



Statewide Coordinated Statement of Need



January 2009

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III. Introduction

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) requires grantees to develop a Statewide Coordinated Statement of Need (SCSN). The SCSN provides a collaborative mechanism for addressing key HIV/AIDS care issues, enhancing coordination, and maximizing effective linkages across Ryan White HIV/AIDS Program Parts.

The Washington State Department of Health, as the state Part B program, is responsible for coordinating the SCSN for the state of Washington. HRSA mandates the Ryan White HIV/AIDS Program Parts participate in the development of the SCSN.

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 2009 SCSN includes:

- An overview of changes in the epidemic
- Emerging trends within the service delivery system
- A summary of key issues within the HIV continuum of care in Washington

The partner document, the 2009-2011 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.

IV. SCSN Development Process

Washington State developed the 2009 SCSN through a participatory process that included input from consumers, providers, and public agency representatives, and a review of epidemiological and needs assessment data.

In November 2008, 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 SCSN Work Group held one full-day meeting. The meeting provided a data and information overview that included:

- HIV/AIDS Epidemiologic Profile
- Unmet Needs Study Results
- Part A Needs Assessment Results and Priorities
- Part B Needs Assessment Results and Priorities
- Part C Statements of Need/Demographics/Priorities from five grantees
- Part D Statement of Need/Demographics/Priorities
- Part F AIDS Education and Training Center (AETC) Statement of Need/Demographics/Priorities

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.

V. Data and Information Used

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, Mark Stenger, 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 Parts Grantees provided overviews of their respective programs/projects and summaries of the most recent needs assessments and demographics of clients served. The Work Group used this information to develop crosscutting goals and strategies.
- *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 Section IX, Inventory of Available Resources.

VI. Overview of HIV/AIDS in Washington¹

Since Washington's first AIDS case was diagnosed in 1982, nearly 17,000 state residents have been diagnosed with HIV disease and roughly, 5,300 people have died of AIDS. After peaking in the early 1990s, HIV diagnosis rates fell for several years before eventually stabilizing near the end of the decade. Recent surveillance data indicate that HIV rates across the state have remained steady for about 10 years. HIV prevalence, or the reported number of people living with HIV disease in Washington, should surpass 10,000 in the latter half of 2008.

HIV-infected individuals living outside King County collectively represent about a third (37 percent) of the statewide disease burden. When compared to King County cases, those living elsewhere in Washington are more likely to be female and to have their

¹ Note: Most of the data included in this section were obtained from the Washington State HIV Surveillance Report, 3rd Quarter 2008. This report is available at http://www.doh.wa.gov/cfh/hiv_aids/Prev_Edu/Statistics/qtr10-08.pdf.

infections attributed to either heterosexual contact or injection drug use. Outside of King County, cases also are more likely to have been diagnosed late in the course of their HIV illness. Racial/ethnic disparities in HIV risk continue to be a source of public health concern in Washington. However, the difference in HIV risk between Whites and other racial/ethnic groups has not changed significantly in recent years, either inside or outside King County.

Incidence (Recently Diagnosed Cases)

Between 2003 and 2007, new HIV diagnoses averaged nearly 600 per year in Washington (Table 1). The term “new HIV diagnosis” refers to all newly detected cases of HIV disease, regardless of whether patients have been diagnosed with AIDS. Roughly one-third (31 percent) of new HIV cases were considered late HIV diagnoses, having received an AIDS diagnosis within twelve months of their initial HIV diagnosis. Most newly diagnosed cases in Washington are White (non-Hispanic), male, or have a history of male-to-male sexual contact.

Table 1. HIV Diagnoses in Washington, 2002-2007

Year of HIV diagnosis:	Newly Diagnosed Cases of HIV Disease							Late HIV Diagnoses		
	2002 No.	2003 No.	2004 No.	2005 No.	2006 No.	2007 No.	2002-2006 No.	%	Rate	2002-2006 %
Total	568	563	558	570	553	613	2,812	100%	9.0	32%
Gender										
Male	481	475	468	489	469	511	2,382	85%	15.3	32%
Female	87	88	90	81	84	102	430	15%	2.7	33%
Age at HIV Diagnosis										
< 20	6	7	4	7	10	23	34	1%	0.4	---
20 - 29	131	112	132	123	141	161	639	23%	15.0	18%
30 - 39	235	232	187	203	179	180	1,036	37%	23.1	32%
40 - 49	138	151	173	164	146	155	772	27%	15.6	37%
50 - 59	43	46	55	58	61	70	263	9%	6.5	44%
60+	15	15	7	15	16	24	68	2%	1.4	54%
Race and Hispanic Origin										
White, non-Hispanic	356	358	348	350	358	362	1,770	63%	7.1	29%
Black, non-Hispanic	113	102	100	108	84	120	507	18%	44.2	36%
Hispanic (All Races)	57	65	61	72	66	92	321	11%	12.2	38%
Asian	21	15	19	21	26	24	115	4%	5.6	44%
Hawaiian/Pacific Islander	4	4	1	3	5	3	20	1%	1.0	---
Amer. Indian /Alaska Native	12	14	16	9	6	6	57	2%	12.1	39%
Multi-race / Unknown	9	5	13	7	8	6	42	1%	--	---
Exposure category										
Male/Male Sex (MSM)	325	333	313	298	316	340	1,585	56%	--	28%
Injecting Drug Use (IDU)	58	44	53	43	41	31	239	8%	--	35%
MSM and IDU	52	37	38	54	38	44	219	8%	--	18%
HR Heterosexual Contact	83	79	68	67	55	46	352	13%	--	39%
Pediatric	0	1	1	0	2	2	4	0%	--	---
Transfusion / hemophiliac	1	1	5	5	0	1	12	0%	--	---
No Identified Risk/ Other	49	68	80	103	101	149	401	14%	--	47%

Historically, Washington has observed slow but steady increases in the proportion of HIV cases diagnosed among women, racial or ethnic minorities, and those acquiring HIV through heterosexual contact. However, recent surveillance data indicate that such increases are no longer taking place.

