HIV/STI Statewide Services (HSSS) Model

Frequently Asked Questions for LPHAs

Last Revision Date: 1.3.2025

This is a working document; new questions and answers may be added.

1. What is the HIV/STI Statewide Services (HSSS) model?

To address increasing needs across Oregon, the Public Health Division, HIV/STD/TB Section (HST), will be implementing a new statewide HIV/STI status neutral prevention and treatment model called HIV/STI Statewide Services (HSSS). This model will be supported by a new Program Element (PE), replacing PE07, PE10 and PE73. This new PE does not impact the delivery of HIV Case Management Services (PE08) or Tribal HIV Early Intervention Services and Outreach (PE74).

This model aims to expand and better integrate HIV/STI services to prevent new infections, ensure quick linkage to comprehensive treatment services, and improve individual and community health. The model aligns with Oregon's End HIV/STI Integrated Plan, using its key strategies to diagnose, prevent, treat, and respond. Activities include, but are not limited to, integrated testing, case investigation and partner services, rapid linkage to care and treatment for persons testing positive, and outreach services.

2. Q. Why a new HIV/STI service model and why now?

Changes are largely being made to address new requirements from our federal funding partners and shifts in HIV/STI burden across the state. Services are currently funded by different methods (PE, reimbursement) and sources, each with distinct requirements and restrictions. Consequently, our service system has become fragmented.

Newest research demonstrates that a status neutral, integrated service model has the greatest impact on HIV/STI. As such, funders now require this type of service model and approach. Furthermore, we have been seeing significant changes in statewide HIV and STI disease burden over the past five years, including increasing impacts in rural and frontier areas of the state.

HST funding for HIV prevention has historically been directed to the eight counties with the highest HIV incidence and prevalence. During the COVID-19 pandemic, Congress allocated funds to increase Disease Investigation Specialist (DIS) workforce capacity in response to inequities in funding and capacity across the state. HST distributed these DIS funds to twenty-six

rural and frontier counties to support case investigation and partner services. Unfortunately, in June 2023, the DIS funds were rescinded by Congress, ceasing funding for the final two years of the grant. Our current funding distribution model does not adequately reflect the shifts in disease burden across Oregon.

Below are some key HIV/STI statewide data trends (2022-2023 data):

- Annual HIV incidence is still highest among people living in urban areas; however, new diagnoses increased most notably in frontier counties. Persons diagnosed outside of urban settings were less likely to be linked to care or virally suppressed in a timely manner.
- People newly diagnosed with HIV are averaging younger in age and are disproportionately Black/African American, Hispanic/Latine, Native Hawaiian/Pacific Islander, or American Indian/Alaska Native.
- Most new HIV diagnoses remain among males having sexual contact with other males; however, we are seeing increases in new cases among cisgender women and people who identify as non-binary or transgender.
- In 2022, roughly 1 in 4 people diagnosed with HIV had a prior STI diagnosis within two years. In an analysis of persons enrolled in Oregon's HIV Early Intervention and Outreach Services (2019-2022), 10% of clients who had multiple STIs during the reporting period, namely syphilis or rectal gonorrhea, seroconverted to HIV within the four-year period of analysis.
- Since 2007, syphilis cases in Oregon have increased dramatically, rising over 3700%.
- In 2023, Oregon had the 17th highest rate of primary and secondary syphilis in the US, with American Indian/Alaska Native communities bearing a significant burden of early syphilis.
- While syphilis primarily occurs among cisgender men, the incidence of early syphilis among cisgender women has increased over 2000% since 2013, with a concurrent increase in congenital syphilis (syphilis in newborns).
- In 2023, Oregon had the 23rd highest rate of congenital syphilis in the U.S., with Native Hawaiian/Pacific Islander and American Indian/Alaska Native populations significantly overrepresented among these cases.

For these reasons, HST has been planning and developing a scalable, status neutral, and integrated HIV/STI service and funding model to maximize available resources and better reflect the realities and needs across the state. We consulted with the National Coalition of STD Directors, the National Association of State and Territorial AIDS Directors, and HIV/STI programs in seven states and hired a national HIV/STI consultant to make recommendations on future HIV/STI services in Oregon.

