the cost of insurance premiums, medical and medication copays, and deductibles for eligible PLWH in Oregon whose income is ≤550% FPL – this eligibility criterion ensures broad coverage for PLWH in Oregon and is a key to our high viral suppression rates. Oregon has the highest rate of virally suppressed clients among all ADAPs.

About half of Oregonians (46%) have group coverage, such as through their employers; 32% are covered by the Oregon Health Plan (Medicaid); 13% by Medicare, 5% by individual plans, and 1% by other coverage. Oregonians access HIV and STI prevention and care services at medical facilities, private medical practices, academic teaching hospitals, Federally Qualified Health Centers, and community clinics. Oregon's AIDS Education & Training Center, a program of the Oregon Primary Care Association and a part of the Mountain West AETC, offers education and training, clinical consultation, and capacity building assistance on prevention, diagnosis, and treatment of HIV and commonly associated co-morbidities, such as viral hepatitis, STIs and substance use disorders, to health care professionals and organizations across Oregon, ensuring high-quality prevention and care services across public and private systems throughout the state.

The 1.4 million Oregonians covered by the Oregon Health Plan (OHP), the state's Medicaid Program, receive services through Coordinated Care Organizations (CCOs). Oregon has the highest rate in the nation for keeping people covered throughout post-COVID Medicaid renewals, due to strategic efforts including community outreach, using automated systems to minimize the need for members to respond, and offering more time for members to respond than any other state.



Oregon's HIV/STI care and prevention infrastructure works with and within these foundational healthcare systems. Oregon has one Part C clinic, Multnomah County Health Department's HIV Health Services Center, located in Portland. Local public health authorities (LPHA) provide HIV/STI care and prevention services in Oregon's 36 counties, in collaboration with a network of organizations providing medical and non-medical case management, including Cascade AIDS Project, Eastern Oregon Center for Independent Living, HIV Alliance, and OHSU Partnership Project. Partners from community-based organizations provide specific services, such as behavioral health (e.g., Quest Center for Integrative Health) or psychosocial and food & nutritional services (e.g., Ecumenical Ministries of Oregon), and/or services to specific communities (e.g., Familias en Acción, Outside In, Urban League). Community-based organizations leverage funds from various private and public sources to support work along the HIV care continuum.

The Part A jurisdiction directly invests in Outpatient/Ambulatory Medical Services to ensure a backbone of expert medical providers who specialize in working with low income individuals living with HIV. This investment increases access to care for those who require safety net support. That expertise is accessed by other communities seeking consultation, by the state prison system, and by clients who regularly transport to the urban core for more confidential, HIV competent and knowledgeable care.

Oregon does not receive Ending the HIV Epidemic (EHE) funding. Our HIV care and prevention system is funded through a network of federal and local grants, state general fund and 340B program income. Oregon receives a federal STI prevention and treatment grant from CDC [STD PCHD (NH25PS005149): $1,071,872] that supports STI and sexual health surveillance, prevention, and treatment.

Leveraged resources include services funded through Oregon's Public Health Modernization Program, a state investment of $112.2 million dollars for the 2023-2025 biennium, designed to build public health capacity, resilience, response, and recovery. Public health modernization dollars support the public health workforce, communications systems, and communicable disease response, among other foundational capacities. However, in 2025, Oregon Governor Tina Kotek released a budget that estimates the State will lose $15 billion in Federal funding for health insurance coverage, food benefits and other programs. Budget losses will accelerate through 2029-31, with most of the losses affecting the Oregon Health Authority, Department of Human Services, and the Department of Transportation. This state budget shortfall may impact the resources available for public health overall, and for HIV/STI care and treatment, specifically.

The Rural Health Transformation Program (RHTP) was established through H.R.1, the federal budget reconciliation bill signed into law on July 4, 2025. In addition to introducing long-term changes to Medicaid and SNAP funding, H.R.1 created this five-year program to support rural health system transformation across the United States. The program is administered by the Centers for Medicare & Medicaid Services (CMS) and provides funding to selected states from Federal Fiscal Year 2026 through 2030. Oregon was awarded $197.3 million in federal funding for the first year (2026) of the Rural Health Transformation Program (RHTP). Twelve community-driven projects focused on community health worker programs, school-based services, and educational initiatives, will receive immediate impact awards. Direct awards will be made to tribal nations, rural hospitals, and local public health authorities. Competitive grants for system transformation will be awarded for 1-2 years. These investments will support a wide range of initiatives, including workforce development, health technology, chronic disease prevention, behavioral health, maternal/child health, tribal healthcare, and regional system partnerships. Although funds cannot supplant existing programming, and are not designed to specifically address HIV, STI, or sexual health, they should help build capacity in underserved areas and may indirectly improve some of the issues identified in this plan, such as medical provider shortages in rural and frontier areas.

There are three 340B covered entities in Oregon specifically generating program income from an original investment of Ryan White HIV/AIDS Program funds. Program Income is generated from the Oregon Health Authority's CAREAssist Program (the AIDS Drug Assistance Program), Multnomah County Health Department's HIV Health Services Center (HHSC, the Part C Clinic) (DATA STILL NEEDED FROM HHSC), and HIV Alliance.

A complete resource inventory, with line listings for all HIV-specific federal and state funding sources, is available in Appendix 4.

Inventory of Substance Abuse Prevention and Treatment Services

Oregon is slated to receive more than $700 million in opioid settlement funds through 2039.

Oregon's public behavioral health system offers a statewide continuum of substance use prevention and treatment services administered primarily through the Oregon Health Authority (OHA) Behavioral Health Division's Addiction Services, which provides policy guidance, Measure 110 implementation, and links to county/community mental health programs and certified SUD providers. Oregon has awarded roughly $800 million in Measure 110 grants since 2021 Behavioral Health Resource Networks (BHRNs) are the primary vehicle for delivering substance use and health and safety services statewide. As cannabis tax revenue has fallen, a projected BHRN funding gap is being partially backfilled by $13 million in opioid settlement dollars, and OHA has shifted to making BHRN funding decisions directly, adjusting awards annually to match available revenue.

OHA maintains an Oregon Substance Use Disorders Services Directory listing state-certified outpatient, residential, detoxification, DUII, and co-occurring disorder programs by county, with contact and website information for each organization.

OHA Behavioral Health and HIV Programs offers information and resources to service planning manuals and local programs serving people using substances. Many of these programs offer sterile equipment, disposal, HIV/HCV testing, naloxone, and direct service referrals to care and treatment.

Oregonians can also use national locators such as FindTreatment.gov and SAMHSA's Opioid Treatment Program Directory to identify nearby residential, outpatient, and medications for opioid use disorder (MOUD) providers in Oregon, including Medicaid and uninsured options. In addition to public-sector resources, coordinated care organizations and large health systems maintain benefit- and region-specific SUD service directories.

Oregon braids and coordinates HIV prevention, care and treatment resources with substance use and overdose prevention and treatment resources, including opioid settlement funds, State Opioid Response (SOR) grants, Measure 110 funds (the Drug Addiction Treatment & Recovery Act), and other sources. Leveraging and coordination remain key strategies for enhancing outcomes in a relatively small state and for ensuring a syndemic approach to addressing the overlapping epidemics of HIV, viral hepatitis, STIs, and overdose. Concrete examples of coordinated services are included throughout this plan. One example is Oregon's PRIME Plus program (Peer Recovery Initiated in Medical Establishments + Infectious Disease Testing and Linkage to Care), a peer recovery support program funded through SAMHSA State Opioid Response grants. PRIME+ peers work with people who use drugs and people at risk of overdose and related health issues, including HIV, viral hepatitis, and sexually transmitted infections, many of whom are out of routine medical and behavioral health care. Currently, 24 PRIME+ peer teams (peers) provide peer support in 20 Oregon counties, including urban, rural, and frontier settings and 17 organizations. PRIME+ has served over 7,500 clients with over 50,000 participant contacts. Additionally, the Part A jurisdiction supports recovery through both SUD and Mental Health peer services as well as a non-Medical Case Management navigator who works with substance using individuals who are experiencing houselessness.

Strengths and gaps

The following section describes the strengths, gaps, and challenges in Oregon's HIV/STI prevention, care, and treatment resources, organized by key strategies of the four pillars of diagnosis, prevention, treatment, and response.

DIAGNOSIS

HIV Awareness

Strengths:

- End HIV Oregon brand recognition – Oregon branded its 2017-2021 Integrated Plan as End HIV/STI Oregon, and has broad community support for its vision, mission, and strategies. We will continue to use this brand for our 2027-2031 plan. A website launched in December 2016 (www.endhivoregon.org) and annual progress reports shared with the community on World AIDS Day for 9 consecutive years have helped maintain visibility.
- Strong regional CBO partners – Oregon has several key subrecipient agencies that serve different parts of the state with status-neutral services, as well as additional CBO partners that promote HIV awareness in specific communities.
- Community-led education and outreach: OHA and local public health authorities (LPHAs) across Oregon have developed formal partnerships with community-based organizations to conduct education and outreach. Funded organizations include CBOs serving priority populations and communities with limited access to health care.

Gaps/Challenges:

- Community partnerships that support a syndemic focus: Oregon does have some partnerships with agencies serving people experiencing housing instability, behavioral health issues, intimate partner violence, and other structural issues, but these can be expanded and deepened to ensure effective coordination, especially during cluster and outbreak response.
- Challenges optimizing use of digital tools: Policies at many local public health authorities prevent the use of social media and other digital tools for HIV/STI awareness and outreach, or limit what types of imagery and messaging is allowable.
- Regional variation: Some parts of Oregon, especially rural and frontier areas, are less receptive to HIV/STI and sexual health awareness messaging. Many of these geographic areas are also experiencing higher HIV/STI rates.

HIV Testing

Strengths

- Free, confidential, integrated HIV/STI testing available statewide: Publicly funded HIV/STI testing is offered statewide, including at LPHAs, community-based organizations, programs serving people using drugs, safety net clinics, mobile health units, and targeted community events. Oregonians can find testing in their community on the End HIV Oregon website, which links to the CDC's testing page. Medical provider education conducted by the AIDS Education and Training Center has expanded the availability of integrated testing at Federally Qualified Health Centers and in private medical practices, as well.
-

- Testing in corrections: A partnership with Oregon Department of Corrections which supports opt-out integrated HIV/VH/STI screening of all adults in custody at intake in the Oregon prison system. It expands testing and education throughout state facilities as well as ensures distribution of release packets to facilitate testing, access to condoms, naloxone, and other resources at re-entry.
- Home-based HIV self-testing options available: Take Me Home offers a free mail-order rapid HIV self-test kit to any Oregonian 14 years of age or older who has not received one in the past 3 months. Users may opt to also receive a rapid syphilis self-test or HCV/STI self-collection test kit with each order. Positivity rates for home testing are consistently higher than clinic-based and outreach testing.
- Easy access to HIV/STI testing data: Oregon provides user-friendly data dashboards which includes data on clinic-based and mail order testing services.

Gaps/Challenges:

- Missed opportunities for routine testing in medical settings: Most HIV testing occurs in the private sector. A population-based cross-sectional study of administrative claims data in Oregon found that approximately 5% of insured Oregonians had HIV testing in the past year (2016), but only 2% had integrated HIV/STI testing. Though these data are old, they are consistent with more recent national data.
- Lack of data to measure population-based testing: The 2024 Oregon BRFSS found that approximately 8.9% of Oregonians 18 years of age and older were screened for HIV in the past year, suggesting persistent gaps in routine, normalized screening. But BRFSS response rates are low and have been declining. We us these data because they are the only current population-based data available, but their utility – especially for reporting on rates among sub-populations – are diminishing.
- Limited HIV/STI testing at emergency departments: Oregon has seen an increase in new diagnoses identified in emergency departments (12.9% of all diagnoses in 2024) and during inpatient hospitalizations (17.5% diagnoses in 2024). Routine, opt-out testing in these settings, particularly EDs, could identify cases earlier among people who may not perceive themselves at risk and may not be testing elsewhere. However, EDs have many competing priorities and are limited in their capacity to do this work without additional funding.
- Gaps in HIV/STI testing in correctional settings: Many Oregon jails do not consistently offer routine, opt-out HIV and/or STI testing at intake or during incarceration, despite serving populations with elevated risk. This is a missed opportunity for early diagnosis and linkage to care. In 2024, Oregon Department of Corrections (ODOC) implemented opt-out testing at prison intake, in line with CDC guidance, but has been inconsistently implemented due to leadership changes since this time. Gaps mean that not all adults in custody are screened as intended, resulting in missed opportunities in a setting more likely to have higher HIV/STI prevalence.
- Substance use and mental health treatment settings: Nationally, fewer than one-third of substance use treatment programs offer HIV testing, and even among facilities treating people with opioid use disorder, fewer than half provide HIV screening, missing key opportunities to reach people at elevated risk.
- Integrated HIV/STI testing remains incomplete: Oregon's four-year EISO evaluation found that integrated HIV/STI testing is key and should be standard practice, yet only about half of syphilis cases and 60% of rectal gonorrhea cases among people not known to have HIV received HIV testing, and roughly one-third received PrEP

referrals, indicating substantial gaps even in focused HIV/STI programs. Still, testing rates went up over the lifespan of the program.

