

# Washington State Statewide Coordinated Statement of Need and Part B Comprehensive Plan 2012-2014

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Prepared by Washington State Department of Health HIV Client Services Program



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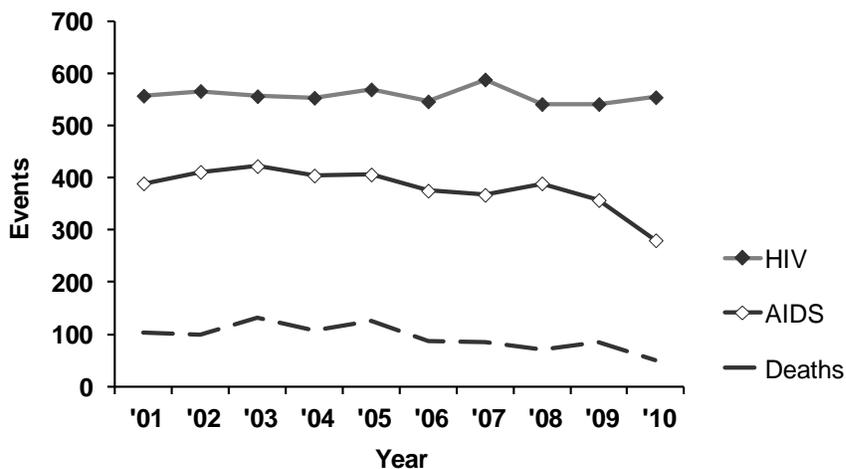
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## Where are we now?

### HIV/AIDS Profile

Since Washington's first AIDS case was diagnosed in 1982, 18,192 new HIV diagnoses have been reported among residents of Washington State. Incidence, or the number of people newly diagnosed with HIV, as determined from recent surveillance data indicate that HIV rates across the state have remained stable over the past ten years. From the epidemic's beginning in the early 1980's, over 13,000 AIDS diagnoses have been reported and HIV has contributed to more than 5,200 deaths. Figure 1 displays the trends for new HIV cases, AIDS diagnoses, and deaths from HIV for the past decade. Earlier diagnosis and better treatments have led to a steady increase in the number of people who are surviving with HIV disease. HIV prevalence, or the reported number of people living with HIV disease in Washington, is likely to surpass 11,000 in 2012, given 10,827 were living with HIV disease in 2010.

**Figure 1.** New HIV Diagnoses, AIDS Diagnoses, and Deaths from HIV Disease, 2001-2010



Most information reported in this section was obtained from the Washington State HIV Surveillance Quarterly Report, 4<sup>th</sup> Quarter 2011 and the various Washington State HIV Fact Sheets published in January 2012. All Washington State HIV/AIDS Surveillance program data presented in this section were reported to the Washington State Department of Health as of December 31, 2011.

### Incidence (Newly Diagnosed HIV)

Across Washington State the number of people newly diagnosed with HIV has remained steady in recent years. Between 2006 and 2010, new HIV cases averaged 553 per year, or 8.4 cases per 100,000 people (Figure 2.). The term "new HIV case" refers to all newly diagnosed cases of HIV disease, with or without AIDS. For nearly a decade, the numbers of new male and female HIV cases have remained approximately the same from year to year. Nearly 85 percent of male cases are gay or bisexual men, while most female cases are reported as heterosexual transmission. Among all new HIV cases, roughly one in six reports a history of injection drug use and this proportion appears to be dropping over time. Since 2001, there have been five cases of vertical HIV transmission from mother to child. Between 2006 and 2010, sixty percent of all new HIV cases in Washington were white, non-Hispanic.

In Washington, HIV disproportionately affects racial and ethnic minorities. Non-Hispanic blacks (3% of the general population) account for 17% of all new cases, while Hispanics (9% of the general population) account for 16% of new cases.

HIV is a disease that affects people of all ages. In Washington, most new cases are diagnosed among middle and older aged adults, but the time between infection and diagnosis can vary greatly. About one in three new cases are detected late in the course of their HIV illness, receiving an AIDS diagnosis within 12 months of the HIV diagnosis. Newly diagnosed HIV cases in Washington also vary by geographic location around the state. Urban areas of the state typically have higher numbers of new HIV cases with King County having a rate of 16.5 new HIV cases per 100,000 between 2006 and 2010 (Figure 4).

**Figure 2.** New HIV Case Rates by Year of HIV Diagnosis, 2002-2010

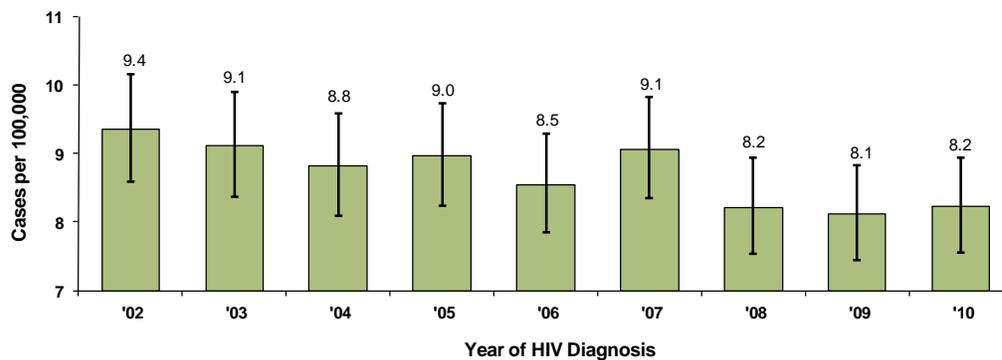


Table 1 contains statewide data describing new HIV cases over time by main demographic characteristics as well as by exposure category with rates by groups for which reliable population estimates are available. Compared to statewide averages, HIV differentially affects several demographic subgroups.

*New HIV among Women*

In Washington State, the number of women newly diagnosed with HIV each year has remained stable. Between 2006 and 2010, new HIV cases among adult and teenage women averaged 87 per year; about three new HIV cases per 100,000 women living in Washington. Most women living with HIV in Washington are white, non-Hispanic, but HIV rates are highest among women belonging to a racial/ethnic minority. Recent HIV rates among black women were more than twenty-times higher than HIV rates of white women (Figure 3). Most female HIV cases in Washington are believed to be the result of unprotected sex with an HIV-positive male partner. Most female cases in Washington became HIV-infected as young or middle age adults, with less than ten percent of the female cases diagnosed in infants or children. Between 2006 and 2010, the median age among new female cases was thirty-four. A third was over the age of forty.

**Table 1. New HIV Cases by Demographic Characteristics, 2006-2010**

Year of HIV diagnosis:	Newly Diagnosed Cases of HIV Disease							Late HIV Diagnoses		
	2005 No.	2006 No.	2007 No.	2008 No.	2009 No.	2010 No.	2006-2010 No.	%	Rate	2005-2009 %
<b>Total</b>	569	546	588	541	541	554	2,770	100%	8.4	34%
<b>Gender</b>										
Male	489	463	490	446	453	483	2,335	84%	14.3	35%
Female	80	83	98	95	88	71	435	16%	2.6	29%
<b>Age at HIV Diagnosis</b>										
< 20	7	12	21	17	22	21	93	3%	1.1	15%
20 - 29	124	140	156	146	140	149	731	26%	15.6	18%
30 - 39	204	175	170	162	156	167	830	30%	18.8	36%
40 - 49	167	145	148	126	137	124	680	25%	14.0	41%
50 - 59	54	59	68	59	65	75	326	12%	7.1	51%
60+	13	15	25	31	21	18	110	4%	2.0	54%
<b>Race and Hispanic Origin</b>										
White	346	350	350	292	317	323	1,632	59%	6.5	30%
Black	106	86	109	101	91	82	469	17%	42.4	40%
Hispanic (all races)	75	63	89	95	85	100	432	16%	14.1	40%
Asian	20	25	22	28	25	25	125	5%	6.0	52%
Native Hawaiian / Pacific Islander	3	5	3	0	3	1	12	0%	8.2	---
American Indian / Alaska Native	10	6	6	12	6	8	38	1%	7.9	48%
Multiple Race	9	11	9	13	14	15	62	2%	6.8	25%
Hispanic only:										
- White	39	32	42	32	29	23	158	6%	5.8	42%
- Black	10	2	2	3	2	0	9	0%	---	---
- Multiple / Other Race	2	5	4	0	3	6	18	1%	---	---
- Unknown Race	24	24	41	60	51	71	247	9%	---	39%
<b>Exposure Category by Gender</b>										
Male only:										
- Male / Male Sex (MSM)	305	311	332	296	315	350	1,604	58%	---	30%
- Injecting Drug Use (IDU)	32	22	21	16	17	21	97	4%	---	47%
- MSM and IDU	57	44	48	31	40	22	185	7%	---	27%
- Heterosexual Contact	32	19	12	20	13	19	83	3%	---	63%
- Pediatric	0	3	0	1	2	7	13	0%	---	---
- Transfusion / Hemophiliac	2	0	0	0	0	0	0	0%	---	---
- No Identified Risk	61	64	77	82	66	64	353	13%	---	56%
Female only:										
- Injecting Drug Use	9	18	12	9	7	10	56	2%	---	---
- Heterosexual Contact	60	54	71	67	63	47	302	11%	---	33%
- Pediatric	0	0	2	1	7	3	13	0%	---	---
- Transfusion / Hemophiliac	0	0	1	1	0	0	2	0%	---	---
- No Identified Risk	11	11	12	17	11	11	62	2%	---	21%

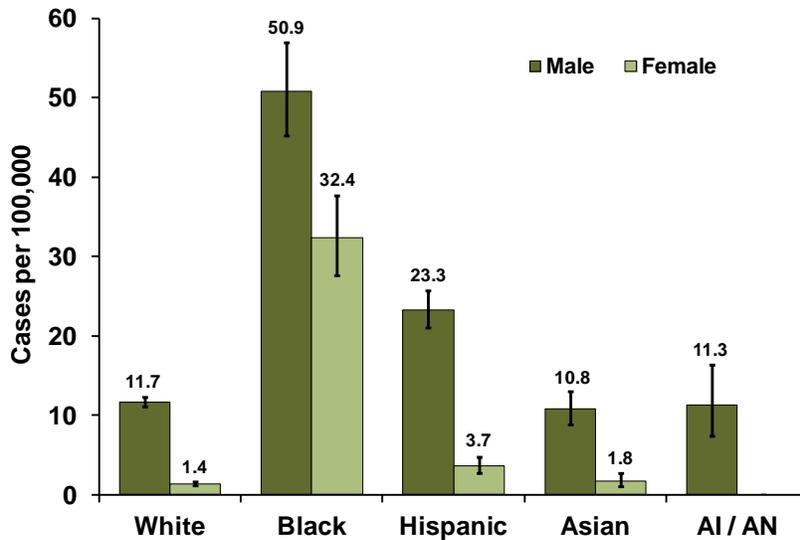
All HIV/AIDS surveillance data reported to the Washington State Department of Health as of December 31, 2011.

*New HIV among Men Who Have Sex with Men*

About four percent of men living in Washington State are either gay or bisexual. Often described as men who have sex with men (MSM), HIV continues to affect this population disproportionately. While

estimates vary, it is likely that at least ten percent of MSM living in Washington are HIV-positive. Between 2006 and 2010, roughly three out of four new HIV cases in Washington were MSM, which equates to about 400 MSM newly diagnosed with HIV each year. Forty (10%) also report using injection drugs. In Washington, approximately two-thirds of MSM HIV cases are white, non-Hispanic. However, a significant number were black (9%) or Hispanic (15%). Most MSM cases are diagnosed in men older than 30 years old and between 2006 and 2010; 39 percent of MSM cases were over the age of 40. Less than two percent are diagnosed before age twenty.

**Figure 3.** New HIV Case Rates by Race/Ethnicity and Gender, 2002-2010



#### *New HIV among African Americans*

Black/African Americans have been more severely affected by HIV than any other race or ethnic group in Washington (Figure 3). Although blacks make up only four percent of the state's general population, each year nearly one in five new HIV cases identify as black/African American. Nationally, the black HIV burden is even greater. For this section, the term African American is used to identify non-Hispanic, black people who were born in the United States. Statewide, the number of African Americans diagnosed with HIV each year remains about the same. Between 2006 and 2010, there were 51 new cases each year on average, most of who were male (76%) and most are believed to have become infected while in their twenties or thirties. MSM contact is the most commonly reported risk factor among African American men with HIV in Washington. Most new African American female cases are the result of heterosexual transmission. Additionally, about one in three African American cases are late HIV diagnoses. Compared to whites, African Americans are nearly 40 percent more likely to have a late HIV diagnosis.

