

**United Way of Lane County  
2010/2011 Strategic/Preventive Proposal**

- A. Name of Organization: HIV Alliance
1. Contact Person: Diane Lang, Executive Director
2. Address: 1966 Garden Avenue  
Eugene, OR 97403
3. Phone: (541) 342-5088 x150 Email: dlang@hivalliance.org
- B. Name of Proposed Services: Needle Exchange Continuation/Expansion  
for Hepatitis C (HCV) Testing, Wound Care, and Rural Outreach
- C. Amount of Funding Requested for a 12 month period: \$15,000

***The undersigned confirm that the information provided in this application is true and accurate and that the application has received / will receive Board approval.***



Signature: Agency Director

03/05/2010  
Date

Bob Burk [electronic]  
Signature: President, Board of Directors

03/05/2010  
Date

## **SECTION I: Strategic/Preventive Action Area**

Which Community Investment Strategic Action Area do the proposed services primarily address? (Please see **Appendix A UWLC 2010 Strategic/Preventive Goals and Funding Strategies for EDUCATION, INCOME and HEALTH.**)

**1. Action Area:** (select one)

**Education:** Preparing children to succeed in school and life.

**Income:** Moving families from poverty to financial stability.

**Health:** Ensuring people have basic access to healthcare.

**2. Strategies:** Based on your selection above, list the specific strategy or strategies the proposed services are designed to address. (*Note: Strategy or strategies listed must come from Appendix A referred to above.*)

Health Strategy: increase the number of patients this existing safety net clinic can serve

Preventive Strategy: evidence based approach to patient directed chronic disease self-management

**3. Provide a *brief*** (no more than one paragraph) executive summary of how you will address the strategies you listed in Question 2, above. Details will be expanded in Section II, questions 1-3.

Founded in 1994, HIV Alliance is the only non-profit health organization in Lane County providing case management and prevention services for the population affected by HIV/AIDS. As part of the agency mission to support people living with HIV/AIDS and to prevent new HIV and Hepatitis C (HCV) infections, activities include Prevention services encompassing mobile needle exchange (NEX) to prevent infections among people who inject drugs (PWID), street-based medical care, risk-reduction counseling, identification of new HIV and HCV infections through testing, and referral services to people newly infected and people at risk for contracting/transmitting HIV and HCV, with targeted prevention to gay and bisexual men, to PWID, to people living with HIV/AIDS (PLWH/A), and to their partners. Establishing partnerships with health care providers outside the Eugene-Springfield urban area and identifying sites for regular needle exchange, wound care, outreach, and testing will increase the agency's capacity to serve at risk populations throughout Lane County.

## **SECTION II: SERVICE IMPACT**

**1. Need, Target Population and Program Description**

**A. Need/Target Population**

Identify the community problem/need the strategies described in Section I address, including the number of Lane County residents affected. Clearly link the need to the Community Investment Strategic Action Area goals and strategies selected in 1 and 2 above. *Also, include local trend information over the last five years as*

*available/appropriate.* Describe how the proposed service(s) reach the intended target population for your Action Area (see Appendix A) and is appropriate to the need.

NEX is dedicated to connecting PWID with information and supplies that reduce the risk of infection with HIV and other blood borne pathogens. Injection drug use (IDU) accounts for 10.9% of all reported HIV cases in the state, with the combined risk factor of men who have sex with men (MSM)/IDU adding another 9.8%. Nearly 20% of all new infections in Oregon could be prevented by educating and empowering people who use drugs to reduce or eliminate their exposure risk. Bringing harm reduction services to this population is challenged by public discomfort with the realities of drug use, and by transience and homelessness that defy systematic approaches. In conjunction with the direct good of reducing the number of shared needles, NEX is the face of HIV Alliance on the street. The exchange van is an important portal to connect vulnerable members of our community with the health and social services they need to best live with or break their addiction.

4,463 (duplicated) Lane County residents were served last year. Confidentiality precludes tracking of unduplicated numbers of clients receiving these services: 584 Testing; 1,138 Outreach; 2,741 Needle Exchange. If program activity continues at the level established during FY10 first quarter we are projected to have a 58% increase in our contacts and a 25% increase in syringes given out over the year. Additional contacts are from outreach in parks and the availability of safer injection kits in the HIV Alliance lobby during regular business hours. United Way funding would provide for medical staff time, and facilitate the development of new partnerships for more rural outreach. Clients come from at least as far as Florence to exchange needles and access wound care services. Increased outreach and medical staff time lead to increased supply use and the need for more trained volunteers, in turn offering new opportunities to connect with clients through services such as a support group for those dealing with HIV/HCV co-infection. As funds, staffing, and volunteers permit, we would also like to add HIV and HCV testing at outreach sites.

The State of Oregon has been providing free HCV tests as a short-term pilot project, and we have been informed this support will not continue. The best means of making the test available to those who are at greatest risk, and to have a dependable supply, is for us to purchase those tests at \$45 per test kit with associated shipping costs and minimum purchase requirements. Modifications to the van would better maintain client confidentiality. In lieu of or possibly in combination with rapid testing, incentives such as gas or food cards might motivate clients to return for their results through conventional testing. While those clients with transportation come to the Eugene/Springfield NEX locations, establishing additional sites in the more rural areas of Lane County would facilitate contact with more clients and partnerships with additional agencies, maximizing health care access.

According to the latest available national statistics published by the Centers for Disease Control and Prevention (CDC), in 2006 of the 34 states with names-based reporting, 36% of people testing positive for HIV also received an AIDS diagnosis either at time of HIV test or within 12 months, considered a "late" diagnosis. That same year Oregon experienced a rate of 44%. Clearly – Oregon faces significant disparities in testing outcomes for HIV.

Rural cases are more likely to be diagnosed late in the course of the disease. The Oregon Department of Human Services breaks out the statistics as follows: in urban Oregon areas 38% of cases progress to AIDS within 12 months of first diagnosis; in mixed urban/rural areas the rate is 42%, and in rural areas the rate is 55%.