HIV/STI Partner Services

Strengths:

- Increased resources for partner services statewide: HIV/STI partner services are available statewide. In 2025, Oregon implemented the HIV/STI Statewide Services model (HSSS), which aims to optimize and streamline the approach and funding for HIV/STI service delivery in LPHAs across Oregon. HSSS funds a range of HIV/STI services, including case investigation and partner services.
- New and improved DIS training: Oregon launched a new training curriculum for DIS, in partnership with the National Coalition of STD Directors (NCSD). A new tribal DIS training is available through the Raven Collective; in late 2025, the Northwest Portland Area Indian Health Board (NPAIHB) used ETHIC funds to issue mini grant opportunities to the nine Federally Recognized Oregon Tribes and NARA NW (the Urban Indian Health Program) to support HIV/STI disease investigation training and capacity. Moreover, the new Certified in Disease Intervention (CDI) initiative, funded by the CDC and administered by the National Board of Public Health Examiners (NBPHE), is an exciting opportunity to standardize and professionalize DIS HIV/STI expertise.
- Integrated case surveillance database: Unlike many other states where disease surveillance databases are more siloed, Oregon uses a homegrown case surveillance database, Orpheus, which is inclusive of both HIV and STIs. This allows for more effective monitoring of co-morbidities. In 2025, further system improvements were made in Orpheus to improve care coordination and data sharing by county.. For example, DIS interviewing new STD cases in people with a previous HIV infection can engage in conversations around linkage to HIV care and viral suppression, and provide needed referrals.

Gaps/Challenges:

- Fewer partners identified through partner services: The number of contacts named for HIV and early syphilis has declined over time, likely due to a combination of individual-level and system-level factors. These include people's inability or unwillingness to engage in interviews or to name partners; overall distrust of the governmental public health system; and the low number of health departments that allow for field work or interviews outside of a clinic setting or regular business hours.
- Balancing resources across the state: HSSS funds were awarded via a funding formula approved by the Coalition of Local Health Officers (CLHO), which has representatives from every LPHA in Oregon, and was designed to account for multiple factors, including disease prevalence, incidence, and social determinants of health. With resources being limited, some counties with higher prevalence and incidence of HIV have expressed concern about resources going to smaller and more remote counties with fewer cases.
- Lack of billing infrastructure to support sustainability: OHA, LPHAs, and CBO partners have been working to implement billing for HIV/STI services for many years, but lack of infrastructure means that most HIV/STI services conducted in the public and nonprofit sectors are still not reimbursed by insurance carriers.

- Staff shortages and turnover: Partner services can be resource intensive. Many LPHAs and tribes are experiencing staff turnover and/or have staff vacancies that remain chronically unfilled.
- Partner services in the digital era: Digital partner services is an essential tool in the modern disease investigation toolbox (including texting and communication through Websites and apps). Many LPHAs have restrictions on the use of digital tools. OHA is working with LPHA to support the development of policies and procedures where possible. In cases where that is not possible, OHA encourages subcontracting with a community-based organization.
- Coordination across systems: Many new HIV and STI cases are diagnosed outside of public sector programs (e.g. primary care clinics, alcohol and drug programs, emergency departments). This requires coordination across multiple systems and individuals. Missed opportunities and delays can occur.

Linkage to Care

Strengths:

- Early Intervention Services and Outreach programs continue to improve health outcomes: Since 2018, OHA allocated additional funding to support EIS and Outreach Services in high prevalence Oregon counties, which resulted in improved linkage to care within 30 days or fewer for people newly diagnosed with HIV. In 2025, Oregon launched a new service model, based on EIS and Outreach Services, called HSSS. HSSS ensures a core level of HIV/STI services in all 36 Oregon counties.

Gaps/Challenges:

- Increased cases in rural and frontier areas: Cases have increased in rural and frontier areas experiencing health care shortages, with less infrastructure to conduct effective responses. Partners report long delays getting newly diagnosed patients linked to medical care because providers are unavailable/have long waits for all patients or are uninterested or unwilling to provide medical care to PWH.
- Delays in linkage to care: People who inject drugs, are houseless, live rurally, and/or receive diagnoses in an ER or urgent care are less likely to be linked to care quickly. People with these characteristics often lack access to health care or have difficulties interacting with available systems.
- System coordination is challenging: A higher proportion of new HIV diagnoses are being identified in emergency departments, through inpatient hospitalizations, and in other non-public venues. This requires a high level of coordination between a variety of systems, programs, and individuals, which can result in delays in care and missed opportunities when not well-executed.

PREVENTION

PrEP/PEP

Strengths:

- Policy changes increase access: Almost all insurers currently cover PrEP, including the package of services necessary to start and stay on PrEP, including doctor's visits, labs, and prescription drug costs. A law passed in the 2025 Oregon Legislature includes injectable PrEP in the package of covered services.
- Pharmacist-delivered PrEP/PEP: Oregon law supports PrEP and PEP access through pharmacies. Pharmacists may prescribe a 30-day supply of PrEP based solely on a negative HIV test result and receive reimbursement for their services. Having more options to get PrEP and PEP through pharmacies may make it easier for groups who have not yet been accessing it, including women, men of color, and rural Oregonians, to get a PrEP prescription. OSU School of Pharmacy has been actively training pharmacists and pharmacy techs on PrEP, PEP, and other HIV-related topics.
- PrEP providers available statewide: There are currently 430 medical providers listed in the Oregon AIDS Education & Training Center's PrEP Provider List.
- Expertise in injectable PrEP: Several medical providers in Part A have developed expertise and confidence in managing patients who choose injectable PrEP, ensuring a viable option for people who would benefit from this option.
- New directory helps people find PEP quickly: Finding PEP in rural and frontier areas has been a challenge, but a new directory lists pharmacies that stock PEP statewide.

Gaps/Challenges:

- Awareness of PrEP is low among some groups who could benefit: PrEP awareness remains low among PWID, low-income heterosexual people, and people living in rural/frontier areas and PrEP usage is extremely low – but new diagnoses among people with these characteristics have increased.
- Changes to PrEP availability: The Ready, Set, PrEP Program ended and PrEP Access Programs through Gilead have changed in recent years. Increases in health insurance premiums in 2025 may mean fewer people insured, with a corresponding increase in demand for patient access programs.
- Pharmacist shortage: Oregon consistently ranks near the bottom among U.S. states for the number of retail/community pharmacies per capita—only Alaska has fewer. Pharmacy closures in 2023-24 reduced already limited access, especially in rural areas, many of which are considered "pharmacy deserts."

Prevention Supplies

Strengths:

- Condoms widely available: LPHAs and CBO partners receive and distribute condoms and lubricant via OHA through CDC prevention funding. In addition, Oregon's One at Home Program provides residents with a free envelope of sexual wellness supplies delivered discreetly to their door, once every 30 days. One at Home, Oregon's condom home-delivery service, has delivered more than 700,000 condoms since it began in 2021.

- Save Lives Oregon Clearinghouse increases access to supplies: Save Lives Oregon is a collaborative of organizations working across Oregon and in tribal communities to reduce drug-related harm and increase individual and community health and safety bv providing supplies, training, and resources. Many organizations which provide services along the HIV status-neutral continuum access supplies and services through Save Lives Oregon.
- PWID report safer behavior, including infrequent usage of used syringes. National HIV Behavioral Surveillance data across the years show that PWID in Portland have reduced harmful behavior associated with injecting. Overdose is a common experience, but many PWID are carrying and using naloxone.

Gaps/Challenges:

- Syringe exchange is unavailable in some parts of Oregon: One third of Oregon counties (33%) do not have syringe exchange services; many of these counties are contiguous, leaving parts of the population with no place to safely dispose of used syringes in exchange for sterile equipment which prevents HIV and viral hepatitis.
- Potential limits to where SSPs can operate: Bills have been proposed in the Oregon Legislature to limit where SSPs can operate. Although a bill has not passed as of this writing, discussions are ongoing and require monitoring.
- Shifts in drug use patterns increase risk: According to NHBS data, substances used by PWID in Portland continue to shift over time and may be associated with changes in injection frequency.

TREATMENT

Access to Medical Care

Strengths:

- Nearly all PLWH in Oregon have access to insurance and ARTs: Between the Oregon Health Plan, Healthier Oregon, and CAREAssist (Oregon's ADAP), which covers insurance co-pays for income-eligible PLWH, nearly all PLWH are insured. CAREAssist income eligibility is ≥550% of the federal poverty level. Individuals who are uninsured and need urgent coverage for prescription medications related to their HIV care may be eligible for up to a 30-day supply through the CAREAssist Bridge Program. For persons who are unable to secure health insurance outside of an open enrollment period or a special enrollment period, CAREAssist can assist with payments for a limited number of medical services and medications necessary for HIV treatment, through the Uninsured Persons Program (UPP). When surveyed, CAREAssist clients overwhelmingly laud the program for its lifesaving services, and Oregon's ADAP has the highest percentage of people who are virally suppressed compared to all ADAPs nationwide.
- CAREAssist Pharmacy Network: CAREAssist clients can access drugs via a statewide network of brick-and-mortar pharmacies and/or through two mail-order retail services, which deliver within 24-48 hours through courier or overnight mail.
- Strong provider network: Oregon has one Part C clinic that provides comprehensive care to patients in medical teams that include a provider, nurse, medical assistant, and medical case manager. In conjunction with the AETC, providers from the Part C clinic offer preceptorships to providers across Oregon and clinicians from OHSU and

other medical systems provide technical assistance. The Oregon AIDS Education & Training Center's HIV Provider List lists HIV medical providers across the state.

- Rapid ART Starts: The HIV Health Services Center at Multnomah County Health Department (the Part C clinic) provides a rapid ART start program (e.g., within 7 days of diagnosis) for patients in the Portland metropolitan area. In addition, about 29 medical providers on the Oregon HIV Provider List advertise themselves as offering rapid ART starts.
- Statewide training and other support for providers are available: The Oregon AETC provides comprehensive training and capacity building services to Oregon medical providers.

Gaps/Challenges:

- Coordination with providers outside the Ryan White system: Medical providers not affiliated with the Ryan White system may be less connected with available resources, which can result in delays or gaps in care. Rapid start, while increasing in availability, is still offered by a fraction of Oregon HIV providers.
- Access challenges in rural Oregon: Oregon contains areas of large land mass and low population; many of these are health professional shortage areas. Wait times of three months to see HIV specialists and mental health providers in rural and frontier Oregon have been reported. Travel time to care in larger cities can be long, involving costly overnight stays.
- Dental care coverage is available, but underutilized: Although CAREAssist provides coverage for dental care, it is perennially underutilized. CAREAssist has increased dental coverage by initiating a yearly dental drive. A shortage of dental providers with HIV expertise exists in all Oregon communities.
- Fewer Part F providers: A long-term Part F provider serving rural Oregon (Lane Community College) discontinued their contract to provide dental services, leaving large parts of the state without Part F dental service as of this writing (mid-2026).

Case Management

Strengths:

- HIV case management is available statewide: HIV case management is available throughout the state. Seven percent of Oregon MMP clients surveyed from 2021-2023 reported an unmet need for case management in the preceding 12 months.
- Client satisfaction: Case management clients generally report high levels of satisfaction with the services they receive.
- Adoption of telehealth/tele-visits: Greater adoption and acceptance of virtual visits make case management services more available to clients with access to digital tools.

Gaps/Challenges:

- Staff turnover: Ongoing staff turnover at several of the key case management provider agencies can be practically and emotionally difficult for clients. Low wages, inflation, and increasingly complex caseloads are contributing factors.
- Telehealth not fully accessed by all: Access to devices and knowledge of how to use telehealth continue to be limited for some clients. Low-income and houseless clients do not have internet, computers, or, in some cases, cell phones. Some areas of Oregon lack high-speed internet or are underserved, creating an access issue.

Housing:

Strengths:

- Range of housing programs available: Oregon Parts A and B provide a range of housing programs to serve clients with different needs. These include motel/hotel vouchers, short-term housing, long-term housing through HOPWA-funded programs, and supportive housing for people with behavioral health needs in the Portland area, the Willamette Valley, Southern Oregon, and Eastern Oregon.
- Transformative benefits reported: Respondents in Part A and Part B supportive housing programs described transformative benefits of achieving stable housing, including tangible successes like completing alcohol and drug treatment, securing employment, or achieving a stable income by applying for benefits.

Gaps/Challenges:

- High rates of unhoused: All parts of Oregon are facing a housing crisis. Clients who experience houselessness will require more support to secure and retain housing afterwards. Oregon's houselessness rate is consistently ranked among one of the highest in the U.S.
- Lack of affordable housing leads to housing instability: Housing coordinators often struggle to find available units in which to place eligible clients. Affordable housing stock has declined due to population growth, high rents, gentrification, low overall vacancy rates, and the destruction of housing units by Oregon wildfires. Oregon lacks over 80,000 affordable rental units for households earning ≤60% of Area Median Income (AMI). Rents and cost of living are generally higher in Portland area.

Food & Nutrition:

Strengths:

- Oregon's regional food network improves food security: Oregonians can access free food at 1,200 sites and 21 regional food banks across Oregon and SW Washington. The online Food Finder tool provides up-to-date information on communities across the state.
- Identifying food insecurity and linking to resources: Oregon's HIV case managers have been working to strengthen relationships with regional food banks and to better identify PLWH experiencing food security through adoption of the Hunger Vital Sign, as part of the intake process for medical case management.
- HIV-specific food resources available: In the Portland area, specific food bank and meal delivery resources serving PLWH are available through Ecumenical Ministries of Oregon's HIV Day Center and Daily Bread Express and Our House/Cascade AIDS Project's Esther's Pantry.

Gaps/Challenges:

- Food insecurity is high and increasing across Oregon: According to the Oregon Food Bank, rates of food insecurity and hunger in Oregon are comparable to those of the 1930s during the Great Depression. One in 8 Oregonians experience hunger. In 2024, Oregon's food bank networks saw 2.5 million visits, a 31% increase from the previous year. Hunger continues to hit some communities the hardest: such as people of color, immigrants and refugees, single moms and caregivers, and people living rurally. Federal

cuts to SNAP and Medicaid are expected to exacerbate hunger and food security in Oregon.

