SEATTLE TRANSITIONAL GRANT AREA COMPREHENSIVE CARE PLAN 2009-2011

SEATTLE TRANSITIONAL GRANT AREA
THREE YEAR COMPREHENSIVE CARE PLAN
2009-2011

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400 Yesler Way, Third Floor, Seattle, Washington 98104
Phone (206) 296-4527 Fax (206) 205-5281

Officers:
Higinio Martinez
Tony Radovich
Erick Seelbach
Robert W. Wood

Members:
Richard Aleshire
Amy Bauer
Charlie Curvin
Shireesha Dhanireddy
Philip Doles
Kathleen Elling
Brandie Flood
Melinda Giovengo
Joseph Grant
Bill Hall
Sarah Kent
Kieu-Anh King
Gerrie LaQuey
David Lee
Marcos Martinez
Eric Miles
Andrew Murphy
Ruth Njoroge
Kris Nyrop
Arthur Padilla
Ron Padgett
Kevin Patz
Jodie Pezzi
Michael Raitt
James Redel
David Richart
German Rodriguez
Pam Ryan

December 8, 2008

Doug Morgan
Director, Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane 7A-55
Rockville, MD 20857

Dear Mr. Morgan:

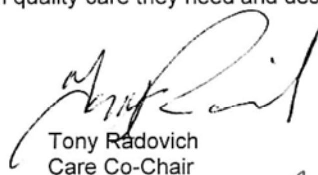
On behalf of the members of the Seattle HIV/AIDS Planning Council, we are writing this letter of concurrence to indicate the Council's commitment to carrying out the goals, objectives and activities listed in this 2009-2011 Comprehensive Care Plan. We are aware that the Ryan White Treatment Modernization Act is due to be reauthorized in 2009. However, we feel that, regardless of the outcome, we will be able to ensure that the following goals are addressed:

- The Council and Grantee will know all of the HIV-related needs, gaps, barriers and service utilization of people living with HIV/AIDS and the service capacity;
- There will be no significant gaps in the highest ranked core services;
- There will be no people living with HIV/AIDS without access to the highest ranked core services and the profile of service utilization will favor disproportionately affected and historically underserved populations;
- Services paid for by Ryan White dollars will continue to be of high and ever improving quality;
- To the greatest extent possible, there will be seamless coordination between Ryan White Part A care and other services;
- The Council and Grantee will be aware of and responsive to changes in the HIV+ population and the surrounding funding and care environment;
- This plan will be completed in three years.

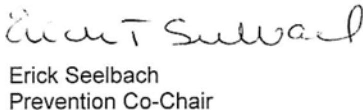
The Seattle TGA has a history and commitment to the needs of PLWH/A, and a track record of innovation which ensures high quality care. By following this plan we will continue to ensure that all PLWH/A get the high quality care they need and deserve.

Sincerely,

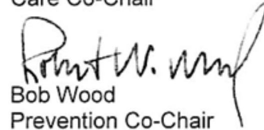
Higinio Martinez
Care Co-Chair



Tony Radovich
Care Co-Chair



Erick Seelbach
Prevention Co-Chair



Bob Wood
Prevention Co-Chair

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Seattle Transitional Grant Area
HIV/AIDS PLANNING COUNCIL
Comprehensive Plan 2009 – 2011

COUNCIL CO-CHAIRS:

Higinio Martinez
Erick Seelbach
Tony Radovich
Bob Wood

SEATTLE TGA HIV/AIDS PLANNING COUNCIL

Richard Aleshire
Amy Bauer
Charlie Curvin
Shireesha Dhanireddy
Philip Doles
Kathleen Elling
Brandie Flood
Melinda Giovengo
Joseph Grant
Bill Hall
Sarah Kent
Kieu Anh King
Gerrie LaQuey
David Lee
Higinio Martinez
Marcos Martinez
Eric Miles
Andrew Murphy
Ruth Njoroge
Kris Nyrop
Arthur Padilla
Ron Padgett
Kevin Patz
Johanna Pezzi
Tony Radovich
Michael Raitt
James Redel
David Richart
German Rodriguez
Pam Ryan
Erich Seelbach
Bob Wood

PLANNING COUNCIL STAFF

Jesse Chipps, Planning Council Administrator
Courtney Speigner, Planning Council Administrative Specialist

PUBLIC HEALTH-SEATTLE & KING COUNTY

Robert W. Wood, MD, Director, HIV/AIDS Program
Frank Chaffee, Manager, HIV/AIDS Program
Jeff Natter, Ryan White Program Manager
Becca Hutcheson, Quality Management Program Manager

Seattle Transitional Grant Area
Comprehensive Plan 2009 – 2011

INTRODUCTION

In the Seattle Transitional Area (TGA) Part A funds are overseen by the Seattle HIV/AIDS Planning Council (Council) which assesses need, prioritizes services and allocates dollars to services, and by the Ryan White Program of Public Health-Seattle & King County (Grantee) which procures services, monitors agencies and conducts quality management activities. This plan describes the activities that the Grantee and the Council will undertake over the next three years in order to maintain and improve high quality care services and address emerging needs.

This plan is beginning in the midst of an economic downturn that will affect many funding streams and many systems that provide care for people living with HIV/AIDS (PLWH). Ryan White dollars have historically been used to fill gaps in these programs and it is clear that those gaps will grow. These challenges will not, however, change the underlying principles that the Council and Grantee use to inform their work. The Council and Grantee have a track record of moving quickly to address emerging needs, while carefully thinking through the effects of their actions. By adhering to these core principles, the TGA will continue to provide the highest quality core services to PLWH in need.

This plan is a work in progress, and will be revisited and revised in response to changing circumstances, including potential changes to the Ryan White legislation in 2009.

EXECUTIVE SUMMARY

Background

The Seattle Transitional Grant Area (TGA) includes King, Snohomish and Island Counties along the northwestern coast of Washington State, on Puget Sound. The Seattle HIV/AIDS Planning Council (Council) is responsible for planning, assessment, prioritization and allocation of federal and some state dollars for HIV prevention and care in King County. The Ryan White Part A Grantee (Grantee) is responsible for procurement, contract monitoring, evaluation and quality management for care services in the county. This plan addresses the work in care services that the Council and Grantee will complete over a three year period, from 2009 through 2011. For the purpose of apportioning prevention and care dollars, Washington State is divided into six AIDSNet regions. King County is Region 4, and Island and Snohomish Counties are in Region 3. Part A and B dollars are pooled and allocated based on living HIV cases. The result is that the majority of Part A dollars are used in King County, with a small portion going to Region 3 for use in Snohomish County. Snohomish County has its own planning process.

The epidemic has steadily grown over the last decade and as of December 31 2007 there were 6,791 PLWH, 0.26% of the TGA's population. Public Health – Seattle & King County's HIV/AIDS Epidemiology Unit estimates that there are an additional 1,237 persons who are infected but don't know their status, and 600 persons diagnosed in other parts of the country who receive care here but are not included among the TGA's reported cases. Prevalent cases are 89% male and 11% female; 69% White, 16% Black, 9% Hispanic, 3% Asian or Pacific Islander and 1% Native American or Alaskan Native. Foreign born PLWH represent 14% of prevalent cases. Seventy-four percent of PLWH live in Seattle, 17% live in other parts of King County, 9% live in Snohomish County and less than 1% live in Island County. Men who have sex with men (MSM) account for 73% of prevalent cases, 11% are among heterosexuals, 9% are men with both MSM and injection drug use risk factors (MSM/IDU) and 6% are among injection drug users (IDU). Populations disproportionately affected by HIV/AIDS in the TGA include MSM/IDU, who have an estimated rate of 24.8% per 100,000, followed by MSM with a rate of 15.8%; this compares to 3.8% or lower for other at-risk populations. Foreign born Blacks and native born Blacks have rates three to five times that of Whites. Hispanics and Native Americans have 1.5 the rate among Whites. Populations that have seen an increase in cases over time include those who are foreign born, over age 45, Asian/Pacific Islander, Hispanic, MSM/IDU and residents of King County who live outside of Seattle.

The Plan and Justification

The Council and Grantee will continue to ensure access to high quality core medical services for all PLWH in King County. This will be done based on carefully collected data which will include client-level data for outpatient/ ambulatory medical care beginning in 2009. The Council will accomplish the seven goals on the right between 2009 and 2011. This plan will both continue the exemplary work already taking place, while continuing to improve quality, increase accountability, and address internal and external changes.

Goal 1: *The Council and Grantee will know the HIV-related needs, gaps, barriers and service utilization of PLWH and the service capacity in the service area.*

Goal 2: *There will be no significant gaps in the highest ranked Core Services.*

Goal 3: *There will be no PLWH without access to the highest ranked Core Services, and the profile of service utilization will favor historically underserved and disproportionately affected populations.*

Goal 4: *Services paid for by Ryan White dollars will be of high and ever improving quality.*

Goal 5: *To the greatest extent possible, there will be seamless coordination between Ryan White Part A care and other services.*

Goal 6: *The Council will be aware of and responsive to changes in the HIV+ population and the surrounding funding and care environment.*

Goal 7: *This plan will be completed in three years.*

SECTION I

WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

A. DESCRIPTION OF THE SEATTLE TRANSITIONAL GRANT AREA (TGA)

The Seattle TGA is comprised of King, Snohomish and Island counties, which cover over 4,400 square miles in Western Washington. With a total population of 2,577,477 (US Census Bureau, 2005-2007 American Community Survey) the TGA is home to 40.5% of the state's population and 69% of prevalent HIV and AIDS cases. These three counties are composed of dense urban areas as well as suburban and rural areas. The most densely populated county is King, which includes Seattle, and has 29% of the state's population and 71% of the TGA's population. Snohomish County has 26% of the TGA's population. Three percent of TGA residents live in Island County. Racial composition varies greatly within the TGA. King County is the most racially diverse, with 27% of the population being non-white. Snohomish County is 18% people of color and Island County is 12% people of color. Asians and Pacific Islanders are the largest people of color population in the TGA (12%) followed by Hispanics (7%) and African-Americans (5%). The largest urban center in the TGA is Seattle, which is on the western coast of King County, on Puget Sound.

The Seattle TGA consists of three counties: Island, Snohomish and King

At first look, the TGA is affluent; King County is home to Microsoft and other technology industries, as well as well as one of the largest philanthropic organizations, the Bill and Melinda Gates Foundation. All three counties in the TGA have median incomes above the national average, with King County having the largest median income of $64,915, in comparison to the nation's median of $50,007. A smaller percentage of individuals in the TGA live below the Federal Poverty Level (FPL) than the national average of 13.3%. King County has the highest rate of individuals living below FPL within the TGA (9.8%). However, with wealth come higher costs, and therefore a larger gap between rich and

poor. The average value of a home in the TGA is $368,702 which more than twice the average of $181,800 for the country as a whole. This disparity is especially striking in King County, where the average home value is $389,200. The median monthly home owner costs in King County, including mortgage, are $1,993, compared to $1,427 in the country as a whole. There is a shortage of housing in the TGA; the vacancy rate is 6.5% compared to the nation's 11.6%, and a higher percentage of people rent, rather than own their homes (36.1% compared with 32.7% nationally).

These disparities have led to a high level of homelessness. According to King County's "Ten-Year Plan to End Homelessness: 2007 Annual Report," it is estimated that 8,400 King County residents are homeless on any given night. Over the course of one year, approximately 24,000 people in King County will have experienced at least one episode of homelessness. Persons of color are disproportionately affected by homelessness. While people of color comprise 22% of the TGA population, they represent 61% of those who are homeless.

In addition to these cost factors, providing services is complicated by the diversity of the population. While the TGA has fewer non-White residents than the country as a whole, a greater percentage of its residents are foreign born. While 12.5% of the nation as a whole is foreign born, that population makes up 19% of King County. According to 2004 school assessment data, 13.3% of all students in Seattle Public Schools have limited English proficiency. Further, foreign born persons are a diverse population; 118 different languages are spoken in homes in King County.

A.2. DESCRIPTION OF THE PART A PROGRAM

Please see parts E and F for a description of currently funded programs.

Public Health – Seattle & King County (Public Health) is the fiscal agent for Ryan White Part A and Minority AIDS Initiative (MAI) funds. Public Health's HIV/AIDS Program (HAP) is the specific unit within the department responsible for administering the Part A and MAI grants. The HIV/AIDS Program is situated within Public Health's Prevention Division, which encompasses a broad range of programs addressing health issues and behaviors, including HIV/AIDS, STDs, tobacco and other drugs, and other chronic and acute disease prevention.

The Ryan White Program Manager (Natter; 1.0 FTE, 0.8 FTE funded by Part A) assumes primary responsibility for overseeing all aspects of procurement, monitoring and contract compliance for the Part A grant, and is responsible for writing the annual Part A application to HRSA and responding to various Conditions of Award during the contract year. The Program Manager is under the supervision of the HIV/AIDS Program Manager (Chaffee; 1.0 FTE, 0.2 FTE funded by Part A), who also oversees

HIV prevention and education programs and HIV/AIDS epidemiology. Other key personnel associated with the Part A program include:

- Contract and Program Monitor (Coomas; 1.0 FTE, 0.6 FTE funded by Part A), responsible for developing contract documents and contract monitoring,
- Contract and Revenue Monitor (Manaro; 1.0 FTE, 0.6 FTE funded by Part A), responsible for processing invoices from all Part A sub-contractors and tracking internal Part A and MAI budget allocations and expenditures,
- Quality Management Program Manager (Hutcheson; 1.0 FTE, 0.9 FTE funded by Part A), responsible for overseeing the Part A Clinical Quality Management program, and
- Administrative Specialist (Hines; 1.0 FTE, funded entirely by Part A) responsible for general office functions and minute-taking at all Part A-related meetings.