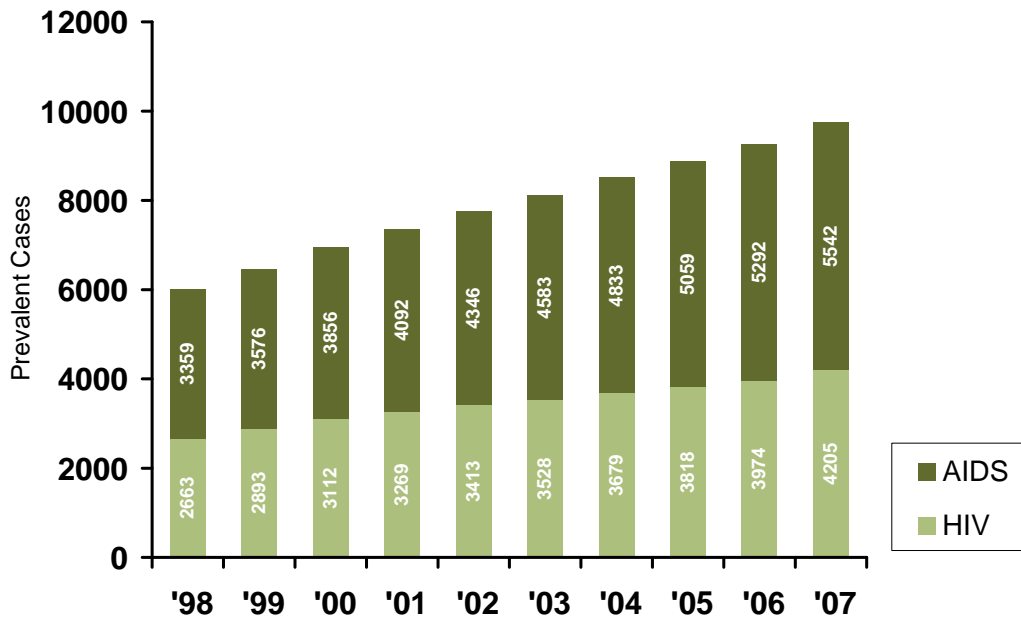
The proportion of HIV cases diagnosed among individuals below the age of 25 has increased in recent years, both inside and outside King County. Younger cases appear to be among men who have sex with men. Increased testing within this risk group may largely explain the proportionate rise in cases. Also on the rise, have been new diagnoses among people over the age of 45, which account for roughly a quarter of all new cases annually.

Although the proportion of new cases attributed to heterosexual contact appears to be stable, cases amongst heterosexual men who inject drugs exhibit a decreasing trend over time, especially outside King County.

Prevalence (Reported Cases)

Prevalence represents the number of cases of illness present in a population at a point in time. Despite decreases in AIDS diagnoses and AIDS deaths, the number of people living with HIV disease in Washington State continues to grow at a rate of about 5 percent per year (Figure 1).

Figure 1. People Living with HIV Disease in Washington, 1998-2007



As of December 31, 2007, there were 9,747 people living with HIV in Washington, 57 percent of whom had AIDS (Table 2).

Table 2. People Living with HIV Disease as of December 31, 2007

	HIV (not AIDS)			AIDS			All Cases of HIV Disease		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
Total	4,205	100%	64.8	5,542	100%	85.4	9,747	100%	150.2
Gender									
Male	3,579	85%	110.7	4,855	88%	150.1	8,434	87%	260.8
Female	626	15%	19.2	687	12%	21.1	1,313	13%	40.4
Current age									
< 20	52	1%	3.0	21	0%	1.1	73	1%	4.1
20 - 29	500	12%	54.3	185	3%	20.1	685	7%	74.4
30 - 39	1,222	29%	138.5	1,108	20%	125.5	2,330	24%	264.0
40 - 49	1,557	37%	159.5	2,413	44%	247.2	3,970	41%	406.7
50 - 59	690	16%	77.0	1,390	25%	155.2	2,080	21%	232.2
60+	184	4%	17.3	425	8%	40.1	609	6%	57.4
Race and Hispanic Origin									
White, non-Hispanic	2,972	71%	57.3	3,844	69%	74.1	6,816	70%	131.5
Black, non-Hispanic	629	15%	266.3	805	15%	340.8	1,434	15%	607.1
Hispanic (All Races)	378	9%	70.1	583	11%	108.2	961	10%	178.3
Asian / Pacific Islander	122	3%	28.3	162	3%	37.6	284	3%	66.0
Amer. Indian /Alaska Native	59	1%	60.2	104	2%	106.0	163	2%	166.2
Multi-race / Unknown	45	1%	--	44	1%	--	89	1%	---
Exposure category									
Male/Male Sex (MSM)	2,688	64%	--	3,345	60%	--	6,033	62%	---
Injecting Drug Use (IDU)	303	7%	--	508	9%	--	811	8%	---
MSM and IDU	312	7%	--	508	9%	--	820	8%	---
HR Heterosexual Contact	425	10%	--	596	11%	--	1,021	10%	---
Pediatric	34	1%	--	15	0%	--	49	1%	---
Transfusion / hemophiliac	21	0%	--	58	1%	--	79	1%	---
No Identified Risk/ Other	422	10%	--	512	9%	--	934	10%	---

About one third (37 percent) of the state’s prevalent HIV/AIDS cases reside outside of King County (Table 3). Within each AIDSNet region, the proportion of cases residing in the lead health district varies widely, from 100 percent in Region 4 to 42 percent in Region 6. The rate of HIV infection is highest in King County (AIDSNet Region 4), where there are approximately 185 HIV cases per 100,000 residents. Outside King County, Region 5 has the highest prevalence rate (99 per 100,000) followed by Region 6 (81 per 100,000).

Table 3. People Living with HIV Disease by AIDSNet Region and County as of December 31, 2007

	HIV (not AIDS)			AIDS			All Cases of HIV Disease		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
AIDSNet Region 1	186	4%	26.2	297	5%	41.8	483	5%	68.0
Adams Co.	1	0%	--	4	0%	--	5	0%	---
Asotin Co.	2	0%	--	10	0%	--	12	0%	56.3
Columbia Co.	1	0%	--	2	0%	--	3	0%	---
Ferry Co.	0	0%	--	1	0%	--	1	0%	---
Garfield Co.	1	0%	--	0	0%	--	1	0%	---
Lincoln Co.	0	0%	--	2	0%	--	2	0%	---
Okanogan Co.	7	0%	--	17	0%	42.7	24	0%	60.3
Pend Oreille Co.	0	0%	--	3	0%	--	3	0%	---
Spokane Co.	158	4%	35.0	218	4%	48.3	376	4%	83.3
Stevens Co.	7	0%	--	5	0%	--	12	0%	27.9
Walla Walla Co.	6	0%	--	24	0%	41.2	30	0%	51.5
Whitman Co.	3	0%	--	11	0%	--	14	0%	32.8
AIDSNet Region 2	146	3%	20.5	232	4%	32.6	378	4%	53.0
Benton Co.	32	1%	19.6	51	1%	31.3	83	1%	51.0
Chelan Co.	17	0%	23.9	20	0%	28.1	37	0%	52.0
Douglas Co.	2	0%	--	1	0%	--	3	0%	---
Franklin Co.	21	0%	31.2	31	1%	46.0	52	1%	77.2
Grant Co.	9	0%	--	17	0%	20.6	26	0%	31.5
Kititas Co.	4	0%	--	10	0%	--	14	0%	36.6
Klickitat Co.	7	0%	--	3	0%	--	10	0%	---
Yakima Co.	54	1%	23.1	99	2%	42.3	153	2%	65.3
AIDSNet Region 3	336	8%	31.0	504	9%	46.5	840	9%	77.5
Island Co.	16	0%	20.4	28	1%	35.7	44	0%	56.1
San Juan Co.	6	0%	--	7	0%	--	13	0%	81.8
Skagit Co.	23	1%	19.9	29	1%	25.2	52	1%	45.1
Snohomish Co.	237	6%	34.5	364	7%	53.0	601	6%	87.6
Whatcom Co.	54	1%	28.7	76	1%	40.4	130	1%	69.0
AIDSNet Region 4 (King Co.)	2699	64%	145.0	3442	62%	184.9	6,141	63%	329.9
AIDSNet Region 5	468	11%	45.2	561	10%	54.2	1,029	11%	99.4
Kit sap Co.	73	2%	29.8	103	2%	42.1	176	2%	71.9
Pierce Co.	395	9%	50.0	458	8%	57.9	853	9%	107.9
AIDSNet Region 6	370	9%	34.1	506	9%	46.7	876	9%	80.8
Clallam Co.	19	0%	27.7	22	0%	32.1	41	0%	59.9
Clark Co.	182	4%	43.9	215	4%	51.8	397	4%	95.7
Cowlitz Co.	39	1%	39.9	42	1%	42.9	81	1%	82.8
Grays Harbor Co.	15	0%	21.2	29	1%	41.0	44	0%	62.1
Jefferson Co.	11	0%	--	9	0%	--	20	0%	69.9
Lewis Co.	8	0%	--	17	0%	22.9	25	0%	33.7
Mason Co.	23	1%	42.1	54	1%	98.9	77	1%	141.0
Pacific Co.	12	0%	55.6	7	0%	--	19	0%	88.0
Skamania Co.	0	0%	--	2	0%	--	2	0%	---
Thurston Co.	60	1%	25.2	107	2%	45.0	167	2%	70.2
Wahkiakum Co.	1	0%	--	2	0%	--	3	0%	---
STATEWIDE TOTAL	4,205	100%	64.8	5,542	100%	85.4	9,747	100%	150.2