Behavioral Health Resources

Strengths:

- New funding available: The Oregon Legislature, through the Oregon Health Authority (OHA) and partner agencies, funded approximately $1.0 billion in public substance use disorder (SUD) services during the 2023–25 biennium. Treatment services represented about 64% of SUD expenditures. Prevention represented about 9%, including about 6% for primary prevention and 3% for harm reduction. Other funding categories included peer-delivered services, recovery supports, drug courts, and other administrative items.
- House Bill 2024 (2025) allocated over $7 million for behavioral health workforce incentive grants, funding stipends, scholarships, and loan forgiveness, as well as targeted reimbursement increases for MAT and outpatient services.
- Robust set of overdose-related services and programs: Services and programs ranging from public awareness campaigns to the Rural Communities Opioid Response Program to X-waivered buprenorphine practitioners are available across Oregon.

Gaps/Challenges:

- High need plus access challenges: Oregon ranks among the most challenged states in the nation for substance abuse and mental health conditions, while at the same time ranking among the worst states for access and engagement with care (see Situational Analysis for more detail).
- Low wages compared to cost of living: As of July 2025, the median annual salary for a Qualified Mental Health Professional (QMHP) in Oregon is $69,560. Although length of experience and certification strongly influence wages, there is no indication that compensation is keeping pace with inflation or addressing recruitment challenges.

RESPONSE

Strengths:

- Quad-County Disease Intervention Specialist Coordination: DIS in Multnomah, Washington, Clackamas, and Clark County, WA regularly collaborate on HIV and syphilis case investigations in the Portland metropolitan area for a stronger, more effective response that is not limited by state or county borders.
- Successful public health response to increased diagnoses in rural areas: There were unexpected increases in HIV across Oregon in 2024–2025, particularly in rural and frontier zip code regions. A cluster in Southwest Oregon was driven by drug use and included more women than would have been otherwise expected. OHA staff worked with LPHA and CBO staff in the affected jurisdictions to develop and implement a multi-modal media campaign led by HIV Alliance. The campaign reached a significant number of Southwest Oregon residents and resulted in increases in mail orders for condoms and HIV home test kits.
- Community partnerships: Services designed by and for the community can support prevention, treatment, and outbreak response. New formal, funded partnerships with 13

CBOs serving people and communities experiencing disproportionate impacts of HIV began in 2026.

Gaps/Challenges:

- Public health infrastructure overtaxed: Deployments, increased hours and responsibilities, and staff turnover have left many public health workers burned out and the system overtaxed. New challenges with funding shortfalls and uncertainties are delaying a full recovery of the system.
- Local public health lacks capacity to bill: Despite ongoing efforts to recoup reimbursements for services provided to Medicaid patients in LPHA settings, many LPHAs lack the infrastructure to bill for covered services.

Approaches and partnerships

Needs Assessment

Needs assessment is ongoing in Oregon. Through the end of 2024, Oregon participated in two special surveillance studies, the HIV Medical Monitoring Project (MMP) and the National HIV Behavioral Surveillance survey (NHBS), which provide annual data related to prevention and care services. NHBS ended in Oregon at the end of 2024. In addition, we conduct special studies on an ad hoc basis, including client and community surveys and focus groups. Finally, we augmented these data with individual interviews with PLWH, surveys of community partners, community Town Hall/listening sessions, and solicitation of public comment to ensure that we had broad community input to inform the goals and objectives in this submission. A list of key needs assessment data sources is available in Appendix 2.

Below is a summary of needs assessment data, organized by the four pillars: Diagnosis, Prevention, Treatment, and Response.

DIAGNOSIS

HIV Awareness:
As promoted on www.endhivoregon.org: *everyone has an HIV status, and all Oregonians need to know theirs.* People living with HIV who are aware of their status can take advantage of life-extending medications, live longer, healthier lives, and prevent transmission to sex partners. **We estimate that 1,135 Oregonians living with HIV are unaware of their status.** Community input and needs assessment indicate that HIV awareness is often low in communities facing the greatest difficulties accessing health care. An increasing number of people newly diagnosed with HIV report "no identifiable risk factors," which may indicate an unwillingness to talk to staff or may indicate a true lack of awareness or acknowledgment of their risk. Raising awareness of HIV through community outreach and education, social media, and other awareness efforts can increase testing and linkage to care for people living with HIV and connect people who are not infected to needed prevention resources.

HIV Testing:
Testing is easy, but too few Oregonians know their HIV status. Only **42.4%** of all adult Oregonians report ever being screened for HIV – far below our goal of **70%.**

Free, confidential HIV testing is widely available throughout Oregon, at public test sites and through the mail-order, self-testing program, Take Me Home. Oregonians can find testing in their community on the End HIV Oregon website, which links to the CDC's testing page.

In 2025, 9,121 Oregonians received HIV testing through a public test site in Oregon, the highest number tested since OHA began tracking community-based testing, and 19 tested positive (0.2% positivity rate).

In 2025, 1150 test kits were distributed through Take Me Home's lab-based mail order self-collection program to people in 31 of 36 Oregon counties; 1.3% were positive for chlamydia, .5% positive for gonorrhea, .3% positive for HCV, and 0% were positive for HIV or syphilis.

Rapid test kits for HIV and syphilis can also be ordered from Take Me Home and Together Take Me Home; rapid syphilis testing became available in January 2025. In 2025, 304 HIV test kits

and 365 HIV/syphilis kits were distributed to people in 29 of 36 Oregon counties. About one-fifth were first-time testers for HIV; 2 of 669 HIV tests (.3%) were positive.

In 2025, there were 894 test kit orders sent to Oregonians from Together Take Me Home (representing 1,681 test kits since people receive 2 tests per order). Twenty-eight percent were first-time testers and .2% tested HIV positive. As reported in the journal AIDS and Behavior, the service appears to increase access for people who may not seek services in clinics, including first-time testers and people in rural areas.

Routine testing in medical settings is needed to identify people who are unaware of their status, particularly since 12.5% of males and 24.2% of females newly diagnosed with HIV in Oregon in 2024 reported no identifiable risk factors – and, not surprisingly, these individuals were more likely to present with delayed diagnosis (e.g., AIDS diagnosis within 90 days or concurrent with initial HIV diagnosis). However, according to the Oregon Behavioral Risk Factor Surveillance System, only 42.4% of Oregonians have ever been tested for HIV. A population-based cross-sectional study of administrative claims data in Oregon found that approximately 5% of insured Oregonians had past-year HIV testing (2016) in a medical setting, and only 2% had integrated HIV/STI testing. These data are old but are consistent with national data on routine annual HIV testing in medical care settings.

Since 2022, gonorrhea and chlamydia rates in Oregon have declined. Syphilis and congenital syphilis cases were highest in 2023-2024 and then fell in 2025. Oregon HIV rates stabilized in 2023 and declined in 2024, while national HIV rates increased in 2023 (2024 national HIV data are pending.)

Linkage to Care

Between 2020-2024, 76% (832/1,090) of people newly diagnosed with HIV in Oregon were linked to care within 30 days (defined as a CD4 or VL 1-30 days after diagnosis; excludes day 0). Overall, linkage to care did not differ by sex at birth, or age at diagnosis. People living in the tri-county Portland metropolitan area were more likely to be linked to care within 30 days than those living outside the tri-county area (83% vs. 68%). Black/African American people were more likely to be linked to care than their White counterparts (86% vs. 75%). People who inject drugs were less likely to be linked to care than men who have sex with men (61% vs. 77%).

Since launching in 2018, Oregon's Early Intervention Services and Outreach Program (now known as HIV/STI Statewide Services or HSSS) has increased the proportion of newly diagnosed people linked to care in 30 days or less and shortened the time between diagnosis and viral suppression.

Oregon has invested in HIV early intervention services and outreach services, initially in high-prevalence jurisdictions and now, statewide. This program is now called HIV/STI Statewide Services (HSSS). Between 2023-2025, 584 HIV cases, 2831 cases of early syphilis (or pregnancy-capable people with syphilis at any stage), and 2669 cases of rectal gonorrhea were enrolled in HSSS. Of these 6,084 cases, 67.2% were interviewed. Among the HIV cases, 83.4% were linked to care within 30 days and 92.7% in 90 days. The median days to care was 9.

PREVENTION

Prevention works. Oregon is considered a low incidence state for HIV, with an annual average of 218 new HIV diagnoses between 2020-2024, but high rates of syphilis, gonorrhea, and viral hepatitis threaten to undermine progress to eliminate new HIV infections.

PrEP

PrEP, the medication to prevent HIV, is an effective, evidence-based primary prevention tool; prescriptions in Oregon have increased, but 60% of Oregonians who could benefit from PrEP didn't receive it in 2024. In 2024, there were 7,721 PrEP users in Oregon, most users were male (89.8%), white (81.6%), and age 25-54 (79.6%). Of more than 33,044 people who tested for HIV at Oregon public testing sites between 2022-2025, 66.6% had heard of PrEP (up from 42%), 22% reported currently taking it (up from 10%), and 25% had taken it in the past 12 months. Among HIV people who tested negative, 93.5% were screened for PrEP eligibility and 60% were given a referral for PrEP.

Oregon's PrEP-to-Need (PNR) ratio measures the number of people prescribed PrEP to prevent HIV compared to the number of people newly diagnosed with HIV each year. A higher number means more people are getting preventive HIV medication; a lower number means not enough people are getting the protection they need. In 2024, Oregon's PNR was 32.04 up from 22.77 in 2021. PNRs make comparison across groups possible. PNRs by available demographics in Oregon are shown below. Oregonians who are female, Black, and/or Hispanic/Latinx have higher unmet need for PrEP. The PrEP-to-Need ratio for Black Oregonians, which has been consistently low, has decreased even further since submission of the last Integrated Plan. Over 70% of Black Oregonians live in Part A TGA counties, giving the TGA a particular responsibility to address PrEP and HIV care disparities.

Oregon PrEP-to-Need Ratios by Sex, Race/Ethnicity, and Age, 2024

Demographic Group	PNR (higher is better)
Oregon Overall	32.04
Sex:	
Male	33.67
Female	22.26
Race/Ethnicity:	
Black	9.06
Hispanic/Latinx	12.6
White	47.03
Age:	
13-24	24.38
25-34	34.22
35-44	34.75
45-54	29.74
55-64	28.38
65+	42.2

Source: AIDSVu

Many communities still have little awareness of PrEP. Data from Chime In, Oregon's arm of the National HIV Behavioral Surveillance survey, indicate that while 74% of the Portland-area

MSM who were surveyed in 2017 had heard about PrEP and about 1 in 4 had used it, only 34.5% of PWID surveyed in 2024 had heard of PrEP (up from 15% in 2021) and 33.9% of people participating in the low-income heterosexual survey had heard of it. Less than 1% of PWID or low-income heterosexuals had used PrEP.

Oregon's Statewide PrEP/PEP Workgroup identified the need for a geographic approach to services for disproportionately impacted by HIV. Oregon lacks medical providers in rural and frontier areas, especially those who can prescribe PrEP/PEP, creates long waits for PrEP appointments and an over-reliance on TelePrEP programs, which are for profit enterprises. Even in the Portland area, workgroup members stated that many primary care providers do not see PrEP prescribing as a part of standard primary care, do not know all the PrEP options, make assumptions about who is a candidate for PrEP, and/or are uneducated about the needs of priority populations for PrEP.

The availability of injectable PrEP may offer additional opportunities to increase PrEP use among people with limited access to health care. However, provider access and education remain low, along with the ability to successfully bill insurance.

PEP, an important secondary prevention tool, can be difficult to access in some parts of Oregon, though no systematic data have been collected on PEP access. The AETC also offers an interactive directory of pharmacies that stock PEP – a useful tool for locating PEP quickly. In 2024, the Oregon legislature passed a law requiring all Oregon hospitals to maintain a policy on PEP prescribing; mandated hospital emergency departments to provide at least a 5-day course of PEP, where indicated; prohibited insurers from requiring cost-sharing or prior authorization for PEP on state-regulated health plans; and required OHA to provide a 28-day course of PEP to rural hospitals annually, if requested.

Primary Prevention: Services for People who Use Drugs

Oregon continues to experience widespread opioid and methamphetamine use and related harms, including overdose and infections associated with injection drug use. To reduce these harms and support connections to care and supportive services, the Oregon Health Authority has collaborated with partners to expand peer service programs statewide since 2017.

Peer-delivered services for people who use drugs have expanded across Oregon, including through mobile outreach and other programs offering prevention supplies (e.g. naloxone). Peer supported HIV/syphilis/HCV testing and linkage to treatment and care has been critical. Peer Support Oregon hosts several statewide peer programs that focus on overdose, infectious disease, and other health issues related to substance use, including PRIME+ (certified peers connecting people at risk of overdose or infection to services and care), U-COPE in Umatilla County (peer-led outreach, prevention, and education for PWUD), Nurture Oregon (integrated maternity, substance use, and social support for pregnant people who use drugs), and PEER-CM, a collaborative study that trains and supports peer organizations across many counties to deliver contingency management to reduce overdoses among people using stimulants.

- PRIME+ peer specialists are now embedded in medical and community settings across much of Oregon and have served several thousand people at high risk of overdose, infectious disease, and other drug-related harms.

- PRIME+ peers routinely deliver overdose education and naloxone, help people set health, safety and recovery goals, and provide practical support (including transportation) to reach substance use treatment, primary care, and social services.

- U-COPE's peer-led outreach in Umatilla County has increased access to prevention services and improved linkage to treatment, including medications for opioid use disorder, for people who use drugs.

- The PEER-CM initiative has trained dozens of peers and supervisors in evidence-based contingency management, with most meeting all core skill benchmarks on first assessment, positioning Oregon's peer workforce to deliver interventions explicitly designed to reduce fatal and non-fatal overdose among people who use stimulants

Primary Prevention: Sexual Health Information & Supplies

Factual HIV, STI, and sexual health information are essential. Lack of awareness or comfort discussing these topics is a key challenge to ending new HIV/STI infections.