The Council, as defined by congressional mandate and HRSA guidance, is a community body of up to 40 members. The Council is comprised of no less than 33% of persons living with HIV/AIDS, as well as service providers in the HIV/AIDS Continuum of Care, members filling representation slots as defined by HRSA and professionals with other related backgrounds and skills. The Council prioritizes care services, allocates categorical HIV care service funds, conducts community needs assessments, conducts Continuum-wide resource and program planning and evaluates the administrative mechanism of the Grantee (Public Health). The Seattle Planning Council is a joint Part A and CDC prevention planning body. Staff to the Council includes the Council Administrator (Chipps; 1.0 FTE, 0.7 funded by Part A), HIV/AIDS Epidemiology staff in charge of conducting care services needs assessments (Barash; 1.0 FTE, 0.25 funded by Part A) and the Administrative Specialist (Speigner; 1.0 FTE, 0.7 FTE funded by Part A).

B. Epidemiological Profile

B.1. Current Local Epidemic

According to 2007 data from Public Health's HIV/AIDS Epidemiology Unit, 6,791 persons were reported as living with HIV infection in the Seattle TGA as of December 31, 2007, or 0.26% of the TGA population. The Epidemiology staff use surveillance data to assess migration patterns, which has allowed them to determine that the TGA has a net increase of 9% or more than 600 additional PLWH receiving services. Although only 40.5% of Washington State's total population lives in the TGA, it is home to over 69% of the CDC-defined cumulative HIV/AIDS cases in Washington.

Total Prevalence of PLWHA, AIDS Prevalence and HIV (not AIDS) Prevalence by Demographic Group and Exposure Category
Transitional Geographic Area (TGA): Seattle, Washington

(Data source: HIV/AIDS Epidemiology Unit, Public Health – Seattle & King County)

Demographic Group/ Exposure Category	TOTAL PLWHA AS OF 12/31/07		AIDS PREVALENCE AS OF 12/31/07		HIV (Not AIDS) Prevalence AS OF 12/31/07	
Race/Ethnicity	Number	% of Total	Number	% of Total	Number	% of Total
White, not Hispanic	4708	69%	2637	69%	2071	70%
Black, not Hispanic	1083	16%	624	16%	459	16%
Hispanic	627	9%	380	10%	247	8%
Asian/Pacific Islander	211	3%	112	3%	99	3%
American Indian/Alaska Native	97	1%	64	2%	33	1%
Multi-Race	53	1%	31	1%	22	1%
Unknown	12	0%	0	0%	12	0%
Gender	Number	% of Total	Number	% of Total	Number	% of Total
Male	6058	89%	3438	89%	2620	89%
Female	733	11%	410	11%	323	11%
Current Age (Years)	Number	% of Total	Number	% of Total	Number	% of Total
< 13 years	15	0%	2	0%	13	0%
13 - 19 years	18	0%	6	0%	12	0%
20 - 44 years	3510	52%	1688	44%	1822	62%
45+ years	3248	48%	2152	56%	1096	37%
Age at Diagnosis (Years)	Number	% of Total	Number	% of Total	Number	% of Total
< 13 years	31	0%	6	0%	25	1%
13 - 19 years	64	1%	11	0%	53	2%
20 - 44 years	5540	82%	3041	79%	2499	85%
45+ years	1156	17%	790	21%	366	12%
Birthplace and race / ethnicity	Number	% of Total	Number	% of Total	Number	% of Total
foreign-born Black	375	6%	225	6%	150	5%
foreign-born other	580	9%	361	9%	219	7%
native-born Black	674	10%	392	10%	282	10%
native-born other	4824	71%	2691	70%	2133	72%
unknown birthplace	338	5%	179	5%	159	5%
Residence at diagnosis	Number	% of Total	Number	% of Total	Number	% of Total
City of Seattle	5002	74%	2779	72%	2223	76%
King County outside Seattle	1143	17%	673	17%	470	16%
Snohomish County	603	9%	368	10%	235	8%
Island County	43	1%	28	1%	15	1%
Exposure Category	Number	% of Total	Number	% of Total	Number	% of Total
Men who have sex with men (MSM)	4930	73%	2690	70%	2240	76%
Injection drug users (IDU)	423	6%	269	7%	154	5%
MSM and IDU	604	9%	380	10%	224	8%
Heterosexuals	753	11%	465	12%	288	10%
Adult transfusion/blood exposure	46	1%	34	1%	12	0%
Mother with/at risk for HIV infection	33	0%	9	0%	24	1%
Pediatric transfusion/blood exposure	2	0%	1	0%	1	0%
TOTAL	6791	100%	3848	100%	2943	100%

PLWHA= People Living With HIV/AIDS

1. No adjustments were made for delays in reporting.
2. Heterosexual cases include 146 that meet the presumed heterosexual definition adopted in 2006 by the Council of State and Territorial Epidemiologists.
3. 448 cases with unidentified exposure category were redistributed proportional to cases reported with known exposure.

HIV/AIDS has had a significantly disproportionate impact on several sub-populations within the TGA (see Table A, on the next page): Blacks (particularly foreign born Blacks), Hispanics, males, MSM, MSM/IDU and Seattle residents.

Foreign born Blacks have the highest rate among all groups, five times higher than among Whites. The rate among native born Blacks is three times and for Hispanics or Native Americans it is 1.5 times, that of Whites. Although Seattle has only 23% of the TGA's population, it has 74% of prevalent HIV/AIDS cases. Cases also reveal a gender disparity in that males make up half of the population but 89% of persons living with HIV/AIDS.

TABLE A: POPULATIONS AND RATES OF PERSONS LIVING WITH HIV OR AIDS HIGHLIGHTING DISPROPORTIONATE PERCENTAGES AND INFECTION RATES (2007)

	TGA POPULATION 7/1/2007	PERCENT OF TOTAL POP.	LIVING WITH HIV/AIDS	PERCENT OF TOTAL PLWHA	RATE PER 100,000 POPULATION
TOTAL	2,617,508	100%	6,791	100%	259.4
Male	***1,308,875***	***50%***	***6,058***	***89%***	***462.8***
Female	1,308,633	50%	733	11%	56.0
White non-Hispanic	1,889,692	72%	4,708	69%	249.1
Black non-Hispanic	***123,285***	***5%***	***1,083***	***16%***	***873.5***
Asian/Pacific Islander non-Hispanic	314,253	12%	211	3%	67.1
Native American non-Hispanic	24,063	1%	97	1%	403.1
Multi-racial non-Hispanic	78,106	3%	65	1%	83.2
Hispanic, any race	187,409	7%	627	9%	334.6
Persons born in the US*	2,164,508	83%	5,498	81%	254.0
Foreign-born persons*	453,000	17%	955	14%	210.8
Foreign-born Blacks*	***31,000***	***1%***	***375***	***6%***	***1,209.7***
US born Blacks*	***92,985***	***4%***	***674***	***10%***	***724.8***
Seattle resident	***594,210***	***23%***	***5,002***	***74%***	***841.8***
Other King Co. residents	1,265,074	48%	1,143	17%	90.4
Snohomish Co. resident	676,898	26%	603	9%	89.1
Island Co. resident	81,326	3%	43	<1%	52.9

2007 population figures from Census Population Estimates, 7/1/2007 (accessed 8/19/08)

*Foreign born estimates are inferred from 2006 American Community Survey

Changes in the distribution of cases over time were identified by the reported date of diagnosis. Persons diagnosed with HIV infection over three, three-year periods (1999-2001, 2002-2004 and 2005-2007) yielded several statistically significant differences between the first and last time periods. Increases were seen in the proportion of PLWH who were foreign born (17% to 22%), aged 45 or older at the time of diagnosis (16% to 23%), Asian/Pacific Islander (3% to 6%), Hispanic (10% to 13%), residents of King County living outside Seattle (16% to 23%) and residents outside King County (9% to 12%). The most significant sub-population increases were among Hispanic males (9% to 12%) and foreign born Blacks (7% to 9%). In terms of mode of exposure, MSM/IDU increased over the period (7% to 10%).

B. 2 EMERGING POPULATIONS

We understand emerging populations to be those populations who have the greatest financial impact on the service system. The 2009 Ryan White Part A grant application for the Seattle TGA identified five emerging populations, which are men who have sex with men (MSM), women, injecting drug users, homeless persons and foreign born blacks. We also monitor sub-populations with growing incidence and assess their needs and impact on the care system. Sub-populations that the Council is looking at currently include residents of South King County, Stimulant Using MSM (regardless of method of use) and older PLWH (45+ or 50+ depending on the measure).

Men who Have Sex with Men (MSM): During the course of the local HIV/AIDS epidemic, MSM have represented the highest percentage of prevalent and incident HIV/AIDS cases. The Seattle TGA continues to recognize MSM as an “emerging population” due to changes in the specific prevention approaches to this population and the rising levels of co-morbidities among MSM PWLH in the TGA. *Increased levels of substance use:* Among comprehensive assessment survey respondents, MSM were significantly more likely to report drug use in the previous 12 months (60% vs. 46%). Based on local rates of methamphetamine (meth) use that are among the highest in the nation, the Seattle metropolitan statistical area was recently designated as one of the eight target sites for the Office of National Drug Policy’s new “Anti-Meth Campaign.” MSM reported using meth at a rate four times higher and inhalant use at a rate seven times higher than other populations. *High prevalence rates:* The HIV/AIDS Epidemiology Unit reports that HIV seroprevalence continues to be significantly higher among MSM than any other population, with 13.8% of MSM who did not inject drugs and 21.9% of MSM/IDU, as opposed to 3.6% or lower in other at-risk populations being HIV+. *Co-infection with HIV and STDs*: After near-elimination of syphilis from King County prior to 1997, by 2007 the estimated incidence of syphilis among MSM had surpassed the 1980s level and is now at 436 cases per 100,000. In King County, syphilis cases in MSM have more than doubled from 76 cases in 2003 to

188 in 2007. The estimated incidence of early syphilis among HIV+ MSM was an alarming 2,290 per 100,000 men, compared to 174 per 100,000 among HIV- MSM. *Higher service gaps for MSM of Color:* On the FY 2007 consumer survey, MSM of Color reported a significantly higher level of unmet need. MSM of Color were significantly more likely than other populations to report unmet need in the core services of home health care (11%), ADAP (10%) and health insurance (10%). In addition, MSM were significantly more likely to report unmet need in Part A-funded transportation services (14%). *Lack of consistent medical monitoring for MSM of Color:* MSM of Color respondents also had significant variations in clinical indicators from white MSM. MSM of Color were significantly less likely than White MSM to know their T-cell counts (70% versus 82%) and viral loads (69% versus 80%). MSM of Color were also significantly less likely than White MSM to be taking antiretroviral (ARV) medications (73% versus 88%), medications for opportunistic infections (16% versus 27%), and medications to manage HIV side effects (19% versus 33%). Furthermore, MSM of Color are significantly more likely than White MSM to be taking medications but not know what the medications are treating (8% versus 3%). Latino focus group participants noted that their medication adherence is complicated by language barriers, cultural norms about taking medications and a lack of trust in Western medicine. *Cultural challenges in accessing and maintaining medical care for MSM of Color:* Providers working with MSM of Color reported that these clients may not participate in the larger gay/bisexual community and may not identify as gay or bisexual within their own communities. This dual isolation decreases the chances that MSM of Color will feel comfortable accessing medical care and other HIV-related services at agencies that primarily serve the gay/bisexual community. In addition, providers to Latinos indicated substantial fear in the Latino population of the possible side effects of medications, which may prevent them from initially accessing medical care. Therefore they often wait to seek HIV care until they are fairly advanced in their disease progression.

Women: Geographic isolation*:* Only 59% of female survey respondents (n=31; 6% of sample) reported living in Seattle, versus 81% of males. Female consumers noted the challenge of accessing HIV services near their homes. Because these women are relatively dispersed throughout the TGA, female survey respondents were twice as likely as males to prioritize medical transportation services. *Women with families:* On the consumer survey, female respondents were significantly more likely than male respondents to report having one or more dependents living with them (32% versus 7%). Providers and consumers noted that for many female PLWH the demands of taking care of other family members often assume greater importance than self-care and medical access. *Lack of consistent medical monitoring:* Female PLWH were significantly less likely than HIV infected males to be taking ARV medications (71% versus 83%) and medications to manage HIV side effects (17% versus 30%). One provider also noted that women tend to be diagnosed at a later stage in the

disease. *Increasing substance abuse among female PLWH:* Female survey respondents were more likely than males to report using cocaine (17% versus 8%) and heroin (6% versus 2%). Providers noted a core group of chemically dependent women who struggle with compliance and frequently utilize emergency services. A mental health service provider noted that 60-80% of her female caseload is chemically dependent at any given time, with increasing numbers of clients using crack cocaine and crystal meth. *Cultural barriers for women of color:* Because of the stigma of HIV within their communities, African American, Latina and foreign-born Black women may experience shame, guilt and isolation related to their HIV status. These women often remain involved in relationships that involve domestic violence because of the daunting financial challenges of being single and managing both their family and their HIV. Current and historical domestic violence often plays a role in preventing women from accessing medical care and other vital HIV-related care services.