A higher proportion of prevalent cases in Region 4 are male (90 percent) versus those living elsewhere in the state (80 percent). Regardless of residence, most cases living across the state are White, non-Hispanic. Region 5 has the highest percentage of Black non-Hispanic cases (21 percent), while Region 2 has the highest percentage of Hispanic

cases (36 percent). Region 2 also has the highest proportion of female cases overall (26 percent).

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. Both inside and outside King County, the majority of prevalent cases are over the age of forty and nearly one-third are over fifty. Region 2 is the only AIDSNet in which more than 40 percent of prevalent cases are under forty years of age.

Statewide, men having sex with men remains the most commonly reported mode of HIV transmission. However, the proportion of prevalent cases attributed to men who have sex with men is much higher within King County (69 percent) vs. elsewhere (49 percent). Two exposure categories include men who have sex with men, those with and without a history of injection drug use. Cases living outside of King County are more likely than those within King County to have been attributed to either injection drug use or heterosexual contact. Region 5 has the highest proportion of prevalent cases attributed to injection drug use (17 percent). The proportion of prevalent cases attributed to heterosexual contact was highest in Region 2 (24 percent).

Emerging Trends

- Combined incidence of HIV/AIDS remains relatively stable at 600 per year.
- The proportion and number of female cases is gradually increasing.
- Men who have sex with men risk, as a proportion of all reported cases, is gradually decreasing; heterosexual risk is gradually increasing.
- Gradual increase in the proportion of cases reported among non-whites.
- The proportion of HIV cases diagnosed among individuals below the age of 25 has increased in recent years.

Implications for the Care Continuum

The total number of persons living with HIV/AIDS continues to increase 5 percent per year leading to rising caseloads and an increasing burden on existing resources. Additionally, the characteristics of persons seeking care are gradually shifting to include increasing numbers of people of color and women. These changes challenge care providers to become increasingly sensitive to culture and gender specific needs and to maintain a continuum of care for increasing numbers of clients within existing staff and financial resources.

The course of the HIV epidemic in Washington has been stable for nearly a decade. Nevertheless, both inside and outside King County, HIV prevention and care providers are sure to face new challenges in meeting the unique needs of a growing and aging population of HIV-infected people.

VII. Unmet Need

Estimation methods

Since 2003, Washington State's Part B and Part A grantees have convened an annual collaborative workgroup to address HRSA's Unmet Need Framework. The workgroup is comprised of Parts A and B grantee staff, HIV epidemiologists from Public Health – Seattle & King County and the Washington State Department of Health and HIV surveillance and special project staff. On at least a semi-annual basis, the workgroup reviews available data to inform the Unmet Need Framework and develops appropriate analysis and reporting methods.

In spring 2006, the workgroup reconvened to discuss refining unmet need estimates in light of Washington State's changing laboratory reporting requirements, information, and guidance provided by HRSA on previous unmet need calculations. The workgroup's consensus was to refine unmet need methodology to take advantage of comprehensive laboratory data to establish care patterns. Previous unmet need calculations relied on the Adult Spectrum of Disease study to adjust laboratory data to account for lab results not reportable under the old reporting criteria. As of September 2006, all CD4 and HIV viral load tests are reportable regardless of result. With a full year of comprehensive care pattern data now available, laboratory data serve as the primary source for determining unmet need. However, laboratory data are estimated to be 15 percent unreported, therefore raw lab match data are adjusted to account for under-reporting of data.

Data sources

- Washington State HIV/AIDS Reporting System (HARS)
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 HARS surveillance registry.

Denominator data for the Unmet Need Framework were calculated by adjusting HIV/AIDS surveillance data for estimated rates of completeness. Surveillance records were obtained 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, 2007. These data were extracted from the HIV/AIDS Reporting System (HARS). Data for the analyses included all cases reported to HARS through June 2008. Denominators for the unmet need analyses were calculated based on conservative estimates of the completeness of

reporting for HIV/non-AIDS cases (90 percent) and for AIDS cases (98 percent) provided by surveillance staff.

Laboratory reporting criteria as of September 2006 require all CD4 and viral loads to be reported to DOH, regardless of result. Care status patterns were obtained by matching comprehensive laboratory reporting data to HARS cases, adjusting for under-reporting 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 2007 (matched records from HARS and LTD) within the PLWH/A population were stratified in categories to estimate 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. Subsequent analyses will be adjusted as the completeness of comprehensive lab reporting improves.

Based on this methodology, the Department of Health estimates that 25.3 percent of Washington State's PLWH who are aware of their HIV+ status are not in care (Table 4). Data from MOSAICA, HRSA’s technical assistant partner, suggests that the range of unmet need across the country is 11-89 percent, with an aggregate estimate of 38 percent. In comparison, Washington State's unmet need estimate (25.3 percent) falls slightly lower than the mid-point of this spectrum, and is evidence of the relative success of the local continuum of care in enrolling and maintaining people living with HIV in primary care and prescription drug programs.