Youth are an important group for primary prevention. According to the 2024 Oregon Student Health Survey, 27.1% of 11th graders and 5% of 8th graders report having ever had sex; 47.6% of 11th graders and 25.1% of 8th graders say they used a condom the last time they had sex. Rates of condom use are much lower than previously reported; however, the wording of the survey has changed since 2022.

Condomless sex with casual partners was common among the populations who participated in the Chime In survey, reported by 58% of MSM (2017), 57% of low-income heterosexual people (2025), and 37% of PWID (2024).

Only 5% of Oregon MMP participants in 2021-2023 reported condomless sex with an HIV-negative or unknown status partner while not virally suppressed or otherwise protected by PrEP. With high viral suppression rates in Oregon, as well as potential partner PrEP use, the risk of HIV transmission from PLWH who know their HIV status is low.

TREATMENT

Treatment saves lives. In Oregon, 74% of people known to be living with HIV were virally suppressed in 2024. Among PLWH with a viral load reported, 94% were virally suppressed. As reported in the Epi Snapshot section, some groups were less likely to be virally suppressed, including people under 30, people with unstable housing, people reporting drug use or sex with a person who uses drugs, people who live rurally, and American Indian/Alaska Native people.

Oregon's Ryan White Program, in conjunction with other medical and social services, works to ensure access to health care for all Oregonians with HIV. The CAREAssist Program provides life-saving drugs to approximately 4,000 PLWH across Oregon each year. According to HIV surveillance data, approximately 46% of PLWH living in the Part A service area and 51% living in the Part B service area are enrolled in Ryan White HIV case management services.

Still, 47% of HIV Medical Monitoring Project participants in 2021-2023 reported at least one unmet service need in the past 12 months, including 39% who reported an unmet medical need and 28% an unmet social service need. PLWH who identified as bisexual or as something other than lesbian, gay, or straight; those aged 25–34; those living below the poverty level; those who were unemployed; and those with any type of disability had higher proportions reporting an unmet social service need.

Portland TGA RW Client Experience Survey: The 2023 Part A client satisfaction included needs assessment questions to identify unmet medical and social service needs among TGA clients. A convenience sample of 531 clients identified some of the major factors impeding their access to care, including mental health issues (endorsed by 38% of respondents), lack of transportation (26%), social isolation (21%), and lack of income (21%).

PLWH needs related to specific service categories are as follows:

Access to High-Quality, Culturally and Linguistically Responsive Medical Care:
No PLWH surveyed between 2021 and 2023 as part of the Oregon HIV Medical Monitoring Project (MMP) lacked health insurance, and only 5% reported an insurance gap in the past 12 months. Despite this high level of coverage, 41% reported using an emergency room for their own health care needs in the past 12 months, and 5% reported visiting the emergency room five or more times. This may indicate a gap in services or challenges accessing usual sources of care.

More than half of PLWH in Oregon (55%) are 50 years or older, and many have comorbid conditions that need ongoing medical management, requiring coordination between HIV specialists, primary care providers, and other medical specialists.

In 2021–2023, most MMP participants (80%) reported being very satisfied with the HIV medical care they receive. Males, people over age 40, and long-term survivors were more likely to be

very satisfied. In contrast, participants aged 25–34 and those experiencing more challenges to getting HIV care, such as problems with money or health insurance, or behavioral health challenges including depression or other mental health issues, were less likely to report being "very satisfied" with their HIV medical care. Those who are not "very satisfied" with their HIV medical care are less likely to be on HIV medications, be adherent to ARTs, be virally suppressed, and receive a past year syphilis screening. They are also more likely to miss a medical appointment, use the ER, and have an AIDS diagnosis.

There are few Spanish-speaking medical or behavioral health providers available in Oregon to serve monolingual Spanish speaking clients.

Case Management Services: 7% of MMP participants reported an unmet need for case management services in the past 12 months in 2021-2023, a significant increase from pre-pandemic times. In 2024, 62% of Part A RWHAP clients used medical case management – the most utilized of all eligible RWHAP services.

Dental Services: 21% of MMP participants reported an unmet need for dental services in the past 12 months in 2021-2023. CAREAssist provides dental coverage to non-Oregon Health plan clients through MODA Dental Delta, but this resource has been consistently underutilized. The program conducts a Dental Drive each year to inform clients of the service and increase enrollment. Several weeks before submitting this plan, the Part F dental provider in the 31 county Balance of State announced they would not apply for continuing funds to provide RWHAP dental services, leaving dental coverage for much of the state uncertain.

Drug & Alcohol Treatment Services: Binge drinking is defined as consuming four or more drinks on one occasion for women or five or more drinks for men. Sixteen percent of MMP clients reported binge drinking in the past 30 days in 2021-2023, similar to the state average.

Reported injection and non-injection drug use in the past 12 months continues to rise. Sixty-three percent of MMP clients reported any drug use in the past 12 months in 2021-2023, compared to 36% in 2015-2017 and 46% in 2018-2020. Sixty-three percent reported using non-injection drugs, and 7% reported using injection drugs.

Increased drug use among people with HIV is consistent with trends in other regions in the US, where fatal overdose was a major contributor to mortality among PWH and, in some regions, including the Pacific Northwest, exceeded HIV-related mortality.

Only 3% of MMP participants in 2021-2023 reported an unmet need for substance use disorder (SUD) treatment services in the past 12 months; however, this need is most certainly under-reported. People who need SUD treatment services may be less likely to participate in the MMP survey and people who need SUD treatment may not recognize their need for those services. Also, as reported in other sections of this plan, Oregon is among the states with the most limited access to addiction treatment in the U.S.

Elder Care: Oregon is experiencing steady growth among older adults, including PLWH and LGBTQ+ people, who may have additional needs. A survey of older adults in Oregon who identify as LGBTQ+ reported many unmet needs and fears about accessing limited care options as they age. More than half of people living with HIV are 50 years or older and more than two-

thirds of PLWH in Oregon (71%) are long-term survivors (diagnosed for 10 years or more). Most PLWH over 50 report comorbidities, including cardiovascular issues, chronic pain, and mobility issues. Between limited affordable housing options and limited caregiving options, many older adults, including PLWH, struggle to receive the care they need.

Food Assistance: In 2021-2023, 7% of MMP participants reported an unmet need for personal food assistance services from SNAP (Supplemental Nutrition Assistance Program) or WIC (Supplemental Nutrition Program for Women, Infants, and Children) and 5% reported an unmet need for meals or food delivery services (meals or food in soup kitchens, food banks, etc.) in the past 12 months. A full 61% of respondents to the 2023 Portland TGA Client Experiences Survey, which samples clients at service agencies, reported food insecurity – an indication of the high needs of clients actively using RWHAP services, which has been addressed with a growing investment of food and EFA allocations.

HIV-Related Discrimination: Twenty-eight percent of MMP participants reported experiencing any type of HIV-related discrimination in 2021-2023.

Housing Assistance: 7% of MMP participants reported an unmet need for shelter or housing services in the past 12 months in 2021-2023, a rate that is likely artificially low due to survey selection bias. One-third (34%) of respondents to the 2023 Portland TGA Client Experiences Survey reported housing insecurity, a much higher rate than the 13% reported in TGA client data overall, and an indicator of the high need among clients actively using RWHAP services. Housing instability has risen in Oregon and people who have experienced houselessness are more likely to be virally unsuppressed.

Intimate Partner Violence: Lifetime prevalence of intimate partner violence (IPV) is common among people living with HIV in Oregon: in 2021-202347% of MMP participants reported lifetime prevalence of IPV. Although IPV can mean different things and can be measured in different ways, this rate appears to be much higher than the general population overall. The CDC estimates that 1 in 3 women and more than 1 in 6 men have experienced "contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact."

Mental Health Services: Eighteen percent of MMP participants reported moderate or severe anxiety in the past 2 weeks in 2021-2023, and 10% reported symptoms consistent with major depression; 13% of MMP participants reported an unmet need for mental health services in the past 12 months in 2021-2023, an increase from previous years. Thirty-eight percent of participants in the 2023 Portland TGA Client Experiences Survey said that mental health concerns impeded their ability to receive HIV medical care.

Peer Support for PLWH: 12% of MMP participants reported an unmet need for HIV peer group support services in the past 12 months in 2021-2023, an increase from previous years.

Smoking Cessation Services: Twenty-six percent are current smokers (2021-2023), down from 33% in 2015–2017, but more than double the proportion of Oregon adults who reported current smoking in 2022. Seven percent reported needing smoking cessation services.

STI Screening:
Co-infection with HIV and other STI is common in Oregon. Oregon and national screening recommendations include screening for HIV, syphilis, chlamydia, and gonorrhea often, every 3-6 months for people at highest risk including men who have sexual contact with men (MMSC) with multiple sex partners, people with previous STI diagnoses, and some people who use recreational drugs, such as methamphetamine. Screening should occur twice during pregnancy and once at delivery. However, only 58% of MMP participants had received syphilis screening in the past 12 months (a decrease from previous years) and 26% had not been screened for gonorrhea or chlamydia in 2021-2023.

Transportation Assistance:
Eight percent of MMP participants reported an unmet need for transportation assistance in the past 12 months in 2021-2023. About 1 in 4 (26%) of respondents to the 2023 Portland TGA Client Experiences Survey said that lack of transportation impeded their ability to receive HIV medical care.

U=U/Treatment as Prevention:
MMP has included a set of questions about U=U for the last five years (2018-2023). More than three-quarters (90%) of respondents have heard that having an undetectable viral load means that you will not pass on HIV to sexual partners; the proportion has steadily increased from 67% in 2018 to 90% in 2023 and reached 92% in 2022.

Knowledge of U=U varies by demographic subgroup, but in recent years the knowledge gaps have closed. In 2018-2023, nearly all respondents in the youngest age group (18-34) reported yes (94%), while the remaining age group proportions decreased with age, and were similar for respondents 50-65 (82%) and 65+ (82%). Latine and White respondents were the most likely race/ethnic group to report yes (86%); Black respondents were the least likely (74%). MMSC were more likely than non-MMSC to report yes.

There is a general positive trend with knowing about U=U and education status; as education increases, the likelihood of reporting yes increases. The highest education group, those with any post graduate education, had the highest reporting yes (93%). Those living below the poverty line were less likely to report yes about U=U knowledge than those above the poverty line (86% vs. 93%).

Vision Services:
Glasses and other vision aids are needed by many PLWH, a population that is aging. A lack of vision benefits can be a challenge, as eye exams and glasses are costly. Both Part A and Part B seek to address vision needs with application of Emergency Financial Assistance expressly allowing and encouraging support for unmet vision needs.

RESPONSE

Ending new HIV transmissions in Oregon requires partnerships across multiple systems to ensure everyone has access to prevention and care services. Detecting outbreaks and clusters of new infections through enhanced surveillance is an essential part of an effective response to HIV/STI. Community partnerships are also required to quickly provide treatment and prevention resources, raise awareness through strategic communications, and – as needed – implement operational and policy responses to limit transmission.

Overall needs related to HIV/STI response:

Tools and training to respond effectively to clusters: Increases in new HIV diagnoses have been observed in rural and frontier areas and among women, people who use drugs, and people who are houseless or have unstable housing. Urban areas contend with larger concentrations of people living with HIV, and those who experience syndemic issues, such as being unhoused, using substances, and involved in the sex economy. Many rural and frontier communities have less infrastructure to draw from in responding to observed increases. Increased diagnoses in communities with complex needs, multiple risk factors, and/or who are less aware of HIV may require new partnerships and strategies to effectively respond.

Threats to HIV/STI prevention and HIV care funding: Budget challenges have led to decreased investment in both prevention and care across the state. Several nonprofit agencies in the Portland metropolitan area have made reductions in HIV/STI testing and related health and safety programming.

Local public health workforce capacity: Oregon's 33 Local Public Health Authorities (LPHAs) face severe and worsening workforce challenges that threaten their ability to prevent disease, respond to emergencies, and protect the health and safety of the state's 4.2 million residents. In 2025, the Oregon Coalition of Local Health Officials (CLHO) identified several chronic challenges LPHAs are facing. These include: (1) chronic underfunding, low wages, and staffing shortages, especially in roles like nurses and epidemiologists in rural areas, (2) burnout and leadership turnover; 33 LPHA directors left between 2021-2025, (3) recruitment challenegs, such as lack of strategic hiring strategies, insufficient HR capacity, and unaffordable housing, particularly in rural and frontier areas. In 2024, the Public Health Advisory Board (PHAB) workgroup identified similar needs for competitive compensation and incentives, strategic hiring and mentorship, and enhanced data and digital skills.

Priorities

The key priorities identified in the needs assessment are as follows. These are organized by pillar, although many are cross-cutting.

DIAGNOSIS:

- Increase opportunities for integrated HIV/STI testing
- Strategies to increase HIV/STI awareness
- Linkage to care for people newly diagnosed with HIV

PREVENTION:

- Prevention services for people who use drugs
- Increase access to PrEP and PEP

TREATMENT:

- Maintain broad access to quality medical case management
- Increase access to mental health services and support
- Increase access to permanent, stable housing

RESPONSE:

- Expand capacity for timely, coordinated responses to HIV outbreaks and clusters
- Provide education and training for health care staff to expand access to high quality medical care for people and communities disproportionately impacted by HIV

NOTE: Oral health and dental care continue to be identified as an unmet need among 1 in 5 MMP respondents. Just weeks before completion and submission of this plan, Oregon learned that its only Part F dental provider in the Balance of State would be ending its Part F grant, leaving a large portion of the state underserved. Therefore, oral health may be identified as a higher priority service area moving forward.