#### *New HIV among Foreign-Born Blacks*

Foreign-born blacks have become a larger part of Washington's HIV epidemic in recent years. Between 2006 and 2010, people who are black and born outside the United States made up nearly half (46%) of all new HIV cases among blacks in Washington. Additional surveillance information indicates that most foreign-born HIV cases became infected while living outside the United States. HIV rates among foreign-born blacks are much higher than those of U.S.-born African Americans. Both HIV rates and case counts are similar between male and female foreign-born black cases. In Washington, most foreign-born blacks with HIV are first diagnosed as middle or older aged adults and about one in two are diagnosed late. Regardless of gender, most foreign-born black cases are reported to be the result of heterosexual

transmission. Additional differences between foreign-born and U.S.-born HIV cases are presented in Table 2.

**Table 2. New HIV Cases by Foreign born Status and Other Characteristics, 2006-2010**

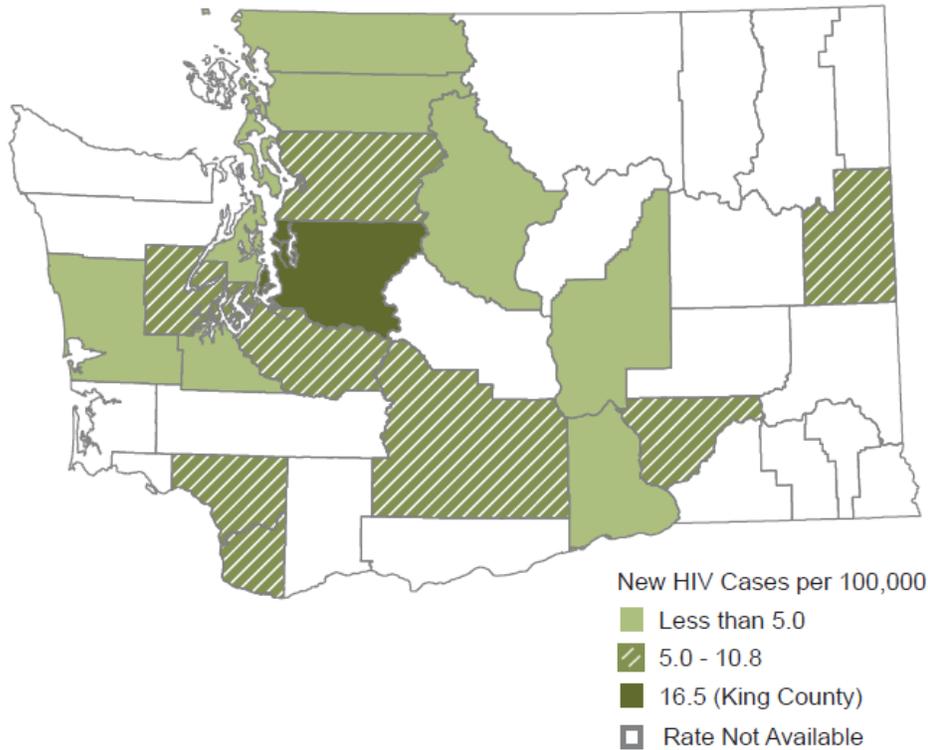
Characteristic:	Proportion of Cases with Select Characteristic at HIV Diagnosis						Total	
	Male %	Age > 30 years %	MSM %	Hetero-sexual %	Late HIV Diagnosis %	Live in King Co. %	No.	%
<b>U.S.-Born</b>								
White	90%	72%	77%	8%	30%	57%	1,481	75%
Black	76%	63%	52%	24%	32%	57%	254	13%
Hispanic (all races)	86%	56%	68%	11%	34%	54%	133	7%
Asian	85%	70%	75%	5%	45%	75%	20	1%
Native Hawaiian / Pacific Islander	100%	71%	100%	0%	29%	57%	7	0%
American Indian / Alaska Native	72%	67%	42%	33%	50%	25%	36	2%
Multiple Race	87%	43%	78%	11%	20%	61%	54	3%
<b>Total</b>	<b>87%</b>	<b>69%</b>	<b>73%</b>	<b>11%</b>	<b>31%</b>	<b>56%</b>	<b>1,985</b>	<b>100%</b>
<b>Foreign-Born</b>								
White	85%	77%	60%	9%	30%	48%	151	19%
Black	52%	72%	11%	42%	45%	65%	215	27%
Hispanic (all races)	89%	72%	55%	15%	44%	52%	299	38%
Asian	84%	75%	56%	12%	49%	67%	105	13%
Native Hawaiian / Pacific Islander	80%	60%	60%	20%	80%	40%	5	1%
American Indian / Alaska Native	50%	0%	0%	50%	0%	50%	2	0%
Multiple Race	75%	75%	50%	25%	63%	75%	8	1%
<b>Total</b>	<b>77%</b>	<b>73%</b>	<b>44%</b>	<b>21%</b>	<b>42%</b>	<b>57%</b>	<b>785</b>	<b>100%</b>

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of December 31, 2011.

### *New HIV among Hispanics*

HIV disease has had a substantial impact on the Hispanic community in Washington State (Figure 3). About one in ten people living in Washington are Hispanic, any race. Yet, between 2006 and 2010, Hispanics represented nearly 16 percent of all people diagnosed with HIV. Year to year, Hispanic case counts remain about the same. From 2006 to 2010, Hispanics in Washington averaged seventy-six new HIV cases per year. Nearly ninety percent of new HIV cases among Hispanics are male and the ration of male to female cases has remained stable over time. Most Hispanic people with HIV are not diagnosed until they are middle or older aged adults. Between 2006 and 2010, over two-thirds (69 percent) of new HIV cases among Hispanics were over the age of thirty. MSM contact is the most commonly reported HIV risk factor among Hispanic cases in Washington, with 73 percent of new HIV cases among Hispanic MSM between 2006 and 2010. While it is estimated that most Hispanic cases were exposed to HIV while living in the United States, more than two-thirds were born in another country. More than forty percent of Hispanic HIV cases are diagnosed late in the course of their HIV illness and compared to non-Hispanic whites, Hispanic cases are nearly twice as likely to be diagnosed late.

**Figure 4.** Average HIV Rates by County, 2006-2010



**Prevalence (Persons Living with HIV Disease)**

Prevalence represents the number of HIV diagnosed people present in a population at a point in time. Earlier diagnosis and better medical treatment options have led to steady increases in the number of people who are surviving with HIV disease. Figure 5 displays the number of people living with HIV disease divided by those with and without an AIDS diagnosis as well. As of December 31, 2011, there were 10,827 people living with HIV in Washington, 57% of whom had received an AIDS diagnosis (Figure 5.).

**Figure 5.** People Living with HIV Disease, 2006-2010

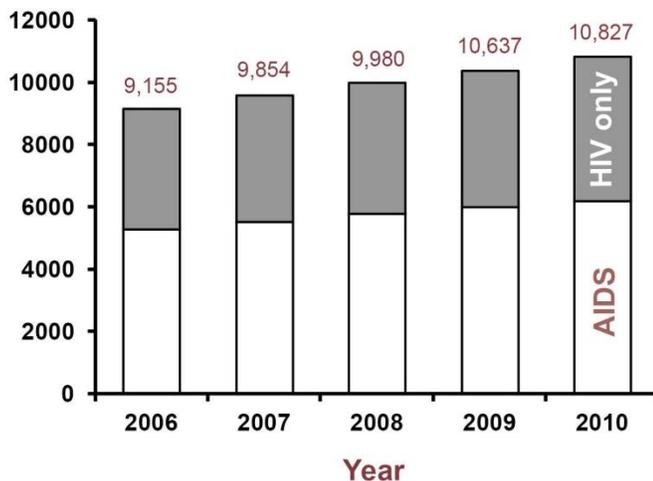


Table 3 contains statewide data describing people living with HIV disease over time by main demographic characteristics as well as by exposure category with rates by groups for which reliable population estimates are available. Various demographic subgroups are noted to be differently impacted by HIV compared to statewide averages and rates. The HIV prevalence rate is 160.8 per 100,000 persons in Washington. Although the majority is male, over 1,500 women were living with HIV in Washington as of the end of 2010. People living with HIV in Washington also vary by geographic location, with over 60% living in King County.

Given widespread availability of effective treatments, people with HIV disease continue to survive for longer periods following their initial diagnosis. Thus, not only are people with HIV growing in number, they are aging. The majority of prevalent cases are over the age of forty and nearly one-third are over fifty. The HIV prevalence rate for people aged 40-49 years is over 400 per 100,000 population in Washington State. At the end of 2010, less than a hundred youth under the age of 20 years were living with HIV disease.

Statewide, men having sex with men remains the most commonly reported mode of HIV transmission. As of December 2010, there were 8,069 HIV-positive MSM living in Washington State. The number of MSM with HIV rises about 4 percent each year. The exposure category of injection drug use is reported for about eight percent of prevalent cases, though higher in males (5%) than females (3%). For prevalent female cases, most are attributed to heterosexual contact.

**Table 3. People Living with HIV Disease by Demographic Characteristics, 2006-2010**

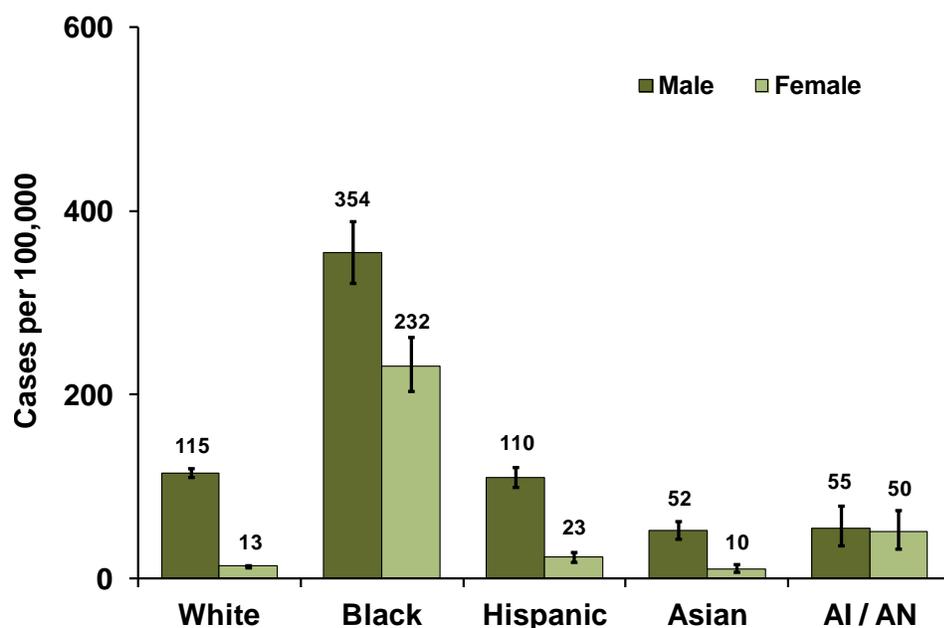
	HIV (not AIDS)			AIDS			All Cases of HIV Disease		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
<b>Total</b>	4,653	100%	68.9	6,193	100%	91.9	10,846	100%	160.8
<b>Gender</b>									
Male	3,934	85%	116.7	5,402	87%	160.8	9,336	86%	277.5
Female	719	15%	21.3	791	13%	23.4	1,510	14%	44.7
<b>Current age</b>									
< 20	63	1%	3.5	14	0%	0.8	77	1%	4.3
20 - 29	573	12%	58.9	210	3%	21.7	783	7%	80.7
30 - 39	1,100	24%	123.2	930	15%	105.1	2,030	19%	228.3
40 - 49	1,686	36%	175.6	2,461	40%	256.3	4,147	38%	432.0
50 - 59	927	20%	97.8	1,899	31%	200.3	2,826	26%	298.1
60+	304	7%	25.3	679	11%	56.6	983	9%	81.9
<b>Race and Hispanic Origin*</b>									
White	3,216	69%	63.7	4,132	67%	82.0	7,348	68%	145.7
Black	697	15%	297.7	942	15%	404.4	1,639	15%	702.2
Hispanic (all races)	475	10%	69.1	729	12%	106.6	1,204	11%	175.7
Asian	136	3%	29.7	175	3%	38.5	311	3%	68.2
Native Hawaiian / Pacific Islander	11	0%	---	28	0%	89.1	39	0%	124.1
American Indian / Alaska Native	55	1%	52.7	106	2%	102.5	161	1%	155.2
Multiple Race	55	1%	28.7	74	1%	38.6	129	1%	67.4
Hispanic only:									
- White	137	3%	22.4	137	2%	22.6	274	3%	45.0
- Black	11	0%	---	14	0%	77.7	25	0%	138.8
- Multiple / Other Race	20	0%	---	9	0%	---	29	0%	---
- Unknown Race	307	7%	---	569	9%	---	876	8%	---
<b>Exposure Category by Gender</b>									
Male only:									
- Male / Male Sex (MSM)	3,000	64%	---	3,714	60%	---	6,714	62%	---
- Injecting Drug Use (IDU)	164	4%	---	358	6%	---	522	5%	---
- MSM and IDU	345	7%	---	571	9%	---	916	8%	---
- Heterosexual Contact	117	3%	---	280	5%	---	397	4%	---
- Pediatric	22	0%	---	8	0%	---	30	0%	---
- Transfusion / Hemophiliac	6	0%	---	38	1%	---	44	0%	---
- No Identified Risk	288	6%	---	432	7%	---	720	7%	---
Female only:									
- Injecting Drug Use	113	2%	---	171	3%	---	284	3%	---
- Heterosexual Contact	485	10%	---	544	9%	---	1,029	9%	---
- Pediatric	29	1%	---	11	0%	---	40	0%	---
- Transfusion / Hemophiliac	7	0%	---	12	0%	---	19	0%	---
- No Identified Risk	85	2%	---	53	1%	---	138	1%	---

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of December 31, 2011.