Table 4 – Percent of Persons in Care in 2007

Group	HIV		AIDS		Total	
	% in Care	% Unmet Need	% in Care	% Unmet Need	% in Care	% Unmet Need
All	67.2	32.8	81.0	20.0	74.7	25.3
Males	66.9	33.1	80.6	19.4	74.5	25.5
Female	68.7	31.3	83.6	16.4	76.1	23.9
White						
Total	70.0	30.0	81.6	18.4	76.3	23.7
Males	69.8	30.2	81.4	18.6	76.2	23.8
Female	71.6	28.4	83.8	16.2	77.4	22.6
Black						
Total	62.1	37.9	85.2	14.8	74.4	25.6
Males	58.7	41.3	85.7	14.3	73.7	26.3
Female	68.4	31.6	84.1	15.9	76.0	24.0

Group	HIV		AIDS		Total	
	% in Care	% Unmet Need	% in Care	% Unmet Need	% in Care	% Unmet Need
Hispanic						
Total	59.0	41.0	69.9	30.1	65.3	34.7
Males	56.7	43.3	69.1	30.9	63.9	36.1
Female	71.0	29.0	75.6	24.4	73.4	26.6
All Other*						
Total	59.8	40.2	84.1	15.9	73.0	27.0
Males	62.6	37.4	82.3	17.7	73.2	26.8
Female	49.8	50.2	90.0	10.0	72.7	27.3

* Other includes Asian, NH/OPI, Multiple and Unknown Race

Assessment of unmet need

Bivariate analyses of unmet need by sex, diagnostic status, race, or ethnicity and mode of exposure reveal:

- There is a difference in overall unmet need status by gender with females more likely to be accessing care than males (23.9 percent versus 25.5 percent unmet need respectively); however, this difference is not statistically significant.
- Persons with HIV, non-AIDS are significantly more likely than persons with AIDS diagnoses to have unmet care need (32.8 percent versus 19 percent, OR 2.0, 95 percent CI 1.9 to 2.2, $p < 0.001$).
- Latinos/Hispanics have a higher unmet need for primary care (34.7 percent) than other racial groups (significant at $p < 0.01$).
- No significant differences emerge among other racial groups, with 23.7 percent of Whites, 25.6 percent of Blacks, and 27.0 percent of persons of other races (Asians, Pacific Islanders and Native Americans) being not in care.
- No statistically significant differences are found in overall unmet need status by mode of exposure.

Washington State Department of Health anticipates working with the Unmet Need workgroup to develop future estimates and to continue to explore significant variations in unmet need by more sophisticated multivariate methods. Additionally, the Medical Monitoring Project, a CDC-sponsored behavioral and medical record abstraction project in which Washington State is participating, will continue maturing. This project will provide a representative sample of HIV-positive patients and HIV care providers that will allow the grantee to assess specific behavioral and structural barriers to care, a valuable complement to current unmet need estimates.

Washington State Unmet Need Framework Table for 2007

Population Sizes		Value	Data Source(s)
Row A.	Number of persons living with AIDS (PLWA), as of 12/31/2007 (reported through 11/2008)	5,263	HARS (HIV AIDS Reporting System) case registry, Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. HARS data are conservatively adjusted for estimated completeness of reporting (97% for AIDS, 95% for Non-AIDS HIV) and to estimate proportion of AIDS cases that 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 12/31/2007 (reported through 11/2008)	4,443	HARS (HIV AIDS Reporting System) case registry, Washington State Department of Health, Office of Infectious Disease & Reproductive Health, Assessment Unit. HARS 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 that 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 12/31/2006 (reported through 12/2007)	9,706	See Above
Care Patterns		Value	Data Source(s)
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period 1/2007 through 12/2007	4,264	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. The data have been estimated at 85% compete. Care patterns are established by matching unique individuals in LTD with HARS surveillance registry.
Row E.	Number of PLWH/ non-AIDS/ aware who received the specified HIV primary medical care during the 12-month period 1/2007 through 12/2007	2,986	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. The data have been estimated at 85% compete. Care patterns are established by matching unique individuals in LTD with HARS surveillance registry.
Row F.	Total number of HIV+/ aware who received the specified HIV primary medical care during the 12-month period 1/2006 through 12/2006	7,250	

Calculated Results		Value	Percent	Calculation
Row G.	Number of PLWA with no evidence of specified HIV primary medical care in 2007	999	19%	Row A - Row C, Percent Value: $(\text{Row E}/\text{Row A}) * 100$
Row H.	Number of PLWH/ non-AIDS/ aware with no evidence of specified HIV primary medical care in 2007	1,457	33%	Row A - Row C, Percent Value: $(\text{Row E}/\text{Row A}) * 100$
Row I.	Total HIV+/ aware with no evidence of specified HIV primary medical care (quantified estimate of unmet need for 2007)	2,456	25%	$(\text{Row A} + \text{Row B}) - (\text{Row F} + \text{Row E})$, Percent Value: $((\text{Row F} + \text{Row E})/(\text{Row A} + \text{Row B})) * 100$

VIII. Inventory of Available Resources

The following table summarizes available HIV-related resources in Washington State. It includes services provided, funding allocated, and number of clients served.

Services Provided	Amount	# of Clients Served
Part A - Public Health - Seattle & King County		
Ambulatory/Outpatient Medical Care	\$1,113,507	747
Food Banks/Home-delivered Meals	\$235,000	240
Housing Assistance/Housing-Related Services	\$893,671	613
Medical Case Management	\$1,451,099	2,123
Medical Nutrition Therapy	\$128,713	745
Medical Transportation Services	\$50,000	100
Mental Health Services	\$330,227	417
Oral Health Care	\$459,911	649
Outreach Services	\$40,000	100
Prescription Drug Program (ADAP)	\$249,652	35
Psychosocial Services	\$78,103	150
Substance Use Services (Outpatient)	\$243,736	160
Total	\$5,237,619	
Part A Minority AIDS Initiative		
Medical Case Management	\$226,814	148
Total	\$226,814	
Part B - Washington State Department of Health		
ADAP Funding		
AIDS Drug Assistance Program	\$4,421,665	4,026
Health Insurance	\$4,002,136	1,800
Ambulatory/Outpatient Medical Care	\$129,987	69
Emergency Financial Assistance (Medications)	\$28,200	63
Food Bank/Home-Delivered Meals	\$46,103	183
Health Insurance Premium Assistance	\$1,610	6
Housing Services/Housing-related Services	\$35,705	161
Linguistic Services	\$3,670	7
Medical Case Management	\$1,895,643	1,794
Medical Nutritional Therapy	\$3,575	20
Mental Health Services	\$124,174	284
Medical Transportation	\$51,134	442
Oral Health Care	\$73,778	177
Psychosocial Support Services	\$6,600	30
Substance Abuse Services - Outpatient	\$1,110	6
Treatment Adherence Counseling	\$21,889	13
Total	\$10,846,679	
Part B Minority AIDS Initiative		
Outreach to Increase ADAP Participation	\$37,078	22
Total	\$37,078	