Actions taken

The following actions were taken during the needs assessment process to address identified needs and challenges:

- ➔ **CBO public health response grants:** The Oregon HIV/STD/TB Section participated in a cross-program Oregon Health Authority Request for Grant Applications (RFGA) process to recruit and award funds to community-based organizations. OHA awarded 125 grants across all program areas; 13 are focused specifically on HIV/STI activities that support this integrated plan in the areas of outreach, testing, provider education, and capacity building
- ➔ **Expanding Medical Transportation to Quality Care:** After a year of planning, Multnomah County on behalf of the TGA created expanded Medical Transportation access to address limited rural access to centralized health and support services for PLWH. This in addition to expanded telehealth care is an early model for addressing gaps in rural access in a constrained funding environment that does not allow for replication of all services in all geographic communities.
- ➔ **HIV Cluster Detection and Response Tabletop Exercises:** In 2026, OHA hosted two HIV Cluster Detection and Response tabletop exercises to improve staff skills and cross-jurisdictional coordination in the event of identified HIV clusters.

- ➔ **Mapping of linkage to care pathways:** Mapping exercises within local jurisdictions to identify gaps and opportunities for connecting newly diagnosed people to HIV medical care in all Oregon communities are underway.
- ➔ **Outreach & education in SW Coastal Oregon** – HIV Alliance led a coalition of partners to address an increase in HIV diagnoses in SW Oregon via a multi-modal campaign in 2024-25. After the campaign finished, increases in rural Coos County on the Oregon Coast indicated a need for continued social media and digital advertising in Coos and Curry Counties. Outcome data from those efforts are ongoing.
- ➔ **Rapid and self-collected HIV/STI testing kits:** NASTAD has received grant funding to conduct community engagement to optimize uptake of mail-order HIV/STI test kits among populations in Oregon communities with limited access to health care. This funding also increases mail order test kit inventory in the state.
- ➔ **Understanding HIV testing patterns and use of doxyPEP:** A study using Oregon's All Payer-All Claims dataset is being designed to better understand patterns of HIV testing and usage of prevention tools like PrEP and doxyPEP.
- ➔ **Understanding increases in new HIV diagnoses among youth and women:** An enhanced surveillance study is being planned to better understand the prevention and care needs of people newly diagnosed with HIV who are under 30. Medical records of all women newly diagnosed with HIV are being reviewed to identify any patterns , which could inform prevention messaging.

Section IV. Situational Analysis

Overview of strengths, challenges and identified needs related to HIV prevention & care systems

Our vision is an Oregon where new HIV and STI transmissions are eliminated and Oregonians with HIV live long, healthy lives.

Structural and social issues impact our ability to achieve our vision. Some communities have limited access to health care at multiple points along the HIV care continuum. Cross-cutting issues, like those discussed in this Situational Analysis, can prevent or facilitate access to comprehensive prevention services, timely HIV diagnosis, linkage to care, and effective treatment for people living with HIV and STI. People and communities disproportionately impacted by HIV are often most impacted by these cross-cutting issues.

Behavioral Health:

Substance Use & Treatment:
According to the 2022–2023 National Survey on Drug Use and Health, alcohol and drug use remain high in Oregon. Approximately 22% of Oregonians ages 12 and older met criteria for a substance use disorder, including approximately 12% with alcohol use disorder and about 10% with an illicit drug use disorder. Nearly one in four Oregon adolescents and adults experienced a substance use disorder, placing Oregon among the highest prevalence states nationally.

Alcohol use remains widespread: more than half of Oregonians reported past-month alcohol use, a level that has remained persistently high.

Oregon's methamphetamine problem has continued to worsen and is now a major part of the state's overdose crisis. In 2023, about 65% of Oregon's overdose deaths involved a stimulant such as methamphetamine, and over half involved both an opioid and a stimulant (reflecting polysubstance use). These trends underscore that Oregon's overdose crisis is increasingly driven by the combined use of methamphetamine with opioids like fentanyl, not just opioids alone. Methamphetamines are regularly reported as drug of choice for houseless individuals, amplifying instability of individuals at great risk of STI/HIV diagnosis as well as transmission to others.

Oregon ranks

- 2nd in the nation for percentage of the population (12 and older) with past month illicit drug use disorder other than marijuana (IDUD) (4.7%) and
- 4th in the nation for prevalence of SUD (21.6%)
- 8thst in the nation for prevalence of methamphetamine use (12 and older) (1.5%)

Oregon continues to face major gaps in addiction treatment. The state has roughly 5,000 residential treatment beds, but needs an additional 3,500 to meet demand. Despite efforts to expand services, access remains limited, particularly for adolescents, and many still face long wait lists. Oregon plans to add 465 new beds by the end of 2026, but treatment shortages continue to strain the system.

Bacterial infections linked to injection drug use continue to cause substantial morbidity and mortality, including serious bloodstream infections and infective endocarditis.

Opioid crisis/Overdoses: Oregon's overdose crisis has continued to worsen since 2020. Drug overdose deaths increased from 824 in 2020 to 1,833 in 2023, more than doubling in three years. While provisional 2024 data indicate a modest decline in deaths (1,480 deaths), Oregon's overdose mortality rate remains above levels prior to 2020 and has continued to rise even as most states have seen declines.

Synthetic opioids, particularly fentanyl, have driven most overdose fatalities. Fentanyl related deaths nearly quadrupled between 2020 and 2022 and accounted for about two thirds of overdose deaths in 2022. Polysubstance use has also increased, with more than half of overdose deaths in 2023 involving both an opioid and a stimulant. Most people who die from overdose have no documented engagement in substance use disorder treatment. Naloxone use has expanded markedly across both EMS and community settings in Oregon: EMS naloxone administrations increased by 48% from 2019 to 2021, and state and local initiatives have distributed well over 100,000 community naloxone kits, with thousands of reported overdose reversals.

Overdose death rates in Oregon have been highest among people aged 35–44, Black/African American and American Indian/Alaska Native communities, and people experiencing houselessness. Males, LGBTQ people, people with substance use, alcohol, or mental health disorders, and people recently released from correctional facilities are also at higher risk of overdose.

Drug-related mortality among Oregonians with HIV has risen sharply over the past decade, with total deaths in this population increasing 73% (from 100 in 2013 to 173 in 2022) and drug-related deaths climbing 460%, outpacing the rise in the general population. In 2022, overdose was the second leading cause of death among people with HIV in Oregon—exceeding cancer and heart disease—driven largely by methamphetamine and fentanyl, which together accounted for nearly one in five deaths. People with HIV are several times more likely than other Oregonians to die from methamphetamine and fentanyl-related causes, with disproportionate impacts among females, people living in rural counties, and Black/African American and multiracial people. Methamphetamine use among people with HIV is associated with poorer ART adherence, higher rates of anxiety, depression, poverty, and houselessness, and greater sexual risk, underscoring the need for integrated approaches that combine HIV care, mental health services, harm reduction, and evidence-based interventions such as syringe services programs, contingency management (CM) for methamphetamine over ramping, and peer-led recovery supports like PRIME+ and PEER-CM.

Mental Health Needs & Service Use: In 2022-2023, Oregon had one of the highest rates in the U.S. of teens and adults with mental illness: an estimated 26.8% had any mental illness in the past year and 28.9% received mental health treatment, both above national averages. About 7.3% of adults had serious mental illness, 9.8% of those 12+ experienced a major depressive episode, and 6.6% of adults reported serious thoughts of suicide in the past year, again exceeding U.S. rates.

Legal System Involvement: In 2022, Oregon's incarceration was 494 per 100,000 people, with about 22,000 people incarcerated in state, local, federal, youth, or other types of facilities at any point in time, a decrease from 2018. People can cycle quickly in and out of jails; each year, about 42,000 unique people are booked into local Oregon jails. Racial inequities in incarceration are well-documented and persist in Oregon: Black/African American and American Indian/Alaskan Native people were overrepresented, while Asian people were underrepresented, relative to their share of the population.

In 2023, state and federal prisons imprisoned over 12,000 people living with HIV (PLWH), about 1.1% of the prison population, and HIV prevalence in prisons remains three times higher than in the general population, with the highest rates among Black incarcerated people. Disproportionate incarceration of Black Americans and other groups experiencing marginalization increases HIV risk in their communities by disrupting health care and HIV treatment, destabilizing housing and income, and reshaping community and sexual networks during incarceration and reentry.

Some PLWH are first diagnosed while incarcerated, but it is more common for incarceration to cause treatment interruptions during incarceration and after release. Recent incarceration is independently associated with worse HIV outcomes and greater use of emergency and inpatient medical services. After release, PLWH often face challenges to sustained HIV care, including unstable housing, gaps in insurance, limited employment opportunities, behavioral health and substance use challenges, which undermine linkage, retention, and viral suppression.

Incarceration among Oregon MMP participants has declined over time, and less than 2% reported any incarceration. This may be partly due to changes in the survey sampling; previously, incarcerated PLWH were interviewed in jail or prison and included in MMP data.

In 2025, OHA and ODOC partnered again through the Oregon Carceral Access & Engagement Network (OCEAN), a reentry initiative funded by a Housing Opportunities for Persons with AIDS (HOPWA) Special Projects of National Significance (SPNS) grant and End HIV Oregon. The program supports people living with HIV who are exiting prison. OCEAN Navigators at three regional Community-Based Organizations (CBOs) receive direct referrals from DOC Health Services, and this network works collaboratively to connect clients to housing, medical care, and other services necessary for viral suppression and overall stability and wellness. PLWH being released from local jails may also be eligible for OCEAN services.

Food Insecurity: Food insecurity is high and increasing across Oregon. According to the Oregon Food Bank, 1 in 8 Oregonians experience hunger. In 2024, Oregon's food bank networks saw 2.5 million visits, a 31% increase from the previous year. Hunger continues to hit some communities the hardest, such as people of color, immigrants and refugees, single moms and caregivers. Food insecurity is notably higher in rural communities, where there are fewer resources.

Oregon ranks 3rd in the nation for Supplemental Nutrition Assistance Program (SNAP) participation, which reflects high levels of economic hardship (e.g., high cost of living, lower wage jobs) and successful state efforts to enroll eligible residents in the program.

More than 740,000 Oregon residents currently rely on SNAP, and an estimated 313,000 individuals may be affected by the federally mandated changes. Specifically, the 2,900 refugees, humanitarian parolees, and approved asylum seekers in Oregon are expected to lose SNAP eligibility under the new rules. In addition, eligibility restrictions are projected to affect a broader range of groups, including veterans and parents of children over the age of 14, thereby introducing new challenges to food assistance. These changes may exacerbate health and housing instability, as 89% of SNAP households are concurrently enrolled in Medicaid, making them more vulnerable to shifts in resource access. The policy is projected to shift $150 million in administrative costs to Oregon taxpayers, with the possibility of hundreds of millions more in future years.

Multiple studies link food insecurity to poor health outcomes for people living with HIV, including lower care retention and higher odds of viral nonsuppression, emergency care use, and mortality. Food insecurity is also associated with increased behavioral and structural vulnerability to HIV acquisition, through pathways such as transactional sex, reduced negotiation power, and limited access to prevention services. Ensuring reliable access to nutritious food is therefore a critical component of HIV prevention and care across the status-neutral continuum, from reducing acquisition risk to supporting engagement, adherence, and viral suppression.

Health Insurance: In 2023, the Oregon Health Insurance Survey found that 97% of Oregonians were covered by health insurance – an increase of more than 11 percentage points – or more than 400,000 people – since 2011. According to the survey, nearly half (46%) of Oregonians are covered by private group policies. About one-third (32%) receive health coverage through the Oregon Health Plan (OHP), Oregon's version of Medicaid. Another 13% have Medicare coverage, 5% have individual coverage, and 1% have other coverage.

Though only 3% are uninsured statewide, regions along the north coast, Eastern Oregon, and parts of Southern Oregon have higher uninsurance rates. Among people who were uninsured, about 1 in 3 statewide were probably eligible for OHP.

The most common reason cited for not having health insurance in 2023 was that premiums were too expensive. Premium increases in 2026 combined with the expiration of enhanced federal premium tax credits, have already contributed to about a 15% decline in Oregon Marketplace enrollment (21,316 fewer people enrolled for 2026 coverage compared to 2025) and are likely to increase the number of uninsured Oregonians, especially among those between 200–400% of the federal poverty level. In addition, federal legislation (HR 1) requiring more frequent recertification and work requirements may result in fewer people enrolled in OHP, as well as increased workload for OHA Medicaid administration, ADAP, and medical case managers who work with PLWH.. Shortened retroactive Medicaid coverage (from 3 months to 1 month for Medicaid expansion enrollees and two months for other eligibility groups) may also create more medical debt for PLWH.

Oregon is expected to lose more than $1 billion in the 2027-2029 biennium and more than $7 billion dollars over a 10-year period due to a provision that penalizes states that provide health insurance to undocumented people. Policy analysis from NASTAD highlights significant concerns about the impacts of HR-1 on Ryan White HIV/AIDS Programs, stating that as the payer of last resort for low-income people, ADAPs will bear the burden of continued medication access when these policy changes take effect.

Many prevention services, including HIV/STI testing and PrEP, are currently covered by health insurance, although there is wide variation in co-pays, out-of-pocket costs, and coverage of labs and other ancillary services. CAREAssist provides co-pays and open-formulary pharmaceutical coverage, meaning it can cover a broad range of prescription drugs, rather than a narrow list of approved medications, to people living with HIV whose income is ≤550% FPL.