People who identify as black are disproportionately affected by HIV in Washington (Figure 6). Again, the description of impact will be considered separately by country of origin for black people living with HIV. In 2010, there were more than 1,000 African Americans living with HIV disease in Washington. The number of African Americans with HIV continues to grow each year by about 4 percent. In

Washington State, most African Americans with HIV (85%) live in the primarily urban King or Pierce Counties, mainly due to the larger numbers of African Americans who live in these counties. However, while there are fewer cases, HIV rates tend to be highest among African Americans who live in rural or less populated areas. In contrast, there were nearly 600 foreign-born blacks living with HIV disease in Washington at the end of 2010. Each year, the number of foreign-born blacks with HIV increase by about 8 percent. The foreign-born black HIV cases in Washington originate from more than 50 different countries including 83 percent that are from sub-Saharan Africa and three percent who are from countries located in the Caribbean Islands. The majority of HIV-positive foreign-born blacks live in King County, Washington. However, the proportion of foreign-born black cases living elsewhere in Washington is slowly increasing.

**Figure 6.** Living HIV Cases by Exposure Category, Gender and Race/ethnicity as of December 31, 2010



### Unmet Need Estimate 2010

#### *Data sources*

Washington State HIV/AIDS Reporting System (eHARS): These data are used to determine population sizes of persons presumed living with HIV/non-AIDS and the number of persons living with AIDS in Washington State.

Laboratory Tracking Database, (LTD), Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit; LTD is a repository of all legally reportable HIV-related laboratory results. These data are required to be reported by all public and commercial diagnostic laboratories without regard to funding source or patient characteristics, and are considered comprehensive for all patients and clinicians seeking HIV-specific laboratory services in Washington State. Care patterns are established by matching unique individuals in LTD with the eHARS surveillance registry.

Denominator data for the Unmet Need Framework were obtained from eHARS surveillance records for persons diagnosed with HIV/non-AIDS or with AIDS and presumed to be living during the 12-month period January 1 through December 31, 2010 and reported to eHARS through March 2012. Though completeness of reporting for HIV/non-AIDS cases has been previously estimated to be >95% and for

AIDS cases to be 97% by 12 months following diagnosis, no adjustments were made to the data presented in the Unmet Need Table (Attachment 5) to account for this assumed reporting delay.

### *Methodology*

Care status patterns were established by matching laboratory reporting data to eHARS cases and analyzing patterns by a variety of sub-group strata including gender, race, ethnicity, mode of exposure and disease progression status (HIV/non-AIDS versus AIDS). Persons with matched laboratory data for 2010 (matched records from eHARS and LTD) within the PLWH/A population were stratified in categories to calculate the total number of patients “in care.” The Unmet Need Framework presents detailed results of specific calculations used to arrive at estimates of the number of persons in care for a variety of strata. The percentage of persons in care was obtained by dividing the number of persons found to be “in care” in each stratum by the total population in that stratum. Estimates of the number and percentage of persons “out of care” were similarly calculated. The Unmet Need methodology is unchanged from the previous year.

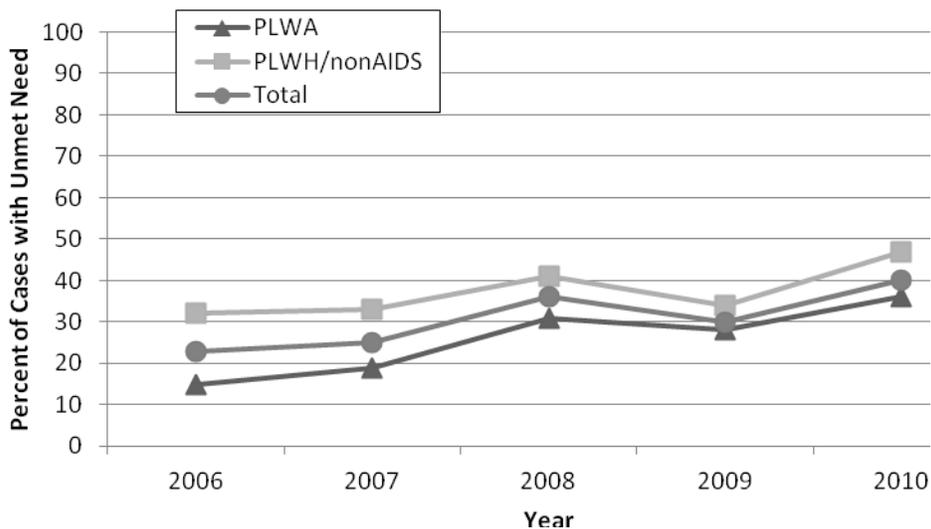
**Table 4. Washington State Unmet Need Framework for 2012, as of March 2012**

Column 1	Column 2	Column 3	Column 4	Column 5
Population Sizes		Value		Data Source(s)
Row A.	Number of persons living with AIDS (PLWA), as of 12/31/2010 (reported through 03/2012)	6303		eHARS (HIV AIDS Reporting System) case registry, Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. eHARS data are conservatively adjusted for estimated completeness of reporting (97% for AIDS, 95% for Non-AIDS HIV) and to estimate proportion of AIDS cases who have migrated out of Washington State (based on surveillance inquiry from destination state's HIV/AIDS surveillance unit).
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, as of 12/31/2010 (reported through 03/2012)	4532		eHARS (HIV AIDS Reporting System) case registry, Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. eHARS data are conservatively adjusted for estimated completeness of reporting (97% for AIDS, 95% for Non-AIDS HIV) and to estimate proportion of Non-AIDS HIV cases who have migrated out of Washington State (based on surveillance inquiry from destination state's HIV/AIDS surveillance unit).
Row C.	Total number of HIV+/aware as of 12/31/2010 (reported through 03/2012)	10835		
Care Patterns		.		Data Source(s)
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period 1/2010 through 12/2010	4050		Laboratory Tracking Database, (LTD), Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. LTD is a repository of all legally reportable HIV-related laboratory results. Revised Code of Washington (RCW) requires reporting of all CD4+ results, HIV viral load results and all HIV-specific indicator tests. These data are required to be reported by all public and commercial diagnostic laboratories without regard to funding source or patient characteristics, are considered comprehensive for all patients/clinicians seeking HIV-specific laboratory services in Washington State. Care patterns are established by matching unique individuals in LTD with eHARS surveillance registry.
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period 1/2010 through 12/2010	2416		Laboratory Tracking Database, (LTD), Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. LTD is a repository of all legally reportable HIV-related laboratory results. Revised Code of Washington (RCW) requires reporting of all CD4+ results, HIV viral load results and all HIV-specific indicator tests. These data are required to be reported by all public and commercial diagnostic laboratories without regard to funding source or patient characteristics, are considered comprehensive for all patients/clinicians seeking HIV-specific laboratory services in Washington State. Care patterns are established by matching unique individuals in LTD with eHARS surveillance registry.
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period 1/2010 through 12/2010	6466		
Calculated Results		Value	Percent	Calculation
Row G.	Number of PLWA with no evidence of specified HIV primary medical care in 2010	2253	0.3574	Row A - Row C, Percent Value: (Row E/Row A)*100
Row H.	Number of PLWH/non-AIDS/aware with no evidence of specified HIV primary medical care in 2010	2116	0.4669	Row A - Row C, Percent Value: (Row E/Row A)*100
Row I.	Total HIV+/aware with no evidence of specified HIV primary medical care (quantified estimate of unmet need for 2010)	4369	0.4032	(Row A + Row B) - (Row F + Row E) , Percent Value: ((Row F + Row E)/(Row A + Row B))*100

Unmet Need calculated using the methodology described above estimates that 40% of Washington State's PLWH who are aware of their HIV positive status are not in care (Table 4). Recent data<sup>1</sup> from the Centers for Disease Control and Prevention (CDC), estimated that 51% of persons with HIV who were aware of their infection and remained in care. In comparison, Washington State's unmet need estimate falls approximately 11% below this national figure, providing evidence of the relative success of the local continuum of care in enrolling and maintaining PLWH in primary care. Trends in Unmet Need over the past five years are displayed in Figure 7. Overall, the percentage of cases for which receipt of primary care that cannot be determined using currently available laboratory data has been increasing. The percentage of cases with unmet need is consistently higher among persons living with HIV/non-AIDS than among persons living with AIDS.

Separate Unmet Need calculations for Ryan White Part A Transitional Geographic Area (TGA) of King, Snohomish and Island Counties estimate that 12% of cases in that region are not in care. King County surveillance staff members perform in-depth investigations documenting current residence and contacting last known health care provider for cases found without laboratory documentation. This process yielded both increased numbers of cases in care and reduced numbers of cases resident in the jurisdiction, which in turn led to a lower and more accurate unmet need result. However, analysis of the King County cases has demonstrated a 33% unmet need when only laboratory documentation is considered, which is similar to the statewide calculation.

**Figure 7.** Unmet Need for persons living with AIDS (PLWA) and persons living with HIV (PLWH/non-AIDS) in Washington State, 2006-2010.



Bivariate analyses of unmet need defined by lack of identified laboratory testing in 2010 examined by demographic (Table 5) and location characteristics reveal:

- Persons with HIV (non-AIDS) are more likely than persons with AIDS diagnoses to have unmet care need (46.7% versus 35.7%).
- There was a 5% difference in overall unmet need status by gender with males more likely to be accessing care than females (39.7% versus 44.2% unmet need respectively).

<sup>1</sup> CDC. Vital Signs: HIV Prevention Through Care and Treatment—United States. MMWR 2011; 60(47);1618-1623.

- Overall, younger age groups have increased proportions of unmet need identified by lack of laboratory testing 2010. Both those younger than 20 years (42.6%) and in the age group of 20-29 (44.9%) years have proportionately more unmet need identified than the 40% seen overall.
- People of the Hispanic racial/ethnicity group have a higher unmet need (43.3%) than other racial groups as well as higher than the statewide percentage.
- Higher proportions of unmet need are observed for persons living with HIV/AIDS with a reported transmission category of IDU (48.1%), heterosexual contact (46.5%) than for those with other reported exposure categories. The percentage for those with medical-related reported transmission is also higher, but this is based on less than 70 individuals.

**Table 5.** Distribution of PLWHA Unmet Need by Demographic and Exposure Category

	<b>Percent with lab test report</b>	<b>Percent Unmet Need</b>
<b>Gender</b>		
Males	60.3 %	39.7 %
Female	55.8 %	44.2 %
<b>Race and Hispanic Ethnicity</b>		
White, not Hispanic	59.6 %	40.4 %
Black, not Hispanic	59.5 %	40.5 %
Hispanic (all races)	56.7 %	43.3 %
Asian and Pacific Islander	67.9 %	32.1 %
American Indian and Alaska Native	63.7 %	36.3 %
Unknown*	65.8 %	34.2 %
<b>Age Group</b>		
<20	57.4 %	42.6 %
20-29	55.1 %	44.9 %
30-39	60.8 %	39.2 %
40-49	61.7 %	38.3 %
50-59	67.3 %	32.7 %
60+	63.2 %	36.8 %
<b>Exposure Category</b>		
MSM‡	61.8 %	38.2 %
MSM and IDU‡	56.7 %	43.3 %
IDU	51.9 %	48.1 %
Heterosexual contact	53.5 %	46.5 %
Pediatric	72.9 %	27.1 %
Medical	51.6 %	48.4 %
No Identified Risk	60.7 %	39.3 %

\* Other includes Multiple and Unknown Race

‡ Male cases only

At the state level, work is currently underway to transition the state laboratory tracking database to a new and significantly improved system which is anticipated to further improve the quality, timeliness and completeness of lab reporting in the state. Also, Washington continues to actively pursue ongoing data integration of content-related systems and program. Developments in these areas are likely to present opportunities to incorporate the additional defining aspect of “provision of anti-retroviral therapy” into the calculation of Washington’s Part B Unmet Need percentage. Furthermore, new activities funded by the HIV Prevention Program’s CDC grant include plans to implement comprehensive follow-up for cases identified without laboratory documentation of care similar to that performed in King County. Such data system enhancements and cross-program integrated efforts will likely provide future evidence that the unmet need in Washington is even lower than that previously measured with the available data.