3. What are "scalable" services?

In the HSSS model, services are defined as Core and Enhanced. Core activities are those which align directly with foundational public health, such as case investigation, and are the minimum required under this PE. Enhanced activities, such as targeted outreach and community education, supplement Core activities. Some counties may only be able to deliver Core services whereas others may deliver all Core and Enhanced activities. Services provided will depend on funding and capacity available at the local level.

4. **If a county is able to provide some but not all Enhanced activities, are their certain Enhanced activities that should be prioritized over others?**

OHA recommends LPHAs use local data and needs assessments to determine which Enhanced activities should be prioritized.

5. **What funding source(s) will support HSSS?**

The new PE is being funded by a CDC HIV Prevention Grant and HRSA, Ryan White Program Income (specifically, insurance reimbursements generated by the AIDS Drug Assistance Program). Each LPHA will be issued two awards – one for each funding source. This is required to appropriately track and report on individual funding streams.

Funds from the above sources as well as from the CDC STD Prevention Grant and state general funds will also be used to support or enhance HIV/STI services throughout the state, such as the Oregon State Public Health Lab subsidized testing programs, Take Me Home (mail order HIV/STI testing), the Bicillin Access Program, cluster detection and response coordination, the ONE at Home program (mail order condoms), bulk condom and lubricant ordering, training, technical assistance, and capacity building activities.

Combining HIV/STI funds allows HST to leverage and expand our existing resources and maximize their impact. These funds are considered resources of last resort and should be used to enhance foundational public health services. LPHAs should leverage and use any and all other funds available to support the provision of HSSS services under the new PE (e.g. State Support for Public Health, PH Modernization, insurance billing).

6. **The new HSSS Program Element says CDC funds should be used first. Why is this and can we spend funds in tandem?**

As much as is feasible, LPHA should use CDC funds first. HRSA is a payor of last resort so requires leveraging other funds (e.g. CDC funds) before using theirs. It is acceptable for an LPHA to spend or use these funds in tandem. OHA staff are available to offer TA to an LPHA around use of funds if needed.

7. **When do you intend to begin this new service and funding model?**

HSSS services will begin July 1, 2025 if formally approved by LPHA Administrators at the Conference of Local Health Officials (CLHO) meeting on January 16, 2025.

8. How and when will you calculate county awards/allocations?

In November 2024, HST presented a variety of formulas to CLHO-Communicable Disease (CLHO-CD) for consideration of HSSS funding. On December 6, CLHO-CD voted to apply a formula using a 50/50 mix of HIV/STI epidemiology and a state approved PH modernization formula. Specifically, CLHO-CD voted to use formula Option 1a (the 50/50 formula mix which mitigates funding impacts to counties) through June 30, 2027. Thereafter, CLHO-CD voted to apply formula Option 1 (the 50/50 formula mix with no mitigation). LPHA Administrators must provide final approval before implementation on July 1, 2025.

For July 1, 2025- June 30, 2028, award calculations by county were presented to CLHO-CD as funding reference documents. Annual award amounts are subject to change based on available funding. Per availability of funding, HST intends to calculate awards for this PE at the beginning of each new three-year funding cycle; a future award would be recalculated in early Spring 2028, using formula Option 1, and would begin July 1, 2028. OHA or CLHO may initiate discussions about use of this formula at any time; however, will be reviewed at least every five years.

9. **What is the public health modernization formula and why was it used as a basis for the funding formula options?**

The PH modernization formula was approved by Oregon's Public Health Advisory Board and has been used by CLHO for the last several years when allocating funds across the state. The PH modernization formula uses a floor or base funding and accounts for equity indicators, such as population, race, rurality, and poverty. For more information, see pages 22 and 32-42 of the 2022 PH Modernization Funding Report.

10. How secure is this funding?

HST has obligated $10 million/year to provide initial funding to LPHAs for a three-year cycle. Funding from these multiple sources cannot be guaranteed beyond annual allocations and obligations.

11. What kind of staff can be funded?

Counties may use funds to support DIS, outreach workers, testers, paid peers, DIS, and nurses providing HSSS services. Allowable staff and services will be further outlined in a Budget Guidance provided before July 1, 2025.