The Rural HIV/STD Prevention Workgroup's *Tearing Down Fences: HIV/STD Prevention in Rural America* published in 2009 by the Rural Center for AIDS/STD Prevention in Bloomington, Indiana cites the following pertinent data:

- Since the early 1990s, 5% to 8% of the annual new AIDS cases have been diagnosed among those who live in non-metropolitan areas, defined by the CDC as counties with fewer than 50,000 residents. Although the proportion of rural people living with AIDS is relatively small, it represented over 51,000 people at the end of 2006. This number is an underestimate since it does not include those who are currently unaware of their HIV+ status, migrate to rural areas after diagnosis, or are diagnosed in urban areas and do not provide their home address to avoid hometown stigma.
- African-Americans account for 48% of rural AIDS cases, Whites 37%, Latinos 10%, and American Indian/Alaskan Native 1.3%.
- Men continue to comprise the majority of reported rural AIDS cases (9.6 per 100,000) at nearly three times the rate for women.
- The largest proportion of new rural AIDS cases diagnosed in 2006 was among adults ages 35-44. Evidence indicates that nearly half of rural HIV infections are diagnosed "late," that is, within 12 months of advancing to AIDS. This suggests that the acquisition of HIV probably occurs most often among rural residents in their late twenties and early thirties.
- Exposure through male to male sexual contact accounts for over half of all male AIDS cases. About 20% are attributed to injection drug use exposure.
- There is an increasing rate of infection among women who are involved in methamphetamine use in the West and Midwest, especially if they inject the drug or have sex with an infected partner.
- Concurrent sexual relationships are not uncommon in rural social networks. This means that as pool of HIV infections increase in rural areas, the chance for new infections increases.
- Since options for sexual partners may be limited in smaller communities, a few people with multiple concurrent partners may spread disease to a large network in rural areas.
- While male to male sexual activity is responsible for the great number of HIV infections, increasingly, heterosexual exposure is spreading the infection to rural women, especially women of color.
- Alcohol and drug use can lead to behaviors that put people at heightened risk for HIV infection. Nearly 20% of rural male adolescents and adults diagnosed with AIDS between 2001 and 2005 were exposed to the virus by injecting drugs.
- Approximately 8% of rural men with AIDS were exposed both by injecting drugs and having male to male sex.
- About 22% of female adolescents and adults living in rural areas attribute their infection to exposure from injecting drugs. In rural areas, an additional 15% of women with AIDS were exposed by having sex with a man who injected drugs.

Local anecdotal evidence from social services personnel includes information that individuals living in rural areas are more inclined toward more serious (i.e., injection) drug use, in part due to reduced opportunities for work and recreation. Some of Lane County's communities outside of the Eugene/Springfield area (e.g., Creswell, Florence) have a higher incidence of heroin use relative to the population, and people who might in Eugene only smoke marijuana, in Florence use heroin. Drug use is more likely to cross class and income levels in rural areas, and drug

users are more likely to be known to one another, and inclined to share needles. Without access to needle exchange, more people are using/re-using the same needles.

HIV Alliance serves clients throughout Lane County, including rural MSM who come to the Eugene/Springfield area seeking social venues, partners, health and social services, and a more open mind set. While the Eugene/Springfield metro area is Oregon's second largest after Portland, in many ways it does not have an urban feel. The small town perception leads some MSM to feeling disenfranchised from both the gay community and the larger community as they hide their sexuality out of concern for their families and/or their own reputation. This may lead some MSM to engage in substance abuse, high-risk sexual behaviors, and delay testing to find out their serostatus.

For both Oregon and the nation, late testers are more often comprised of individuals: over the age of 50, from Hispanic and other communities of color, who inject drugs, and those who presume themselves to be low risk (heterosexual transmission). In Oregon, these communities often face barriers to accessing HIV testing or believe they are not at risk for HIV. As noted by the Rural HIV/STD Prevention Workgroup, evidence indicates that about half of rural HIV infections are diagnosed late.

Late testers are creating serious consequences for Oregon. Late testers are more likely than others to have been unknowingly transmitting HIV to their partners in the years prior to their HIV or AIDS diagnosis. Additionally, late testers do not receive the benefit of early HIV treatment and therefore tend to have poorer long term health outcomes, which only increases the overall cost of HIV care.

## **B. Service Description**

Describe the proposed services for which you are requesting funds. Be very specific. The description should be a clear and logical response to needs outlined in Section 2, question 1A. Describe how your proposed services are designed to effectively meet the Community Investment Strategic Action Area goals and strategies selected in Section 1. Describe the research or evidence based methods which justify the proposed approach.

The dual goals of NEX are: 1.) Interrupt the spread of HIV/HCV and 2.) Increase access to health care, drug treatment and detox for PWID. Outcomes to be measured include contacts, new syringes distributed, safer injection kits distributed, used syringes returned for disposal, HIV and HCV tests administered, new HIV and HCV cases identified, patients seen by the Wound Care doctor, and referrals to other social services.

United Way Strategic Funds will be used to:

- Increase staff time to build relationships, conduct outreach and increase access to HIV Prevention services to PWID in rural areas
- Purchase safer injection supplies for at risk PWID in rural areas currently underserved
- Provide medical provider time and wound care supplies for a wound care site to bring access to basic medical care for Lane County residents who inject drugs.

Based on the program coordinator's conversations with clients, priority would be given to Veneta, Pleasant Hill and Oakridge, and Cottage Grove. Services would include outreach to homeless camps and parks, as well as identifying community gate keepers who do exchange for their community, and take needles and supplies directly to them. The mobile van would work best. It may also be possible to establish a partnership with one or more social service providers

to provide needle exchange and wound care services at a fixed site.

Continuation/expansion of the HCV testing and wound care components of the HIV Alliance's needle exchange (NEX) program, and rural outreach with the mobile van will increase access and reduce barriers to health care for people below 200% of FPL, especially those who are uninsured and with few, if any, resources for healthcare. 685 of the NEX contacts at the mobile van reported that they were currently homeless.

This Health Strategy is designed to increase the number of clients HIV Alliance, an existing safety net clinic, can serve. This Preventive Strategy also includes access to medical care in which clients receive counseling on chronic disease management such as diabetes. NEX currently operates 4 days a week: including three evenings at sites convenient and non-intimidating to the community of people who exchange syringes, and once a week at the agency office. Our program is a one-for-one syringe exchange, with many clients exchanging for other people. In addition to syringes and safer injection kits, NEX offers wound care services and supplies, safer sex supplies, HIV and HCV tests, and hepatitis A & B vaccines, when available.

The Wound Care Project is the only street based medical access program in the area. This is medical care run with a harm reduction approach. We have seen that this approach leads to engagement with PWID who have become very skeptical of medical care providers. The trust that our NEX workers build with PWID facilitates the referral to our Wound Care physician. Initially titled the Wound Care Project with the idea that the provider would be addressing abscesses, it was quickly apparent that our clients needed much more than that. Our provider also works with clients on managing chronic illness like diabetes and treats post surgical wounds. Many clients tell us that they either lack insurance or fear they will be treated poorly if they seek medical care in traditional settings. Our medical staff frequently report client acknowledgement and appreciation for saving them from a trip to the emergency room.

Using our integrated HIV testing, outreach, and education programs as a template, our NEX coordinator has taken on the responsibility of creating parallel programs and policies for HCV. With expansion of staff time and supplies we have seen a reduction in HCV and hospital treatment needs for subcutaneous infections. Preventing HIV and HCV infections, connecting individuals living with chronic infections to case management, and saving thousands of health care dollars, all positively contribute to the health and well-being of our community.

Needle exchange is an evidence based method. In cities with Syringe Exchange Programs (SEPs), prevalence of HIV dropped 8.6% annually. In cities without SEPs, HIV prevalence increased on average 8.1% every year.<sup>1</sup> In San Francisco, injection frequency among Injection Drug Users decreased from 1.9 injections/day to 0.7, and the % of new initiates into injection drug use decreased from 3% to 1%.<sup>2</sup> HIV Alliance uses the client-centered term: People Who Inject Drugs (PWID).