VIII. Inventory of Available Resources, continued

Services Provided	Amount	# of Clients Served
Part C - Country Doctor Community Health Centers		
Primary care, RN clinical care coordinator, adherence counselor, medical case management	\$514,628	337 Primary Care Plus 35 Dental Care
Part C - Community Health Association of Spokane		
Primary care, dental, dental, mental health services, nutritional counseling, case management, pharmacy, labs, adherence counseling, DSHS on site	\$411,700	31 Dental 198 Medical
Part C - Harborview Medical Center/Madison Clinic		
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
Part C - Interfaith Community Health Center		
Primary care, dental, mental health services, nutritional counseling, case management, prescription drug coverage, labs, adherence counseling/support, access to clinical trials	\$451,349	140
Part C - New Hope Clinic/Yakima Valley Farm Workers		
Primary health care, medical, dental, PHN nursing case management, chemical dependency counseling, mental health, nutrition, adherence monitoring and management, pharmacy	\$347,315	224
Part D - Northwest Family Center		
Case Management	\$700,989	501
Psychosocial Support	\$117,693	231
Primary Medical Care	\$19,750	21
Outreach	\$21,375	40
Client Advocacy	\$33,116	170
Total	\$892,923	
AIDS Education and Training Center	\$2,328,146	1,887 health care providers
Housing Opportunities for Persons with HIV/AIDS (non King County)	\$622,000	643
Title X - Washington State Department of Health Family Planning and Reproductive Health Section		
Enhance HIV Prevention Services in Family Planning	\$584,000	4,254

IX. Summary of Existing Needs, Service Provision Issues, and Gaps

The following information is summarized from provider presentations the work group meeting and includes Ryan White HIV/AIDS Program grantees as well as other providers of services to HIV-positive individuals.

Part A Seattle TGA

Needs Identified in the 2007 Comprehensive Needs Assessment

Overview:

In 2007 Part A's needs assessment emphasized Core Services. Respondents chose services in two different lists. In the first, core service list, they could choose up to five services, and in the second support service list, they could choose three. Because of this change, data could not be compared with that of previous years.

Top Priorities:

1. Ambulatory/Outpatient Medical Care: Ranked second among providers (75 percent of providers chose this as one of their five core service priorities) and third among consumers (73 percent of consumers chose this as one of their five core service priorities) as a priority. However, only 4 percent of consumers and 9 percent of providers identified a gap in this service. Qualitative data suggest that the barrier to care has to do with mental health, addiction, and lack of housing, which keep some consumers from care.
2. Health Insurance: Consumers ranked health insurance first in priority (79 percent) and providers ranked it sixth (62 percent). Seven percent of consumers and 26 percent of providers identified this as a gap. However, providers perceived that increased state funding, and the opening of the Washington State High Risk Insurance Pool as covering this gap.
3. AIDS Drug Assistance Program: Consumers ranked the AIDS Drug Assistance Program second (75 percent) and providers ranked it fifth (65 percent) in importance. Fifteen percent of providers and 5 percent of providers saw this as a gap, however providers did not comment on the barrier they saw to consumers getting this service.
4. Medical Case Management: As a priority, consumers ranked medical case management fifth (57 percent) and providers ranked it third. Again, this was a low service gap, with 4 percent of consumers and 8 percent of providers identifying a gap. Providers noted an increase in required documentation as a barrier, while consumers noted that there was strain on the system with case managers having higher case loads, and there being a high turnover among case managers.
5. Housing Services: Housing services was the only support service to rank in the top five. Both consumers and providers listed housing as the number one support service priority. Forty-eight percent of consumers identifying this as one of their three support service priorities and 79 percent of providers doing the same. This service also ranked as a high gap, with 16 percent of consumers identifying it as a gap and 64 percent of providers doing so.

However, the majority of housing problems faced by consumers as identified in qualitative data were things that were outside of the power of Ryan White funding. Paramount among these was the barrier for people who had a criminal background. The Council chose to put a caveat on this category, which directs agencies to work together on this issue.

6. Oral Health Care: Prioritized fourth among consumers (66 percent) and seventh among providers (37 percent), Oral Health Care was the number one gap for both providers (57 percent) and consumers (33 percent). A new statewide method for addressing this problem is hoped to have an impact on the amount of available oral health care for HIV+ people in King County.
7. Mental Health Services: While there has historically been a great disparity between the ranking of this service among providers and consumers, both see it as an important service. Providers ranked it first (79 percent) and consumers sixth (31 percent), with both groups listing it as the number one gap (10 percent for consumers and 54 percent for providers). While providers noted an ongoing increase in patients with co-occurring mental health issues that interfere with HIV treatment, consumers noted the difficult interplay between mental health and substance abuse treatment as a barrier.

Part B - Washington State

Overview:

In 2008, Part B changed its needs assessment to mirror those made by Part A in 2007. The 2008 needs assessment gave emphasis to Core Services. Respondents could choose five services out of a list of 15 services. The services included the AIDS Drug Assistance Program, seven medical core services, and seven support services.

Washington State Department of Health conducted the survey between July 1, 2008 and August 31 2008. The results suggested that the Ryan White care system was doing a good job of ensuring care and core services. Key findings from consumer surveys included:

- Over half (53 percent) reported suffering from a mental health illness in the past year, including depression, anxiety, manic depression, obsessive compulsive disorder, post-traumatic stress disorder, and schizophrenia
- 44 percent had been diagnosed with AIDS
- 85 percent were taking at least one antiretroviral medication
- 87 percent had seen a physician in the last 3-months
- Top service priorities included HIV related prescription drugs, ambulatory/outpatient medical care, health insurance premium and cost sharing assistance, oral health care, and medical case management
- Top service gaps included oral health care, medical nutrition therapy, psychosocial support services, mental health services, housing services, and medical transportation.

Key findings from provider surveys

- Top service priorities included ambulatory/outpatient medical care, medical case management, HIV related prescription drugs, health insurance premium and cost sharing

assistance, mental health services, oral health care, and outpatient substance abuse services.

- Top service gaps included mental health services, oral health care, medical transportation, housing services, psychosocial support, and outpatient substance abuse services.

In terms of HIV prevention,

- 49 percent of consumers discussed sexual transmission of HIV with their primary medical provider; 36 percent had discussed sexual transmission of HIV with their case manager
- 23 percent of consumers discussed substance use and HIV transmission with their primary medical provider; 24 percent discussed substance use and HIV transmission with their case manager

Recommendations focused on:

- Assuring access to HIV medications
- Exploring differences in satisfaction with case management services and working to ensure that these services are available to all persons living with HIV who need them
- Reducing gaps in dental care
- Ensuring HIV prevention/harm reduction services for persons living with HIV
- Developing a more coordinated and comprehensive approach to addressing substance use and mental health issues.