12. If we want to do regional HSSS work, can HST give our funds to another designated LPHA to do this work?

Yes, this is allowable. HST will require signed authorization from the Administrator of each LPHA which elects to pass on some or all of their funds to another LPHA for work done under this PE. HST strongly supports regional partnerships and collaboration, whether that involves sharing funds or not.

13. **What if we do not need all the funds we are awarded under the new funding formula? What happens to that unspent money?**

If an LPHA does not use all of the funds allocated to them under this PE, remaining funds will be reallocated to address emerging and future service needs across the state.

14. **Will carryover of HSSS funds be allowed?**

No. In this new model, carryover of funds will not be allowed from one fiscal year to the next. This ensures funds are used in the timeframe they were obligated. Monitoring unspent funds is challenging and has resulted in programs growing bigger than their annual allocations can support. Allowing carryover of funds is not sustainable and makes it difficult for HST to commit longer term funding for HSSS.

15. **Were syphilis case reimbursements included in calculating the county baseline funding and will these reimbursements continue with HSSS implementation?**

Syphilis case reimbursements were not included in county baseline calculations. In July 2019, syphilis case reimbursements were introduced to address the initial rise in syphilis cases observed across the state. These reimbursements were made to support all counties in their response, particularly those seeing a rise; however, were primarily offered to support counties who did not otherwise receive direct funding from HST. Reimbursement costs have increased annually and payments, as designed, are no longer sustainable. In the HSSS service delivery and funding model, syphilis case reimbursement will be discontinued; however, funds previously used to make these payments will be redirected to support HSSS services.

16. **In the past, HST reimbursed us for rapid HIV and syphilis test kits. Will this continue?**

No, the plan is to discontinue test kit reimbursement to LPHAs under this new model. Funds previously used to make test kit reimbursements will be redirected to fund HSSS services. LPHAs may use funds received under this PE to directly purchase rapid HIV and/or syphilis test kits and build these purchases into annual budgets. HST does intend to provide limited statewide HIV/STI test kit reimbursements to non-LPHA entities in the future.

17. **Can funds be used to purchase test kits?**

LPHAs may use funds received under this HSSS PE to directly purchase rapid HIV and/or syphilis test kits and build these purchases into annual budgets. The HSSS Standards and Budget Guidance will provide explicit detail about purchase of supplies, including test kits. These documents will detail types of test kits permissible, any funding caps or restrictions on testing, and any related reporting requirements.

18. Can funds be used for incentives?

Incentives may be purchased with CDC funds only and must meet funder requirements (e.g. for allowable services only, each incentive cannot exceed $25, only gas or grocery store gift cards, no cash payments). OHA requires agencies have an incentives policy in place before they can be purchased/used with these funds. This information will be detailed in the HSSS Budget Guidance.

19. **Will HST continue to cover lab testing through the Oregon State Public Health Lab (OSPHL)?**

Yes, HST will continue to fund a variety of HIV and STI lab tests for LPHAs through OSPHL. In fact, beginning July 1, 2025, HST intends to expand the STI Wraparound Program to all LPHAs under the new HSSS model. LPHAs must follow specific requirements around eligible populations and the ways in which tests must be ordered.

20. **Can we use HSSS funds to provide HIV Pre-Exposure Prophylaxis (PrEP) or Post Exposure Prophylaxis (PEP) medications to patients?**

No, use of funds to purchase HIV PrEP or PEP medications is not permissible. Individuals who need assistance accessing free or low-cost HIV PrEP medication should be referred to those assisting with PrEP navigation in your county or region. Additionally, HIV PrEP is covered by the Oregon Health Plan. For more information about PrEP coverage and financial assistance, please see Oregon's PrEP Guide.

21. What is happening with statewide programs like Take Me Home and One at Home?

HST plans to continue these statewide programs as long as funding is available to do so.

22. What are the reporting requirements for HSSS?

Each funder has specific mandatory reporting requirements. Data reported at the local level will be used to meet federal reporting requirements. To ensure HST can meet funder requirements for reporting, LPHAs will need to develop an annual HSSS workplan and budget, submit a mid-year and annual report, and enter data in Orpheus (including entering HSSS-specific data elements previously called the EISO window). In addition, LPHAs will need to enter HIV testing data into a CDC testing database (as it applies) and submit expense and revenue reports. HST will provide templates. Data will be required for any testing performed under this PE, regardless of method of

testing or result (i.e. rapid tests supported through this PE, our subsidized testing program with OSPHL).