## **2. 2010/2011 Service Objectives and Outcomes**

### **A. Service Objectives (# people to be served and/or services provided):**

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<sup>1</sup> Study comparing HIV prevalence rates in 103 cities. World Health Organization (2004). Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission. <http://www.who.int/hiv/pub/advocacy/>

<sup>2</sup> Watters JK, Estilo MJ, Clark GL, et al. Syringe and needle exchange as HIV/AIDS prevention for injection drug users. Journal of the American Medical Association. 1994; 271:115-120.

You may choose the 12-month reporting period that best matches your data collection system as long as the period begins in calendar year 2010.

**12-Month Service Objectives:** 07/01/2010 through 06/30/2011  
 (Month/Day/Year) (Month/Day/Year)

**Proposed Service Objectives:**

- Reduce the reuse of injection drug supplies
- Increase access to needle exchange services (including wound care)
- Prevent unintended syringe sticks and the reuse of syringes
- Identify new HCV infections
- Identify new HIV infections
- Reduce number of health problems related to injection drug use and prevent Emergency Department admissions

**B. Proposed Services Outcomes** (measurable statement of intended effect on target population.)

Dates should match the service objective dates you specified in question 2 A.

**12-Month Outcomes:** 07/01/2010 through 06/30/2011  
 (Month/Day/Year) (Month/Day/Year)

**Proposed Outcomes and Performance Measures for each proposed service** (provide in table format, correlating measures to proposed outcomes):

Outcomes	Measures
<i>Specific to rural program expansion</i>	
Increase access to one for one exchange for rural residents	12,000 needles exchanged in rural exchange locations
Increase awareness of HIV/HCV status in at risk populations in rural Lane County	50 at risk rural residents are provided an HIV/HCV test
Increase access to medical care for NEX clients in Lane County	125 NEX clients receive medical care
<i>Existing program</i>	
Provide new syringes and other new safer injection supplies	315,000 new syringes distributed; 2,300 contacts
Offer safer injection kits in HIV Alliance lobby	600 safer injection kits distributed
Collect used syringes from drop boxes	12,000 syringes collected from drop boxes
Collect and destroy used syringes	310,000 used syringes returned for disposal
Provide HCV screenings and referrals	100 HCV screenings (depending on continued availability)
Provide HIV Counseling and Testing	50 PWID receive counseling and testing; 40 PWID receive results
Provide abscess and wound care	156 clients receive wound care; 80% of clients in need receive services

If PWID use only new supplies and do not share, the risk for HIV/HCV is decreased or eliminated. Number of abscesses and other infections and health problems related to injection with used syringes are reduced. Used syringes are destroyed, decreasing prevalence of HIV/HCV in community. Focus Population members will know their HCV status, and their HIV status and risk. Emergency Department admissions related to injection drug use are reduced. Health outcomes for PWID are improved.

**Note:** Please include a copy of your Logic Model if one was developed. It is excluded from the 15 page limit.

Under separate cover please see "Theory of Change," the existing Logic Model developed by the HIV Alliance in November 2008.

### **3. Tracking Systems**

What systems will be used to track the impacts and outcomes of the services provided and support continuous improvement? (e.g., telephone logs, client files, client satisfaction survey, pre-test/post-test, software systems, etc.) Please note if a tracking system is already in use, or if it will be developed to support the program.

Each time a client accesses NEX services, an intake is conducted. This form gathers information regarding the client's demographics, the number of supplies they receive, and other services they need. Each client is tracked using a unique identifier, and all intake forms are entered into a database. This allows us to track the number of needles exchanged, the number and type of supplies given, the number of HIV/HCV tests provided, the site location, and the client demographics. This tracking system will continue to be used in order to track the specific goals of this strategic proposal, and will provide the information needed to determine whether or not the specific goals of rural outreach and wound care expansion are met.

## **SECTION III: SERVICE MANAGEMENT**

### **1. Client Involvement**

Describe your client involvement systems and how they lead to more efficient and effective services. For example: How are clients involved in service planning, offering feedback or making suggestions about your services? How do you measure client satisfaction? How do your feedback systems lead to more effective services? Please provide examples.

The agency encourages clients to give feedback in many ways. Suggestion boxes are available and prominent at service locations, and the forms clients fill out include space to make comments. As a proponent of client centered care, HIV Alliance trains all staff to view services as client directed. Staff members are encouraged to seek feedback from clients. In planning NEX, clients have been utilized to determine site location, types of services, and service gaps. A recent example includes the Overdose Survey that was administered to clients. In seeking to assist clients in reducing the harm and potential fatality caused by drug overdose, our NEX Coordinator developed a client survey tool. The clients were asked how and when they experienced overdose and in what way our NEX program could help them address this issue in their community. A majority of clients indicated that they would like to be trained in rescue breathing/CPR. Our team developed a plan and began training client with a certified CPR volunteer in March. This is just one example of how client feedback has been critical in the development of this program. Current agency plans include a satisfaction survey in all

programs, beginning in 2010 with a Dental Client survey in January, and a Client Services Client survey in March, with plans to conduct Prevention program surveys May - June 2010.

## **2. Coordination/Collaboration**

Describe specifically how you work with others in the community to maximize service to the people you serve. List any formal relationships, the nature of the partnership and the type of agreement (i.e. Memorandum of Understanding, Service Agreement, Contract or other documentation.)

HIV Alliance staff members are co-founders of and active participants in the Lane County Harm Reduction Coalition (LCHRC). NEX Coordinator Jeff Nichols is currently Chair. Program Director Renée Yandel and Prevention Coordinator Tony Aaron Fuller are also members. The Coalition works towards the common goal of reducing the negative impact of injection drug use on public safety and community health and includes members of law enforcement and health care professionals. Other partnerships include Lane County Public Health (LCPH) in developing protocols and referrals; White Bird Medical Clinic, Eugene Police Department, and LCPH in the collection of used needles, and PeaceHealth for the incineration of those used needles. We have a referral agreement with Buckley Detox, and they are a member of the LCHRC. Wound care services are provided in partnership with the federally qualified health clinic, Riverstone. They hire and provide clinical oversight of our Wound Care provider. Dr. Kalli Phillips accepts a drastically reduced rate for sharing her expertise with NEX one evening a week, accompanied by a volunteer wound care nurse.

HIV Alliance was sought out by the Oregon Department of Human Services' Statewide Viral Hepatitis Planning Group. As with HIV, people who inject drugs are at increased risk of HCV. The CDC estimates about one quarter of HIV-infected persons in the US are also infected with HCV. Therefore, the State recognized the value of dovetailing HCV screening, education, and data collection with the HIV prevention activities already underway at NEX.