### Early Identification of Individuals with HIV/AIDS

As of December 31, 2009, there were 10,832 persons diagnosed and living with HIV in Washington. Using the Early Identification of Individuals with HIV/AIDS unaware estimate, the department estimates that there were 2,757 HIV positive persons unaware of their HIV status as of December 31, 2010.

The following table provides the number of HIV tests conducted and results in 2010.

#### 2010 HIV Counseling and Testing - Statewide

Measure		# of Tests
i.	Total number of HIV tests conducted.	18435
ii.	Total number informed of their HIV status (HIV positive and HIV negative).	13955
iii.	Total number NOT informed of their HIV status (HIV positive and HIV negative).	4358
	Number of Declined Testing	5
	Number of Indeterminate Result informed	1
	Number of Indeterminate Result NOT informed	0
	Number of Invalid Result informed	6
	Number of Invalid Result NOT informed	5
	Number of No Confirmatory Test informed	10
	Number of No Confirmatory Test NOT informed	0
	Number of No Test Result informed	1
	Number of No Test Result NOT informed	17
	Number of self indentified as Previous Positive informed	66
	Number of self indentified as Previous Positive NOT informed	11
	Total Tests	18435
iv.	Total number of HIV positive tests.	162
	Total number of HIV positive informed of their HIV status.	149
	Total number of HIV positive referred to medical care.	135
	Total number of HIV positive linked to medical care.	105
	Total number of HIV positive NOT informed of their HIV status.	13
v.	Total number of negative tests	18273
	Total number of HIV negative informed of their HIV status.	13890
	Total number of HIV negative referred to services.	527
	Total number of HIV negative NOT informed their HIV status.	4383

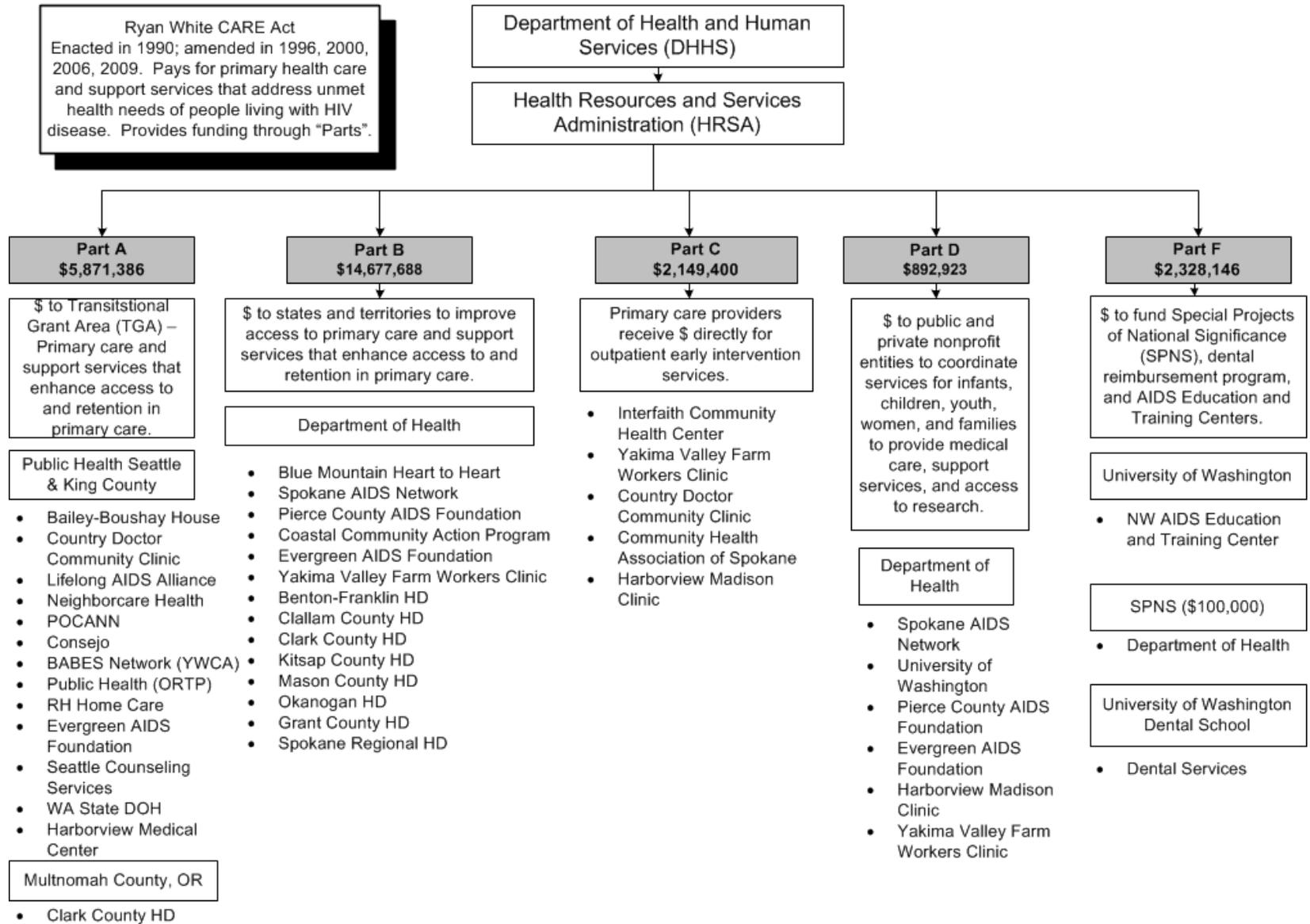
## Inventory of Available Resources

The following table, chart, and map summarize HIV-related resources and their distribution in Washington State including services provided, funding, and number of clients served.

Services Provided	Amount	# of Clients Served
<b>Part A - Public Health - Seattle &amp; King County</b>		
Core Medical Services		
Outpatient/Ambulatory Medical Care	\$951,300	1,670
EIP/ADAP (Part A)	\$40,385	13
Food Bank/Home-delivered Meals	\$360,037	926
Medical Case Management	\$2,008,168	2,754
Medical Nutrition Therapy	\$64,500	406
Mental Health Services	\$375,225	326
Oral Health Care	\$405,000	623
Substance Abuse Services - Outpatient	\$237,000	130
Support Services		
Home/Community-based Health Services	\$205,000	18
Housing Assistance/Housing-related Services	\$669,970	399
Referral Services	\$29,998	233
Treatment Adherence Support	\$258,700	238
Total	\$5,605,283	
<b>Part A Minority AIDS Initiative</b>		
EIP/ADAP	\$266,103	80
Total	\$266,103	
<b>Part B - Washington State Department of Health</b>		
Core Medical Services		
ADAP Funding		
AIDS Drug Assistance Program	\$4,421,665	4,026
Health Insurance Premium Assistance	\$4,002,136	1,800
ADAP Supplemental	\$731,101	69
Part B Supplemental	\$121,213	63
ADAP Emergency Relief Funding	\$660,158	183
Part B Base Award		
Core Medical Services		
Medical Case Management	\$1,486,226	1,709
Medical Nutrition Therapy	\$24,215	78
Support Services		
Medical Transportation	\$22,438	385
Substance Abuse Services - Outpatient	\$300	3
Food Bank/Home-delivered Meals	\$89,547	461
Total	\$14,677,688	
<b>Part B Minority AIDS Initiative</b>		
Outreach to Increase ADAP Participation	\$60,583	45
Total	\$60,583	

<b>Services Provided</b>	<b>Amount</b>	<b># of Clients Served</b>
<b>Part C - Country Doctor Community Health Centers</b>		
Primary care, RN clinical care coordinator, adherence counselor, medical case management	\$514,628	337 Primary Care 35 Dental Care
<b>Part C - Community Health Association of Spokane</b>		
Primary care, dental, dental, mental health services, nutritional counseling, case management, pharmacy, labs, adherence counseling, DSHS on site	\$411,700	31 Dental 198 Medical
<b>Part C - Harborview Medical Center/Madison Clinic</b>		
Primary care, medical case management, mental health, medical nutrition therapy (though not funded with Part C; just Part A), health education, and pharmacy	\$435,692	2,060
<b>Part C - Interfaith Community Health Center</b>		
Primary care, dental, mental health services, nutritional counseling, case management, prescription drug coverage, labs, adherence counseling/support, access to clinical trials	\$440,065	132 Primary Care 42 Dental-only
<b>Part C - New Hope Clinic/Yakima Valley Farm Workers</b>		
Primary health care, medical, dental, PHN medical case management, mental health, nutrition, adherence monitoring and management, pharmacy	\$347,315	254
<b>Part D – Washington State Department of Health</b>		
Medical Case Management	\$321,433	372
Health Insurance Premium Assistance	\$131,467	20
Outpatient/Ambulatory Medical Care	\$246,628	197
Outreach Services	\$41,250	40 (# of programs)
Health Education/Risk Reduction	\$1,070	50
Medical Transportation	\$ 3,859	60
Direct Service Total	\$745,707	
<b>AIDS Education and Training Center</b>		
	\$2,328,146	1,887 providers
<b>Housing Opportunities for Persons with HIV/AIDS</b>		
Tenant based rent assistance, short term mortgage, rent and utility assistance, security deposits, and supportive services including case management, nutritional assistance, transportation assistance	\$1,123,083	675
<b>Title X - Washington State Department of Health Family Planning and Reproductive Health Section</b>		
Enhance HIV Prevention Services in Family Planning	\$100,000	1,000

## Ryan White CARE Act funding in Washington





## Description of Need

### Part A and B - Statewide Needs Assessment

In 2011, Public Health Seattle-King County (PHSKC) and Washington State Department of Health's HIV Client Services and Assessment Unit collaborated to conduct a statewide needs assessment. For the consumer assessment, PHSKC and HIV Client Services added local questions to the Washington State HIV Medical Monitoring Project (MMP) questionnaire. MMP, using a sampling framework developed by the Centers for Disease Control and Prevention, contacted persons living with HIV. In addition, the Assessment Unit pulled a random sample from the surveillance database, known as the Enhanced Needs Assessment (ENA). MMP and the ENA interviewed 445 persons who represented a diverse sample, including populations that have traditionally been difficult to reach such as homeless, recently incarcerated, and HIV+ persons not in care. For the provider survey, all known HIV providers, including those funded and not-funded by Ryan White, were contacted and invited to participate.

The following table shows the results of the 2011 consumer survey and the 2010 provider survey. In this table, a Priority Service is one that respondents report needing to maintain or improve their HIV-related health; Utilization means respondents report currently using this service; and a Gap is a service that respondents report they need for their HIV health, but cannot get.

Service	Consumers			Providers	
	Priority %	Utilization %	Gap %	Priority %	Gap %
Outpatient Ambulatory Medical Care	90	97	1	83	12
EIP (ADAP & Insurance)	80	79	11	90	41
Oral Health Care	79	63	27	31	70
Medical Case Management	64	71	7	86	17
Food Bank/Home-delivered Meals	38	29	11	16	9
Mental Health Services	31	30	12	72	63
Psychosocial Support	30	28	11	36	45
Housing Services	27	12	12	80	74
Emergency Medications	26	7	7	19	21
Referral	19	22	7	4	11
Medical Nutrition Therapy	19	23	10	7	9
Medical Transportation	17	13	8	32	35
Substance Abuse Services - Outpatient	10	11	2	47	60
Rehabilitation Care	9	11	6	2	7
Treatment Adherence Counseling	7	5	3	23	12
Home Health Care	7	8	3	4	13
Health Education/Risk Reduction	5	9	1	6	4
Substance Abuse Services - Inpatient	4	2	2	36	52
Hospice Care	2	1	1	0	5
Childcare	1	<0.1	2	.5	9

As in previous surveys, four services were prioritized by well over half the respondents. These were outpatient/ambulatory medical care, EIP (ADAP & Health Insurance Premium Assistance), oral health care and medical case management. Well over half the respondents indicated that they used these services. With the exception of oral health care, only a small number of respondents identified these four services as a gap. Oral health care was the only gap identified by more than 25% of respondents.

## **Part C, D, F, non-Ryan White Providers – Identified Challenges and Issues**

The following lists the service provision challenges experienced by other Ryan White Parts.