Injection drug users (IDU): *Frequent periods of homelessness and incarceration:* Chemical dependency service providers reported that approximately 30% of their PLWH clients were homeless during the previous 12 months. Injection drug using respondents to the consumer survey (n=36, 7% of responses) reported recent rates of homelessness five times higher than non-IDU (31% versus 6%). Rates of incarceration among this population are also extremely high, particularly for drug-related offenses. IDU survey respondents were over nine times more likely that non-IDU PLWH to have been incarcerated in the past year (28% versus 3%), and providers noted that jail stays tend to interrupt HIV medical care. *Mental illness as a co-morbidity:* Across the board, providers reported increasing rates of mental illness in their IDU clients. As a result, IDU were significantly more likely than other populations to identify mental health services as a priority (49% versus 32%). Focus group participants who inject meth reported mental health services as a critical component in their substance abuse recovery and HIV care adherence. *Co-infection with hepatitis:* FY 2006 Public Health data reveal that 80% of HIV+ IDU present evidence of exposure to hepatitis C, and 70% have been exposed to hepatitis B. *Difficulty in linking and maintaining active users in services:* Providers noted that PLWH who are actively using drugs are more likely to fall out of care and become non-adherent to medication regimens. When substance abuse leads to severe medical problems and/or incarceration, they may start seeking care again. As a result, injection drug users were significantly less likely to be taking antiretroviral medications (66%) than both substance users who do not inject (84%) and non-drug users (81%). Injection drug users were significantly more likely than non-injection substance users to have missed a medical appointment (36% versus 6%), missed a social services appointment (43% versus 5%) and missed doses of HIV medications (53% versus 14%) in the last 12 months. *MSM and LGBT friendly treatment:* As noted earlier, meth use is much more significant among MSM PLWH than other sub-populations. Meth-using MSM focus group participants reported

that they have a difficult time accessing substance abuse services in which they can feel comfortable being explicit with their treatment provider or program about issues related to sexual orientation. Although many favored a peer mentoring recovery model, several noted the challenges of this model when applied to meth use and MSM, such as temptation to relapse.

Homeless persons: *High co-morbidity rates:* Data from King County's Mental Health/Substance Use Access Project estimate that between 70-80% of Seattle's homeless adults are clinically mentally ill and 30-40% are alcohol and/or drug dependent. PLWH survey respondents who were currently homeless or had been homeless in the past year (n=38; 8% of sample) were almost 17 times more likely to have been incarcerated in the past year than other PLWH (34% versus 2%). Recently homeless persons were also more likely to report substance use in the previous 12 months (71% versus 55%) and significantly more likely to have injected drugs in the previous 12 months (29% versus 5%). *Inconsistent medical monitoring and poorer medical/health outcomes:* Recently homeless respondents were significantly less likely than non-homeless PLWH to know their T-cell count (62% versus 77%), significantly more likely to have a T-cell count under 200 (30% versus 13%), significantly less likely to know their viral load (51% versus 76%), and significantly less likely to have an undetectable viral load (25% versus 73%). They were also significantly less likely to be taking antiretroviral medications (50% versus 84%), but more likely to be taking medication without knowing what it is treating (13% versus 5%).

Foreign born Blacks: *Increasing HIV infection rates:* In 1995, foreign born Blacks in King County accounted for 10% of all cases of HIV infection among all Blacks. However, from January 1, 2006 through December 31, 2007, foreign born Blacks accounted for 46% of all incident AIDS cases among Blacks in the TGA. Foreign born Blacks now comprise 34% of all prevalent HIV/AIDS cases among Blacks, with seroprevalence rates among foreign-born Blacks (1.7%) almost double those of native-born Blacks (0.9%). The majority of cases among foreign born Blacks are due to heterosexual transmission (42%) or have no identified risk (50%), while 58% of native born Blacks are MSM or MSM-IDU, and 15% are IDU. AIDS Spectrum of Disease data suggests that foreign born Blacks are more likely than other Blacks to receive late diagnoses of HIV infection, when CD4 cell counts are already at low levels, indicating a potentially dangerous delay in HIV testing. *Inconsistent medical monitoring:* Foreign born Blacks were significantly less likely than other populations to know their T-cell count (53% versus 23%) and their viral load (60% versus 25%). They were also significantly less likely to be taking antiretroviral medications (67% versus 17%). *Stigma of HIV/AIDS and associated fear of confidentiality breaches:* Focus group participants expressed concern that information about their serostatus would find its way back not only to their local communities, but also to their families in

Africa. As a result of this fear, providers reported that they often see these clients late in their HIV disease when they become symptomatic and can no longer avoid medical attention. Focus group participants also reported fear as a barrier to telling family members in their household about their HIV status. This results in difficulties with adherence to medications and treatment protocols due to a lack of safe space to follow through in their own homes.

South King County Residents (SKCR): *Epidemiologic Trend:* There is an increase in the number of PLWH residing in King County but outside of Seattle (16% to 23%), the majority of these live in South King County. *Less knowledge about health status:* SKCR were significantly less likely than non-SKCR to know their T-cell count (68% versus 77%), significantly less likely to know their viral load (67% versus 76%) and significantly more likely be taking medication without knowing what it is treating (10% versus 5%). *Fewer medical visits and less satisfaction with distance to medical care:* SKCR were significantly less likely than non-SKCR to see a doctor three or more times in the past 12 months (78% versus 82%) and were significantly less likely to be satisfied with the distance they had to travel to get to their medical provider (58% versus 87%). *Geographic Isolation:* Cites in South King County are not only up to 50 miles from Seattle, where the majority of services are, they are also miles apart from one another. SKCR are spread throughout that area; there is not a "critical mass" of PLWH in any one community. *Poverty:* While incomes were similar between SKCR and non-SKCR, the former had more dependents. Once adjusted for that factor, SKCR PLWH were significantly more likely than non-SKCR to be living below 100% of FPL (60% versus 43%). In the 2009 comprehensive assessment outlined in this plan, more specific information about where people live will be gathered to determine the practicability of creating a satellite clinic.

Stimulant Using Men who have Sex with Men (SUMSM): *Epidemiologic Trend:* MSM/IDU PLWH have increased from 7% to 10% of new infections. While not all SUMSM inject (method of delivery for methamphetamine, for instance, is often determined by the variety of the drug available at any given time) stimulants are closely correlated with sexual risk-taking. *Drug use in MSM:* While surveillance data does not collect information on the drug used, both prevention and care needs assessment data indicate that methamphetamine (meth) and cocaine are the drugs of choice among MSM who use drugs. In the STEAM assessment, which assessed risk behavior in 369 Black MSM (both HIV+ and HIV-) 63% of HIV+ respondents and 42% of HIV- respondents had used crack in the past 12 months. Twenty three percent of HIV+ respondents had used meth in the past 12 months. In the 2007 comprehensive needs assessment, MSM were significantly more likely to have used drugs in the past year than non-MSM (40% versus 35%) and were particularly more likely to have used meth (12% versus 3%). Another concern is the extent to which MSM are beginning to use stimulants after

becoming HIV positive. In Project Rewards, a contingency management program seeking to reduce meth use in MSM, 60% of HIV+ participants indicate that their use of meth began at some point after they became HIV+. Although there is a strong correlation between meth use and poor dental health (called "meth mouth") and White MSM were more likely to identify a gap in oral health care, needs assessment data do not, at this point, indicate other health problems. Although meth using MSM were no more likely to have a low CD4 count or detectable viral load than other MSM, more exploration needs to be done. One of the needs assessment activities outlined in this Plan is to conduct an assessment related to drug use and adherence and other medical outcomes among MSM.

Older PLWH: *Epidemiologic Trend:* There is an increase in the number of persons who are 45 or older at the time of diagnosis (16% to 23%), but additionally, the population of people with HIV is aging. As of 6/30/08, 52% of those living with HIV in King County were age 45 or older. *More Advanced Disease:* PLWH over age 50 responding to the needs assessment (36% of the sample) were significantly more likely than younger respondents to be disabled by AIDS (61% versus 43%). They were also significantly more likely to be taking medications to treat side effects (35% versus 25%), to be taking medications to treat opportunistic infections (29% versus 22%) and to be on ARV treatment (86% versus 80%). This population was statistically more likely to have seen their provider three or more times in the past 12 months (88% versus 78%). While this population has more advanced HIV disease, the data do not indicate a lack of access to care. Those over age 50 were no more likely to express dissatisfaction with medical care than those under age 50, and in many cases they were significantly more likely to be pleased with their care. They were also less likely to identify service gaps. All of the 50+ respondents had been to the doctor at least once in the last year. Despite their advanced level of disease, they are just as likely to have an undetectable viral load as younger PLWH. This population has been difficult to define; as part of this Plan, additional analysis of existing epidemiologic and needs assessment data will be done to determine if more striking differences exist based on where the cut off for "older" PLWH is placed.

C. DESCRIPTION OF LOCAL, REGIONAL AND STATE RESPONSE TO THE EPIDEMIC

The first case of AIDS was diagnosed in the TGA in 1982, and it was the only case that year. Seattle already had a world wide reputation for STD research (much of which was on gay men) and also had the Seattle Gay Clinic, which provided medical services to gays and lesbians. Despite being a "second wave" city, Seattle and King County moved quickly to respond to the epidemic. In June of 1983, the Seattle City Council passed a resolution declaring AIDS a medical emergency and providing funding, which went to Public Health to create the AIDS Surveillance, Assessment and Education Program, which was then only the second city/county AIDS program funded in the United States.

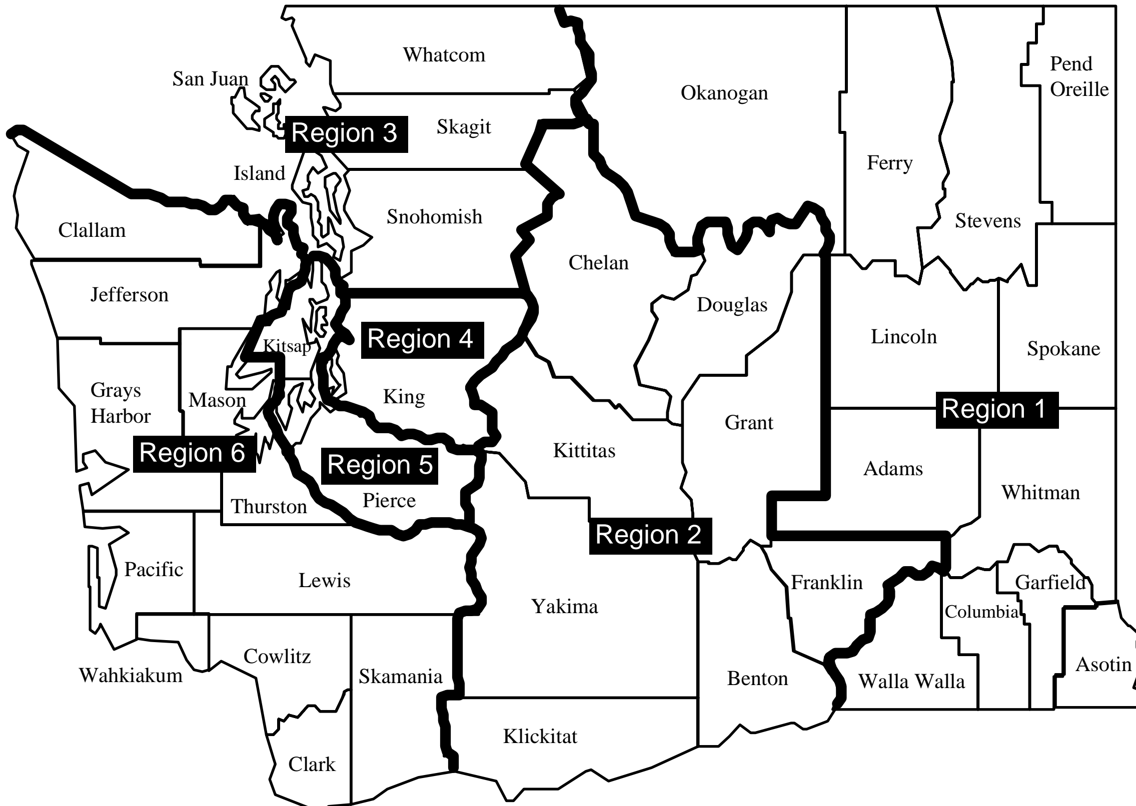
That same year, Seattle Gay Clinic began providing volunteer care for people with AIDS, and the seeds that would grow into larger community based organizations were planted. By 1984, the area's largest public health hospital, Harborview, had formed an AIDS clinic, and other public and non-profit organizations grew in response to the epidemic. The TGA continued to be on the cutting edge, opening the second needle exchange in the U.S., shortly after our neighbor to the south, Pierce County, opened theirs.