## **3. Diversity / Accessibility**

*"United Way of Lane County believes that respect for and understanding of all cultures, peoples, and lifestyles are central to our mission of helping people care for one another. To that end, United Way will demonstrate that it values diversity in its funding of programs in Lane County. We will attempt to promote and recognize programs and organizations which provide culturally appropriate services, ensure access for people needing those services, and show a valuing of diversity in volunteer, staff, and service systems." --United Way of Lane County's Diversity Statement*

Describe how diverse segments of the community have access to the proposed services. Describe your efforts to continuously improve services to underserved populations. Diversity can include but is not limited to: race, gender, ethnicity, physical ability, sexual orientation, age, familial status, economic status, rural/urban location.

HIV Alliance programs are staffed by leaders in advocacy for vulnerable populations, LGBTQ issues, and disease prevention. This is a result of agency development and modification of job descriptions to include experience with target communities, and recruitment of experienced volunteers and interns for staff positions. The strategic plan includes goals of creating a path to employment for volunteers, leading to greater ability to hire staff with existing experience with the population we serve, and a commitment to diversity among board members and other volunteers. In all aspects of our work, HIV Alliance seeks to provide services that meet the

needs of clients and the community in a way that is population specific and appropriate. Rural HIV prevention and care must fit the attitudes, needs, and culture of the community and those being served.

Lane County supports many different types of communities, rural and urban, conservative and liberal, native to this place and new arrivals. HIV, however, does not respect labels or boundaries – everyone in the community is affected by an HIV infection whether directly by a diagnosis or secondarily through the cost to health care system, job market, etc. Still weighed down by stigma, people at high-risk for HIV are often pushed to the margins of those communities, both by peers and by health professionals. Once at the margin, risks compound each other, including the burdens of struggling with disclosure, living on a low income, managing a chronic disease, experiencing homelessness, or struggling with mental illness. In this climate, it is critical that intervention-based outreach be delivered effectively and compassionately to high risk populations.

HIV Alliance recognizes the need for services outside the Eugene/Springfield metropolitan area, and has selected the United Way as our primary partner in expanding an existing successful program into rural areas where there is proven need regarding the benefits of needle exchange and street-based medical care.

#### **4. Use of Volunteer and Partnership Resources**

Describe how you use volunteers. Include type of positions they hold, number of volunteers, and total volunteer hours per year. Describe your capacity to mobilize additional community partners and/or in-kind resources in conjunction with the proposed services.

Volunteers help with needle exchange, testing, and data entry. Volunteers are critical to the success of our programs, and are trained in cultural diversity alongside our staff members. Agency wide in FY09 223 volunteers logged 7354.15 hours. Volunteer dedication to the needle exchange program is such that individual volunteers represented approximately ten percent of the volunteer corps and approximately twenty-five percent of total volunteer hours. Volunteer numbers and hours have increased significantly in FY10 to date over FY09. Forty-six percent of FY10 volunteer hours have been donated to prevention programs with 30% of total volunteer hours going specifically to NEX.

NEX is a syringe exchange integrated with complementary services tailored to the specific risks of injection drug use. This model is made possible by several partnerships and our involvement with the Lane County Harm Reduction Coalition as referenced in Section III. Service Management 2. Coordination/Collaboration. A renewed in-kind donation of needles and supplies from PeaceHealth allows our dollars to go much further. In the interests of community safety we are now regularly collecting used syringes from drop boxes at White Bird Medical Clinic, Lane County Public Health, Buckley Detox, and the police substation at 6<sup>th</sup> and Monroe, in a neighborhood recognized for a higher prevalence of injection drug use.

The previously referenced partnership with the State planning group has highlighted the potential of working relationships between governmental and private agencies that accomplish more together than either group could do apart. NEX is stronger for professional relationships and a number of state sponsored HCV screening kits, while the Planning Group has access to a hard-to-reach population and a cost-effective way to add services without duplication.

#### **5. Budget**

- A.** Complete the budget form (Appendix B) included separately.
- B.** Describe the return on the UWLC investment. Include such factors as demonstrated cost effectiveness and efficiency of service delivery, how you will leverage other financial investments to support the work and the sources of other financial investment for this work. Describe how the work improves the effectiveness of the human services network in Lane County.

Increasing the number of Lane County residents who know their HIV status will help them, and the greater community who frequently bear the cost, by reducing the number of HIV transmissions and by getting those who are HIV positive into early medical care thus improving their long term health outcomes and decreasing overall healthcare costs. As people learn their HIV status they take steps to prevent the transmission of HIV. The CDC published in their *HIV Prevention in the United States: At a Critical Crossroads* (2009), that each HIV infection prevented saves approximately \$355,000 in the cost of providing a lifetime of care and treatment, making this request a cost effective use of funds.

If Sana Needle Exchange prevents even one HIV infection, it saves over \$600,000, if lost wages are also included. In the past two years, no clients of the Needle Exchange have tested positive for a new HIV infection. One study estimated a cost-effectiveness ratio of \$20,947 per HIV infection prevented by needle exchange, using the \$600,000 figure.<sup>3</sup>

Needle exchange costs per client include: \$0.09 for a clean needle, \$1.22 for a wound care kit, \$11.85 for a visit with the NEX wound care medical provider, and \$18.00 for an HIV test; Total cost to prevent the spread of HIV: \$31.16.

Additionally,

- Every dollar is doubled in effectiveness, reducing Hepatitis C and Methicillin-resistant Staphylococcus aureus (MRSA) in addition to HIV infections.
- Providing street based medical care keeps people healthy and out of the Emergency Department.
- Providing wound care supplies along with new needles empowers people who inject drugs to prevent skin infections.

**C.** If you are requesting funding for Capital investment, including funding for physical space or renovation, you must include the full cost of the capital project and how you will fund the balance outside the UWLC amount.

**6. Follow-Up**

If you received a United Way Allocation in 2009, the United Way volunteer-led review panel will receive copies of your most recent panel summary report. Were there any concerns or conditions for continued funding identified by the United Way review panel during the last review?

Yes  No

If yes, how have these been addressed by your agency?

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<sup>3</sup> 11 Laufer FN (2001) Cost-effectiveness of syringe access as an HIV prevention strategy. *Journal of Acquired Immune Deficiency Syndromes*. 28(3): 273-78.

**7. Governance, Management & Organizational Capacity**

Briefly describe how this program fits into your organizational structure, how it will be managed, and how oversight will be provided. ***Complete Appendix C, Required Compliance Documentation, Exhibit A – Best Organizational Practices and Management.***

Required Compliance Documentation Previously Submitted with Basic Needs Application

Describe the ability of the organization to carry out the proposed services successfully and efficiently based on current resources, i.e. expertise of staff, diversity of funding sources, board composition and involvement, fiscal and governance systems and facilities.

HIV Alliance has a proven history of service to the target populations and as a community-based organization has developed trust with vulnerable populations including those in rural Lane County. Founded in 1994, when several local AIDS service providers merged, HIV Alliance became the only not-for-profit health-based organization in Lane County whose mission is to support individuals living with HIV/AIDS and to prevent new HIV infections. HIV Alliance plays a critical role in our community by often being the first and only organization working with high risk populations in Lane County. We receive guidance and expertise from a fourteen-member Board of Directors as well as a Board of Advisors comprised of forty influential community leaders. Renee Yandel is an ideal Program Director having worked in almost every department in the agency in her tenure here as one of the longest term employees of HIV Alliance. Prevention Coordinator Tony Aaron Fuller brings diverse experience and a passion for the work. The exchange van is primarily staffed by program coordinator Jeff Nichols, our resident expert in drug and alcohol addiction, HIV infection, and hepatitis infection.