Top Priorities:

1. AIDS Drug Assistance Program: Consumers ranked the AIDS Drug Assistance Program first (85 percent of consumers chose this as one of their five core service priorities) and providers ranked it third (71 percent of providers chose this as one of their five core service priorities) in importance. Three percent of consumers and 2 percent of providers saw this as a gap. Clients commented on how vital the Early Intervention Program, which administers Washington's AIDS Drug Assistance Program, is to their lives.
2. Ambulatory/Outpatient Medical Care: Consumers ranked ambulatory/outpatient medical care second (74 percent), while providers ranked it first (80 percent) as a priority. However, only 4 percent of consumers and 6 percent of providers identified a gap in this service. Clients and providers stated that living in rural areas is a barrier to medical care. Rural areas may not have local HIV specialist or a physician willing to take Medicaid.
3. Health Insurance: Consumers ranked health insurance third in priority (73 percent) and providers ranked it fourth (56 percent). Four percent of consumers and 9 percent of providers identified this as a gap. The majority of clients stressed the importance of the State's commitment to pay for health insurance premiums and Medicaid spenddown. Both providers and clients are frustrated with the application process. They would like better coordination between DSHS and the Early Intervention Program regarding spenddown and medically needy programs. Providers stated that the length of time it takes HIV/AIDS clients to apply for and receive disability income and dental care, multiplies all other problems and issues.

4. Oral Health Care: Consumers prioritized oral health care fourth (64 percent) and providers prioritized it sixth (31 percent). Oral health care was the number one gap for both providers (41 percent) and consumers (27 percent). Providers stated that a barrier to oral health care is the lack of dental groups willing to accept Medicaid coupons or become EIP providers.
5. Medical Case Management: Consumers ranked medical case management fifth (59 percent) and providers ranked it second (72 percent) as a priority. Again, this was a low service gap, with 4 percent of both consumers and providers identifying a gap. Providers noted an increase in required documentation as a barrier.
6. Emergency Financial Assistance (Medications): Consumers ranked emergency financial assistance sixth (34 percent) and providers ranked it eleventh (11 percent). Both consumers (8 percent) and providers (14 percent) ranked this seventh as a service gap.
7. Mental Health Services: While there has historically been a great disparity between the ranking of this service among providers and consumers, both see it as an important service. Providers ranked it fifth (53 percent) and consumers seventh (18 percent), with consumers ranking it fourth as a service gap (11 percent) and providers ranking it first (41 percent). Providers stated that access to good mental health therapy is limited, especially for Medicaid clients. Providers noted that mental health issues interfere with HIV medical treatment.
8. Food Bank/Home-delivered Meals: Consumers ranked food bank/home-delivered meals eighth by consumers as a service priority (16 percent) and providers ranked it thirteenth (4 percent). Eight percent of consumers and 10 percent of providers identified it as a gap.
9. Housing Services and Medical Transportation: While housing services and medical transportation tied as the ninth-ranked service priority among consumers (11 percent), providers ranked housing services eighth (16 percent) and Medical Transportation ninth (16 percent). Consumers also ranked these two services as equivalent gaps (10 percent). Providers identified medical transportation as a larger gap (35 percent) than housing (27 percent). Providers feel that housing is a growing need as there is little adequate and affordable housing for clients. As housing concerns become more important, health care becomes less important. Transportation is an issue for clients living in rural areas.
10. Substance Abuse Services – Outpatient: For this category, there was a large disparity in how consumers ranked this category. Consumers ranked it fourteenth (2 percent) and providers ranked it seventh (30 percent). Only 2 percent of clients identified it as a gap, while 17 percent of providers identified it as a gap.

Minority AIDS Initiative (Part B & A)

Service Provision Challenges

- 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 many 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

Service Provision Challenges

- Lack adequate resources (money and staffing) to extend services to all locations of the State where it is needed or requested
- Health coverage is complex and challenging for many patients to access and maintain
- Federally Qualified Health Clinics (FQHC) exist, however Washington needs many more. Nationally, the FQHC program is only funding the 200 poorest counties in the nation.
- Rural physicians are not taking any new Medicaid/Medicare clients, forcing more clients to turn to Part C clinics for services.
- Numbers of clients are increasing with no comparable increase in funding.
- HIV stigma continues to be an issue in rural communities, creating barriers to service.

Part D – Northwest Family Center

In 2007, Ryan White Part D Network served 910 HIV positive and 519 affected individuals. Of the total served 44 percent were white, while whites represent 70 percent of state population. Twenty-two percent of those served were black, while blacks represent 15 percent of the states population. Sixteen percent of those served were Hispanic, which slightly exceeds the number of Hispanics in the population of Washington (10 percent). In Washington State, 30.8 percent pf the population is 25-44 years old. Of the Network’s population, 60 percent are within that age range and 61 percent have contracted HIV through heterosexual transmission. The majority of clients served and resources are targeted to this population.

Service Provision Challenges

- Poor understanding of the needs of HIV-infected women, children and families (43 percent of whom live outside King County) and a lack of the services to meet these needs
- Increasing number of clients and flat or decreased funding, including reduced state and local resources
- Change in service provision necessitated by the increased caseload and decreased funding, i.e., the cessation of educational services in favor of case management services

Part F - AIDS Education & Training Center (AETC)

Educational Needs

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):

1. Nutrition for HIV-infected patients
2. Psychosocial issues of HIV disease
3. Risk assessment
4. HIV in patients with alcohol/chemical dependency issues
5. New/emerging treatment options for HIV
6. Cultural aspects of HIV care and treatment
7. HIV and women
8. Risk reduction
9. HIV in patients with mental health issues
10. Sexually transmitted infections in HIV-infected patients
11. HIV/Hepatitis C co-infection
12. Managing the newly diagnosed HIV-infected patient
13. Oral health & HIV
14. Counseling & testing (including rapid testing)
15. Sexual exposure prophylaxis
16. PEP
17. Case management
18. Prevention with positives
19. Complementary/alternative medicine and HIV
20. Co-managing HIV: Role of primary care providers

Provider Practice Pre-training Assessment Data: Selected Key Findings

1. Eighty percent of providers indicated that at least 1-24 percent of their patients were HIV-infected (N=156). Approximately 48 percent and 34 percent indicated that 1-24 percent of their HIV-infected patients are co-infected with Hepatitis C or TB, respectively.
2. About 27 percent of providers indicated that at least some percent of their patients aged 13-64 received opt-out testing (N=161)
3. Providers (N=513) rated their overall level of knowledge as basic (22 percent), intermediate (50 percent), or advanced (28 percent)

Existing Needs

1. 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
2. Ongoing HIV/AIDS training on a wide range of treatment topics in rural and other underserved health care settings
3. 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)
4. Health care provider education and training on the management of HIV-infected persons with multiple diagnoses

5. Trainings to understand the impact of patient use of alternative medications combined with antiretroviral treatment
6. Oral health and HIV training in primary care settings to diagnose and manage HIV-related oral lesions
7. Trainings on HIV in prisons and jails because of the increased number of HIV-infected inmates
8. Trainings that provide continuing education units across a range of professional disciplines

South Puget Intertribal Planning Agency (SPIPA)

Service Provision Challenges

- There is little culturally appropriate dissemination of HIV/AIDS information unless provided through specific American Indian/Alaska Native grants.
- There is a lack of connection between tribes and local health jurisdictions on HIV/AIDS information dissemination.
- Due to the limited amount of HIV information presented in a culturally competent way, tribes do not see themselves at risk for HIV infection and often do not clearly understand modes of transmission.
- Many 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.
- There is a lack of funding for testing, routine medical care, as well as for expensive HIV care. Most Indian Health Services' Clinics are funded at 60 percent capacity--meaning that 60 percent of staff performs 100 percent of the work--and are rated at Priority One, which means they can only serve patients with life-threatening illnesses.