From the beginning, the community was involved in providing oversight of funding, beginning with the Public Health AIDS Advisory Committee, which was formed in 1983. This group, and its later incarnations, began to shape the principles that would guide HIV funding in the TGA for many years. Some of these included:

- Emphasis on quality care: Some of the earliest activists responding to the epidemic were physicians, nurses, epidemiologists and other Public Health professionals. While little was known about the disease in the early days, they balanced care and research, and always strove to provide the best care possible.
- Emphasis on getting the newly diagnosed into care: Even before an antibody test for the disease was created, public and private providers assessed patients for the disease, and provided support for their care.
- Collaboration: Community activists, agencies and Public Health worked together to create the best possible continuum of care and prevention. Sometimes they agreed, sometimes they didn't, but they supported each others' work in unique ways.
- Non-Duplication of services: In response to seeing "turf wars" in other cities over limited AIDS dollars, locally there was a clear practice of working together and ensuring that resources were used wisely and not in duplication.
- Care and Prevention Coordination: One of the ways that duplication was reduced was in combining various steering and advisory committees. The result was not only that care systems worked together, but also that they worked closely with prevention systems, so that today it is seen as one continuum.

The Washington State AIDS Omnibus Act was passed in 1988, providing guidance and state funding to address the AIDS epidemic. One of the things that the law did was to divide the state into six regional networks or "AIDSNets." Each of the six AIDSNets was responsible for planning and distribution of funds through the largest county health department within the region. King County was

designated as AIDSNet Region 4, the only one-county AIDSNet. Island and Snohomish Counties were grouped with Whatcom, Skagit and San Juan counties as AIDSNet Region 3, led by the Snohomish Health District. While the AIDSNet system was created for distribuiting AIDS Omnibus dollars, it has since been used for planning and distribution of CDC, and later Ryan White pooled Part A & B funds.



Washington AIDSNet Regions

Note that Region 4 is the only single county region, and that the other two counties in the TGA, Snohomish and Island, are in Region 3. Clark County has been part of the Portland TGA since 1998.

Washington's Pooled Parity Model. In 1990, when the Ryan White legislation was enacted, Washington received Title II (now Part B) dollars, and determined that those funds should be allocated to each of the AIDSNets based on living AIDS cases. As a result, the majority of funds went to AIDSNet Region 4, King County, with the largest number of cases in the state. In 1992, the Seattle EMA (now TGA), consisting of King, Snohomish and Island Counties became, eligible for Title I (now Part A) funding. To distribute the funds equitably, it was decided that Parts A & B should be pooled, and dollars should then be allocated to each of the six AIDSNets based on living AIDS cases, with the understanding that Part A dollars could only be spent in King, Snohomish and Island counties. The net result was that, until recently, all Part A dollars stayed in King County, which sometimes received Part B dollars, as well. The model was later refined to include HIV as well as AIDS cases, and to

account for the dollars Clark County receives from the Portland TGA. Over time, the proportion of HIV cases in King County has diminished in comparison with the rest of the state, and an increasing portion of Part A funds have been allocated to Snohomish County. Planning for these dollars happens in the Region 3 HIV/AIDS Planning Council (which receives part of it's parity allocation from state Part B funds and part from Seattle TGA Part A funds) and the Snohomish Health District.

D. ASSESSMENT OF NEED

D. 1. NEED FOR PRIMARY MEDICAL CARE AND OTHER CORE MEDICAL SERVICES; GAPS IN CARE

Biennial Comprehensive Assessment of Need for Care Services in King County

Between the months of August and December 2007, the Council and its staff conducted a comprehensive needs assessment of HIV/AIDS care services in King County. This type of assessment has taken place every other year for the past 14 years, with adjustments over time to meet changing needs. For 2007, the survey portion was changed significantly from previous years. Respondents were asked about core and support service priorities separately and were permitted to choose fewer support services, giving a numerical advantage to core services.

Methods: Several strategies were employed to gather data for the process:

- Creation and distribution of written surveys to PLWH throughout King County in English and Spanish (506 valid surveys returned)
- Creation and distribution of written surveys to providers of HIV-related services (including medical, dental, medical case management, mental health, substance use treatment and support services) throughout King County, (136 valid surveys returned)
- Focus groups conducted with eight subpopulations of PLWH
- Interviews conducted with 12 key informants

General Findings from the 2007 Needs Assessment

Demographics: The survey portion of the assessment reached a sample that was representative of the epidemic in King County, with the exceptions that Black/African American consumers were under-represented (14% of respondents but 17% of the epidemic) and heterosexuals were over-represented (12% of survey respondents but 10% of the epidemic). Over time, demographics of the respondents to the consumer survey have changed along with the epidemic. Not surprisingly, the population responding to the survey is aging. The percentage of PLWH over age 40 responding to the survey was 61% in 2003, 68% in 2005 and 79% in 2007. Respondents over age 50 increased from 14% in 2003 to 26% in 2005 to 36% in 2007. Another change over time is in the number of consumers taking ARV medications. In the 2005 survey, 74% of respondents were on ARVs, but in 2007 the number

jumped to 81%. While the majority of respondents were residents of Seattle (79%) a significant number report living in South King County (14%). It is believed that this migration is due to lower housing costs in South King County.

Substance abuse, in particular the use of stimulants, is a significant problem among King County PLWH. Eighteen percent of the respondents to the survey, primarily MSM, indicated that they had used meth in the past 12 months, and 16% indicated using cocaine (crack or powder) in that same time period.

Priorities and Gaps for Ryan White Core and Support Services

Services were listed in their component parts in easy-to-understand language, and consumers were asked to identify up to five core and three support services that were most important in helping them with HIV/AIDS-related health issues. Providers were similarly asked to identify up to five core and three support services that were the most important in helping their clients with HIV/AIDS-related health issues. Responses were then rolled up into the Ryan White service categories such that, if someone identified more than one component of a service, (such as "help finding housing" and "short term emergency housing") the entire category would only receive one vote per respondent. In previous years, all services were listed together, and respondents could choose up to seven services. The table on the following page illustrates the results in order of the consumers' priorities, with bold font indicating a core service.

2007 PRIORITIES				
Service	Consumers (N=506)		Providers (N=136)	
	Rank	%	Rank	%
Health insurance	**1**	**79%**	**7**	**62%**
AIDS Drug Assistance Program	**2**	**75%**	**6**	**65%**
Outpatient/ambulatory medical care	**3**	**73%**	**3**	**75%**
Oral health care	**4**	**66%**	**10**	**37%**
Medical Case Management	**5**	**57%**	**4**	**74%**
Housing services	6	48%	2	79%
Food bank/meals	7	45%	12	21%
Psychosocial support	8	41%	8	51%
Mental health services	**9**	**31%**	**1**	**79%**
Rehabilitation services	10	26%	17 (tie)	4%
Transportation services	11	20%	11	26%
Medical nutrition therapy	**12**	**10%**	**15**	**7%**
Substance abuse services (outpatient)	**13**	**8%**	**5**	**65%**
Home healthcare	**14**	**6%**	**14**	**7%**
Hospice services	**15**	**6%**	**16**	**4%**
Substance abuse services (inpatient)	16	5%	9	47%
Health education/risk reduction	17	5%	13	13%
Child care	18	1%	17 (tie)	4%

The Council knows that the perspective of both providers and consumers is important to their decision-making process. Consumers have the day-to-day experience of living with the disease and seeing first hand how services impact their HIV care, while providers have a perspective on the needs of a broad range of consumers. As a result, the Council combines these lists into one by averaging the priority response percentages of each. For the 2007 assessment, the Council chose to give a slight advantage to consumer responses (weighting them at 55% vs. 45% for providers), primarily for philosophical rather than practical reasons. The combined priority list follows.

Combined Ranking of Priorities for FY 2009-10 Prioritization and Allocation

Final Rank	Service Category	Consumer Priority	Provider Priority
1	**Ambulatory/Outpatient Medical Care**	**3 (73%)**	**2 (75%)**
2	**Health Insurance**	**1 (79%)**	**6 (62%)**
3	**ADAP**	**2 (75%)**	**5 (65%)**
4	**Medical Case Management***	**5 (57%)**	**3 (74%)**
5	Housing Services	1 (48%)	1 (79%)
6	**Oral Health Care**	**4 (66%)**	**7 (37%)**
7	**Mental Health Services**	**6 (31%)**	**1 (79%)**
8	Psychosocial Support Services	3 (41%)	2 (51%)
9	Food Bank/Home Delivered Meals	2 (45%)	5 (21%)
10	**Substance Abuse Services (Outpatient)**	**8 (8%)**	**4 (65%)**
11	Substance Abuse Services (Inpatient)	6 (5%)	3 (47%)
12	Medical Transportation Services	5 (20%)	4 (26%)
13	Rehabilitation Services	4 (26%)	7tie (4%)
14	**Medical Nutrition Therapy**	**7 (10%)**	**9 (7%)**
15	Health Education/Risk Reduction	7 (5%)	6 (13%)
16	**Home Health Care**	**9 (6%)**	**8 (7%)**
17	**Hospice Care**	**10 (6%)**	**10 (4%)**
18	Child Care	8 (1%)	7tie (4%)

To determine gaps, consumers were asked to identify *all* services that they needed, but could not get. Providers were asked to identify any services that *their clients* needed, but could not get. On the next page is a table of consumer- and provider-identified gaps. As above, bolded items indicate a core services.

2007 GAPS				
Service	Consumer (N=506)		Providers (N=136)	
	Rank	%	Rank	%
Oral health care	**1**	**33%**	**2**	**57%**
Rehabilitation services	2	19%	8	23%
Housing services	3	16%	1	64%
Psychosocial support services	4	14%	6	32%
Mental health services	**5**	**10%**	**3**	**54%**
Food bank/meal	6	10%	16	7%
Transportation services	7	8%	9	21%
Health insurance	**8**	**7%**	**7**	**26%**
Medical nutrition therapy	**9**	**7%**	**13 (tie)**	**9%**
Home healthcare	**10**	**6%**	**10**	**18%**
AIDS Drug Assistance Program	**11**	**5%**	**11**	**15%**
Medical case management	**12**	**4%**	**15**	**8%**
Outpatient/ambulatory medical care	**13**	**4%**	**13 (tie)**	**9%**
Substance abuse services (inpatient)	14	3%	4	49%
Substance abuse services (outpatient)	**15**	**3%**	**5**	**46%**
Hospice services	**16**	**2%**	**17**	**3%**
Health education/risk reduction	17	2%	18	2%
Child care	18	1%	12	15%

While consumers and providers have listed very different priorities, the gaps they identify are more closely aligned. In particular, gaps in oral health care and housing are noted by both groups. Consumers and providers were able to list as many gaps as they wanted, but it is interesting that neither listed as many gaps as they did priorities, and consumers tended to list even fewer gaps.

Comparing service gaps with service priorities helps determine the magnitude of potential system inadequacies and supports strategic planning and resource allocation decisions. The following table lists the top 10 consumer-identified service priorities in comparison with the gap ranking and percentage for each service.

2007 CONSUMER PRIORITY AND GAP COMPARISON				
Service	PRIORITY		GAP	
	Rank	%	Rank	%
Health insurance	**1**	**79%**	**8**	**7%**
AIDS Drug Assistance Program	**2**	**75%**	**11**	**5%**
Outpatient/ambulatory medical care	**3**	**73%**	**13**	**4%**
Oral health care	**4**	**66%**	**1**	**33%**
Medical Case Management	**5**	**57%**	**12**	**4%**
Housing services	6	48%	3	16%
Food bank/meals	7	45%	6	10%
Psychosocial support	8	41%	4	14%
Mental health services	**9**	**31%**	**5**	**10%**
Rehabilitation services	10	26%	2	19%
Transportation services	11	20%	7	8%
Medical nutrition therapy	**12**	**10%**	**9**	**7%**
Substance abuse services (outpatient)	**13**	**8%**	**15**	**3%**

In looking more closely at consumer priorities, there are some service categories that were ranked higher by specific sub-populations. The table on the next page outlines these differences.

CONSUMER SERVICE PRIORITY RANKINGS

(Collapsed into Ryan White funding categories)
(N=506)

With Significant Sub-Population Differences (p<.05)

Rank	Service (core services bolded)	#	%	Significantly HIGHER priority for…
1	**Health insurance**	400	**79%**	MSM of color (83.5%), White MSM (85.2%)
2	**AIDS Drug Assistance Program**	380	**75%**	White MSM (83%)
3	**Outpatient/ambulatory medical care**	369	**73%**	
4	**Oral health care**	334	**66%**	
5	**Medical Case Management**	288	**57%**	Recently homeless (79%)
6	Housing services	243	48%	Recently homeless (82%), MSM/IDU (66%)
7	Food bank/meals	228	45%	MSM/IDU (63%)
8	Psychosocial support	207	41%	Women (57%)
9	**Mental health services**	157	**31%**	Recently homeless (50%)
10	Rehabilitation services	132	26%	
11	Transportation services	101	20%	Black/African American (31%)
12	**Medical nutrition therapy**	50	**10%**	Women (23%), Black/African American (17%)
13	**Substance abuse services (outpatient)**	40	**8%**	MSM/IDU (26%), Recently homeless (26%), Women (15%)
14	**Home healthcare**	31	**6%**	
15	**Hospice services**	28	**6%**	
16	Substance abuse services (inpatient)	25	5%	Recently homeless (18%), MSM/IDU (14%)
17	Health education/risk reduction	23	5%	
18	Child care	3	1%	Women (6%)

While consumers were asked to list all of their service gaps, there was a minimum of gap noted overall. However, some populations were more likely to identify gaps in certain services. On the next page is a table outlining these differences.