We have become more self-sufficient and sophisticated in our approach to fundraising, integrating it with expanding our volunteer and education networks. With the support of our Boards we have expanded programming in the areas of education, volunteer recruitment, training, and retention, needle exchange, wound care, and HCV awareness and testing, even in these times of economic uncertainty, as the need for our services has increased. NEX has been recognized as in the top ten percent of needle exchanges nationwide. We have a well organized program, the trust of the community we serve, and staff who are experts in their fields.

HIV Alliance seeks to provide services that meet the needs of clients and the community in a way that is population specific and appropriate. Our capacity to manage large and collaborative projects is evidenced by our dental program. Through a 5 year grant from the Health Resources and Services Administration (HRSA), HIV Alliance has piloted a Dental Program which connects PLWHA to free oral health care and educates dental hygienists on working with the special health needs of PLWHA. The organization's dental program currently operates within 15 counties. It is an innovative model anchored by partnership with the community college dental education facility and the federally qualified health center. The dental program includes both direction service and a research/data collection component managed by a research group at Boston University. HIV Alliance has been a leader among grant recipients in terms of data collection and data quality.

**8. Policy Adherence**

UWLC requires all service partner organizations to follow and adhere to the following UWLC Policies and Certification Documents:

- **Non-Discrimination Certification**
- **USA Patriot Act Anti-Terrorism Compliance Measures**
- **Agency Direct Fundraising Policy**
- **Donor Designation Policy**

***Read and sign Exhibit B, United Way of Lane County Policies and Certification Documents, included in Appendix C.***

Required Compliance Documentation Previously Submitted with Basic Needs Application

**Appendix A**  
**UWLC 2010 Strategic/Preventive Goals and Funding Strategies for**  
**Education, Income & Health**

**HEALTH**

**Vision:** Increase access and reduce barriers to health care for people below 200% of FPL

**Action:** Ensuring people have basic access to healthcare

**GOAL:** **By 2020, connect an additional 15,000 uninsured or underinsured Lane County residents to a community-based system of healthcare**

**Target Population:**

Families and individuals with incomes below 200% of FPL who are uninsured or underinsured

**Scope:**

Funding for patient direct care services will be provided through the Basic Needs Investments funding mechanism (*not* the Strategic Investments). Healthcare for the purposes of United Way Community Investments is defined as Physical Health, Mental Health, Substance Abuse, Dental Services, and Prescription Support

**Health Strategy:**

- Any strategies that are designed to increase the number of patients existing safety net clinics can serve will be considered.
- Individual agency proposals and/or joint proposals will be welcomed.

**Preventive Strategies:**

- Evidence based approach to patient directed chronic disease self-management

**Agency Capacity Building:**

- As above and/or including systems reform

Note: Proposals that have the potential to impact multiple funding strategies (Education, Income and Health) may receive extra points in the scoring process.

**APPENDIX B  
BUDGET**

Attached separately as an Excel spreadsheet.

# Strategic/Preventive Investment Application

## Proposed Services BUDGET

(fill in the yellow cells)



Agency Name:

HIV Alliance, Inc.

Proposed Services:

NEX Expansion for HCV Testing, Wound Care and Rural Outreach

	Prior 12 Months	Future 12 Months
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### REVENUE/SUPPORT

	Prior 12 Months	Future 12 Months
United Way Funding/Request (do NOT include Donor Designations)	\$15,084.00	\$15,000.00
Public Support: Contributions/Fundraising Events (include Donor Designations)	\$12,192.00	\$44,336.00
Government Funding	\$10,000.00	\$10,000.00
Foundation/Corporation/Other Grants or Major Gifts	\$56,132.00	\$70,000.00
Program Service Fees or Membership Dues	\$0.00	\$0.00
Other Revenue	\$0.00	\$0.00
<b>Total Revenue</b>	<b>\$93,408.00</b>	<b>\$139,336.00</b>

Actual Estimated

### EXPENSES

	Actual	Estimated
Personnel Related	\$35,400.00	\$54,583.00
Client Assistance	\$42,815.00	\$51,750.00
Other Direct Program Expenses	\$5,852.00	\$19,069.00
Administrative Overhead	\$9,341.00	\$13,934.00
<b>Total Expenses</b>	<b>\$93,408.00</b>	<b>\$139,336.00</b>

<b>NET</b> (should be zero)	<b>\$0.00</b>	<b>\$0.00</b>
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What percent of your <b>agency</b> budget do these proposed services represent?	6%	7%
What percent of your <b>agency</b> revenue is the United Way request?	1%	1%
Number of employee FTE's (full-time equivalents) in proposed services?	1.25	1.75
Percentage United Way request to overall proposed services revenue	16%	11%
Administrative overhead percentage applied to proposed services	11%	11%

Completed by:

Melissa Edwards, Finance Director

HIV Alliance

# Theory of Change

November 2008

## **OVERVIEW**

This theory of change was developed by the HIV Alliance Program Planning Committee over the course of 2008. The diagram is intended to serve as an aid in planning, evaluation and program and partnership development for the HIV Alliance.

This theory of change is an approach to understanding the logic behind the HIV Alliance's programs. At its essence, it presents the sequence of preconditions that must exist for the Alliance to achieve its ultimate goal, or vision of success. Some of these preconditions are supported by program interventions. Others are assumed to occur on their own given particular conditions. Some preconditions lend themselves easily to measurement and are more concrete, while others are more abstract and harder to ascertain. The theory of change posits that when all preconditions are achieved, the HIV Alliance will achieve its vision of success.

## **HOW TO READ THE DIAGRAM**

The accompanying diagram presents the sequence of preconditions leading to the vision of success, or ultimate goal. The diagram was developed from the bottom up, beginning with the most basic preconditions and progressing towards the higher-level or more advanced preconditions. While the diagram can be read from the top down or the bottom up, it is recommended to read it from the bottom up.

The first page of the diagram provides an overview of the HIV Alliance's theory of change as well as keys to the symbols and programs represented in the diagram. The agency's vision of success is that HIV has no negative impact on our community. When this is achieved, the HIV Alliance will have fully succeeded. There are two key preconditions that must exist to achieve this vision – that there are no new HIV infections and that people living with HIV/AIDS experience no negative impact as a result of HIV/AIDS. The second and third pages present the preconditions that must be in place for these two "primary preconditions" to exist. Because of the size of the diagram, these are split into two separate pages for the two primary preconditions.

Throughout the diagram, each rectangular box represents a precondition. The lines connect upward to the next level preconditions. For instance, on the bottom right corner of the second page of the diagram, "People have accurate information about non-risky behaviors" is a precondition of "people believe that non-risky behavior prevents infection." The shaded boxes represent critical preconditions. These are preconditions that are central to the theory because, for example, many other preconditions flow through them or because they are particularly challenging to achieve or prove. It is these preconditions that are well-suited for measurement in program evaluation. By monitoring and evaluating the achievement of particular preconditions, we can be more certain of the validity of the theory and the progress towards our vision of success.