Housing: Oregon has the highest rate of chronic homelessness in the nation; 44% of individuals experiencing homelessness in Oregon meet the criteria for chronic homelessness, defined as having a disability and either being homeless for more than one year or experiencing repeated episodes of homelessness over several years. Safe, decent, and affordable housing provides a critical foundation for PLWH to access medical care and supportive services, begin and stay on HIV treatment, and achieve viral suppression. A 2016 systematic review of more than 150 high-quality studies found that lack of stable housing was almost universally associated with worse health outcomes for PLWH, while housing assistance was associated with better outcomes, and more recent studies continue to find that homelessness and housing insecurity are strongly linked to poorer ART adherence, viral suppression, and overall health. Rising housing costs, low vacancy rates, and loss of affordable housing stock due to gentrification and wildfires have created a statewide housing crisis, as mentioned previously in this Plan. Behavioral health issues, including mental health conditions and addictions, present additional challenges to clients trying to secure and maintain stable housing in an extremely difficult market.

Houselessness is a particular concern that affects both inability for PLWH to maintain their health and viral suppression, and puts vulnerable individuals at greater risk of an HIV/STI diagnosis. Multnomah County is contending with over 18,000 houseless individuals, about 2/3rds of all known houseless people in Oregon (approximately 27,000). The impact of houselessness is increasingly borne by Black, Native American, and Native Hawaiian/Pacific Islander individuals, with a near doubling of the number of unhoused people who are non-white in recent years. Housing experts in Multnomah County are predicting a considerable increase in houseless individuals over the next year, despite shelter bed growth and given a constrained funding environment for the foreseeable future.

Proposed changes to the 2026 federal budget have significant implications for housing programs serving individuals with HIV/AIDS. Specifically, the budget proposed eliminating dedicated funding for the Housing Opportunities for Persons With AIDS (HOPWA) program. In Oregon, HOPWA resources are administered through programs such as the Cascade AIDS Project (CAP), City of Portland, and the Oregon Housing Opportunities in Partnership (OHOP) program. Under the proposed federal changes, HOPWA funding would be discontinued and its functions merged into the broader Emergency Solutions Grant (ESG) program, potentially altering both the allocation of resources and the delivery of housing services to affected populations. A significant portion of HIV service dollars are currently dedicated to housing support across Oregon, with positive outcomes in viral suppression and housing stability – progress that could be stalled or reversed with budget reductions.

In Oregon, PLWH who report stable housing are more significantly more likely to be virally suppressed.

Intimate Partner Violence: As noted earlier, 47% of PLWH (based on 2021-2023 MMP participants) report lifetime prevalence of IPV. IPV can affect HIV prevention and care at all points of the HIV care continuum. For example, IPV can increase risk of HIV infection by limiting a person's ability to negotiate safer sex and safer drug use. IPV can prevent the ability to engage in HIV medical care and other social services for PLWH, and to stay adherent to ART. For people already diagnosed, a person's HIV status may be weaponized, with disclosure sometimes increasing the risk or severity of IPV.

Pharmacy Access and 340B Policy: The 340B Drug Pricing Program is a federal program administered by the Health Resources and Services Administration (HRSA). Eligible providers who serve low-income people are known as covered entities (CEs). CEs can purchase outpatient medications at a discount, and then obtain reimbursement through insurance, when applicable. The purpose of the 340B Drug Pricing Program is to stretch scarce resources as far as possible, providing more comprehensive services to more eligible people. Oregon's AIDS Drug Assistance Program, CAREAssist, is a covered entity. CAREAssist currently uses 340B allowable reimbursements to fund approximately 80% of its program budget. Funds from 340B reimbursements are also used to support other services for PLWH, such as case management, housing, behavioral health, early intervention and outreach. These supportive services help PLWH remain virally suppressed. In 2020, pharmaceutical manufacturers began restricting distribution of 340B priced drugs to contract pharmacies; at least 29 manufacturers have enacted restrictions on 340B covered entities using contract pharmacy models. These restrictions eliminate the CAREAssist Program's ability to obtain insurance reimbursements to cover costs. CAREAssist has made programmatic shifts to ensure compliance with shifting regulations, while retaining maximum coverage for PLWH statewide. Ongoing policy changes related to 340B at the state and federal levels require constant monitoring to ensure impacts on Oregon's ADAP are mitigated and client impacts are minimal.

Poverty: Economic well-being in Oregon draws on the concept of the Household Survival Budget, which represents the minimum income required to live and work. It includes housing, childcare, food, transportation, health care, technology, and taxes—within the current economic context. Notably, this measure excludes savings for emergencies or long-term financial goals such as higher education or retirement. Studies show that in 2023, household costs in every Oregon county substantially exceeded the Federal Poverty Level (FPL), set at $14,580 for a single adult and $30,000 for a family of four. In 2023, of Oregon's 1.7 million households, 12% (208,441) had incomes below the FPL, while another 30% (528,716) were ALICE (Asset Limited, Income Constrained, Employed) households — those with incomes above the FPL but still below what is needed to meet the Household Survival Budget for their household size and location. Altogether, 42% (737,157) of households in Oregon fell below the ALICE Threshold, indicating a significant portion of the population facing economic insecurity.

A major concern regularly voiced among PLWH in the TGA is the high cost of living in an urban area where HIV specialty services are most available contrasting with the requirement to be under a FPL level to remain eligible for life-saving RWHAP services. By definition, the Ryan White program serves low-income people, and yet individuals are at risk of losing needed services if they earn a living wage. In the TGA, the current FPL limit for services is 300% or about $45,000 per year. Average housing rental costs in Portland alone are $18,000/year. 300%

FPL is not even middle income given the state average household income of $89,000. In order to retain services that are essential for them to stay healthy, PLWH are required to remain in poverty.

U.S. studies consistently show that poverty and poverty-related factors are linked to worse HIV outcomes: for example, poverty and overlapping indicators of economic hardship are associated with lower care engagement, reduced ART adherence, and higher odds of viral non-suppression.

Rurality: Rural Oregon faces unique vulnerabilities related to HIV and STI, including challenges to health care, lack of HIV awareness, and lack of access to basic resources like housing, transportation, and food. Many rural and frontier areas of Oregon lack medical services, including primary and specialty care, dental and mental health care, and prenatal care.

Areas of Oregon with Greatest and Least Unmet Medical Service Needs, 2025

Greatest Unmet Need Areas	*2025*	*2024*	*Least Unmet Need Areas*	*2025*	*2024*
East Klamath	23	21	*Portland SW*	78	78
Warm Springs	26	25	*Tigard*	72	73
Port Orford	29	32	*Lake Oswego*	72	70
Powers	29	32	*Portland NE*	71	71
Drain/Yoncalla	30	32	*Oregon City*	70	69
Gold Beach	30	38	*Bend*	69	68
Swisshome/TriangleLake	30	34	*Hood River*	68	67
Chiloquin	32	31	*Eugene/University*	68	69
Yachats	33	36	*Portland NW*	67	69
Cave Junction	35	36	*Beaverton*	67	68
Lowell/Dexter	35	35			
Merrill	35	36			

table credit: OHSU Office of Rural Health, 2025; 0=least access; 90=best access

Nearly all Eastern Oregon counties, and much of Southern Oregon and the Coast, are designated as Governor's Health Care Shortage Areas.

In 2024, 1,045 PLWH in Oregon (12%) lived in rural areas, with an additional 106 living in frontier counties; about 45% of PLWH lived in urban-designated counties (n=3,832), while another 42% (n=3,581) lived in urban/rural–designated counties. PLWH in rural and frontier areas were less likely to be virally suppressed than those living in urban areas and more likely to have a late diagnosis (defined as an AIDS diagnosis within 90 days of HIV diagnosis), posing a potential risk of transmission to the community as well as poorer health outcomes for affected individuals. In 2024, new HIV diagnoses (per 100K) decreased in urban regions, while rural regions experienced an uptick in recent years, as mentioned through this plan. Statewide, syphilis cases have been declining since 2022; however, in rural and frontier areas, syphilis cases increased between 2022 and 2023 before declining in 2024, but not at the same rate as in urban areas.

Sex Work: People who exchange sex for money, drugs, housing, or other resources have increased vulnerability to HIV and other sexually transmitted infections (STIs) for multiple reasons. This population often faces socioeconomic disadvantages, substance use, unstable housing, and limited access to prevention and health services, all of which contribute to higher levels of risky sexual behaviors (such as multiple partners and inconsistent condom use) and increased exposure to violence and coercion compared with those who do not exchange sex. Research shows that people who exchange sex are more likely to engage in sexual and drug-related risk behaviors and have higher HIV prevalence than those who do not exchange sex, underscoring their elevated risk.

Transactional sex was reported by 12.2% of PWID (2024), 8.1% of low-income heterosexuals (2025), and 6.1% of MSM (2017) participants of the Chime In study, conducted in the Portland metropolitan area.

STI Epidemic: Among the highest priority for HIV testing and referral to status-neutral services (e.g., PrEP, linkage to HIV care) are people with a syphilis or rectal gonorrhea diagnosis; this is a key part of our HIV/STI Statewide Services (HSSS) Program. Oregon's STI rates, as reported throughout this plan, are high (although decreasing) and the DIS workforce experiences high turnover.

Tribal Nations: Rates of HIV among American Indian/Alaska Native people in Oregon are 8.7/100,000, which is higher than the rate for Oregonians overall (5.0/100,000). Rates of syphilis, including congenital syphilis, are also elevated among AI/AN people. The Nine Federally Recognized Tribes of Oregon and NARA NW (the Urban Indian Health Program) are leading efforts to end HIV in tribal nations, guided by initiatives like Tribal Public Health Modernization and the Indigenous HIV/AIDS Syndemic Strategy. Partnerships with the Northwest Portland Area Indian Health Board/Tribal Epidemiology Center and the Oregon Health Authority support implementation of Oregon Senate Bill 841 (2025), which authorizes the Oregon Health Authority to enter into agreements with federally recognized Tribes and tribal epidemiology centers for improved public health data sharing, including supporting tribal investigation of reportable diseases. A new tribal DIS training is available through the Raven Collective; in late 2025, the Northwest Portland Area Indian Health Board (NPAIHB) used ETHIC funds to issue mini grant opportunities to tribal nations to support HIV/STI disease investigation training and capacity.

Viral Hepatitis B and C: The prevalence of hepatitis B and C in Oregon and related mortality are among the highest in the nation, with people in Oregon nearly four times, and three times more likely to die from hepatitis B or C than the US average (respectively). Further, the impact of this morbidity and mortality predominately impact our rural citizens as well as disproportionately our Asian, Native Hawaiian, and other Pacific Islander communities (HBV) and Black, African American, American Indian/Alaskan Native (HCV) communities. Over the past 10 years, the epidemic of opioid and methamphetamine use has contributed to increasing rates of hepatitis C among persons under age 30 and who inject drugs. Due to systemic challenges that increase risk factors, Black and American Indian and Alaska Native populations are twice as likely to contract hepatitis C, compared with the state average. Without treatment, chronic hepatitis C can progress to cirrhosis, liver cancer and death. Although curative antiviral therapy exists, only about a quarter of Oregonians with hepatitis C have been cured (regardless of insurance type), and most

counties lack enough knowledgeable prescribers relative to need. Oregon's Viral Hepatitis Elimination Plan identifies expanding screening, linkage to care, vaccination, harm reduction, and equitable access as priorities to meet 2030 elimination goals. Recent evidence shows that and leveraging individuals with lived experience with telehealth significantly increases treatment uptake and cure rates.

Summary: The HIV care and prevention landscape in Oregon will require intentional navigation as policy changes and funding stream reductions are implemented during 2027-2031. HIV epidemiology, diagnosis, care engagement, service gaps, and social determinants such as housing, food insecurity, income, mental health, and substance use are all likely to be affected. Recent changes to federal policy and organizational structures (CDC, HRSA, Medicaid, SNAP, and other health programs) clarify the need for integrated and community-specific services to address the complex needs of people living with HIV in Oregon. Maintaining Oregon's high rates of insured people and high viral suppression rates among PLWH will be priorities, as will ensuring ongoing access to HIV/STI prevention and care resources, especially for priority populations and people with limited access to health care.

People and Communities Disproportionately Impacted by HIV

Based on local data that reveal unmet needs and disparate outcomes across the HIV care continuum, we have identified seven communities disproportionately impacted by HIV. These people and communities are listed below, with the recognition that many people may identify with more than one of these groups.

- Black/African American people
- Hispanic/Latine people
- Men who have male sexual contact (MMSC)
- People who use drugs
- People who live in rural & frontier areas
- People under 30
- People with unstable housing

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

Section V. Oregon Goals and Objectives, 2027-2031

DIAGNOSIS

Testing is easy but too few Oregonians know their HIV status. Many people in Oregon still receive their diagnosis years after infection, often because of the onset of an illness that might have been prevented with early testing and treatment. Knowing one's HIV status creates opportunities for people to enjoy better health and longer life – and protect partners from transmission. Oregon aims to increase overall awareness of HIV and STI, especially among people and communities disproportionately impacted by HIV, to increase HIV and STI testing, and to expedite linkage to care for people who test positive. Our goal is for everyone with HIV and STI to be diagnosed as early as possible.

U.S. Ending the HIV Epidemic (EHE) modeling indicates that current annual testing rates (estimated at ~4–5% of insured adults nationally, which matches estimates from an Oregon study of insured adults) must triple and be sustained for several years to meet the goal of ≥95% people with HIV being aware of their infection.

Baseline rates presented are based on most current Oregon data available at the time of writing (2026).