### *Minority AIDS Initiative (Part A & B)*

- Access to medical care and prescription drugs
- Lack of information and education in the African American community about HIV in general and the benefits of care
- African American consumers have concerns about confidentiality, lack of peer support, and number of African American providers with HIV expertise
- Although consumers were generally satisfied after being connected with services, some consumers expressed distrust about entering the services
- Consumers are facing other issues such as housing instability, substance abuse, mental health issues, and incarceration

### *Part C – Country Doctor Community Health Centers, Community Health Association of Spokane, Harborview Medical Center/Madison Clinic, Interfaith Community Health Center, New Hope Clinic/Yakima Valley Farm Workers*

- Lack adequate resources to extend services to all locations of the state where it is needed
- Health coverage is complex and challenging for patients to access and maintain
- Increasing barriers to helping patients establish and maintain insurance continues to overburden providers
- Federally Qualified Health Clinics (FQHC) exist, however Washington needs more
- Rural physicians are not accepting new Medicaid/Medicare clients, forcing more clients to turn to Part C clinics for services
- Physician recruitment and retention in rural areas is difficult and is resulting in provider shortages
- Numbers of clients are increasing with no comparable increase in funding
- HIV stigma continues to be a significant issue in rural communities creating barriers to service
- State budget cuts result in service cuts with costs and patients subsequently being shifted to Part C clinics

### *Part D – Washington State Department of Health*

- Poor understanding of the needs of HIV-infected youth and the services needed to successfully engage them in the care system and transition them from pediatric to adult primary HIV care
- Increasing number of clients and flat or decreased federal, state, and local resources
- As women tend to prioritize support services more than other populations, the trend towards preferences to fund primary medical care over support services (medical case management, housing, and medical transportation) has had a significant impact on the Part D system

### *Part F – Northwest AIDS Education & Training Center (NW AETC)*

- Educational needs of providers served were determined using pre-training surveys and post-training evaluations; the following twenty topics emerged as priority educational needs (in descending order):
  - Nutrition for HIV-infect patients
  - Psychosocial issues of HIV disease
  - Risk assessment
  - HIV in patients with alcohol/chemical dependency issues
  - New/emerging treatment options for HIV
  - Cultural aspects of HIV care and treatment
  - HIV and women
  - Risk reduction

- HIV in patients with mental health issues
- Sexually transmitted infections in HIV-infected patients
- HIV/Hepatitis C co-infection
- Managing the newly diagnosed HIV-infected patient
- Oral health & HIV
- Counseling & testing (including rapid testing)
- Sexual exposure prophylaxis
- PEP
- Case management
- Prevention with positives
- Complementary/alternative medicine and HIV
- Co-managing HIV: Role of primary care providers
- Provider Practice Pre-training Assessment Data: Selected Key Findings
  - Eighty percent of providers indicated that at least 1-24% of their patients were HIV-infected (N=156) and approximately 48% and 34% indicated that 1-24% of their HIV-infected patients are co-infected with Hepatitis C or TB, respectively
  - About 27% of providers indicated that at least some percent of their patients aged 13-64 received opt-out testing (N=161)
  - Providers (N=513) rated their overall level of knowledge as basic (22%), intermediate (50%), or advanced (28%)
- Existing Needs
  - Providers who administer culturally sensitive care and treatment to different cultural groups, especially those serving African Americans, Hispanics, and persons with a first language other than English
  - Ongoing HIV/AIDS training on a wide range of treatment topics in rural and other under-served health care settings
  - Advanced treatment updates for more experienced clinicians centering on antiretroviral regimens, new STD treatment protocols, hepatitis C and HIV co-infection, women and HIV, and drug interactions (e.g., antiretroviral medications with street drugs and with hepatitis C treatments)
  - Health care provider education and training on the management of HIV-infected persons with multiple diagnoses
  - Trainings to understand the impact of patient use of alternative medications combined with antiretroviral treatment
  - Oral health and HIV training in primary care settings to diagnose and manage HIV-related oral lesions
  - Trainings on HIV in prisons and jails because of the increased number of HIV-infected inmates
  - Trainings that provide continuing education units across a range of professional disciplines

*South Puget Intertribal Planning Agency (SPIPA)*

- Lacking culturally appropriate dissemination of HIV/AIDS information unless provided through specific American Indian/Alaska Native grants
- Poor coordination between tribes and local health jurisdictions on HIV/AIDS information dissemination
- Tribes and tribal members do not see themselves at risk for HIV infection and often do not clearly understand modes of transmission due to the limited amount of HIV information presented in a culturally competent way
- Some tribal members will not participate in HIV testing that includes blood draws due to historical experiences and lack of trust in the public health system

- Lack of funding for testing, routine medical care, and for expensive HIV care because most Indian Health Services' Clinics are funded at 60% capacity and are rated at Priority One meaning they can only serve patients with life-threatening illnesses

#### *Medicare/Medicaid*

- A stable, aging population means more participants in Medicare and Medicaid
- Health Care Reform and Medicaid Expansion means that specific HIV data may not be available to the HIV planning communities as Medicare will not share disease-specific, individual data and managed care plans do not give the data to Medicaid
- There will likely be Medicaid funding cuts at the state level
- Case management is not popular with the federal agencies that question the cost-effectiveness of this service
- Federal grants to fill in the gaps are being eliminated with an expectation that states will step in with funding
- The federal administration is decreasing funding from Housing and Urban Development (HUD) with an expectation that states and local jurisdictions will fund more programs for housing and homelessness

#### **Needs of Special Populations**

The stigma surrounding HIV continues to impact people living with the disease. Consumers and providers stress that HIV stigma is a barrier to obtaining services for HIV care, mental health, oral health, affordable housing, and access to medication. The most disenfranchised members of society are those most at risk for HIV. Many people with HIV experience stigma and may not seek treatment for fear of disclosure within their own communities. The ongoing negative stigma of HIV directly affects access to HIV care and prevention services.

#### *Inmates*

Reentry for former inmates is a complex process. The stigma and physical challenges associated with HIV/AIDS creates barriers to employment, housing and reunification with family and friends. The need for assistance with health care is integral to an ex-offender's ability to remain healthy and productive.

#### *Gay and Bisexual Men*

As medications become more effective and people live longer with HIV, HIV is increasingly perceived as a manageable chronic illness. This has presented a shift in the way that some gay and bisexual men think about HIV. Some men who engage in high-risk behavior may not perceive themselves to be at risk for infection, may not take precautions when engaging in sexual activities, and/or may not seek out prevention services. Additionally, some gay and bisexual men are infected with HIV and are unaware of their status. Factors that contribute to this include underestimating personal risk, having limited opportunities for testing (real or perceived), and being recently infected. MSM who do not identify as gay or bisexual may not possess skills necessary to negotiate safer sex practices; may not seek out HIV testing because of perceived stigma; and/or may not acknowledge or know certain risk behaviors increase the potential for HIV infection/transmission.

#### *Women*

In Washington, there has been a decrease in living cases of men who have sex with men and a reciprocal increase in women and people of color. Women may face the triple burden of racism, classism, and sexism. Coming from an economically disadvantaged background may further compound the effect of HIV. Navigating the continuum becomes problematic by itself and finding culturally competent care and services is an additional challenge.

Women who engage in high-risk behavior may not perceive themselves to be at risk for infection, may not take precautions when engaging in sexual activities, and/or may not seek out prevention services. Furthermore, their care providers may not perceive them to be at risk for HIV and thus do not offer them HIV testing or information. Additionally, some women are infected with HIV and are unaware of their status. Because of perception of low risk, some women may not possess skills necessary to negotiate safer sex practices; may not seek out HIV testing because of perceived stigma; and/or may not acknowledge or know certain risk behaviors increase the potential for HIV infection/transmission.

A lack of culturally competent service providers in the target groups' geographic location may create barriers to regular testing. HAVHS currently funds a limited number of HIV testing sites throughout the state, nearly all of which are centered in urban corridors. For women seeking testing in non-urban areas or in urban areas with no HAVHS-funded site, the cultural competence of providers may create barriers to accessing HIV testing services. Oppression and stigma (including homophobia, racism, poverty, and lack of access to health care) continue to have an appreciable impact on the lives of women. In addition, language barriers for foreign-born women may create impediments to the accessibility and appropriateness of available HIV testing and referral services.

#### *Undocumented*

Providers in Washington State report increasing numbers of clients with HIV who have difficulty receiving services because of their undocumented status. This population often avoids accessing services because of fear of deportation. The result is later diagnosis in their disease progression, leaving them in greater crisis and need for service. While Ryan White HIV/AIDS Program funded providers are not required to link service provision to a client's documentation, most of the programs, such as Medicaid and Medicare, do require documentation. These clients become more dependent upon the Ryan White HIV/AIDS Program funded services and have a greater resource impact on these services.

Hispanic MSM who are recent immigrants often lack access to health care and may not possess the skills to effectively navigate the U.S. medical system. Language barriers for foreign-born Hispanic MSM may also create impediments to the accessibility and appropriateness of available HIV testing services.

#### **Shortfalls in Healthcare Workforce**

Ryan White HIV/AIDS programs need to enhance partnerships and relationships with non-HIV specific providers and programs. There is a need to assess and identify the barriers to communication, collaboration, and coordination at the system, provider, and client levels. This will improve collaboration and systematic coordination between the Ryan White HIV/AIDS Program system and the non-HIV specific systems in program planning and development, provider cross-training, joint meetings, and planned interactions.

People with HIV are living longer with the success of current treatment modalities. While this is good news, it also brings with it some new challenges for HIV service providers. An aging client population means that HIV providers are faced with learning to deliver services that meet the needs of an elderly population. Now HIV-positive individuals who are aging have to deal with complicating illnesses that are the result of aging, not just side effects of HIV treatment, such as diabetes, heart disease, and osteoarthritis. Complicating this issue are the effects of long-term HIV therapy that are not well understood. The ability of HIV providers to manage this changing need will be largely dependent upon their ability to collaborate with the health and human service providers with expertise in aging and disease-specific needs.

Washington needs to continue to strive to coordinate HIV care among institutions and service providers. Coordination of care strengthens the service continuum for people living with HIV/AIDS and ensures that funds fill gaps in care. According to the Washington Office of Community and Rural Health, the primary

care provider infrastructure is under stress. The number of physicians in direct patient care has been declining or has remained stagnant in most counties surveyed. With steady population growth in most counties--there has been a slow erosion of primary care capacity. Although few counties are experiencing extreme provider shortages, most Washington counties are at or approaching stress levels. Access for new Medicare patients is a significant and growing concern in Washington. More than half of the primary care physicians in the counties reported they were no longer accepting Medicare patients without restrictions.

### *Rural Populations*

The HIV epidemic in Washington State is increasingly rural (70% of people living with HIV/AIDS lived in the Seattle area in 1982-89 versus 64% in 2002-2004) but has still not reached a *critical mass* necessary to see funding allocation shifts. Increased cost of living in urban areas has forced patients to relocate to rural areas. Clients living longer have resulted in increased caseloads statewide, including rural areas. Resources continue to be minimal in rural communities. Many rural communities are designated Primary Care Shortage Areas, suffering from a lack of primary care medical providers. Transportation for the poor, elderly, and/or disabled is a serious concern. According to an assessment conducted 2001, half of Washington's rural counties had no public transportation services and routes were limited in many rural areas of urban counties.

### *Increased Case Load*

Given widespread availability of effective treatments, people with HIV disease continue to survive for longer periods following their initial diagnosis. Providers report an increase in clients accessing their programs and epidemiology data indicates a steady 5% annual increase of people living with HIV in Washington. However, funds and other resources are not always available to assist those into care. Ryan White program funding for most of Washington's HIV programs has been level the past few years. Connecting people to care and ensuring standard of care treatment has been challenging with flat level funding.

To provide key services to all clients, agencies have limited the range of services provided and often rely on other health and social service providers in their communities outside of the Ryan White System. As communities cut or reduce non-HIV-specific support programs, clients look to HIV-specific programs as a *safety-net*; a function the federal government did not intend the Ryan White program to perform.

The impact of cuts anywhere in the continuum of care affects all other services and programs in the continuum. The need to increase coordination and collaboration among all of the health and human service programs accessed by people living with HIV becomes even more important. HIV programs, in particular, must work much more closely with other health and human service programs that are, or could be, utilized by their clients.

### *Multiple Diagnoses*

Provider needs assessment data, provider experience, and other study results all reflect an increasing number of HIV-positive individuals who have multiple co-morbidities such as mental health illness, substance misuse/abuse, and Hepatitis C infection. A majority of clients are also below 100% and 200% of the federal poverty level (FPL). Poverty is one of the major factors that affect a client's ability to access services and maintain an HIV care and treatment regimen.