Text in circles found around the diagram represent assumptions that are made by the theory that, if not true, could limit the accuracy of the theory of change.

The small circles with numbers represent HIV Alliance program interventions. Their position in the diagram represents where they contribute to the theory of change. They contribute to the achievement of the assumption found above them.

On the third page of the diagram, there is a segment that is floating on its own at the bottom center of the page. This segment, which deals with income needs of PLWH/A connects at several different points to the rest of the diagram. These connection points are represented with a dollar sign.

## **HOW TO USE THE THEORY OF CHANGE**

There are a number of ways that the HIV Alliance can use its theory of change. Here are just a few:

### **1. Monitoring and Impact Evaluation**

This is the most immediate use of the theory of change. By identifying the preconditions underlying the HIV Alliance's theory of change, it is possible to identify a path towards its vision of success. By developing indicators to measure critical preconditions, it is possible to monitor progress towards the vision. In addition, while it is often challenging to measure some of the more advanced preconditions because they are more abstract concepts, if the logic underlying the theory of change is sound, then measuring more basic preconditions can reliably indicate the achievement of higher-level preconditions.

The critical preconditions are considered the most important preconditions to develop indicators to measure, but indicators can also be developed for other preconditions as desired.

In addition to measuring program impact, the monitoring process may validate or suggest changes to the theory itself.

### **2. Partnership and Program Development**

Given the scope of HIV/AIDS, it is no surprise that the HIV Alliance does not currently run program interventions to address every precondition. In some cases, this is a limitation of resources, time or capacity. In other cases, some preconditions may not be suited for direct program intervention. Instead, they may be better served through programs at lower-level preconditions.

By analyzing the distribution of program interventions across the theory of change diagram, it is possible to identify gaps, where additional programming would contribute the most to attaining preconditions and achieving the vision of success. Then the HIV Alliance can either seek funding and plan to implement programming in these areas or seek out partners to provide programs. It may be helpful to map current partner programs onto the theory of change to get a fuller picture of all programs contributing to the HIV Alliance's effort to achieve its vision of success.

### **3. Outreach and Public Relations**

The theory of change presents a clear picture of the theory and assumptions that underlie the HIV Alliance's work. Because if this, it may be useful in explaining the Alliance's work to those outside of

the organization. However, it is a complicated diagram and assumes that the person reading it already has some understanding of both the work of the HIV Alliance and the issues surrounding HIV programming in general. Therefore, it may be better shared with those who have already been introduced to the organization. The theory of change may also be a useful tool for new staff training and orientation.

#### **4. Strategic planning**

The diagram represents a big picture view of the way that HIV Alliance hopes to create change and make a lasting impact in the community. As the agency makes plans for the future, it should consider all of the preconditions that contribute to their vision of success and how they can work strategically to ensure that these preconditions are in fact achieved. This may involve all of the other uses of the theory described above. In addition, the HIV Alliance may consider structuring its strategic plan around the theory of change or using as a presentation tool to elucidate the strategic plan.

# Theory Overview

Vision of Success:  
HIV has no negative impact on our community

No New Infections  
(To Page 2)

PLWH/A experience no  
negative impact  
as a result of HIV/AIDS  
(To Page 3)

NO STIGMA - Underlies Entire Theory

⑥

## Theory Key

Behaviors\*\* occur but do not  
have risk

Critical Precondition

Client  
achieves  
nutritional  
health

Other precondition

①

Program intervention (see  
Interventions Key)

PLWH/A Identify  
themselves for support  
and become clients

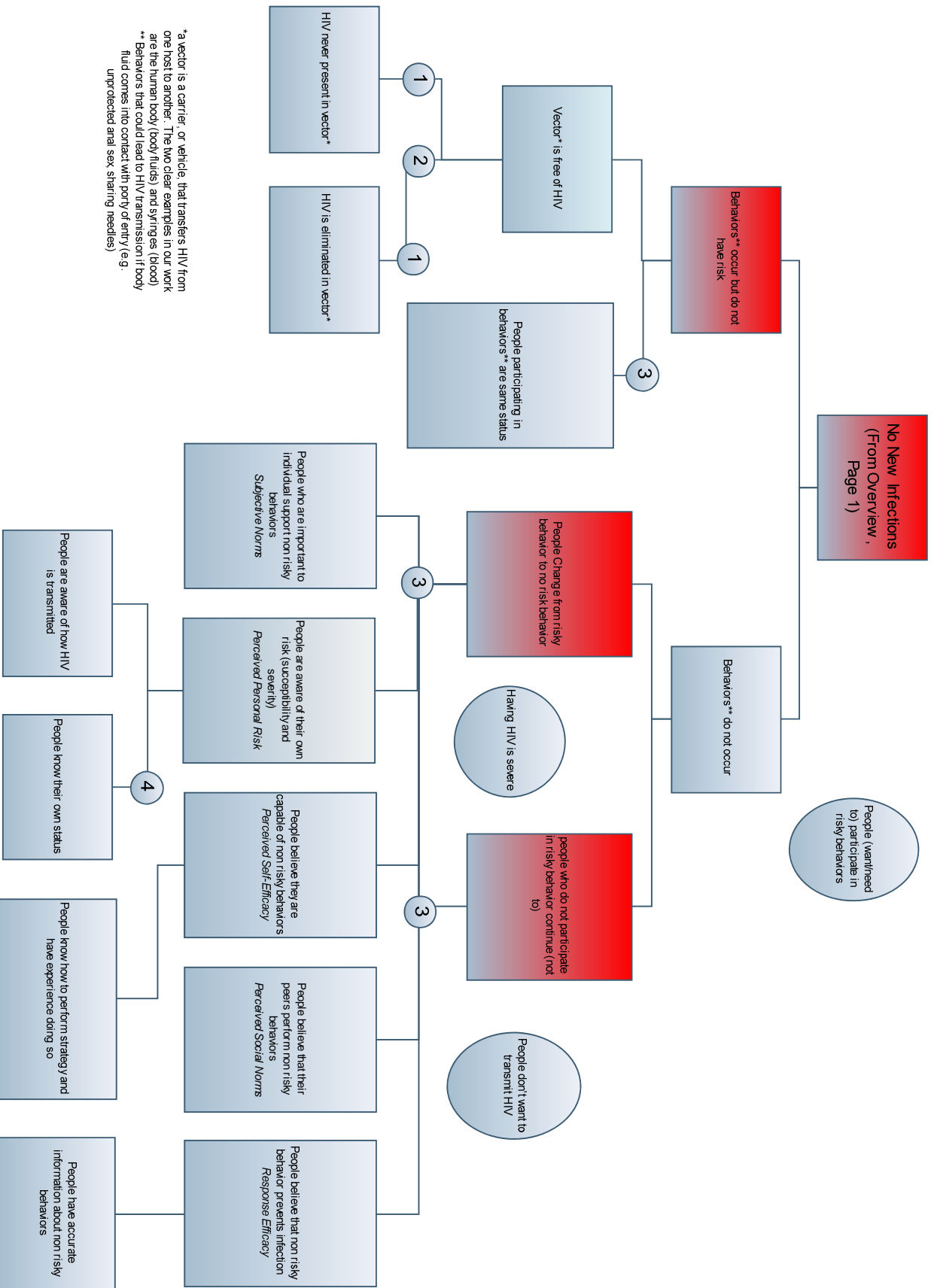
Assumption



Connection point for Income  
Branch of preconditions (see  
page 3)