Medicare/Medicaid

Service Provision Challenges

- A stable, aging population means more participants in Medicare and Medicaid.
- The new Medicare program means that specific HIV data will not be available to the HIV planning communities. 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.
- Case management is not popular with the federal agencies that question the cost-effectiveness of this service. It appears there is a move to medical case management.
- Federal grants to fill in the gaps are being eliminated. There is an expectation that states will step in and fund the gaps now.
- The federal administration is decreasing funding from Housing and Urban Development (HUD). There is an expectation that states and local jurisdictions will fund more programs for housing and homelessness.

XI. Cross-Cutting Goals and Issues

Based on the information presented during the SCSN work group meeting, members identified four crosscutting goals:

1. Provide a dynamic, client-centered continuum of HIV care that emphasizes core services
2. Address the service needs of underserved populations
3. Link prevention and care
4. Adapt to changing social and political landscape

These goals provide the framework for discussing relevant issues and gaps in HIV-related services in Washington State. Following each of the four crosscutting goals is a discussion of background information to support the goals, current and future strategies, and any identified service-related gaps. Ideally, grantees will use these crosscutting goals and strategies, where applicable, in the development and revision of their respective comprehensive plans.

1. Provide a Dynamic, Client-centered Continuum of HIV Care that Emphasizes Core Services

- a. Level or decreased funding coinciding with an increase in the number of clients and complexity of needs jeopardizes provision of a continuum of HIV care services that focus on core medical services.

Increase in number of clients

Statewide, annual numbers of new HIV diagnoses have been stable in recent years. Between 2003 and 2007, new HIV diagnoses averaged nearly 600 per year in Washington.

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 percent annual increase of people living with HIV/AIDS in Washington. However, funds are not always available to assist those into care. Ryan White HIV/AIDS Program funding for most of Washington's HIV/AIDS Programs has been level in the past few years. Connecting people to care and ensuring standard of care treatment has been challenging with flat level funding.

Range of services

To provide key services to all clients, agencies have limited the range of services provided. To compensate for the reduction in local level health and human support services, HIV-positive individuals are forced to rely on a continuum of care that extends beyond HIV-specific programs. If 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 HIV/AIDS 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/AIDS becomes even more important. HIV/AIDS 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 experiences and special study results all reflect an increasing number of HIV-positive individuals who have multiple diagnoses such as mental health illness, illegal substance use/abuse, hepatitis C infection. A majority of clients are also below 100 percent and 200 percent 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/AIDS care and treatment regimen.

b. Continue to align with the Ryan White HIV/AIDS Program

The Ryan White HIV/AIDS Program is based on the following principles²:

- Serve the neediest first
- Focus on life-saving and life-extending services
- Increase prevention efforts
- Increase accountability
- Increase flexibility targeting primary care sites to previously underserved areas

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 of care encompasses outreach, case findings, and primary, secondary, and tertiary prevention. The continuum of care may require coordination of long-term care, primary care, therapy, non-medical services, public benefits, insurance, and legal services.³

c. Identify non-HIV specific, under-utilized resources.

As HIV disease progresses, many persons become disabled or lose their jobs, and rely on public entitlement or private disability programs for income and health care benefits. These programs include Social Security Disability Income and Supplemental Security Income. Medicare and Medicaid are primary payers for health care because of the onset of disability and depletion of personal funds.

² United States Department of Health & Human Services Fact Sheet, "Ryan White Care Act Reauthorization Principles," July 27, 2005.

³ Shi, L. and Singh, D. 2004. Delivering Health Care in America, A Systems Approach. Jones & Bartlett Publishers.

HIV service providers and programs are now collaborating with health and human service systems by applying for funding from sources that had not been recognized as an “HIV funding source” in the past. For example:

- HIV providers are receiving funding for seniors or refugees with HIV from programs that work with seniors or with refugees and have not traditionally funded HIV programs.
- Providers are recognizing the importance of case conferencing with the other programs and providers working with their clients who have co-morbidities and multiple diagnoses, even in non-clinical settings.
- Providers are enhancing collaboration with service providers such as Title X family planning programs, Department of Social and Health Services’ Aging and Adult Services Administration, Vocational Rehabilitation, and Division of Alcohol and Substance Abuse; Veterans Administration; Department of Corrections; mental health services; and local housing authorities.
- Providers are increasing knowledge about specific program components among external health service providers to improve continuum of care.

The Ryan White HIV/AIDS Programs in the State of Washington 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.

d. Address the statewide funding crisis in Public Health

There is currently only 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/AIDS 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.

There is no taxing authority for public health. Cities are not required to contribute. County authorities are required only to provide for support for TB services. Funding each year for public health must come from the Legislature through the state budget process.

The needs exceed the taxing authority (incorporation into cities). Cities do not have to contribute to basic services. 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/child health issues there are reductions statewide in maternity support services and WIC. Immunizations are being reduced or eliminated for low-income consumers, including those with HIV.

e. Adapt the care continuum to reflect data-driven client needs (system accountability)

The current HIV care continuum tends to reflect historically evaluated client needs. The system of HIV care in Washington State 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 upon the most empirical data and information reflective of current client needs. The process includes:

- Integrate client-level data collection and analysis into service planning and provision.
- Coordinate the comprehensive needs assessment across the state and across all parts, particularly Ryan White HIV/AIDS Program Parts A and B.

2. **Address the Service Needs of Underserved Populations**

a. Identify the populations

Increase ability to conduct Unmet Need analyses

In a system of care with increasing caseloads and decreasing resources, focusing on clients already accessing the system is often the priority of most providers. It is difficult to conduct effective outreach to hard-to-reach populations who need HIV care the most--and need the most care.

Conduct cross-cutting Needs Assessment to stratify results by populations

Identify possible demographic and geographic factors including race, age, gender, ethnicity, language, geography, and country of origin

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 aging and disease-specific needs.