Five-Year Goals:

- Increase awareness of HIV/STI among all Oregonians
- Diagnose all Oregonians with HIV as soon as possible
- Link people newly diagnosed with HIV to care quickly and seamlessly

Objective 1.1 Increase proportion of Oregonians living with HIV who know their HIV status by 5% (from 91.2% to 96%)

1.1.1 Support community-designed and -led education and outreach programs
1.1.2 Develop and disseminate community awareness materials and media to provide evidence-based information about sexual and drug user health, including options for prevention, testing, care, and treatment
1.1.3 Conduct targeted medical provider education to normalize discussions about sexual and drug user health, HIV/STI testing, and prevention options like PrEP and doxyPEP between providers and patients

Objective 1.2 Increase proportion of Oregonians ever tested for HIV by 67% (from 42% to 70%)

1.2.1 Increase testing in routine health and medical care settings (e.g., primary care, specialty care, urgent care/emergency departments) via provider education and systems/workflow changes
1.2.2 Conduct focused testing and outreach through HIV/STI partner services
1.2.3 Build local capacity to implement data-driven testing initiatives focused on people and communities disproportionately affected by HIV

1.2.4 Support statewide availability of mail order, rapid and self-collected testing
1.2.5 Expand testing in carceral settings and alcohol and drug programs

Objective 1.3 Increase proportion of newly diagnosed individuals linked to care within 30 days by 22% (from 74% to 90%)

1.3.1 Provide a status-neutral approach to HIV testing by offering linkage to prevention services for people who test negative and immediate linkage to care for people who test positive
1.3.2 Strengthen partnerships between private and public medical providers and health care systems
1.3.3 Ensure client-centered services are available in a timely manner to people newly diagnosed with HIV
1.3.4 Increase provider education and access to HIV care for people living in rural and frontier Oregon
1.3.5 Improve linkage to care supports and resources for those who are unstably housed or using substances

Outcome Measures & Data Sources:

- # of newly diagnosed persons with HIV (Oregon HIV Surveillance System)
- % of adult Oregonians who report ever testing for HIV (Behavioral Risk Factor Surveillance System)
- % newly-diagnosed people with HIV linked to care within 30 days (Oregon HIV Surveillance System; track both 0-29 and 1-30)
- (exploratory): offer rate, test completion rate, positivity rate (All-Payer/All Claims dataset); linkage to care (Oregon HIV Surveillance System)

PREVENTION

Prevention works. Through a combination of behavioral and biological interventions, we aim to eliminate new HIV transmissions in Oregon. PrEP, PEP, services for people who use drugs, distribution of supplies (e.g. condoms), education and outreach are all key prevention strategies. In addition, we know that HIV and other STI must be addressed together – we will increase STI-focused HIV prevention strategies, like integrated HIV/STI testing, partner services, and delivery of status-neutral services statewide.

Baseline rates presented are based on most current Oregon data available at the time of writing (2026).

Five-Year Goals:

- Prevent new HIV infections among Oregonians
- Prevent new syphilis and gonorrhea infections in Oregon and eliminate congenital syphilis
- Ensure people and communities disproportionately affected by HIV have access to comprehensive prevention services

Objective 2.1 Decrease new HIV diagnoses by 20% (from 217 to <175 cases/year)[2]

2.1.1 Increase provider education, training, and linkage to care workflows among providers serving people and communities disproportionately impacted by HIV
2.1.2 Provide access to condoms and other prevention supplies for people with limited access to health care or other challenges
2.1.3 Support integration of HIV/STI education and testing in substance use disorder, carceral and re-entry programs and services
2.1.4 Ensure access to PEP, particularly in rural and frontier areas of Oregon

Objective 2.2 Increase PrEP prescriptions by at least 5 percentage points[3]

2.2.1 Increase the number of providers trained and ready to prescribe PrEP
2.2.2 Increase PrEP awareness, uptake, and use among people and communities disproportionately impacted by HIV
2.2.3 Continue to build capacity for Oregon pharmacies to dispense PrEP and PEP
2.2.4 Leverage existing partner services to connect clients to PrEP
2.2.5 Promote long-acting PrEP, where appropriate

[2] Our 2027-2031 goal of reducing cases to below 175/year is an ambitious interim goal on our way to eliminating new HIV infections, since we simultaneously aim to increase testing and diagnosis.

[3] To meaningfully reduce HIV incidence at a population level, health systems should aim to boost PrEP coverage by at least 5 percentage points, working toward the national target of 50% coverage among those for whom PrEP is indicated, and avoid any declines, as even small drops quickly erode progress.

Objective 2.3 Support & expand syphilis and gonorrhea screening, prevention, and treatment

2.3.1 Ensure that all people treated for syphilis and rectal gonorrhea receive HIV testing and referral to PrEP
2.3.2 Support use of innovative prevention strategies, like doxyPEP and expedited partner therapy
2.3.3 Increase provider education and practice transformation to improve integrated HIV/STI interventions
2.3.4 Build statewide capacity among key medical and community partners to respond to syphilis and congenital syphilis
2.3.5 Increase access to STI/HIV screening, prevention, and treatment in community settings (e.g., correctional settings, drug treatment, mobile clinics)
2.3.6 Increase the proportion of pregnant people with syphilis who initiate treatment at least 30 days before delivery

Objective 2.5 Ensure 100% of people diagnosed with Tuberculosis receive HIV screening, linkage to care and treatment

2.5.1 Provide clinic-based or self-testing HIV screening options to people under active treatment for TB
2.5.2 Ensure all people co-infected with TB/HIV receive a CD4/VL while under active TB treatment
2.5.3 Ensure all people co-infected with TB/HIV are linked to HIV care and receive case management to ensure initiation/continuation/completion of both therapies.

Outcome Measures & Data Sources:

- # of new diagnoses, by highest priority population
- # of medical providers listed on PrEP Provider Directory, # of new providers added, geographic coverage of providers (OHA Administrative Data)
- # and rate of PrEP prescriptions, PrEP-to-Need ratio (AIDSVu, Oregon All Payer/All Claims Data)
- # of syringe services programs (OHA Administrative Data)
- # of pharmacists and pharmacy technicians who have received approved training for pharmacist prescribed PEP and PrEP, # of unique pharmacy locations who have trained staff, by county (OHA Administrative Data)
- % of pregnant people with syphilis who initiate treatment at least 30 days before delivery (Oregon STI Surveillance Data)
- Rates of syphilis and congenital syphilis (Oregon STI Surveillance Data)

TREATMENT

Treatment saves lives. Early diagnosis and linkage to HIV medical care, along with services to promote access to and retention in treatment, support the development and maintenance of viral suppression. As a chronic condition, people living with HIV need ongoing support to maintain viral suppression and to achieve positive health outcomes across the life-course. Wide promotion of U=U messaging is also an important element of ending new HIV transmissions in Oregon by supporting the key strategy of treatment as prevention.

Baseline rates presented are based on most current Oregon data available at the time of writing (2026).

Five-Year Goals:

- Treat HIV quickly and effectively
- Ensure viral suppression is achieved and maintained by supporting Oregonians with HIV to stay in medical care
- Find and reconnect people with HIV who are out of care (or never in care) to ensure viral suppression

Objective 3.1 Increase the proportion of PLWH who are virally suppressed by 17% (from 77% to 90%)

3.1.1 Ensure Oregonians retain access to health insurance and high-quality HIV medical care
3.1.2 Ensure access to HIV medical case management for all Oregonians with HIV
3.1.3 Support expansion of rapid ART start programs across the state, so people newly diagnosed with HIV can start care quickly after diagnosis (ideally, within 7 days)
3.1.4 Ensure core and supportive services identified in the needs assessment as priorities (e.g., mental health support, housing, food assistance) are available to PLWH statewide

Objective 3.2 Close the gap in linkage to care and viral suppression rates for people and communities disproportionately affected by HIV

3.2.1 Increase housing opportunities for PLWH across Oregon
3.2.2 Leverage non-RWHAP housing resources and ensure needs of PLWH are represented in statewide housing initiatives
3.2.3 Provide linkage to care and housing support services for people exiting correctional settings
3.2.4 Ensure income stability among PLWH (through SSI referral process, DHS partnerships, and other strategies)
3.2.5 Develop partnerships with mental health and substance use treatment providers to ensure coordinated care for dually diagnosed people

Objective 3.3 Identify and engage or reengage 50% of PLWH who are out of care (OOC) or never in care (NIC)

3.3.1 Conduct annual audit of Surveillance data to identify PLWH who are out of care/never in care. Share lists with local public health partners for follow-up

3.3.2 Identify and address challenges for individuals who are OOC and NIC, in coordination with community partners

3.3.3 Conduct outreach and provide education to CAREAssist clients who are not regularly filling medications and/or not in case management and out of care

Outcome Measures & Data Sources:

- % of newly diagnosed people receiving ART within 30, 60, and 90 days of diagnosis (Oregon HIV Surveillance Data)
- % of PLWH virally suppressed (Oregon HIV Surveillance Data)
- % of PLWH stably housed (Oregon HIV Surveillance Data, HIV Medical Monitoring Project, Oregon Administrative data)
- % of PLWH who are linked to care in 30 days and virally suppressed x demographic and behavioral factors (Oregon HIV Surveillance Data)

RESPONSE
Ending new HIV transmissions in Oregon requires partnerships across multiple systems and communities. Communities with limited access to health care display worse outcomes across the HIV status neutral continuum. Detecting outbreaks and clusters of new infections through enhanced surveillance is an essential part of an effective response to HIV/STI. Strong community partnerships are also required to quickly provide treatment and prevention resources and implement policy responses to limit transmission.

Five-Year Goals:

- Identify HIV outbreaks and clusters
- Increase linkage to HIV medical care and HIV prevention services among those in networks affected by rapid transmission
- Ensure people living with HIV in Oregon have access to healthcare to optimize positive health outcomes and prevent further transmission

Objective 4.1 Direct resources to people and communities disproportionately affected by HIV

4.1.1 Support community-led interventions across the status-neutral continuum through direct funding and technical assistance
4.1.2 Provide technical assistance and other requested support to non-RWHAP or HIV-specific partners working with people and communities disproportionately affected by HIV to amplify HIV/STI efforts
4.1.3 Ensure ≥50% of medical provider educational opportunities target rural and frontier providers. Ensure collaboration and engagement between HIV and STI specialists and those who have less frequent interface with HIV/STI cases.

Objective 4.2 Increase capacity and implementation of activities for detecting and responding to HIV clusters and outbreaks

4.2.1 Analyze HIV surveillance data to detect transmission clusters and monitor HIV drug resistance and HIV genetic diversity
4.2.2 Support use of innovative, field-based testing modalities for use in responding to HIV clusters and outbreaks
4.2.3 Support lab testing and reporting
4.2.4 Facilitate communications to ensure rapid information about treatment and prevention resources to reduce transmission

Objective 4.3 Pursue systems and policy change to ensure a sustainable future for HIV/STI services

4.3.1 Build LPHA and CBO capacity to bill Medicaid and other insurance providers for HIV/STI services
4.3.2 Monitor 340B legislation that will impact Oregon's Covered Entities. Leverage 340B, where possible, to support eligible services along Oregon's HIV continuum of care.

4.3.3 Develop state government and tribal capacity to fully implement SB841 (tribal data sharing law) to support HIV/STI disease investigation

Outcome Measures & Data Sources:

- HIV care continuum measures (HIV testing, HIV diagnosis, linkage to care, viral suppression) by race/ethnicity (Oregon HIV Surveillance System)
- Number and type of funded partnerships with community groups (Oregon administrative data)
- Cluster and outbreak data (Oregon Surveillance Program administrative data)

Updates to other strategic plans used to meet requirements

Not applicable. Oregon is not an EHE jurisdiction and did not use other plans to meet the requirements of the Integrated Plan and SCSN.

Section VI. Implementation, Monitoring, and Jurisdictional Follow Up

Implementation Approach

The Oregon Health Authority, which is the Part B grantee and Prevention/Surveillance grantee, is responsible for ensuring implementation, monitoring, and follow up of activities listed in this integrated plan, in partnership with Multnomah County Health Department, the Part A grantee and co-author of the 2027-2031 Plan. Oregon's HIV Planning Bodies – the End HIV/STI Oregon Statewide Planning Group (OSPG, integrated Part B Care and Statewide Prevention Group) and the Part A Planning Council will use the plan as a living document and roadmap to guide its HIV planning throughout the year.

Implementation

Oregon has developed the following tools and procedures to assist with implementation of the plan:

- We have distilled the plan's goals and objectives into a Strategy Map that is updated at-least annually and widely shared with partners and community members
- Oregon reports on our high-level goals and objectives using the user-friendly End HIV Oregon data dashboards.
- Each OSPG meeting includes updates on the plan and, as needed, workshopping of ideas. We use a standard presentation template to show where the presentation content fits into the plan. Presenters also receive guidelines to help them draw explicit connections between their presentation content and the Integrated Plan. The 1st meeting of each calendar year includes an update on the previous year's accomplishments and any changes to the plan.
- The Part A Planning Council reviews plan objectives bi-annually and discusses them as part of their federally mandated processes (such as the Priority Setting & Resource Allocation [PSRA] process).
- OHA and contracted partners responsible for plan activities will discuss and mutually report on progress during regular contract administration meetings.

Monitoring

OHA and MCHD staff will review the plan and its strategy map on a quarterly basis; updates will be provided at OSPG meetings by the Part B and Prevention grantees and to the Part A Planning Council by the Part A grantee on an at-least annual and as-needed basis. As always, needs assessment and planning are ongoing.

OHA and Part A staff will meet formally at an annual monitoring meeting to review the plan together and make updates. Informal meetings will take place regularly, as needed, throughout the year. Updates to the plan will be released each year in conjunction with Oregon's annual End HIV/STI Oregon progress report, which is our high-level report to the community about our progress related to integrated plan goals. Each year, on World AIDS Day, this progress report is published in English and Spanish on our End HIV Oregon website and is shared widely through our networks and social media.

The annual monitoring meeting, involving Part A, Part B, and Prevention/Surveillance, will be held in late summer each year, to ensure time for community planning bodies to review updates and provide input, and for information to be included in the annual Progress Report, released

annually on World AIDS Day. This meeting will include a review of relevant data and data systems, analysis of performance measure data, development/updating of plans for including planning bodies in the monitoring (e.g., developing specific agendas/agenda items for planned planning body meetings), and an evaluation of the planning process (e.g., reviewing needs assessment data and community planning body demographics, planning additional, ongoing needs assessment activities).