## Interventions Key

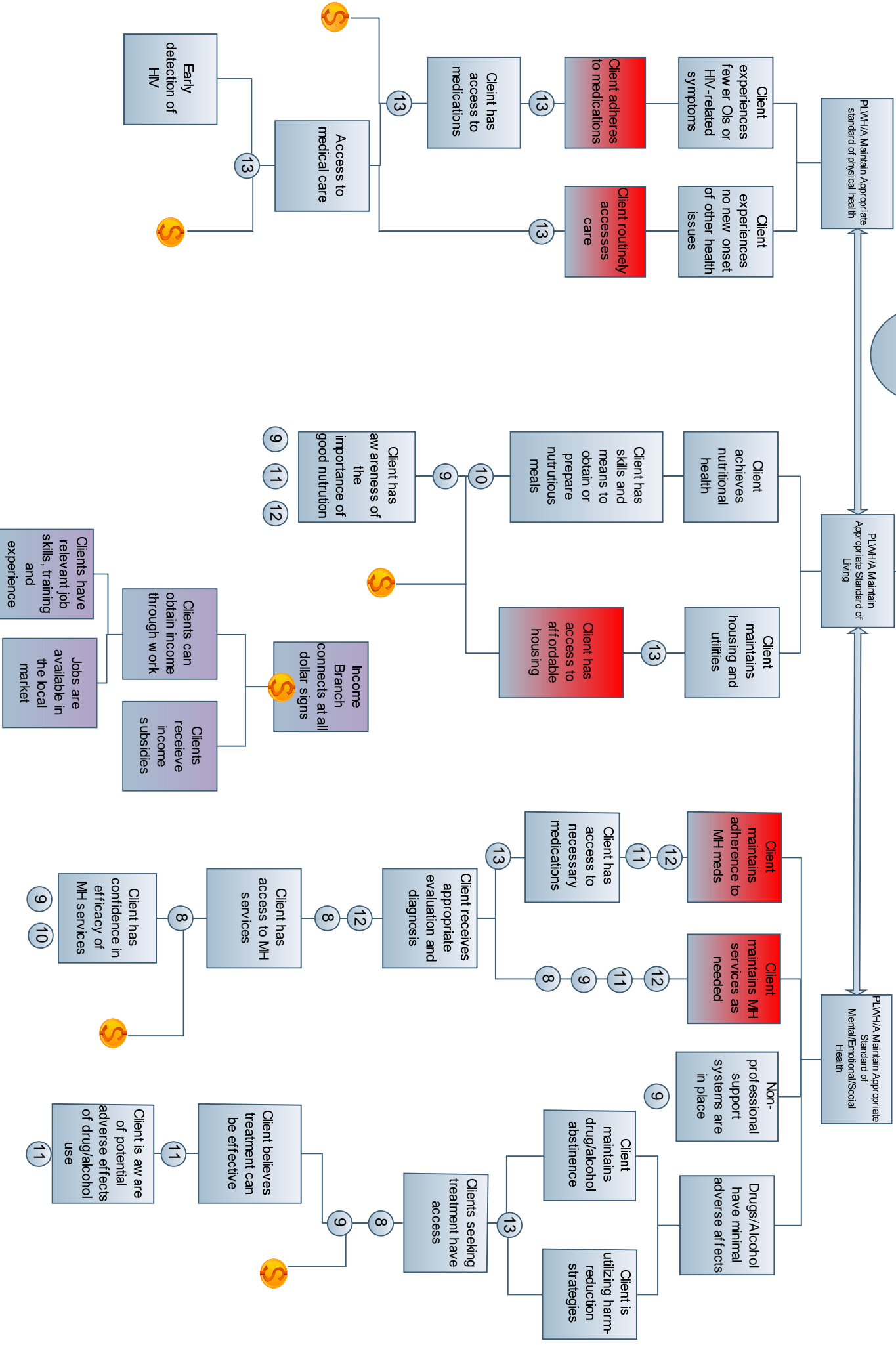
- ① Vaccines; Cure
- ② Syringe Exchange
- ③ Behavioral Interventions
- ④ Counseling, Testing and Referral Services (HIV Anti-body Test)
- ⑤ Community Education (Shift beliefs and attitudes)
- ⑥ Information and Referral Services
- ⑦ Emergency Financial Assistance
- ⑧ Advocacy
- ⑨ Information and Referral
- ⑩ Support Services Distribution
- ⑪ Education
- ⑫ Nursing Interventions
- ⑬ Combination of Interventions 8-12



\*a vector is a carrier, or vehicle, that transfers HIV from one host to another. The two clear examples in our work are the human body (body fluids) and syringes (blood)  
 \*\* Behaviors that could lead to HIV transmission if body fluid comes into contact with port of entry (e.g. unprotected anal sex, sharing needles)

PLWHA experience no negative impact as a result of HIV/AIDS (From Overview , Page 1)

PLWHA identify themselves for support and become clients



## **HIV Alliance Program Committee Indicator Development**

### **Prevention**

- For the “Risky Behaviors occur but do not have risk”, the following were proposed:
  - o Rate of exchange of needles
  - o Serosorting of MSM, needle users, HIV+
- For “People Change from risky to no risk behavior”:
  - o Community identification process for MSM – community perceptions of at-risk behavior
  - o Cessation of needle use
  - o Cessation of unprotected sex
- For “People who do not participate in risky behavior continue not to”:
  - o Prevalence of IDU
  - o Prevalence of unprotected sex
  - o Question of whether any data was available from Lane County Public Health
  - o Suggestion that the Looking Glass program might serve as a good sample to monitor risky behavior by youth

### **Care and Treatment**

- Client adherence
  - o Self-reported adherence
- Routine access to care
  - o % of clients with a doctor appt every 6 months
  - o % of clients with a viral load lab every six months
  - o Could be measured as 0, 1 or 2+ per year as poor, moderate and ideal
- Access to affordable housing
  - o Need is measured on an acuity scale of 1-4
  - o Those with highest need have access to OHOP long-term program
  - o Emergency funds are also available for temporary housing crises
  - o One indicator may be:
    - (Waitlist for OHOP + Those deemed instable)/Total case load
    - Or (those with need met)/(total need)

# Attachment A

## United Way of Lane County Best Organizational Practices and Management

**Agency Name:**     HIV Alliance    

The following questions represent generally accepted best practices for the management and governance of non-profit organizations. Please respond with **Yes** or **No**. If **No**, provide a brief explanation. (Note: These are not required and some policies and activities may not be appropriate for your agency.)