CONSUMER SERVICE GAP RANKINGS
(Collapsed into Ryan White funding categories)
(N=506)

With Significant Sub-Population Differences **(p<.05)**

Rank	Service (core services bolded)	#	%	Significantly HIGHER gap for…
1	**Oral health care**	166	**33%**	White MSM (40%)
2	Rehabilitation services	94	19%	
3	Housing services	80	16%	Recently homeless (68%), Black/African American (29%), Latino/a (25%)
4	Psychosocial support services	71	14%	
5	**Mental health services**	51	**10%**	Recently homeless (26%)
6	Food bank/meal	48	10%	African American (26%), Women (25%), Recently homeless (24%), Heterosexual (21%)
7	Transportation services	40	8%	MSM of color (14%)
8	**Health insurance**	35	**7%**	MSM of color (11%)
9	**Medical nutrition therapy**	33	**7%**	Recently homeless (16%)
10	**Home healthcare**	30	**6%**	
11	**AIDS Drug Assistance Program**	23	**5%**	MSM of color (10%)
12	**Medical case management**	20	**4%**	
13	**Outpatient/ambulatory medical care**	18	**4%**	Black/African American (11%), Recently homeless (8%)
14	Substance abuse services (inpatient)	17	3%	
15	**Substance abuse services (outpatient)**	15	**3%**	Recently homeless (11%), MSM/IDU (9%)
16	**Hospice services**	9	**2%**	
17	Health education/risk reduction	8	2%	
18	Child care	4	1%	Black/African American (7%)

In January of 2008, eight consumer focus groups and 12 key informant interviews were completed to add a qualitative perspective to these quantitative data. The Council used these additional data to inform their prioritization and allocation process. They were also helpful in identifying barriers, listed later in this document.

One service category in which these data were particularly helpful was Oral health care. Consumers in focus groups noted long waiting periods for services and said that some services, such as root canals and crowns, weren't covered. This was echoed in key informant interviews. Providers also noted that one of two Ryan White funded providers was going to stop doing basic dentistry, and that the other was at capacity (literally, they did not have the physical space to add dentists or chairs). The Council and Grantee used this information to partner with the State to provide additional services in King County.

In addition to asking about priorities, gaps and demographic information, the written survey also asks consumers a series of questions about their health and knowledge of their health. These include questions about T-cell and viral load counts, as well as whether consumers are taking medication and whether they know what the medication is treating. One-fourth of consumers responding to the survey did not know their CD4 or viral load counts, but these numbers were much higher for certain subpopulations. For instance, while 26% of the overall sample did not know their viral load, 33% of Latino/as and 49% of Black/African Americans did not. Fifty-three percent of consumers had an undetectable viral load, but only 44% of Latino/a and 27% of Black/African Americans had an undetectable viral load. The majority of consumers (81%) stated that they were taking ARV medications, and some stated that they were taking medications to manage side effects or treat opportunistic infections. Only 29 people (6%) stated that they were taking medications, but didn't know that they were treating. However, Black/African Americans were more likely to not know what the medications they were taking were treating (12%), and several populations were less likely to be on ARV medications. These included women, heterosexuals, Latino/as, Black/African Americans, persons who were foreign born and those who had been homeless in the past 12 months. The disparity was most marked among the recently homeless and African American groups, with only 57% of African Americans and 49% of recently homeless persons being on these medications. The survey did not ask consumers why they were not on medications.

Each time the survey portion of the assessment is done it includes information about priorities, gaps and demographic information, including everything from gender to drug use to knowledge of CD4 counts. There is also one additional section that changes each time. In 2007, that section was on satisfaction with outpatient/ambulatory medical care. Consumers were asked to rank their satisfaction with primary care in response to 11 statements which covered interactions with providers and reception staff. Overall, responses were positive, agreement ranging from 84% to 95% of respondents. Consumers were also asked where they received care, and no significant differences between consumers' opinions of Ryan White funded providers in comparison to private doctor's

offices were identified. Eighty-five percent of respondents noted that they “strongly agree” with the statement, “my provider treats me with respect,” with another 10% marking “agree,” and no sub-population being more or less likely to agree. The statement that received the lowest response was “I am satisfied with the hours that my provider is available.” Only 83% of consumers agreed or strongly agreed with the statement, and both recently homeless and MSM/IDU consumers were less likely than others to agree. Similarly, consumers were less satisfied with the distance they had to travel to see a provider, with 83% agreeing or strongly agreeing that they were satisfied. Women and heterosexuals were least likely to agree with this statement. This is not surprising, as these two groups are more likely to reside in south King County but receive their care at Madison Clinic, which is located in Seattle.

The 2009 Comprehensive Needs Assessment

Findings of the 2007 assessment, along with changes brought about by the 2006 Ryan White reauthorization, led to significant service changes. A key component of this Plan is the accomplishment of comprehensive assessments in 2009 and 2011. The 2009 assessment will evaluate changes made to the system and their affect on the broad range of populations with HIV.

D. 2. UNMET NEED:

Estimation methods: Prior to September 2006, only CD4 counts below 200/mm3 and detectable HIV viral loads were reported in the Washington State laboratory database. As a result, previous unmet need calculations relied on the Adult Spectrum of Disease study (ASD) to adjust laboratory data to account for lab results not reportable under the old reporting criteria. The revised Washington State code now requires that all CD4 and HIV viral load tests are reported regardless of result. This new reporting framework now allows Public Health’s HIV/AIDS Epidemiology Unit to track HIV-related laboratory tests to establish care patterns. With almost two full years of comprehensive care pattern data now available, laboratory data continue to serve as the primary source for determining baseline unmet need.

Unfortunately, gaps exist in Washington State’s lab reporting system, requiring calculation adjustments on the local level. These gaps include results not reported to state labs, such as some of the clients served in the Veterans’ Administration and Indian Health systems, as well as clients receiving labs through research studies. In addition, a need exists to adjust unmet need calculations for those persons who have moved away and can no longer be considered part of the population who could access services.

Calculation adjustments are based on results from an ongoing Public Health project to identify and refer into care all persons with no evidence of laboratory results in the past 12 months. Starting in September 2007, Public Health's HIV/AIDS Epidemiology Program was awarded funding for a ground-breaking new program called the NOTICE (Not In Care) Project. NOTICE identifies clients who have fallen out of care by periodically reviewing the state HIV/AIDS laboratory database to determine which clients do not appear to have had any viral load or CD4 tests in the past year. Once these data have been gathered, a NOTICE staff member attempts to locate the client to determine if the client is still a King County resident or is getting lab tests from a non-reporting entity.

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 the Seattle TGA.
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.

NOTICE project data, Public Health: The NOTICE project is designed to identify, locate and refer into care all King County residents diagnosed with HIV who have no evidence of a laboratory test in the past 12 months. As of August 2008, 419 case investigations had been initiated, and 228 are resolved. Fourty-two percent of the resolved cases were found to have moved away from King County.

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 AIDS and presumed to be living during the 12-month period of January 1 through December 31, 2007. These data were extracted from HARS. Data for the analyses included all 2007 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%) and for AIDS cases (98%) provided by surveillance staff.

Care status patterns were obtained by matching comprehensive laboratory reporting data to HARS cases and making adjustments based on NOTICE Project data for PLWH out-migration. 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. Following the overall analysis, PLWH sub-populations were stratified in categories to estimate the total number of patients in and out of care by gender, HIV versus AIDS status, race/ethnicity and mode of transmission.

Based on the methodology described above, Public Health's HIV/AIDS Epidemiology Unit estimates that **19.3% of the TGA's PLWH (1,314 out of 6,791 PLWH who are aware of their HIV+ status) are not in care**. Data from MOSAICA, HRSA's technical assistant partner, suggests that the range of unmet need among Part A entities across the country is 11%-89%, with an aggregate estimate of 38%. The Seattle TGA unmet need estimate falls 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 PLWH in primary care and prescription drug programs.

However, further data from the NOTICE program suggests that the Seattle TGA's 19.3% "unmet need" estimates may actually be considerably lower than projected. In addition to the 42% of resolved cases who were confirmed as having moved out of the TGA, 108 cases were found to be getting care from sources that did not report to the state laboratory database. This is good news, and a testament to the referral and service delivery systems in the region. The NOTICE project will continue to be funded partially in FY 2009 through Part A Quality Management funds rather than through Part A service dollars, since the outcomes related to the program are more appropriate for system assessment than for actual client service delivery.

Assessment of unmet need

Demographics and location of PLWH who are not in care: Bivariate analyses of unmet need by sex, diagnostic status, race/ethnicity and mode of exposure reveal:

- There is a statistically significant difference in overall unmet need status by gender with females more likely to be accessing care than males (12.6% versus 20.2%, respectively, OR 1.6 to 2.5, P<0.001).
- Persons with HIV, non-AIDS are significantly more likely than persons with AIDS diagnoses to be not in care (23.6% versus 16.1%, OR 2.5 to 3.2, p<0.001).
- Latinos/Hispanics have a higher unmet need for primary care (26.8%) than non-Hispanics (26.8% versus 18.6%, OR 0.51 to 0.76, p<0.001).

- No significant differences emerge among other racial groups, with 18.8% of Whites, 17.6% of Blacks and 19.5% of persons of other races (Asians, Pacific Islanders and Native Americans) being not in care.
- Non-MSM are more likely than MSM to not be in care (26.8% versus 16.4%, OR 1.1 to 1.5, $p<0.001$).

Prevention Needs:

The Council is responsible for prioritization of 100% of CDC and 50% of Washington State AIDS Omnibus prevention funds. Using prevention planning funds the Council conducts assessments of the needs of various populations. Two assessments are particularly relevant to prevention work with HIV+ clients. Additionally, the provider survey of the comprehensive care needs assessment included prevention questions.

Biennial Comprehensive Care Needs Assessment: Care Provider Survey Supplemental Questions

As part of the 2007 Comprehensive Needs Assessment, the provider survey asked care providers to respond to the items listed below regarding sexual and drug use risk reduction.

How frequently do you talk to your clients about sexual risk reduction? (Check one)

- ☐ Every visit
- ☐ Less than every other visit
- ☐ Every other visit
- ☐ Never
- ☐ N/A to my work

How frequently do you talk to your clients about drug use risk reduction? (Check one)

- ☐ Every visit
- ☐ Less than every other visit
- ☐ Every other visit
- ☐ Never
- ☐ N/A to my work

Please check how much you agree/disagree with each of the following statements about your work with sexual risk reduction:	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
I feel comfortable talking to my clients about sexual risk reduction.					
There is a subset of my clients with whom I do not feel comfortable talking to about sexual risk reduction.					

I talk to all of my clients about sexual risk reduction.					
I feel adequately trained on sexual risk reduction.					
I am familiar with the community resources I can refer my clients to for ongoing help with sexual risk reduction.					
I personally hand my clients sexual risk reduction materials.					
Please check how much you agree/disagree with each of the following statements about your work with drug use risk reduction:	**Strongly Agree**	**Somewhat Agree**	**Neither Agree nor Disagree**	**Somewhat Disagree**	**Strongly Disagree**
I feel comfortable talking to my clients about drug use risk reduction.					
There is a subset of my clients with whom I do not feel comfortable talking to about drug use risk reduction.					
I talk to almost all of my clients about drug use risk reduction.					
I feel adequately trained on drug use risk reduction.					
I am familiar with the community resources I can refer my clients to for ongoing help with drug use risk reduction.					
I personally hand my clients drug use risk reduction materials.					

Talking to clients about risk reduction was strongly correlated to provider type. All dentists, for instance, either stated that they never spoke to their clients about sexual risk reduction (47%) or that it was not applicable to their work (53%). Dentists were more likely (20%) to report talking to their clients about drug use risk reduction. Medical providers and case managers were most likely to talk to their clients about sexual risk reduction (97% and 96% respectively), although medical providers did so more frequently (79% of medical providers discussed it every visit or every other visit in comparison with 30% of case managers). These two types of providers were more similar with respect to discussing drug use risk reduction, with100% of case managers and 97% of medical providers discussing this with their clients. Most did so at least at every other visit (63% and 66%, respectively).

Among those providers who regularly discussed risk reduction with their clients, the majority (97%) felt comfortable talking to their clients about both drug use and sexual risk reduction, but far less indicated that they personally handed risk reduction materials to their clients. Medical providers were the least likely to do so; 29% handed out sexual risk reduction materials and 26% handed out drug use risk

reduction materials to their clients. Case managers were more likely to do so; 39% handed out sexual risk reduction materials and 66% handed out drug use risk reduction materials to their clients.

In the 2009 assessment, providers will be asked why they are less likely to hand materials to clients than to have discussions with them.