There is currently a limited dedicated funding source for public health in Washington State. Counties are required to fund many of the public health programs and services provided for basic services for HIV clients. Public health services have been the safety net in terms of HIV testing, TB, STD, HIV medical care, and case management for low income HIV clients. For maternal and child health issues, there are reductions statewide in maternity support services and WIC. The state has reduced or limited funding for immunizations for low-income consumers, including those with HIV.

The current HIV care continuum tends to reflect historically evaluated client needs but is changing to reflect current, data-driven, client needs. There is a tendency in any system towards stability and stasis; however, when the client needs, the epidemic, and the political landscape are constantly changing, a system that does not change to meet those needs risks becoming entrenched and ineffective.

There is movement to a resource allocation process based on empirical data and information that reflects *current* client needs. The process includes:

- integrating client-level data collection and analysis into service planning and provision;
- coordinating the comprehensive needs assessment across the state and across all parts, particularly Ryan White HIV/AIDS Program Parts A and B; and
- giving attention to Health Care Reform and Medicaid Expansion and their upcoming impact on HIV care delivery.

Washington's response to HIV disease requires a comprehensive continuum of care, including emergency care, primary care, housing, mental health, social support, and non-medical services. The continuum encompasses outreach; case findings; primary, secondary, and tertiary prevention; and the coordination of these services with non-medical services, public benefits, insurance, and legal services.

Being in medical care and receiving antiretroviral therapy decreases the likelihood of a persons living with HIV infecting others. An extensive integrated system to increase HIV testing among highest risk populations and efficiently connect them to care is needed to ensure that people who need antiretroviral care have access to it. Integrating prevention protocols into medical care settings helps persons living with HIV adopt behavioral changes that protect them and their partners from other sexually transmitted infections, viral hepatitis, and reduces the transmission potential for persons living with HIV not yet receiving antiretroviral. For persons living with HIV with suboptimal adherence to medical care or who have dropped out of care, effective systems are needed to engage these people and resolve issues that are barriers to access.

#### *Provider Training*

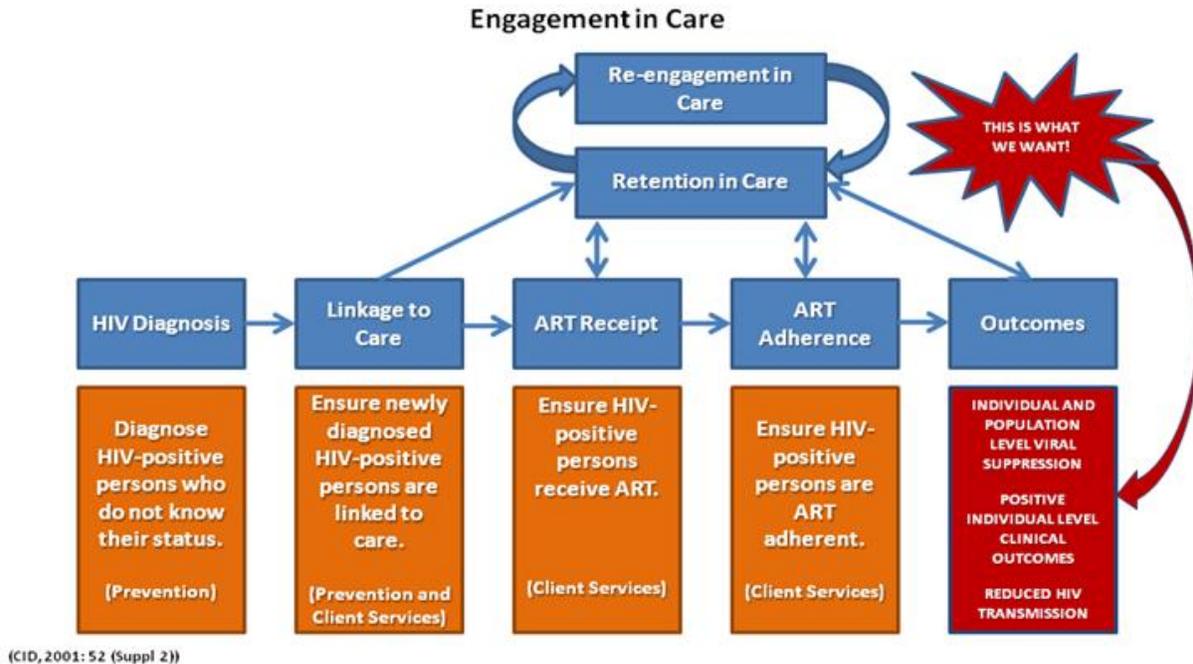
Washington needs to continue to offer provider training that encompasses not only medical and treatment-related information but also a range of competencies related to interpersonal interaction. This includes communication skills, cultural competencies, and understanding complex medical and psychosocial needs of persons with HIV and mental health disorders or addiction.

### **Prevention and Service Needs**

The role of HIV prevention services in finding HIV+ people and linking them to care and the role of HIV medical care and antiretroviral treatment in preventing new HIV infections are inextricably connected. Collaborative, evidence-based action by current and future partners is needed to confront this reality. Using the principles outlined in the diagram below, Washington State will integrate HIV prevention and care services to build a coherent statewide system to support achievement of goals consistent the early intervention of individuals living with HIV/AIDS (EIIHA):

- Prevent new HIV infections
- Find PLWH who need HIV medical care and treatment
- Engaging PLWH in HIV medical care and treatment
- Retaining PLWH in medical care, including adherence to treatment
- Re-link PLWH with service interruptions to medical care and treatment

## HIV TREATMENT AS PREVENTION



### Activities:

- Breakdown policy and legal impediments to align the continuum of HIV prevention and treatment services in Washington to address the challenges of the current epidemic
- Reorganize state and local agencies to make more effective use of resources
- Engage new partners in the battle against HIV
- Plan and execute strategies to combat the HIV epidemic using transparent, participatory processes
- Improve evaluation of existing and new programs to assess progress toward strategic outcomes
- Improve quality and efficiency within integrated HIV prevention and care programs
- Use evaluation and population-based data to drive planning and program development
- Improve public information and education to generate and maintain public support for integrated HIV prevention and care initiatives

### Gaps:

- Historical silos put us behind the curve
- Appropriate data and analysis not yet available to guide efforts in some cases
- Need to improve partnerships with private sector providers, insurance plans, etc.
- Washington jurisdictions and agencies are at different stages of readiness for realigning and targeting services to the areas and populations with greatest need

## Barriers to Care

### HIV+ Persons in Care

The most pervasive barriers identified by people living with HIV to entering and remaining in care include, but are not limited to, inadequate transportation, inadequate housing, unmet mental health and substance abuse needs, and burdensome administrative requirements. Stigma, language, incarceration, and lack of opportunities for peer involvement create further barriers.

### *Housing*

Lack of housing hinders clients' ability to access and comply with HIV-related services and treatment. This is related to the relative priority and immediacy individuals place on securing safe, stable housing versus seeking health care. Inadequately housed persons living with HIV have difficulty with receipt and storage of and compliance with medications.

Housing needs of people living with HIV/AIDS are more diverse and may not be specifically a result of a person's HIV infection. More consumers experience increasingly complex physical, emotional, and behavioral health issues and other challenges that influence their housing stability. When coupled with low income and a challenging housing market, housing stability becomes difficult. Access to housing is further complicated by factors related to mental illness, substance use, chronic homelessness, histories of incarceration, immigration status, and language and cultural barriers. Housing and service providers are focusing more energy, time, and resources on populations that face multiple challenges in accessing or maintaining housing in addition to a lack of financial resources. Housing alone will not solve the underlying issues for many consumers. However, these issues often cannot be addressed when an individual is not stably housed.

### *Transportation*

Transportation barriers limit access to and compliance with services, especially in rural areas where the public transportation infrastructure is non-existent. This issue is particularly salient given the recent dramatic increase in gasoline prices, which affects individuals with their own means of transportation as well as agencies that provide transportation assistance.

### *Mental health and Substance Abuse*

Providers report that many clients have unmet mental health and substance abuse needs that influence their ability to stay in the care system. Many of these clients have difficulty navigating the systems of care. These barriers are exacerbated by limited financial and organizational resources available to address these needs. The overall state system of care for people with mental health and substance abuse issues has been impacted by state budget shortfalls that have resulted in decreased Medicaid coverage of mental health services. The spectrum of services available is limited due to the unique needs of these clients. For example, housing for clients with a history of chemical dependency is limited. Because of the complexity of these clients, more time and money are required.

### *Poverty*

Poverty remains one of the greatest barriers to an HIV-positive individual accessing and successfully maintaining medical treatment for HIV disease. National economic indicators show increasing numbers of people living in poverty while Washington's Ryan White Program receives flat or decreased funding for services. Increased unemployment rates and the possibility of clients losing employer sponsored insurance compounds this situation. Washington's ADAP has had an increase in clients who have never needed Ryan White programs, or were ineligible due to income, enrolling in the program.

The majority of clients cared for in the HIV services continuum of care are poor. The safety net at both the local and state level is eroding, and clients turn more frequently to their HIV service providers for assistance with multiple needs, some unrelated to HIV. There are simply not enough resources to meet the need, forcing HIV providers to reduce services provided or focus services only on clients with the most severe need. The risk in this is that the clients assessed with less need can very quickly become severe need clients without basic assistance.

### *Stigma and Language*

Real and perceived stigma about HIV, sexual orientation, mental health, and substance abuse affects the availability and accessibility of services as well as clients' willingness to access care.

Lack of Spanish speaking providers and translation services makes it difficult to meet the needs of an increasing population of Hispanic clients. Translators may not have sufficient medical background to convey complex information about HIV care. In addition, foreign-born populations in Washington are from an increasing diverse number of counties with linguistic and cultural needs that are difficult to address given that any one language may constitute such a small portion of the overall population of PLWH.

#### *Incarceration*

Incarceration can cause a disruption in care for persons living with HIV who do not disclose their HIV status. Upon release from prison or jail, clients may not prioritize accessing care relative to their other needs. Washington State Department of Corrections has a discharge planning process for those who are coming out of the state correctional system. However, the local jail system is fragmented and without a consistent and clear policy on treatment and linkage to care for persons living with HIV.

#### *Administrative Requirements*

Recent years have seen many changes to the EIP application process, including an increase emphasis on health insurance, 6-month enrollment, medical provider verification of HIV status, and documentation of antiretroviral fills. Clients and providers do not always understand the administrative requirements necessary to access Ryan White services. They find the paperwork and eligibility process burdensome and confusing.

#### *Data Infrastructure*

Administrative requirements from federal funders related to quality improvement and accountability has placed an increasing administrative burden on the care system. This takes time and resources away from addressing client needs. The lack of data infrastructure and personnel dedicated to managing agency data often results in case managers and case manager supervisors becoming over-burdened, stretched, and burned out because they are fulfilling both roles. Washington is developing a more streamlined and efficient approach to data collection and reporting. However, it will still require the dedication of significant personnel resources to manage an agency's quality initiative and ensure compliance with federal requirements.

### **Individuals Aware of their HIV Status but not in Care**

Individuals not in care experience a variety of barriers, or set of barriers, real or perceived, that keep them from accessing and remaining in care.

#### *Administrative Process*

Clients who have previously been in care and dropped out may find the administrative process to re-enter the care system too burdensome and confusing. There are multiple documentation requirements for clients to access Ryan White care services including Early Intervention Program and health insurance applications, income eligibility, case management assessments, and Social Security Administration paperwork.

#### *Fear and Denial*

Feeling of personal failure and fear of rejection may make it difficult for some clients who have dropped out of care to re-enter the care system. Fear of diagnosis and denial about their HIV status may prevent persons from entering care. Asymptomatic clients may not feel compelled to seek or stay in care services, especially in light of the shift toward thinking of HIV as a long-term chronic illness. Fear of domestic violence may prevent clients from accessing care because they do not want to disclose their status to their partner. Fear of losing custody of children or being deported for undocumented status may keep persons from accessing care.

### *Stigma*

Clients may not feel comfortable engaging with a care system that appears to be different from their own culture, race, ethnicity, sexual orientation, or language. Stigma about HIV among providers and community member can discourage clients from accessing care.

Prior experiences of being treated with disrespect by providers, agency staff, or disease intervention specialist can result in a person not accessing care services. Newly diagnosed persons may have received poor linkages between receiving a positive test and referral for services.

### **Individuals Unaware of their HIV Status**

Historically, HIV prevention services, including HIV testing, have not been well coordinated with Ryan White care services in Washington State. This was primarily due to separate federal funding requirements and fragmented resource allocation under Washington's previous regionalized HIV service delivery system. In 2011, in response to legislative directives, Washington State disbanded the regional system and centralized the administration of HIV prevention and care services within the Washington State Department of Health. This transition to state administration of HIV services offered DOH the opportunity to create a more integrated system for the delivery of services intended to identify individuals unaware of their HIV status, make them aware of their status, and link them to HIV care and treatment. Washington State's strategy is the result of commitment by DOH and Public Health Seattle & King County.