<b>ORGANIZATIONAL MISSION AND DIVERSITY</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
<b>A. Mission</b>			
1. Our agency has a written mission statement that reflects our purposes and values.	√		
2. The board regularly reviews our agency's mission statement.	√		
3. Our agency engages in annual planning that helps define organizational and divisional goals.	√		
<b>B. Diversity</b>			
1. Our agency's governance and operations strive to be inclusive of all parts of our community.	√		
2. Our agency strives to reflect the diversity of the community we serve.	√		
3. Our agency has a written policy and practice of non-discrimination in the following areas:	√		
a. Employment (recruitment, hiring, assignment, promotion, discipline, termination)			
b. Board and committee participation			
c. Volunteer selection			
d. Service delivery			

<b>FINANCIAL MANAGEMENT</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
<b>A. Audit</b>			
1. Our agency has an annual audit or review done by an independent certified public accounting firm.	√		
2. If yes, the reports and management letter (if provided) are reviewed by a finance committee or the board.	√		
<b>B. Financial Transactions and Controls</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. Our board has approved a policy specifying that dual signatures are required on checks over a certain amount.	√		
2. Our board has approved a delegation of authority to specified levels of management that shows types and limits of spending or approval authority.	√		

<b>C. Money &amp; Investments</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. Bank deposits are FDIC insured and account balances are at or below the \$250K limit.	√		
2. The board has adopted an investment policy that is regularly reviewed.	√		
3. Securities, mortgages, insurance policies and similar instruments are under the control of the executive director, chief financial officer, or board member.	√		
<b>D. Capital Equipment</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. The board approves all equipment purchases, leases, and related renewals over a certain dollar amount.	√		
2. Periodic physical inventories are taken and compared with the capital equipment ledgers.	√		
<b>E. Accounts Payable</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. The board has approved a written purchasing policy.	√		
2. All deposits for payroll taxes, employee retirement contributions, etc. are made in a timely manner.	√		
3. Purchases for or on behalf of employees are made pursuant to a board-established policy.	√		
4. Credit cards are issued in the agency's name but assigned to specific employees and in line with board policy.	√		
5. Credit card usage by employees is limited to use specified by board policy and is periodically reviewed by supervisors or, in the case of the executive director, the budget or finance committee.	√		
<b>F. Employees Expense/Reimbursement</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. We have a board-approved policy governing if and when salary advances (draw), travel advances, and per diems are provided to staff.	√		
2. There is a travel and employee expense reimbursement policy approved by our board.	√		
3. Employees are required to submit expense reports for all reimbursements within 60 days of expenditures.	√		
4. The board assures that the executive director's travel and expense reimbursement are reviewed and approved.	√		
<b>G. Budgeting and periodic financial reports</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. Our agency forecasts financial requirements for proposed program activity and optimum use of funds.	√		
2. The executive director prepares an annual comprehensive operating budget and capital budget, presents the budget to the board for approval, and establishes controls to assure that budgetary objectives are achieved.	√		
3. Substantial changes in the budget are presented to the board for approval.	√		
4. Our board, or the financial committee:	√		
a. Reviews the financial statements (statement of			

activities, statement of position) on a quarterly basis			
b. Receives explanations of major variances.			
c. Receives a comparison of actual to budgeted expenditures for the reporting period and year-to-date by program.			
d. Reviews source and amounts of funding by function.			
<b>GOVERNANCE</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
<b>A. Board of Directors</b>			
1. Our agency has a governing board of citizen leaders.	√		
2. Our board is a volunteer group serving without compensation.	√		
3. Each board member has received training, as well as guidance materials on board governance and our agency operation.	√		
4. Our board ensures the creation of and approves agency policies and procedures.	√		
5. Our board hires, terminates, evaluates, and sets compensation for the executive director.	√		
6. Our board delegates responsibility for day-to-day agency operations to the executive director.	√		
7. Our board meets at least quarterly. Indicate how often: <u>monthly except Aug &amp; Dec</u>	√		
8. Our agency creates and maintains permanent board minutes.	√		
9. Our agency ensures continuity by having overlapping board member terms.	√		
10. Our board's nominating process ensures that the board remains appropriately diverse with respect to gender, ethnicity, culture, economic status, disabilities, and skills and/or expertise.	√	√	We struggle with representation from Latino & African-American/Black communities, but we always are trying!
11. Our board has a process for handling urgent matters between meetings.	√		
12. Each board member has contact information for the entire board.	√		
13. Our board evaluates the executive director on an annual basis.	√		
14. Over the last year, at what percent of your board meetings did you have a quorum in attendance? Indicate percentage <u>90%</u>	√		
<b>B. Bylaws and Policies</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. Our agency has written bylaws.	√		
2. Our agency provides each board member a copy of the bylaws.	√		
3. Our bylaws state the requirements for a board quorum.	√		

4. Our board regularly reviews the bylaws.	√		
5. Our agency has written operational policies and procedures.	√		
6. Our board has approved a code of ethics for both staff and volunteers, which includes provisions for ethical management, client confidentiality, publicity and fundraising practices.	√		
7. Our agency has a written conflict of interest policy and a mechanism for resolving conflicts should they occur.	√		
8. Our board ensures that the agency has personnel policies and written job descriptions.	√		
<b>C. Board Committees</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. Our agency has standing and special committees that have been established to achieve efficiency of operations and share responsibility for decision-making.	√		
2. Our agency's board members serve on at least one board committee.	√		In lieu of committee membership, some Board members serve in a special advisory capacity (usually <u>more</u> time), e.g., PR & media advisor
3. Our agency committees meet on a regular basis (monthly or quarterly).	√		
4. Our agency committees' activities and recommendations are reported to the board (verbally or in writing) for approval/action.	√		
<b>D. Compliance with legal requirements</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. Our agency complies with all applicable legal, local, state, and federal operating and reporting requirements, including non-discrimination and non-profit requirements.	√		
2. We have been the subject of a governmental investigation in the last 24 months.		√	
<b>E. Insurance</b>	<b>Yes</b>	<b>No</b>	<b>Other/Explain</b>
1. We have liability insurance covering volunteers, staff and board of directors.	√		
2. We have general liability coverage.	√		

Agency Name:     HIV Alliance    

Prepared By (Name):     Diane Lang    

Title:     Executive Director    

Date:     1/5/10

## Attachment B

### United Way of Lane County UWLC Policies and Certification Documents

**“I hereby certify that**

HIV Alliance

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(print agency name)

**agrees to follow and adhere to the following UWLC Policies and Certification Documents:”**

- **Non-Discrimination Certification**
- **USA Patriot Act Anti-Terrorism Compliance Measures**
- **Agency Direct Fundraising Policy**
- **Donor Designation Policy**

**Signature, Agency Director:** \_\_\_\_\_



**Print name:** Diane B. Lang

**Date:** 1/5/10