Prevention Project 2004:

Based on CDC mandates, HIV+ persons have been identified as the highest ranked population for community planning bodies' prioritization processes. Decisions about prevention interventions for and with PLWH have rarely taken into account knowledge, attitudes, behaviors and beliefs of PLWH themselves. "Prevention Project 2004" is a needs assessment project that interviewed 270 PLWH in Seattle/King County to determine what types of personal risk reduction activities they have adopted, what types of interventions and messages they felt would be most effective among their peers, and in what form these interventions should be presented. Data reveal that:

- Many commonly held assumptions about the attitudes and beliefs among King County PLWH about prevention interventions and messages are incorrect;
- PLWH expressed relatively high degrees of comfort in talking to a wide range of service providers about sexual and drug use risk reduction;
- Intensive interpersonal prevention programs, such as prevention case management and support groups, rated far higher on the list of helpful interventions than more general interventions, such as community outreach and media campaigns; and
- Responsibility-based prevention messages are more likely to be well-received than had been previously acknowledged.

Information gathered from this project has been used to influence funding decisions and the development of new intervention strategies. In particular, data on specific sub-populations of PWLH (MSM, MSM/IDU, heterosexual IDU and racial/ethnic populations) reveal distinct differences in the ways in which interventions should be tailored.

STEAM, 2008 Prevention Assessment with African American MSM

African American MSM, while a small overall population, are significantly over-represented in the HIV data in comparison with White MSM. In 2008 the Council conducted an assessment of risk behavior among African American MSM, for use in prevention planning. The assessment consisted of 369 interviews with Black MSM in King County, 96 of whom were HIV+. Results indicated that this population engaged in a significant amount of high risk behavior. Participants had a large number of partners (18% indicated having five or more male anal sex partners in the past 12 months) and high

level of anal sex without condoms (27% had unprotected anal sex with two or more partners in the past 12 months). Forty-four percent of HIV- respondents and 38% of HIV+ respondents indicated having unprotected sex with at least one partner (whose HIV status they did not know) in the last 12 months. There was also a high correlation of drug use, especially stimulant use, with sex. Respondents were asked what drugs they used with their partner *the last time they had sex*; 14% indicated that they used crack the last time they had sex, 3% used powder cocaine, and 5% used meth. Only about 7% of the sample had injected drugs in the past 12 months, but of those, 54% had shared needles. While about 21% of the HIV- respondents had a mental health diagnosis, a much larger proportion of HIV+ respondents (47%) had one. Similarly, while 4% of HIV- respondents had been diagnosed with syphilis in the past 12 months, 11% of those who were HIV+ had. Only limited analysis of this data has been done at this time, but it will be completed in early 2009.

E. DESCRIPTION OF THE CURRENT CONTINUUM OF CARE

Care for PLWH in King County is provided through a network of private practitioners, clinics, hospitals, public and non-profit programs throughout the county. Central to ensuring that PLWH have access to needed services is a medical case management system. In addition to these core services, dollars support a limited number of services that help PLWH to access and be retained in care. The table on the following page is an inventory of the non-Ryan White service system.

E.1. SERVICES RESOURCE INVENTORY

Agency	Description
CORE SERVICES:	
CASE MANAGEMENT (MCM)	
YouthCare	Provides medical case management (MCM) for PLWH 15 to 24 years old, and at-risk youth. Serves PLWH through Part D funding.
PHSKC-Needle Exchange	The King County needle exchange program employs a case manager who helps get users (some of whom are HIV+) into services.
University Of Washington Virology Clinic	Provides MCM to PLWH seen at the Virology Clinic. In the past this clinic has received Part A dollars to supplement its work but will no longer receive these funds beginning with the 2009 grant year.
People of Color Against AIDS Network (POCAAN)	Provides MCM to PLWH of color through Minority AIDS Initiative (MAI) funding.
Consejo	Provides MCM to Latino/a PLWH through MAI funding
HOME HEALTH	
Department of Social and Health Services	The majority of in-home skilled nursing, personal care and home chore services for PLWH are provided through the state's Medicare and Medicaid programs.
HOSPICE AND SKILLED NURSING CARE	
Bailey Boushay	A 35-bed residential skilled nursing facility for people with HIV
Evergreen Hospice	Provides hospice care in connection with Evergreen Hospital in east King County
Highline Hospice	Provides hospice care in connection with Highline Hospital in south King County
MENTAL HEALTH	
Seattle Counseling Services	Formerly supported through Part A funds, SCS was successful in finding other funds to support its HIV+ clients and continues to see an increased number of HIV+ consumers.
Community Psychiatric	A county-wide non-profit clinic system providing a variety of mental health services
Seattle Mental Health	A county-wide non-profit that has a history not only of serving HIV+ clients, but also of providing training and consultation to HIV services providers—especially psychosocial support providers
Valley City	Provides counseling in south King County and consultation with several HIV providers, such as Bailey Boushay.
Crisis Clinic	Provides phone-based emergency crisis intervention and referrals to on-going mental health providers.
Private Providers	HIV+ people with insurance can and do access private providers.
ORAL HEALTH CARE	
University of Washington Dental School	While UW dental school has no HIV-specific care, low income persons can get some dental services from students at the school.
Private providers	Those persons who have dental insurance or Medicaid can receive care from dentists throughout the county. However, a limited number of dentists accept Medicaid clients.
OUTPATIENT/AMBULATORY MEDICAL CARE (AND INPATIENT SERVICES)	
Primary Infection Clinic	Located near Harborview Hospital, this clinic provides medical care to newly infected PLWH.
Children's Hospital Regional Medical Center	This large children's hospital includes an HIV clinic for children.
Pike Market Clinic	This is another Seattle community clinic which provides care to PLWH, and has a case manager from Lifelong stationed at it
45th Street Clinic	This Seattle community clinic provides care for PLWH in the north part of the city and has specialty clinics for homeless youth.
Pioneer Square Clinic	This Seattle community clinic is located in the south part of downtown Seattle and sees many homeless and chronically inebriated clients.

Carolyn Downs Clinic	This community clinic provides care for low income people in south Seattle.
Seattle Indian Health Board	This full service clinic serves Native Americans and Alaskan Natives with a wide range of medical services.
Swedish Hospital Medical Center	This private hospital system is the largest in the county and provides care to significant numbers of PLWH.
International Clinic	This clinic at Harborview Hospital serves recent immigrants to the area and sees many high-risk members of foreign born Black communities. Public Health is currently doing a joint project with this clinic to increase testing in this population.
Group Health Cooperative/Virginia Mason Hospital	Regional HMO system including clinics and hospitals that service PLWH in Seattle and outlying parts of King County.
King County Jail Health	There are two jails in King County, one in Seattle and one in Kent, that have health care provided by Public Health providers. People in jail receive all appropriate HIV medical care, and staff have a close linkage to other HIV providers.
Highline Hospital	This medical center provides HIV care to PLWH in south King County (Burien). At least one south King County HIV provider is connected with this hospital.
VA Medical Center	This medical center provides HIV care to military and former military in the county.
Valley Medical Center	This hospital provides HIV care to PLWH in southeast King County (Renton). Several southeast King County providers are connected with this hospital.
Overlake Medical Center	This hospital is in Bellevue and provides care to east King County PLWH. Many east King County providers are connected to this center.
Northwest Hospital	This hospital provides medical care for PLWH in northwest Seattle.
Evergreen Community Healthcare	In Kirkland, this medical center provides services to PLWH in east King County.
Madrona Medical Group	A practice of private providers seeing PLWH patients in east Seattle.
Minor & James Medical Center	A practice of private providers seeing PLWH patients in central Seattle.
Polyclinic	A practice of private providers seeing PLWH patients in central Seattle.
University Of Washington Virology Clinic	This clinic, connected with the University of Washington Medical Center, sees a significant number of PLWH as outpatients.
SUBSTANCE ABUSE TREATMENT (OUTPATIENT AND INPATIENT)	
Evergreen Treatment Services	Public Health subcontracts with ETS to provide opiate replacement therapy for both PLWH and other users, and PLWH get services here using funding from a variety of other sources.
Therapeutic Health Services	Public Health subcontracts with THS to provide opiate replacement therapy for both PLWH and other users, and PLWH get services here using funding from a variety of other sources.
King County Detox	While detox is never the ideal treatment option, this county agency has a lot of experience working with HIV+ clients.
Thunderbird Treatment Center	Connected with Seattle Indian Health Board, this treatment program is geared toward the cultural needs of Native Americans and Alaskan Natives.
Recovery Centers of King County	These centers, spread throughout the county, provide services to a variety of clients and have expertise in working with a variety of different types of addictions.
Downtown Emergency Services Center (DESC)	Provides substance abuse counseling and mental health counseling for homeless persons, including PLWH.
Seattle Counseling Services	Provides substance abuse counseling and harm reduction, targeting methamphetamine using MSM. Funded partly by prevention and some care funds, this program is one of the few that provide culturally competent services to sexual minorities.

Support Services	
Complementary Therapies	
Bastyr University	A nationally recognized Naturopathic and Chinese Medicine school that offer reduced fee services to PLWH.
Private Providers	State law requires insurance companies to cover some alternative treatments, allowing insured people with HIV to have access to these services.
Food/Meals	
King County Food Bank Network	This county-wide series of non-profit Food Banks provides food to low income persons in every community in the county. In many cases, these food programs have relationships with Washington farmers to provide fresh fruits and vegetables.
Housing	
Building Changes (formerly AIDS Housing of Washington)	In addition to providing technical assistance throughout the country, Building Changes develops housing projects in King County. They began with Bailey Boushay, a 24-hour skilled nursing facility for people with AIDS. Since that time they have helped to develop Cal Anderson House, Shirley Bridge Bungalows, and a number of other developments with units set aside for people with HIV.
Plymouth Housing Group	A housing developer and manager which manages the Cal Anderson House as well as many buildings with set-aside units for PLWH, and includes Shelter Plus Care services.
Downtown Emergency Services Center (DESC)	Manages the Lyon Building, which has apartments for HIV+ chronically homeless persons with mental health and/or substance abuse issues. DESC also has shelters and case management for the chronically homeless.
Seattle Housing Authority	Has transitional and permanent housing as well as rental assistance and has set asides for people with AIDS.
King County Housing Authority	Has transitional and permanent housing as well as rental assistance and has set asides for people with AIDS.
Capitol Hill Housing Improvement Program (CHHIP)	Provides units in the neighborhood with the highest per capita AIDS rate in King County.
Low Income Housing Institute (LIHI)	Manages low income housing which includes set asides for PLWH.
YouthCare	Provides service-enriched emergency and transitional housing for street involved youth ages 12 to 21, some of whom are PLWH.
Compass Center	While there are many shelter systems in King County, Compass is the one that serves the greatest number of people with HIV.
Legal Services	
King County Bar Association	Provides free volunteer legal services for low income people, including PLWH.
Prevention Services for PLWH	
Consejo	Provides Comprehensive Risk Counseling Services (CRCS) to Spanish speaking PLWH.
Lifelong AIDS Alliance	Provides CRCS to PLWH, and African American MSM.
Psychosocial Support	
BABES Network/YWCA	Provides peer-led support groups and one-on-one support to HIV+ women and heterosexual men in Washington through Part D as well as Part A funds.
Dunshee House	Began as Seattle AIDS Support Group, providing support groups to PLWH. The agency had broadened its mission to provide services to the LGBTQ community.
Testing & Counseling for HIV and Other STIs	
Public Health STD Clinic at Harborview Hospital	The primary provider of HIV and STD testing in western Washington. This program diagnoses the majority of new cases and newly diagnosed PLWH are immediately moved into care. Funded primarily from CDC and Washington State AIDS Omnibus dollars.

Gay City	A prevention provider to the LGBTQ communities that provides HIV testing for MSM at their offices and off site.
Center for MultiCultural Health	A prevention provider to the African American and foreign born Black communities, CMCH provides HIV testing at their offices and off-site for foreign born Blacks and African American men.
TRANSPORTATION	
King County Metro	All low income and disabled people in King County are eligible for reduced bus and ferry fare. Metro also has Access vans for those who are disabled.
Neighborhood House	Has a fleet of vans and provides transportation for low income people in King County.
Hopelink	This program provides transportation through Medicaid funding.
UTILITY PAYMENT ASSISTANCE	
All Public Utilities	Puget Sound Energy, Seattle City Light and other utility providers have utility assistance programs for low income and disabled people in the county.

E.2. RYAN WHITE PART A FUNDED SERVICES PROFILE

The following information is from the 2009 implementation plan. Awards for 2009 have recently been announced, but contracts have not yet been negotiated, and therefore the final service units are not yet known. Service units in the table are based on initial estimates in the implementation plan.