23. **Is subcontracting allowed and what services can be subcontracted to another organization?**

LPHAs may subcontract the provision of integrated HIV/STI testing services (defined as a Core activity) and any of the HSSS Enhanced activities (e.g. targeted outreach, support for harm reduction services, condom distribution, targeted community education, targeted capacity building). All other HSSS Core activities (e.g. case investigation, partner services, outbreak response) are those designed to be performed by an LPHA due to statutory requirements and PH authority.

24. **Can a Subcontractor get access to Orpheus and the CDC testing database to do this work on our behalf?**

Subcontractors may have access to the CDC test database to enter HIV testing data. However, Orpheus access is restricted to LPHAs, some Tribes, or to an organization/entity assuming local public health authority.

25. **How do HSSS activities connect with OHA's Public Health Accountability Metrics?**

Oregon's Public Health Advisory Board (PHAB) creates LPHA accountability metrics. There are several approved PHAB metrics, specific to syphilis and congenital syphilis, noted in the HSSS Program Element. The HSSS service model is designed to identify persons with HIV and/or STIs and link them to care and treatment. Syphilis is a priority for integrated screening and testing, case investigation, partner services, and outreach, all of which directly impact PHAB syphilis metrics. LPHAs can track progress toward these metrics in data dashboards.

26. **What training and technical assistance will be available from your office?**

HST will provide training and technical assistance to LPHAs in several formats before and throughout the funding cycle. Initial training is being planned to begin prior to July 1, 2025. HST will provide a HSSS Standards Guidance as well as a Budget Guidance to ensure LPHAs understand what is allowable and to facilitate success with implementation. After launch, we plan to have quarterly check-in meetings with LPHAs. HST welcomes input on training and technical assistance needs and preferences. In addition, HST will offer "office hours" with our program and fiscal staff to provide technical support, troubleshoot issues, and respond to any questions.

27. **Our LPHA is currently a recipient of PE07 and/or PE73. How is the HSSS PE similar or different from these other PEs? What happens now?**

The HSSS PE was written to include and combine activities defined in PE7, PE10 and PE73 and replace them. For those receiving both PE7 and PE73 funding now, activities and reporting requirements will be similar.

Decisions made by CLHO related to the HSSS funding formula and implementation mean any PE07, PE10 and PE73 funding will be phased out and replaced with HSSS awards/allocations on July 1, 2025.

28. What are the requirements for Not in Care (NIC) work?

Each year OHA runs a list of people who have not had a lab reported in Orpheus for at least 16 months. The HIV surveillance staff work to pair this list down using a variety of resources (e.g. out of state record searches, CARE Assist, voter registration, etc.,) to confirm current residence and vital status. Once the list is pared down, OHA makes the list available to the LPHA. Once the list is received, we recommend a NIC investigation begin. The details of the NIC process will be outlined in the HSSS Standards Guidance; however, includes doing a review of any medical records available, attempting contact with the medical provider, reaching out to the person as appropriate, etc. There are recommendations for the order of work and number of attempts to make in this Standards Guidance. NIC work can be done by the LPHA directly or a delegated Ryan White Provider. If the LPHA decides to delegate this work, OHA will need the LPHA to sign a form which would permit our office to release the county's NIC list to the delegated partner. This is outlined in the HSSS Program Element.

29. Under this new PE, what if we receive less or more money than we receive now? How do we go about changing our program model?

HST staff will be available to provide consultation and technical assistance for LPHAs that experience a change in funding.

30. How does HSSS address Oregon Health Authority's strategic goal to eliminate health inequities?

The HSSS model addresses shifts in HIV/STI burden across the state, directs resources to support priority populations, and maximizes and leverages funds to support a broader statewide reach. Although HSSS funding is still not enough to provide the level of HIV/STI services we know is needed in Oregon, we believe the HSSS model is fairer and more equitable than our previous service and funding model and allows all counties to ensure Core HIV/STI services are available in their jurisdiction.

31. Who can I reach out to if I have additional questions?

Alison Goldstein, OHA's HIV/STI Prevention and Surveillance Program Manager, can be reached by email at alison.goldstein@oha.oregon.gov or by phone at 971-372-1394.