### *Barriers to HIV Screening in Clinical Settings*

Core medical service providers cite lack of time as one of the factors serving as a barrier to risk screening and risk reduction interventions in clinical settings. Providers also frequently identify low reimbursement rates by health care financing entities as an impediment. New strategies are needed to overcome these barriers and effectively integrate HIV prevention into medical services, including primary medical care, mental health services, substance abuse treatment, and medical case management.

Evidence-based prevention models are available for application within care settings. However, a number of factors may limit uptake and implementation of prevention interventions as a component of HIV care and treatment. HIV core medical service providers need education, training, materials, and policy support to successfully integrate prevention messages in care settings. They also need necessary financial and human resources.

### *Cultural Competency*

Sexual health is an essential part of medical care; but routine risk screening, risk reduction counseling, and integrated systems that promote sexual health for all patients are not consistently available in clinical settings. Some medical service systems with relatively good sexual health programs may overly rely on patients to volunteer their risk factors or may not provide free well care visits frequently enough to meet the needs of people with higher risks.

HIV care providers outside the Ryan White system may receive insufficient training to perform prevention with diverse populations or lack representation with their organizations from diverse communities. Policy underpinnings to support culturally appropriate, evidence-based HIV prevention activities in clinical settings are insufficient in some organizations that provide HIV care services. Better training, technical assistance, and care coordination are needed to assist health care providers to meet the needs of clients with underlying mental health and substance use issues who often need intensive and sustained prevention services.

### *Lack of Integration of Care and Prevention Services*

There are very few examples of integrated or co-located care/prevention services in Washington State outside King County. CDC-funded prevention programs often are located in community-based prevention agencies or health departments apart from medical care settings, including Ryan White Program-funded sites. While minority providers have developed capacity to provide prevention services, their capacity remains limited and programs may not be linked or integrated into other social service and clinical service providers.

### *Enhanced HIV testing*

Rapid testing has demonstrated great value in identifying HIV-positive individuals outside clinical settings; this may create challenges to immediately linking newly diagnosed individuals to medical care and treatment or other care services. More effective collaboration between nonclinical testing agencies and HIV care providers, supported by improved community infrastructure is needed to meet this challenge.

### *Barriers to HIV Testing in Alternative Settings*

HIV testing may not be available in substance abuse treatment and mental health facilities, jails, homeless shelters, in some areas of the state where persons at high risk for HIV infection or transmission may be found

### *Failure to Adapt Prevention Messages*

Effective HIV prevention services are needed throughout the lives of PLWH. HIV prevention must be dynamic and responsive to changing needs and be appropriate to PLWH and their communities. Use of new communication technologies and evolving education programs will be needed to effectively serve younger high risk populations as well as existing ones that have become saturated with currently available prevention messages.

### *Lack of Access*

The HIV epidemic in Washington does not recognize political boundaries. Areas of the state with the highest HIV prevalence are distributed geographically into zones that include multiple jurisdictions. To increase access to HIV prevention services that are gateways to HIV medical care and treatment, deployment of resources should be flexible and minimally hindered by jurisdictional boundaries. Transition to a more strategic approach to programming is likely to present challenges to LHJs and CBOs that are accustomed to a more fragmented infrastructure, and some new partners may be needed to facilitate access to HIV prevention and treatment services in the parts of Washington most affected by the epidemic.

### *Late Diagnosis for PLWH Entering Care*

The shift in the priorities of the Centers for Disease Control (CDC) toward their “Prevention for Positives” program means that there are reduced resources at the local level to do prevention outreach and counseling/testing targeting the newly identified populations. Prevention programs have shifted focus to the populations with the highest incidence, but an unacceptable number of PLWH still receive a late diagnosis and entry into care in Washington State.

## Where do we need to go?

### Evaluation of 2009 Comprehensive Plan

The Washington State Comprehensive Plan identified five goals for 2009 to 2011. Each goal and its progress are below:

*To achieve and maintain a more equitable, effective system of HIV care, Washington State Department of Health will know the HIV-related needs, gaps, barriers, and service utilization of persons living with HIV as well as the service capacity in the service area.*

In the past year, HIV Client Services has worked with the Department of Health's HIV Assessment Unit and Public Health – Seattle & King County to modernize its needs assessment approach for 2011. Instead of using a convenience sample, we randomly selected people living with HIV to improve the reliability of the findings even with a lower response rate. HIV Client Services improved the assessment instrument to ensure that the information needed to make tough decisions was there in light of a poor budget outlook. We have investigated and implemented additional assessment capacity to learn more about those out of care or poorly maintained in care - the people least likely to respond to surveys.

*There will be no significant gaps in the highest ranked core services.*

Despite cuts in state funding and level federal funding, HIV Client Services has continued to provide the services most prioritized and utilized by Ryan White clients. These are core services such as the AIDS Drug Assistance Program, Medical Case Management, Outpatient Ambulatory Care, and Health Insurance Premium Assistance. The Early Intervention Program's implementation of client-level data collection over the period will also improve HIV Client Services' ability to assess gaps in the top ranked core services provided by the program.

*There will be no persons living with HIV without access to the highest ranked core services and the profile of service utilization will favor historically underserved and disproportionately affected populations.*

During the period 2009-2011, HIV Client Services created and strengthen partnerships to identify people believed to be out of care and connect them with medical and social services. HIV Client Services established a contract with a local health jurisdiction in the county with the largest number of people estimated to be out of care, a significant portion of them ethnic/racial minorities, to contact people identified through the surveillance system. Furthermore, we developed a partnership with the AIDS Service Organization providing case management and housing service in the jurisdiction and with the primary HIV medical provider to link those contacted back into the care continuum.

*Medical HIV Case Management services paid for by Ryan White Part B will be of high and ever improving quality.*

Ryan White Part B Medical HIV Case Management made systematic improvements to its quality management program during the period 2009-2011. All Medical Case Management contracts include quality management as a contractual obligation. Each provider is required to report statewide performance measures and two quality assurance measures, as well as use that data to select a quality improvement project. All case managers and case management supervisors received in-person training on the new quality management expectations. HIV Client Services has made great strides in improving the collection of client-level data including receiving a HIT Improvement SPNS grant.

HIV Client Services released new Medical HIV Case Management Standards in 2010. With help from the Case Management Planning and Evaluation Group, HIV Client Services revised and updated the standards to provide more guidance, support, and information to case management agencies across the state. Regional two-day trainings for all case managers in both the Seattle TGA and Part B service areas accompanied the release of the standards.

*To the greatest extent possible, there will be seamless coordination between Ryan White Part B and other services.*

At every level, all Ryan White services try to coordinate to whenever possible. A clear example of the coordinated services is EIP's strong relationship with its provider network and with both Part A and Part B case management agencies. Considering recent budget cuts, Ryan White Part B has worked closely with other HIV providers – including Ryan White Providers, Medicaid, the VA, and private providers – to coordinate the continued delivery of care and consistent messaging to shared consumers.

## **Goals, Issues, and Priorities**

### **2012-2014 SCSN Crosscutting Goals, Issues, and Priorities**

The SCSN 2012 Workgroup identified the following crosscutting goals, issues, and priorities that Ryan White Grantees might use in the determination of allocation of funds:

Use technology & data systems to enhance HIV care delivery

- Reduce burden of reporting requirements
- Create technology linkages to allow identification and capture of relative information being stored in separate systems
- Streamline verification and accountability procedures
- Engage in continuous quality management to ensure that services are accomplishing intended goals

Empower people living with HIV (PLWH) to be active participants in their health care and to be community leaders

- Educate and involve PLWH in advocacy, peer navigation, and care teams
- Train PLWH on how to be effective on planning bodies
- Engage PLWH in their health care
- Implement and promote self-management programs and tools for PLWH

Integrate HIV services into Washington's medical and human services continuum of care

- Develop strong linkages between service providers to maximize cross-agency collaborations
- Integrate HIV care services into basic primary care
- Prepare for Affordable Care Act by training primary care providers at Community Health Centers
- Refer PLWH to appropriate mental health, housing, and substance abuse treatment services

Ensure access to quality health care and HIV medications for all people living with HIV in Washington

- Improve access to care services for PLWH with significant co-morbidities
- Remove barriers to care for vulnerable populations such as drug-users, incarcerated, those living with mental illness, and the homeless
- Create a case management team for high-risk individuals for linkage and retention in care
- Develop a system of care that integrates larger social determinants, such as poverty, marginalization, and access to education and health care

Improve the integration of prevention and care services for persons living with HIV

- Find PLWH who need care and treatment services
- Engage PLWH in care and treatment services
- Identify system barriers that keep people out of care, particularly in the period immediately following diagnosis
- Retain PLWH in care and treatment services

### National HIV/AIDS Strategy

National AIDS Strategy	Washington State Cross Cutting Goals & Activities
Goal 1. Reduce the number of people who become infected with HIV	<p><i>Improve the integration of prevention and care services for persons living with HIV</i></p> <ul style="list-style-type: none"> <li>• Increase HIV prevention efforts where HIV is most heavily concentrated</li> <li>• Expand targeted efforts to prevent HIV infection</li> <li>• Increase opt-out testing</li> </ul>
Goal 2. Increase access to care and optimizing health outcomes for people living with HIV	<p><i>Integrate HIV services into Washington's medical and human services continuum of care to increase access to providers of clinical care and related services for persons living with HIV</i></p> <ul style="list-style-type: none"> <li>• Identify non-HIV specific, under-utilized resources</li> <li>• Develop a system to immediately link persons who are newly diagnosed HIV positive persons to continuous quality care</li> <li>• Support persons living with HIV with co-occurring health conditions and challenges to meet their basic needs</li> </ul>
Goal 3. Reduce HIV-related health disparities	<p><i>Ensure access to quality health care and HIV medications for all people living with HIV in Washington</i></p> <ul style="list-style-type: none"> <li>• Reduce stigma and discrimination against people living with HIV</li> </ul>
Key Step 1: Increase the coordination of HIV programs	<p><i>Empower people living with HIV to be active participants in their health care and to be community leaders</i></p> <ul style="list-style-type: none"> <li>• Increase coordination of HIV programs across Ryan White parts</li> </ul>
Key Step 2: Develop improved mechanisms to monitor and report on programs progress	<p><i>Use technology and data systems to enhance HIV care delivery</i></p>

## How will we get there?

**Strategy: Increase equity in access to and improve the quality of social service and health care services throughout the state.**

**Plan:** Increase the number of health service providers in rural and suburban areas who see HIV positive clients for HIV primary care or primary care in consultation with a HIV specialist.

**Activities:** The Ryan White Part B Community Programs Planning Group (CPPG) will request and review data to understand the geographic and demographic distribution of people living with HIV believed to be out of care. **Responsible parties:** CPPG, Community Planning Coordinator, Infectious Disease Assessment Unit **Timeline:** By July 01, 2013

**Activities:** The CPPG will work with Ryan White Part B case management agencies to identify medical providers in areas in need of HIV medical providers and refer them to Project ECHO – a joint project between Harborview Medical Center and the NW AETC. **Responsible parties:** CPPG, HIV Client Services Community Programs staff **Timeline:** By July 01, 2013

**Activities:** The Early Intervention Program will continue to recruit and contract with providers throughout the state who wish to be serve EIP clients and will adhere to a reimbursement schedule that maintains provider participation **Responsible parties:** Early Intervention Steering Committee, EIP Provider Contracts Coordinator, HIV Client Service Program Manager, HIV Client Services Operations Supervisor **Timeline:** Ongoing

**Plan:** Increase the knowledge and skills of social service providers providing medical HIV case management providers.

**Activities:** Develop a formal consultation network for medical HIV case management providers. **Responsible parties:** Statewide Case Management Coordinator **Timeline:** By August 01, 2013

**Activities:** Provide learning opportunities for medical HIV case management providers to increase their knowledge of medical and social issues. **Responsible parties:** Statewide Case Management Coordinator, Northwest AETC **Timeline:** Ongoing

**Plan:** Increase coordination between social service and medical providers to improve retention and linkage to care services.