Agency	Description
CORE SERVICES:	
MEDICAL CASE MANAGEMENT (MCM) ($1,400,000 PER YEAR)	
Harborview Madison Clinic (HMC)	Provides MCM services to PLWH in a public health hospital clinic. In 2009 HMC will enroll 55 clients into care, provide 1,872 30-minute treatment adherence sessions to 624 clients and provide 1,540 referrals to 780 clients. HMC provides additional MCM through MAI funding.
Public Health Seattle & King County-Jail Health Services	Provides MCM services and discharge planning to PLWH in the two King County jails. In 2009 Jail Health will enroll 100 clients into care, provide 150 30-minute treatment adherence sessions to 75 clients and provide 417 referrals to 100 clients.
Lifelong AIDS Alliance	Provides MCM services to PLWH in a community-based setting, and at off-site provider locations. In 2009 Lifelong will enroll 70 clients into care, provide 2,328 30 minute treatment adherence sessions to 776 clients and provide 1,141 referrals to 1,035 clients. Additionally, Lifelong was chosen by Snohomish County to provide MCM services there. With Part A dollars, they will enroll 43 clients into care, provide 278 30 minute treatment adherence sessions to 90 clients and provide 172 referrals to 120 clients.
△ Country Doctor Community Clinic	Provides MCM services to PLWH in two community clinics. This is a new program, and information on service units is not yet available.
△ Northwest Family Center	This provider is part of Public Health – Seattle & King County, and is the Part D grantee. NWFC will end its MCM program in 2009, due to cuts in funding to overhead costs. Funds will follow clients to other existing programs, such as HMC, where the majority of NWFC clients receive their medical care.
△ UW Virology Clinic	This provider will continue to provide MCM services to PLWH receiving their medical care at the Virology Clinic but will no longer receive Part A dollars.
OUTPATIENT/AMBULATORY MEDICAL CARE (MEDICAL CARE) ($1,283,000 PER YEAR)	
Harborview Madison Clinic (HMC)	Provides comprehensive medical services to low income PLWH in a site at TGA's largest public health hospital. In 2009 HMC will provide 2,232 office visits to 465 clients, 1,438 pharmacy encounters with 230 clients, and 253 health education encounters with 146 clients.
Country Doctor Community Clinic	Provides comprehensive medical services to PLWH at two community clinic sites. In 2009 Country Doctor will provide 315 office visits to 178 clients, 2,156 treatment adherence encounters with 134 clients, and 1,696 risk reduction counseling sessions with 178 clients.
Bailey Boushay	Provides medication management for high risk PLWH in their HIV-specific adult day health program. In 2009 Bailey will provide 11,490 medication management encounters to 216 clients.
ORAL HEALTH CARE ($443,000 PER YEAR)	
Puget Sound Neighborhood Health Centers (PSNC)	Provides care in a multi-site dental clinic system. In 2009, PSNC will provide 1,084 general dentistry visits to 411 clients, 26 crown visits to 18 clients and 143 denture visits to 62 clients.
Washington State Department of Health Office of HIV Client Services	Manages a statewide dental pool for PLWH which enrolls private and public dental providers as eligible to be reimbursed for their services to PLWH through this pool. In 2009, using Part A dollars, the dental pool will provide

	2,640 general dentistry visits to 330 clients, 38 crown visits to 26 clients, 135 denture visits to 60 clients and 30 endodontic visits to 15 clients.
MENTAL HEALTH SERVICES ($372,000 PER YEAR)	
University of Washington HIV Psychiatry at Harborview Hospital	Provides under- or uninsured PLWH with psychiatric assessments, therapy and medication management. In 2009, they will provide 814 one-hour intake and assessment sessions to 319 clients and 755 one-hour individual therapy sessions to 105 clients.
Public Health – Seattle & King County – Jail Health Services	Provides mental health services to PLWH while they are in jail and link them to community providers upon release. In 2009 Jail Health will provide 75 one-hour intake and assessment sessions to 75 clients, 775 one-hour individual therapy sessions to 75 clients and will link 35 clients to community mental health providers.
△ Northwest Family Center	Previously, the NWFC program had a mental health provider connected to it. That program was stopped in 2008, and clients were moved to other programs.
SUBSTANCE ABUSE TREATMENT, OUTPATIENT ($240,000 PER YEAR)	
Public Health HIV/AIDS Program	Provides opiate replacement therapy to PLWH who are IDU. In 2009 the program will provide 120 months of methadone treatment to 20 PLWH.
Seattle Counseling Services	Provides individual and group substance abuse counseling to substance using PLWH, most of whom are meth users. In 2009, SCS will provide 170 individual treatment sessions to 32 clients and 305 group sessions to 25 clients.
MEDICAL NUTRITION THERAPY ($131,000 PER YEAR)	
Lifelong AIDS Alliance	Provides nutritional counseling, education, assessments and supplements by a registered dietician. In 2009, Lifelong will conduct 100 assessments and provide 300 counseling sessions to 100 clients, and provide 1,600 supplement packages to 200 clients.
Harborview Madison Clinic	Provides nutritional counseling, education and assessments by a registered dietician. In 2009, Madison Clinic will conduct 235 assessments and provide 810 counseling sessions to 810 clients.
SUPPORT SERVICES:	
HOUSING SERVICES ($900,000 PER YEAR)	
Multifaith Works	Provides transitional housing for PLWH in five group-living environments. In 2009 Multifaith will provide 4,303 transitional bed nights to 39 clients and 1,971 medical respite bed nights to 24 clients
Rosehedge	Provides 24 hour enhanced assisted living services to PLWH in three adult family home settings. In 2009 Rosehedge will provide 2,230 enhanced bed nights to 29 clients.
Lifelong AIDS Alliance	Provides housing assistance to PLWH. In 2009 Lifelong will place 40 clients into emergency housing, 60 clients into transitional housing, 35 clients into permanent housing and provide emergency rental grants to 35 clients. Additionally, they will provide 15,000 housing advocacy sessions with 318 clients.
FOOD BANK/HOME-DELIVERED MEALS ($225,000 PER YEAR)	
Lifelong AIDS Alliance	Provides PLWH with a variety of home-delivered meals and bags of groceries. In 2009, Lifelong will provide 29,480 meals to 182 clients, and 6,882 bags of groceries to 252 clients.
△ Bailey Boushay	Newly funded for 2009, Bailey Boushay will provide meals to the PLWH in their adult day health program.
PSYCHOSOCIAL SUPPORT SERVICES ($78,000 PER YEAR)	
BABES Network/YWCA	Provides peer support counseling and referrals to core medical services to female PLWH. In 2009, BABES will conduct 1,800 peer counseling sessions to 110 PLWH, make 75 referrals for 40 clients and conduct 35 support groups for 65 clients.

F. Barriers to Care

Lack of Integrated Mental Health and Substance Abuse Services

Providers and consumers alike identified a need for greater integration between substance abuse treatment and mental health services, as many consumers have both problems, and there are very few programs with an integrated approached. Providers noted ever increasing levels of mental illness and chemical dependency among their clients and identified mental health as the number one priority. Consumers noted that, while outpatient substance abuse treatment is effective for opiates, consumers wanting to get off of stimulants such as meth have more success with inpatient treatment, followed by groups or counseling. However, there are limited inpatient treatment slots. Additionally, MSM consumers report that inpatient facilities are often homophobic to the point of it being unsafe for men to disclose that they are gay. This often makes the treatment less successful. Part A dollars do not currently fund outpatient treatment because it is not a core service, and is very expensive. However, King County recently passed a new sales tax increase, the proceeds of which are directed to mental health and substance abuse treatment services. Some Council members have been involved in committees set up to distribute these funds and are pushing for increased cultural competency in these services.

Overloaded, Increasingly Formalized Service System

Consumers and providers also agree that increased formality and case load burden in the Part A service system creates barriers for some of the most vulnerable clients. While the system moves toward increased accountability, some clients report that they feel both a lack of privacy, as well as a need to spend additional time finding and reporting information. Consumers also feel that their providers do not have enough time to help them. Providers note that increased formality and less time makes it more difficult for them to build rapport with the most vulnerable clients. They note an increased amount of time spent on record keeping. This problem will likely continue to increase with the growing number of consumers, limited dollars and the introduction of client-level data reporting.

Medicaid

Medicaid provides tens of millions of dollars of services to PLWH in the TGA. Over one-fifth (22%) of PLWH in the TGA are enrolled in Medicaid and will receive an estimated $32,469,691 in care from this source in 2009. These services include in-and outpatient medical care, prescription drugs, dental care, home health care, mental health counseling and a variety of other home and community-based support services.

In the past, the Washington State Early Intervention Program (EIP/ADAP) has paid spend down for their clients in anticipation of costs, so that consumers could get the broader benefits offered by Medicaid and provide seamless care. However, EIP is no longer allowed to anticipate these costs and can only pay expenses once incurred. Because this means that consumers must—at least for a time--pay costs up front, this imposes a new burden on clients and additional costs for the program. Because spend down happens all at once rather than gradually, and HIV medications are very high cost consumers are hit with medication bills at the beginning of the spend down period often in excess of their income. While EIP could reimburse them for the costs, consumers often cannot pay the costs at all, and therefore medications must be covered solely by EIP/ADAP. Once the spend down amount has been reached, consumers can be put into Medicaid, but during the spend down period they are unable to access services offered by Medicaid, such as transportation and dental care. These costs are then bourn by the Ryan White system. Similarly, those consumers who have previously been dual eligible (Medicare and Medicaid) will not be so, because, with Medicare Part D paying their prescription costs, little if anything is contributed to spend down, and these consumers must also seek services through Ryan White.

Medicare and Medicare Part D

For about 15% of clients in the TGA, Medicare is the primary payer for healthcare and medications. However, care is required on the part of consumers and their medical case managers to ensure that the plans chosen offer the medications they need and that consumers re-enroll each year. The complexity of the program has caused problems, especially for those consumers with co-occuring disorders such as mental illness or chemical dependency. Additionally, there is a hole in Part D coverage each year when a specific dollar amount is reached. At this point, ADAP takes over to provide HIV medications. For consumers with additional non-HIV-related conditions, they lose coverage for those conditions at this point.

Methamphetamine Use

Meth is a significant problem, and meth injection is the principal type of injection drug use associated with HIV infection in King County. Providers report that they are seeing not only increased numbers of meth users becoming positive, but also an increased number of HIV+ persons beginning meth use. While providers in King County have significant experience working with people who use meth, behaviors, attitudes and health outcomes associated with the drug are a barrier to care and successful outcomes. First, meth use causes rapid and severe declines in dental health, which in itself may affect nutrition and medication adherence. Secondly, having a history of meth use may limit a person's ability to qualify for other services, such as permanent housing. Some landlords will not

take any tenant with a meth use background. Finally, meth use is associated with periods of extreme paranoia, which often prevent users from seeking or accepting care.

Increased Cases in Part Due to In-Migration of PLWH

Several factors across the continuum of care have converged to increase the number of persons living with HIV in King County. In prevention, significant attention is given to outreach, testing and counseling and increasing the number of those who know their status. Linkages between these programs and care are strong, so the newly diagnosed are immediately moved in to care (where the majority remain). Due to ARV treatment and excellent care, consumers are living longer lives, and therefore remaining in the system. In addition, because of its quick response to the epidemic, Seattle gained a national reputation as a good place to be if you have HIV, resulting in a net influx of 6% of PLWH from other parts of the country (2% out-migration, 8% in-migration). As the TGA does not receive dollars for cases reported in other parts of the country, this means fewer dollars per client. Local and state dollars have not kept pace with growing case loads and may now be further reduced.

Potential Changes to the Ryan White Treatment Modernization Act

National organizations indicate support for reauthorizing the Ryan White Act as it is currently written. Were this to be the case, several factors in the current legislation would have a negative effect on care for PLWH. The first of these is the rule related to transitional housing, which indicates that the service is limited to 24 months *over the life of the client*. Because the most vulnerable PLWH are facing co-occuring disorders such as mental illness and substance abuse, it is not uncommon for these clients to cycle through the temporary housing system multiple times due to relapse. Add to this the very limited stock of permanent housing, and the problem is exacerbated. Another concern in the Seattle TGA is the Severity of Need Index which is to be used to determine all or part of supplemental awards. Because the index relies only on data that are available uniformly throughout the country, some of the unique issues faced in the Seattle TGA are not part of the equation. A third concern is that Ryan White formula funds are allocated based on the number of living cases diagnosed in an area, rather than the number of cases currently residing in the area. Because the Seattle TGA has a greater in-migration than out-migration, the result is a greater burden. A fourth issue in the current legislation is the definition of what is included in the Maintenance of Effort (MOE) calculation. In the past, all HIV-related costs provided through local sources were included. The new definition narrowly defines the MOE as relating only to HRSA-recognized core and support services. Prevention funding, which previously was included, has an impact on PLWH. One excellent example of this is needle exchange which, in addition to providing clean needles, also creates a venue in which consumers can begin to explore the possibility of treatment with needle exchange staff, who can also offer vouchers.

Since this expensive and politically charged service is no longer part of the MOE, it becomes vulnerable to local budget cuts. This can also be said of testing and counseling, and any number of other programs that affect PLWH.

The Washington State Budget

Governor Gregoire announced her proposed budget for the biennium beginning July 1, 2009 on December 17, 2008. While this budget has yet to be approved by the legislature, it proposes significant cuts to a number of safety net programs affecting PLWH. The state makes a generous contribution to EIP/ADAP, above that required by the Ryan White legislation. While funds to the program are not being cut from current levels, the additional $3 million dollars needed to maintain the current level of service has been significantly reduced. Other non HIV-specific programs which are utilized by PLWH are proposed for cuts. One is the General Assistance/Unemployable (GAU) program. This program has provided assistance to people in the two-year gap between becoming disabled, and getting on Social Security Disability. This program is being completely eliminated. Another cut involves reducing reimbursement rates for mental health services, hospital in-and outpatient services, and chemical dependency treatment.