OHA and Multnomah County Health Department will provide updates to CDC and HRSA as part of routine monitoring of awards.

Evaluation

Process evaluation – OHA and MCHD staff review progress on goals, objectives, and activities on a quarterly basis, including review of:

- Smartsheet/Excel data related to completion of work plan tasks
- Administrative data that provide a quantitative perspective on progress (e.g., contracts, grants, and MOUs; # of self-test kits ordered; CAREAssist enrollment stats)
- Evaluation data that provide a qualitative perspective on progress (e.g., client satisfaction surveys, interviews and focus groups with clients and providers, partner and community member feedback)

Outcome evaluation – OHA's Surveillance staff tracks End HIV Oregon metrics and updates the End HIV Oregon data dashboards on an at-least annual basis.

Improvement, Reporting & Dissemination

Needs assessment and review of data are ongoing, and responsibility for these activities is shared between OHA, MCHD, and a wide range of subrecipients and community partners. Individual programs and agencies collect data and evaluate their programs and processes on a regular basis. Overall quality improvement processes for Oregon's Integrated Plan include:

- quarterly review of plan goals, objectives, strategies, and progress on activities by OHA and MCHD staff;
- update on plan progress and solicitation of feedback at OSPG and Part A Planning Council meetings. Feedback is documented in meeting notes;
- annual Plan Review meeting between OHA and MCHD that includes review of relevant data and recommendations for revisions and improvements to plan;
- share suggested revisions and improvements to plan with planning groups; formalize revisions based on community input;
- document revisions and improvements in annual progress report published annually on End HIV Oregon website and shared widely with partners, community members, and people living with HIV;
- review of related outcomes and activities by other advisory groups, such as the CAREAssist Community Advisory Group, the Part B Case Management Taskforce, and the Statewide Quality Management Committee.

Updates to other plans used to meet requirements

Not applicable. Oregon is not an EHE jurisdiction.

Section VII: Letters of Concurrence

Appendix 1: Integrated Plan Checklist

To be added last

Appendix 2: Needs Assessment Inventory

(April 2026)

I. Quantitative Data Sources (e.g., surveys, reportable disease data, program utilization data)

Data Source	Populations	Types of Data Collected	Other Considerations	Key Domains
AIDSVu	People with a PrEP prescription	PrEP use	National data – not consistent with Oregon APAC data but reliably available on an annual basis and more timely. Used for End HIV Oregon metrics.	Prevent
All Payer All Claims Data (APAC)	People with a medical claim (public/private) related to HIV/STI/HCV	HIV/STI/HCV testing and treatment, PrEP use, health insurance, health care utilization	Delays in accessing data make APAC unreliable for annual metrics, consistent & ongoing evaluation	Diagnose, Prevent, Treat, Respond
American's Health Rankings	Oregonians	Food insecurity	Used to compare MMP data to Oregon population as a whole	Treat
Behavioral Risk Factor Surveillance System (BRFSS)	Oregon population age 18+	HIV testing Other health behavior Risk of acquiring HIV	Methodological limitations related to phone surveys, low response rate in recent years.	Diagnose, Prevent
CDC HIV testing program data	People who test for HIV through public programs	Testing location, results	Public testing represents a minority of people who test for HIV in Oregon	Diagnose
Census	Oregonians	Variety of demographic measures, SDOH	Useful for contextualizing all other measures and denominators	Diagnose, Prevent, Treat, Respond
Chime In/National HIV Behavioral Surveillance System (NHBS)	Rotating populations every 3 years: MSCM,	HIV/STI testing, PrEP knowledge and use, wide range of	Portland metro area only Annual data collection—population-specific data every 3 years Will not continue after 2025 in OR	Diagnose, Prevent,

	PWID, low-income heterosexuals	behaviors, SDOH measures		Respond
Early Intervention Services & Outreach (EISO)	People enrolled in EISO (newly diagnosed with HIV, diagnosed with STI, partners of people with HIV/STI, people tested through outreach testing)	Incidence, prevalence, care patterns, PrEP referrals, HIV/STI co-infection/(missed) opportunities for prevention, linkage to care	Some challenges with validity of PrEP data Replaced by the HSSS Model in 2025.	Diagnose, Prevent, Treat, Respond
Oregon ESSENCE (Oregon's Syndromic Surveillance Project)	Oregonians who had an ED or urgent care visit	Chief complaint, diagnosis, demographics	Attempted to estimate HIV testing trends but procedure codes are not complete for all facilities	Diagnose
Federally Qualified Health Center survey	FQHC providers	XX	Representative sample of XX FQHCs in Oregon	XX
HIV/STI Statewide Services (HSSS)	Oregonians engaged in status neutral HIV/STI prevention and care.	Incidence, prevalence, care patterns, PrEP referrals, HIV/STI co-infection/(missed) opportunities for prevention, linkage to care, clusters	New model (replacing EISO) as of 2025	Diagnose, Prevent, Treat, Respond
HIV Medical Monitoring Project (MMP)	People living with HIV	Wide range of care and behavior measures, stigma & discrimination	Small overall N participate each year. Response bias due to low response rate, though data are weighted to be representative. Add local Qs each year. national data at: https://www.cdc.gov/hiv/statistics/systems/mmp/index.html	Treat, Respond

		, SDOH. Unmet needs	Because of a pause in funding, the project was paused in 2025-2026	
Hospital and Emergency Department Discharge Data	People who have been discharged from an inpatient hospital or emergency department	HIV/STI testing (procedure codes), age, gender, patient zip code, ICD diagnoses	Completion rates are better than ESSENCE, but data aren't as current. Excluded are Veterans Administration hospitals, rehabilitative care hospitals, long-term care facilities, and most psychiatric hospitals	Diagnose
National Survey on Drug Use and Health	Oregon data from national survey	Drug use – prevalence, behaviors, access issues	Statewide data from national survey helps contextualize needs and barriers	Prevent, Treat
OHOP/HOPWA/ Housing	People living with HIV (w/ housing needs)	Housing needs and use, other SDOH	Multiple programs with different measures HOPWA EHE Planning Tool: https://ahead.hiv.gov/	Treat, Respond
Oregon Health Insurance Survey	Oregonians	Insurance coverage, health care needs	Contextual data related to health insurance landscape	Treat, Respond
Oregon HIV Surveillance Data (eHARS, ORPHEUS)	People who test positive for HIV	Testing location & date, CD4 and viral load results, time to viral suppression, HIV cluster detection and response data,	See HIV Surveillance Report, Supplemental Reports, and Data Tables: https://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-and-prevalence-2025.html for additional data	Diagnose, Prevent, Treat, Respond
Oregon's Local Public Health Workforce Report, 2025	Leaders at 33 LPHAs	Public health workforce & system capacity issues	Building on the 2021 report, this edition presents new data, identifies ongoing barriers—such as low pay and leadership turnover—and outlines actionable policy recommendations	Respond
Oregon Older Adult LGBTQ+ Survey, 2021	LGBTQ+ Oregonians age 55+	Variety of measures, including PLWH-specific.	Oregon DHS LGBTQIA2S+ Initiatives for Older Adults	Diagnose, Prevent, Treat,

		Stigma, discrimination, SDOH		Respond
Oregon State Health Assessment (SHA), 2025	Oregonians	HIV/STI diagnoses by demographics	Cross-cutting synthesis of community input and data on HIV, STI, and related SDOH; used to contextualize HIV/STI syndemic needs	Diagnose, Prevent, Treat, Respond
Oregon STI surveillance data (ORPHEUS)	People who test positive for STI	Testing location & date, participation in partner services, coinfections, including HIV, HCV, TB	Syphilis, GC, chlamydia, other STI Rectal GC data may have reliability issue – not all clinicians swab for rectal/not all labs mark samples accurately	Diagnose, Prevent
Oregon Student Health Survey/Youth Behavioral Risk Factor Survey	Oregon youth, 8th & 11th grades	Sexual knowledge & behavior, substance use, trauma/ACEs, other health behaviors	Only includes youth who attend school	Prevent
Overdose-Related Services & Projects by Oregon County	People who use overdose services	Overdose-related and behavioral health services and projects	In 2025, Comagine changed their methodology in counting SSPs	Prevent
Portland TGA Client Experiences Survey, 2023-2024	PLWH receiving services in the TGA	Access to care, needs, trauma-informed care, challenging life situations	500+ Ryan White TGA clients	Treat, Respond
Public Health Workforce Interests and Needs Survey (PH-WINS)	Public health professionals	Workforce needs	Conducted in 2014, 2017, 2021, 2024. National and regional data. Includes an agency login.	Respond
Ryan White HIV/AIDS Program data	People living with HIV (enrolled in	Program utilization, needs & unmet needs, care & treatment	People enrolled in ADAP (statewide, large population) People enrolled in HIV case management (Part B easily accessed;	Treat, Respond

	RHWAP Programs)	needs/outcomes/costs, health insurance coverage, income	Part A CAREWare is different—no interface) Program service reports:	
Take Me Home (TMH) (OR) or Together Take Me Home Program (national) (TTMH) (self-testing & self-collection data)	People who use home test kits for HIV/STI testing	HIV/STI testing	Small N, data collection is voluntary and therefore incomplete. Includes people who ordered the tests, not necessarily those who used them.	Diagnose
Tribal Sexual Health Capacity & Needs Assessment	Nine Tribes of Oregon	HIV/STI clinical capacity	Conducted by the Northwest Portland Area Indian Health Board and used as baseline data for planning technical assistance	Diagnose, Prevent, Treat, Respond
Vital statistics (Oregon, National Death Index, Social Security Death Master File)	People with HIV (who have died)	HIV mortality data, disparities, coinfections		Treat, Respond
Vulnerability Assessment, 2020	People who inject drugs	Estimated areas most vulnerable to IDU-related outbreaks	Mathematical modeling used to predict vulnerability to IDU-related outbreaks of acute HCV. Useful, but unclear how transferable data are to HIV	Prevent, Respond

II. Qualitative Data Sources (e.g., focus groups/interviews, community forums, evaluations, crowdsourcing/public comment)

Data Source	Populations	Types of Data Collected	Other Considerations	Key Domains
Cafecitos led by Familias en Acción	Latine community members and service providers	Input on data trends in HIV diagnosis and treatment among Latine people in Oregon	Convenience sample of Latine community members and providers; statewide representation	Diagnose, Prevent, Treat
CAREAssist (ADAP) Client Interviews & Focus Groups, 2023	CAREAssist clients	New questions: 2019: needs & barriers related to pharmacy 2022: U=U, service priorities 2023: trauma informed services; social support; mental health, vision, and dental health needs;	Small N=124 (31% response rate, 2023) to collect in-depth information about timely topics of interest; used to implement programs or policies	Treat
Community Listening Sessions with Black/African American Community in Portland, 2022-2023	Black/African American community members and partners	Opinions, barriers, strengths, and priorities related to HIV testing, PrEP, and stigma	A6/End HIV Oregon Communications Campaign Listening Sessions, 2022–2023 – four sessions with 51 Black/African American adults about HIV testing, stigma, message resonance, and preferred campaign strategies	Diagnose, Prevent, Respond
Community Town Halls with PLWH and Ryan White Providers	PLWH and Ryan White providers	Service needs and priorities	Four Town Hall-style focus groups conducted in Feb/march 2026 with PLWH (1 for English speakers, 1 for Spanish speakers) and Ryan White providers (1 for Part A, 1 for Part B)	Treat
End HIV/STI Oregon Statewide Planning Group (OSPG) Survey and Input	Range of partners, including PLWH and people vulnerable to HIV	Priorities and community data related to issues across the HIV care continuum	OSPG survey in 2025; 4 meetings/year covering a range of topics	Diagnose, Prevent, Treat, Respond

HIV/STI Partner Services Assessment	People with recent STI diagnosis enrolled in EISO	Knowledge, attitudes, behavior related to partner services	Conducted in highest HIV prevalence Oregon counties	Diagnose, Prevent, Treat, Respond
PrEP Connect Data	Partners participating in 3 PrEP Connect meetings	PrEP knowledge, awareness, implementation barriers and strategies	Statewide groups of providers and community members invested in expansion of PrEP use	Prevent, Respond
PRIME Plus program	PWID, people who use drugs	Interviews & administrative data related to prevention and treatment needs, testing	Research study and multi-level intervention in many Oregon counties	Diagnose, Prevent, Treat, Respond
Rural Oregon Formative Assessment for Media Campaign	Rural Oregonians	Knowledge, attitudes and behavior related to HIV, especially testing & PrEP	Online focus groups and surveys. Market research, not PH assessment	Diagnose, Prevent, Respond
Ryan White Part A Client Focus Groups, 2024	PLWH living in Portland metro (Part A)	challenges with accessing care and support services, experiencing stigma, and the need for more culturally responsive care	(N=24). Black, Indigenous, People of color living with HIV in the Ryan White Program.	Treat, Respond
Ryan White Part A Priority Setting & Resource Allocation Process	PLWH living in Portland metro (Part A)	Service priorities	Part A planning Council members, BIPOC data team members, community members	Treat
Self-Testing/Self-Collection Kit Listening Session	HIV/STI prevention partners	HIV testing needs	June 2022 listening session on home testing and home-based HIV/STI self-collection attended by 49 state, local, tribal, and CBO partners	Diagnose, Respond
U-COPE Rapid Needs Assessment of	PWID in Umatilla County	Facilitator, barriers, ideas for improving access to health care,	Secondary data review. Interviews with 20 service providers, 20 clients. Data collected in Feb 2022	Diagnose, Prevent, Respond

PWID in Umatilla County		SUD treatment, screening, peer, and harm reduction services		

Appendix 3: Summary of Findings from Community Town Halls, 2026

(to be added last)

Appendix 4: Oregon HIV Prevention, Care & Treatment Resources Inventory