Men who have sex with men continue to be the majority of clients in Washington State. 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.⁴ Coming from an economically disadvantaged background may further compound the effect of HIV. Navigating the continuum becomes problematic by itself. Finding culturally competent care and services is an additional challenge.

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.

Identify possible institutional factors including incarceration, homelessness, mental health, and substance use

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 underlying issues often cannot be addressed when an individual is not in stable housing.⁵

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 and/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.

An increasing number of dually and multiply diagnosed people living with HIV are in care, and providers report seeing more clients with severe mental health issues. Many of these clients have difficulty navigating the systems of care. The spectrum of services available is limited due to the unique needs of these clients. For example, housing for

⁴ Priscella, et. Al. 1996. Women living with HIV infection. Nursing Clinics of North America 31(1):97-104.

⁵ "2004 Seattle-King County HIV/AIDS Housing Plan," Prepared by: AIDS Housing of Washington; Prepared for: City of Seattle, Human Services Department, September 2004.

clients with a history of chemical dependency is limited. Because of the complexity of these clients, more time and money are required.

Use client level data to determine service deficiencies

b. Plan a coordinated response

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 or marginal 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 restrictions⁶.

The HIV epidemic in Washington State is increasingly rural (70 percent of people living with HIV/AIDS lived in the Seattle area in 1982-89 versus 64 percent in 2002-2004) but is still not at a “critical mass” necessary to see funding allocation shifts. Increased costs in urban areas force patients 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. In 2001, half of Washington’s rural counties had no public transportation services, and routes were very limited in many rural areas of urban counties.

- Identify providers willing to fill service gaps by type, geography, skill set, and practice setting.
- Identify public resources to provide services such as Ryan White funding across all parts, Medicaid, Medicare, Veteran’s Administration, state funding, and local funding.
- Identify independent funding sources to provide services such as other grants and private insurance.
- Build and assure sustainability of resources

c. Staged implementation plan

- Shore up existing, successful services

⁶ Schueler, Vince; *Access to Primary Care Physicians For Medicare and Medicaid Patients in Context: A Comprehensive Assessment in Twelve Washington State Counties*, Office of Community and Rural Health, Washington State Department of Health, July 2003.

- Identify areas of expansion
 - Identify areas of new service delivery by geography, population, type of service
- d. Provide technical assistance where necessary
- Provider training
 - Information technology infrastructure
 - Quality management, quality improvement, and quality assurance

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.

3. **Linking Prevention and Care**

a. Increasing burden

The increasing number of people living with HIV has resulted in an increased demand for care services and an increase in potential HIV transmission or HIV reinfection. Integrating prevention messages into the care setting is critical but difficult because of the need for providers to focus on the most critical care needs as a priority.

b. Funding disparity--care vs. prevention

Prevention programs are traditionally funded at a much lower rate than care and treatment programs. Since 1990, prevention dollars nationally have increased from approximately \$225 million to approximately \$695 million. Care and treatment dollars in the Ryan White HIV/AIDS Program alone have increased from \$400 million to \$2.2 billion. Some prevention providers have indicated they do not want to use their limited resources to offer prevention interventions to HIV-positive clients because of this disparity.

c. Lack of time for prevention interventions in core medical service settings

Core medical service providers are finding themselves forced to continually reduce the length of time allowed with a client because of increasing client load, decreasing cost reimbursement by health care financing entities, and data reporting requirements. Because a high percentage of clients present with complex care needs, including multiple morbidities, there is little time to fit prevention interventions into client visits.

d. Lack of prevention interventions and cultural fluency in core medical service settings

There are a series of secondary issues related to a lack of evidence-based prevention models in care settings, all of which create significant barriers to providing prevention interventions as a component of HIV care and treatment:

- HIV core medical service providers lack support with integrating prevention messages in care settings.
- Care provider expertise on the evidence-based prevention models for care settings that do exist is limited. Extensive training will need to happen to assist care providers to utilize proven models.
- Sex is not seen as essential or a vital part of health, especially in the care setting. Of 301 providers surveys in Washington State, 68 percent indicated they do not conduct a routine sexual history with their patients; 31 percent conducted a sexually history only with sexually active adults.
- Prevention messages that do exist in care settings are the “weaker” portion of care services.
- Models do not generally exist or do not work well in all communities.
- There is a lack of knowledge by providers on how to perform prevention with diverse populations.
- Inexperienced providers dealing with a higher risk population of clients with underlying mental health and substance use issues are even less likely to have the skills to provide prevention intervention services to these clients.

e. Minimal integration/co-location of care/prevention services

There are very few examples of integrated or co-located care/prevention services across the state. The majority of CDC-funded prevention programs are located in community-based prevention agencies and health departments as opposed to clinical settings and/or 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.

f. Enhance HIV testing

- While rapid testing has a great deal of value in identifying HIV-positive individuals in non-traditional settings, this also creates a challenge in immediately engaging these individuals in care services. This challenge requires even greater collaboration between the agencies doing the rapid testing and the HIV care providers.
- HIV testing is not available in non-traditional care settings such as substance abuse treatment and mental health facilities.
- Routine health care does not consistently include HIV testing.

g. Adapting HIV prevention messages

One type of prevention message or intervention does not work for everyone. HIV is a chronic disease. Prevention interventions for HIV+ individuals must be dynamic and respond to cultural constructs as well as changing needs over a long period.

h. Late diagnosis for lower prevalence populations

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 are shifting their focus, based on the HIV epidemiology in the state, toward the HIV groups with the highest prevalence. This means that fewer prevention services are targeting younger populations and emerging populations with lower prevalence, resulting in late diagnosis and late entry into care for these groups.

4. **Adapt to Changing Social and Political Landscape**

a. Impact of poverty

In the current economic crisis, 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.

b. Statewide standards of care for HIV care services

Washington helps assure that HIV-positive individuals and their families receive high quality, professional, cost-effective, and appropriate services funded under the Ryan White Program. Washington State implemented standards of care for HIV case management services in April 2007. Washington is working to expand the standards of care to include all core medical services.

c. Move towards increased quality management and system accountability

Washington State is implementing a statewide, cross-part electronic client-level data reporting system. We are in a position to enhance the quality and usefulness of outcomes-based reports and communications about the state of the HIV continuum to community partners and to provide appropriate information to policy makers. The grantee welcomes the assistance of HRSA in this process, including standardized data reporting requirements across all Ryan White Program parts

d. Reduced federal funding may create lack of safe and affordable housing

A decrease in Housing & Urban Development (HUD) federal funding, combined with increasingly complex physical, emotional, and behavioral health issues and increased housing costs, has resulted in more HIV-positive individuals facing homelessness.

e. The Sunset of the Ryan White Program in 2009

The Ryan White Program will sunset in October 2009 and this has an unknown impact on the current system of care for HIV+ individuals.

f. Stigma

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 care.

g. Policy Development

Washington is aware that Congress may debate new healthcare reform legislation that could improve HIV+ individuals' access to ongoing healthcare.

XI. References

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For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).