**Activities:** Research coordination models, such as medical home models and peer navigators, which could be implemented. **Responsible parties:** HIV Client Services Community Programs staff, CPPG **Timeline:** By March 31, 2013

**Activities:** Diffuse innovative coordination models and provide technical assistance so that they are adapted to meet unique regional needs. **Responsible parties:** CPPG, HIV Client Services Community Programs staff, CMPEG **Timeline:** By December 31, 2013

**Activities:** Network CAREWare to provide medical HIV case managers with tools to track medical care information in a uniform manner. **Responsible parties:** HIV Client Services Operations Supervisor, Data Coordinator **Timeline:** By December 31, 2012

**Plan:** Monitor the changing needs of PLWH, the utilization of services, and the quality of care.

**Activities:** Improve the statewide needs assessment process to ensure that Ryan White is serving the needs of PLWH by conducting on-going assessments and incorporate data from the Medical Monitoring Project. **Responsible parties:** Seattle TGA Planning Council, CPPG, Community Planning Coordinator, Community Programs Supervisor, Washington State MMP staff **Timeline:** By August 31, 2012

**Activities:** Continue to monitor the quality of the services throughout the Ryan White care continuum via the Ryan White cross-parts collaborative and use the data to develop meaningful quality improvement projects. **Responsible Parties:** Quality Management Planning and Evaluation Group (QMPEG) **Timeline:** Ongoing

**Activities:** Continue implementation of client-level database as begun under 2011 SPNS Grant. **Responsible Parties:** HIV Client Services Operations Supervisor, HIV Client Services Data Coordinator **Timeline:** By December 31, 2012

**Cross-cutting Issues:**

- Ensure access to quality health care and HIV medications for all people living with HIV in Washington
- Integrate HIV services into Washington's medical and human services continuum of care
- Use technology & data systems to enhance HIV care delivery

**Strategy: Empower people living with HIV (PLWH) to take on responsible active leadership in all aspects of their care.**

**Plan:** Provide community leadership opportunities for PLWH

**Activities:** Actively recruit and provide support to PLWH to be involved in planning groups and quality management activities. **Responsible Parties:** Community Planning Coordinator, Seattle TGA Planning Council Staff, EIP Steering Committee, Local/Regional Community Advisory Boards, current consumer representatives on planning groups, QMPEG, Washington HIV/AIDS Community Advocacy Network **Timeline:** Ongoing

**Activities:** Provide learning and teach opportunities for PLWH. **Responsible Parties:** Community Planning Coordinator, Statewide Case Management Coordinator, Seattle TGA Planning Council Staff **Timeline:** Ongoing

**Plan: Create an environment that supports PLWH to be active members of their care team**

**Activities:** Train medical and social service providers to involve PLWH in their care team **Responsible Parties:** Statewide Case Management Coordinator, NW AETC **Timeline:** Ongoing (Initiate by August 31, 2012)

**Activities:** Provide training for peer health navigators who provide guidance to PLWH who are part of a care team **Responsible Parties:** Part D Program Coordinator (pilot program initiated by Part D), Statewide Case Management Coordinator, NW AETC, Ryan White Social Service Providers **Timeline:** By August 31, 2012 (initiated by Part D program)

**Activities:** Provide educational opportunities to PLWH who want to learn more about HIV medical care **Responsible Parties:** Ryan White Social Service Providers, Statewide Case Management Coordinator, Community Planning Coordinator, Local Community Advisory Boards **Timeline:** Ongoing

**Cross-cutting Issues:**

- Empower people living with HIV (PLWH) to be active participants in their health care and to be community leaders
- Ensure access to quality health care and HIV medications for all people living with HIV in Washington

**Strategy: Improve access to Washington State’s ADAP program and to safety-net programs for all eligible people living with HIV in Washington State.**

**Plan:** Ensure that EIP is payer of last resort so that funds are available to provide services to all eligible clients.

**Activities:** Streamline the 6-month reassessment of eligibility process to assess that all clients meet current eligibility criteria. **Responsible Parties:** EIP Eligibility Specialists, HIV Client Services Operations Supervisor, Statewide Case Management Coordinator **Timeline:** By December 31, 2012

**Activities:** Implement data share agreements that assist in determining current eligibility status for clients (for example: Employment Security Department, Health Care Authority, Washington State High Risk Insurance Pool/Pre-Existing Condition Pool – Washington State) **Responsible Parties:** HIV Client Services Operations Supervisor **Timeline:** December 31, 2012

**Activities:** Collaborate with Health Care Authority and the Department of Health and Human Services to apply for a Medicaid Expansion Waiver (1115 Waiver) to increase access to Medicaid for people living with HIV under 133% FPL. **Responsible Parties:** HIV Client Services Program Manager, Office of Infectious Disease Director **Timeline:** By December 31, 2012

**Plan:** Improve administration of the Early Intervention Program to improve access

**Activities:** Monitor and implement P-D-S-A cycles to improve wait-times and processing procedures for eligibility determination. **Responsible Parties:** HIV Client Services Quality Management Committee, HIV Client Services Operations Supervisor, EIP Eligibility Staff **Timeline:** Ongoing

**Activities:** Modify Medical HIV Case Management Standards to implement Benefits and Entitlements Counseling as a formal component of the Medical Case Management system. **Responsible Parties:** Community Programs Supervisor, Statewide Medical Case Management

Coordinator, Case Management Planning and Evaluation Group (CMPEG) **Timeline:** by Fall 2012

**Cross-cutting Issues:**

- Integrate HIV services into Washington’s medical and human services continuum of care
- Ensure access to quality health care and HIV medications for all people living with HIV in Washington
- Use technology & data systems to enhance HIV care delivery

**Strategy: Improve Linkage, Retention, and Reengagement of PLWH to medical and social service**

**Plan:** Washington State Department of Health HIV and Viral Hepatitis Section will implement Category C funding received from the CDC with support from HIV Client Services, STD Services Section, Public Health Seattle & King County, and other local health jurisdictions.

**Activities:** Implement electronic reminders to increase HIV testing among those at highest risk for HIV infection. **Responsible Parties:** STD Services, Linkage to Care Coordinator, Partner Services Coordinator **Timeline:** Ongoing (initiate by December 31, 2012)

**Activities:** Promote Routine Testing for all people in Washington State by revising the Washington State Administrative Code. **Responsible Parties:** Office of Infectious Disease Director, HAVHS Program Manager, Infectious Disease Legislative Liaison, HIV/STD Program Directors at PHSKC **Timeline:** by December 31, 2012

**Activities:** Implement intensive linkage protocol and monitoring for those newly diagnosed. **Responsible parties:** Linkage to Care Program Coordinator, Local Health HIV Program Directors **Timeline:** Ongoing (initiate by December 31, 2012)

**Activities:** Investigate PLWH for who there is no laboratory data available to determine if they have been lost to care. **Responsible parties:** Infectious Disease Assessment Unit, statewide disease investigation services **Timeline:** Ongoing (initiate by December 31, 2012)

**Activities:** Implement strategies for assisting PLWH who have been lost to care to reengage in care using existing partner services and medical case management programs, as well as contributing additional resources and expertise **Responsible parties:** Linkage to Care Program Coordinator, Community Programs Staff, Partner Services Program Coordinator **Timeline:** Ongoing (initiate by December 31, 2012)

**Cross-cutting Issues:**

- Improve the integration of prevention and care services for persons living with HIV
- Ensure access to quality health care and HIV medications for all people living with HIV in Washington
- Use technology & data systems to enhance HIV care delivery

## **Coordinating Efforts across the Care Continuum**

As can be seen above, these strategies and goals requires the participation of a wide variety of service delivery partners including all Ryan White grantees and providers, their associated planning groups, and community partners and providers not funded directly by Ryan White. The Washington State Department of Health and other Ryan White Grantees have a mixed history of engaging and collaboration but cooperation has increased significantly over the past several years and resources have diminished and new grant and funding opportunities have increasing called for partnership. It is also evident from the diversity of agencies and sectors represented in the SCSN workgroup and in the responsible parties that the above activities are part of statewide coordinated effort to improve care for people living with HIV in Washington State.

## **How will we monitor progress?**

### **Client Level Database**

The implementation of a client level database is a joint project between the Washington State Department of Health HIV Client Services program and the Washington State Ryan White cross-parts quality collaborative named the Quality Management Planning and Evaluation Group (QMPEG). HIV Client Services received a SPNS grant from HRSA for the implementation of the database.

The project will network all CAREWare users which constitutes the vast majority of Ryan White providers in Washington State. The project will eventually also link the database to specific information in the surveillance system and to the ADAP client database known as HIV/AIDS Data System, or HADS.

The client level database will improve the ability of the grantees to monitor the utilization and quality of services within the continuum.

### **Cross-Parts Quality Collaborative**

The Quality Management Planning and Evaluation Group (QMPEG) is comprised of representatives from all Ryan White grantees in Washington State and consumers representing each part. Together these stakeholders identify and develop performance measures that will help the group evaluate the quality of the Ryan White Care Continuum.

All Ryan White providers report on the performance measures to their grantee and the grantees submit the information to QMPEG.

## **Appendix A - Statewide Coordinated Statement of Need (SCSN)**

The Statewide Coordinated Statement of Need (SCSN) is a written statement of need developed through a locally chosen collaborative process with other Ryan White HIV/AIDS Treatment Extension Act of 2009 programs. The SCSN includes a discussion of existing needs assessments, an overview of epidemiological data, existing quantitative and qualitative information, and trends or issues affecting HIV care and service delivery in Washington State.

By providing the foundation for the development of goals, objectives, and resource allocation decisions, SCSN serves as a framework for programmatic action that will strengthen Washington's response to HIV over a three-year planning process.

The 2012 SCSN includes a determination of the population with HIV, who are aware of their status but not in care, individuals who are unaware of their HIV positive status, an understanding of primary care and treatment in Washington State, and a consideration of available resources.

The partner document, the 2012-2014 Part B HIV Comprehensive Plan outlines future priority goals, principles, and strategies to enhance the quality of care across the state of Washington, as well as to monitor progress in meeting these goals and objectives.

### **SCSN and Comprehensive Plan Development Process**

Washington State developed this document through a participatory process that included input from consumers, providers, and public agency representatives, and a review of epidemiological and needs assessment data.

The Washington State Department of Health, as the state Ryan White Part B program, coordinated the process. However, all Ryan White HIV/AIDS Program Parts were equally responsible for the development of the process, their organization's participation, and the development and approval of a collaborative product.

In April 2012, the Washington State Department of Health, HIV Client Services Program (Part B Grantee), convened the SCSN Work Group to discuss crosscutting issues among the Ryan White HIV/AIDS Program Parts A, B, C, D, and F, the minority AIDS initiative and the Washington State Department of Corrections. The meeting provided a data and information overview that included:

- HIV/AIDS Epidemiologic Profile
- Unmet Needs Study Results
- Needs Assessment Results and Priorities
- Statements of Need/Demographics/Priorities from Ryan White grantees

Ryan White HIV/AIDS Programs submitted an inventory of funding sources, services provided, and number of clients served. After reviewing the data and inventory of funding sources, the SCSN Work Group worked in small groups to identify themes, emerging trends, and crosscutting goals in Washington's HIV/AIDS continuum of care.

In addition, the Ryan White Part B Community Programs Planning Group meeting, committee members provided input and guidance on priority strategies and activities for the Comprehensive Plan to compliment the goals developed by the SCSN workgroup. Several members also reviewed and submitted feedback on the final product.

## Data and Information Sources

Washington State Department of Health developed the SCSN using information provided by Work Group members. The following discussion describes the data and information sources used:

- *HIV/AIDS Epidemiology and Unmet Need Update* – The Washington State Department of Health, Infectious Disease and Reproductive Health’s Assessment Unit staff provided an HIV/AIDS epidemiology and unmet need overview to the Work Group. This presentation summarized trends in HIV/AIDS incidence and prevalence data and modes of transmission and described the unmet need calculation.
- *Ryan White HIV/AIDS Program Parts Grantee Presentations* – the Ryan White HIV/AIDS Program Grantees provided overviews of their respective programs and projects and summaries of the most recent needs assessments and demographics of clients served.
- *Funding Landscape Review* – Grantees for Ryan White Parts A, B, C, D, and F completed a funding spreadsheet to describe recent Ryan White HIV/AIDS Program funding and services provided. Housing Opportunities for Persons with HIV/AIDS (HOPWA) and Title X Planning also completed the funding worksheet. This information is included in Inventory of Available Resources.

## SCSN Participants

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Part B Representative

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Infectious Disease Legislative Liaison – Washington State Department of Health

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Infectious Disease Assessment – Washington State Department of Health

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Part C - Interfaith Community Health Center

### **Debra Adams**

Part C - Yakima Valley Farm Workers Clinic

### **Linda McVeigh**

Part C - Country Doctor Community Clinic

### **Cheryl Cervantes**

Part C – Community Health Association of Spokane

### **Pegi Fina**

Part C - Harborview Madison Clinic

### **Rhonda Bierma**

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### **Amber Casey**

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### **Brenda Higgins**

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### **Mary Annese**

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### **Jutta Riediger**

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