SECTION II

CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES

The Council and Grantee have been and continue to be committed to providing PLWH with those services that will help them to live longer, healthier lives with HIV. Toward this end, decisions are made under a set of 12 principles, which are outlined here.

Principles Underlining the Continuum of Care

1. **Flexibility:** The Council will identify and address changes in the local epidemic and resource environment through short-and long-term planning. Allocation decisions will reflect and adapt to these changes.
2. **Needs-Based Services:** The Council will allocate resources to allow people living with HIV to access services appropriate to their level of need, and relies upon providers to conduct periodic individualized assessment in order to determine changes in the level of need for each client served.
3. **Systems Integration and Linkage:** The Council will work to affect system integration, linkage, and coordination with other public and private systems of care as indicated by client needs (e.g., mental health, chemical dependency, housing and prevention).
4. **Oversight and Monitoring:** The Council supports Public Health – Seattle & King County in their work to oversee and monitor care services that are prioritized and funded by the Council.
5. **Innovation:** Upon the identification of gaps in service delivery or emergent service needs, the Council will, through its prioritization process and other mechanisms, promote the development, implementation and evaluation of innovative programs.
6. **Assessment:** The Council will conduct formal, on-going assessment of community needs and the service delivery system in collaboration with Public Health.
7. **Cultural Competency:** The Council will demonstrate its commitment to diversity by ensuring representation by a broad array of communities, and relies upon providers to deliver services in a culturally appropriate manner.
8. **Care/Prevention Integration:** Wherever possible, the Council will encourage the incorporation of primary and secondary prevention into the care delivery system.

9. **Cost Effectiveness:** The Council relies upon providers to deliver services funded through Council allocations in a high-quality and cost effective manner.
10. **Mobilization:** The Council promotes a broad response to the HIV epidemic from many sectors of the community. This includes mobilizing volunteer involvement in service programs, planning and advocacy.
11. **Prioritization:** For each prioritization process, the Council will develop and implement clear policy to prioritize funds, so as to eliminate as many barriers to primary care as possible through an array of services.
12. **Leadership:** The Council recognizes and takes seriously its role as a community leadership body. This leadership role includes decision making on behalf of the entire King County community, including those affected by HIV, and bases decisions upon the data available as well as the experiences of its diverse representatives. The Council will make a good faith effort to inform community members of the rationale behind its decisions.

A. SHARED VISION FOR SYSTEM CHANGES:

AN OPERATIONAL DEFINITION OF THE CONTINUUM OF CARE AND CORE SERVICES

Continuum of Care: The set of services and programs, funded by a variety of sources, which help PLWH to learn their HIV status, get into high quality medical care, stay in medical care, engage with and be successful in medical care, live a healthy and productive life with HIV and (when the limits of state-of-the-art medical care have been reached) to die in a supportive environment. The Council monitors a range of funding and service provision resources throughout the community so that it can use Ryan White dollars to fill gaps in services. The Council assesses the available resources, determines gaps and barriers and uses Ryan White dollars to fill gaps in the highest priority core medical services before providing funding to support services. In the past, the Council considered its role in contributing to the continuum of care as filling gaps in all services that could be funded by Ryan White dollars, based on locally identified need. The Council still uses locally identified need, but puts additional emphasis on core services in the needs assessment (consumers and providers can choose more core services than support services as priorities) resulting in higher rankings for core services.
Core Services: The 13 services defined by the Ryan White legislation as being essential to the HIV medical needs of those living with HIV. These are:

- Outpatient and ambulatory health services (Medical Care)
- Health insurance premium and cost sharing assistance (Health Insurance)
- AIDS Drug Assistance Program (ADAP)
- Medical case management, including treatment adherence (MCM)

- Oral health care (Dental Care)
- Mental health services (Mental Health)
- Substance abuse outpatient care (Substance Use Treatment – Outpatient)
- Medical nutrition therapy (MNT)
- Home health care (Home Health)
- Hospice services (Hospice)
- Early intervention services (EIS)
- Home and community-based health services
- AIDS pharmaceutical assistance (Local Medication Assistance)

Support Services: Those services and programs that are needed by PLWH to achieve their HIV-related medical outcomes. The Council only considers for funding those support services which can *document* that they have an effect on the *HIV clinical status* of PLWH. If additional services among HRSA's 17 can demonstrate this outcome, they will be added to this list. Those currently considered include:

- Housing services (Housing)
- Psychosocial support services (Psychosocial Support)
- Food bank/home delivered meals (Food/Meals)
- Substance abuse inpatient services (Substance Abuse Treatment-Inpatient)
- Medical transportation services (Transportation)
- Rehabilitation services
- Health education/risk reduction (HERR)
- Child care services (Child Care)

Therefore, the vision of the future in the TGA is of a limited continuum of high quality, outcome-based services in which Ryan White dollars are used to fill gaps, support the underserved and improve quality of care. Decisions made about funding changes will continue to be led by the community and be science-based and data-driven.

System Changes:

The service system in the Seattle TGA is solid but as resources dwindle and the number of cases continues to grow, the array of services available to PLWH will be further reduced. The Council will be mindful of new and growing gaps in core services brought about by cuts to other local, state and federal programs such as Medicaid, the State contribution to ADAP, and the housing, mental health and substance abuse treatment systems.

B. SHARED VALUES FOR SYSTEM CHANGES:

GUIDING PRINCIPLES THAT SHAPE THE HIV-RELATED SYSTEM OF CARE IN THE REGION

The history of collaboration among the entities involved in HIV care and prevention in Washington State makes for a solid set of shared values. These are best described by the Statewide Coordinated Statement of Need.

Statewide Coordinated Statement of Need (SCSN): The Washington State Part B Grantee convened a workgroup comprised of representatives from Parts A, B, C, D & F to revise Washington's SCSN in late 2008. While the SCSN is currently in draft form, the work group developed four cross-cutting themes, which either guide or challenge HIV service provision in the state. These are to:

1. ***Provide a dynamic, client-centered continuum of HIV care that emphasizes core services***
    - ***Address the reality of ever-increasing need and ever-decreasing resources***
    - ***Align with the Ryan White HIV/AIDS Program principles***
    - ***Identify non-HIV specific, under-utilized resources***
    - ***Address the statewide Public Health funding crisis***
    - ***Adapt the continuum to reflect data-driven client needs***
2. ***Address the service needs of underserved populations***
    - ***Identify the underserved populations***
        - ***Increase ability to conduct unmet need analyses***
        - ***Ensure that needs assessment results can be stratified by population***
        - ***Consider traditional and unique demographic indicators***
        - ***Identify institutional factors***
        - ***Use client-level data to determine specific service deficiencies***
    - ***Plan a coordinated response***
    - ***Implement the plan in stages***
    - ***Provide technical assistance where necessary***
3. ***Link Prevention and Care***
    - ***Identify effective prevention interventions for care setting, while addressing limited provider time***
    - ***Increase prevention/care service co-location***
    - ***Reduce barriers to universal HIV testing***
    - ***Increase prevention and testing efforts for populations that have high levels of late diagnosis***

4. ***Adapt to the changing social and political landscape***
    - ***Use quality management reviews and client-level data collection to increase system accountability***
    - ***Ensure that services are a good value for the money***
    - ***As local, state and federal funding decreases for all services used by PLWH, ensure that the Ryan White system stays intact and meets it's goals***
    - ***Actively participate in conversations regarding funding and how it is used, not only in the Ryan White system***
    - ***Ensure that policies for HIV care are science-based and data-driven***

All providers and planners in Washington State are struggling to maintain high quality services while facing significant challenges:

- In addition to resource limitations and local and state budget shortfalls, Washington State does not have a dedicated source for Public Health funding.
- The number of persons living with the disease continues to grow due to new diagnoses, in-migration from other states and reduced death rates.
- The complexity of serving people with HIV increases as the number of consumers presenting with co-morbid conditions grows.

SECTION 3

HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

In the 2006-08 Comprehensive Plan, the Council made many changes that emphasized *Core Medical Services* from needs assessment through allocation. For 2009-11, the Council is emphasizing services that can *demonstrate that they positively affect the HIV-related health outcomes of PLWH*. With this in mind, the Council has adopted seven goals which both continue the strong work completed over the past three years and bring new initiatives to further strengthen that work. These goals and objectives were identified and approved by the Council at its December 8, 2008 meeting.

GOAL 1: THE COUNCIL AND GRANTEE WILL KNOW THE HIV-RELATED NEEDS, GAPS, BARRIERS AND SERVICE UTILIZATION OF PLWH AS WELL AS THE SERVICE CAPACITY IN THE SERVICE AREA.

NEW INITIATIVES:

OBJECTIVE 1: Obtain a complete picture of utilization of services through client-level data.

OBJECTIVE 2: Assess PLWH beginning or increasing drug abuse and determine their specific HIV-related needs.

OBJECTIVE 3: Assess if and why there is under-utilization of some high-ranking Core Services by historically underserved and/or disproportionately affected communities.

ONGOING, UPDATED INITIATIVES:

OBJECTIVE 4: Gain a clear picture of consumer needs and system capacity through the quantitative and qualitative assessment tools known as the Comprehensive Care Needs Assessment.

OBJECTIVE 5: Gain a clearer picture of programs, essential to PLWH, that are outside of the Ryan White Part A system.

OBJECTIVE 6: Obtain technical assistance from HRSA to improve measures of cost effectiveness and outcome effectiveness.

OBJECTIVE 7: Collect and organize all other available data for use by the Council.

GOAL 2: THERE WILL BE NO SIGNIFICANT GAPS IN THE HIGHEST RANKED CORE SERVICES.

ONGOING, UPDATED INITIATIVES:

OBJECTIVE 1: Utilize all available data to determine and fill gaps in the highest ranked services.

GOAL 3: THERE WILL BE NO PLWH WITHOUT ACCESS TO THE HIGHEST RANKED CORE SERVICES, AND THE PROFILE OF SERVICE UTILIZATION WILL FAVOR HISTORICALLY UNDERSERVED AND DISPROPORTIONATELY AFFECTED POPULATIONS.

ONGOING, UPDATED INITIATIVES:

OBJECTIVE 1: Enroll those not in care into primary medical care and ADAP

OBJECTIVE 2: Eliminate disparities in care for disproportionately affected and historically underserved populations.

GOAL 4: SERVICES PAID FOR BY RYAN WHITE DOLLARS WILL BE OF HIGH AND EVER IMPROVING QUALITY.

ONGOING INITIATIVES:

OBJECTIVE 1: Continually assess quality of Ryan White services.

OBJECTIVE 2: Review and update service standards and measures periodically.

OBJECTIVE 3: Engage in system-wide quality improvement.

OBJECTIVE 4: Require providers to engage in program-level quality improvement activities.

OBJECTIVE 5: Obtain client feedback on Ryan White services.

GOAL 5: TO THE GREATEST EXTENT POSSIBLE, THERE WILL BE SEAMLESS COORDINATION BETWEEN RYAN WHITE PART A AND OTHER SERVICES.

ONGOING INITIATIVES:

OBJECTIVE 1: Ensure coordination between all Ryan White Parts in Washington State.

OBJECTIVE 2: Ensure coordination between HIV prevention, testing and counseling and early intervention services.

OBJECTIVE 3: Links will be established and/or strengthened between the HIV system and Substance Abuse Prevention, Substance Abuse Treatment, Mental Health, Corrections, Medicaid, Housing and other systems affecting the health of PLWH.

GOAL 6: THE COUNCIL WILL BE AWARE OF AND RESPONSIVE TO CHANGES IN THE HIV+ POPULATION AND THE SURROUNDING FUNDING AND CARE ENVIRONMENT.

ONGOING INITIATIVES:

OBJECTIVE 1: Be aware of and responsive to emerging health trends in PLWH.

OBJECTIVE 2: Be aware of and responsive to demographic and psychosocial changes in the epidemic.

OBJECTIVE 3: Be aware of and responsive to changes in local, state and federal funding and legislation that impacts PLWH.

GOAL 7: THIS PLAN WILL BE COMPLETED IN THREE YEARS.

ONGOING INITIATIVES:

OBJECTIVE 1: Have regular check-ins on the Comprehensive Plan.

OBJECTIVE 2: Update the plan as needed.

OBJECTIVE 3: Write the 2012-14 Comprehensive Plan as new goals emerge.

SECTION IV

HOW WILL WE MONITOR OUR PROGRESS: HOW WILL WE EVALUATE OUT PROGRESS IN MEETING OUR SHORT- AND LONG-TERM GOALS?

At the end of this section is a grid for this plan, which lists, step-by-step, the actions that the Council and Grantee will undertake over the next three years.

A. IMPROVING CLIENT-LEVEL DATA

Goal 1, Objective 1 of this Plan notes that the state will begin collecting client-level data for Medical Care with a statewide database in 2009. At the present time, providers report their progress in aggregate to the Grantee on a quarterly basis. The new system will allow the Grantee to access data regularly and un-duplicate clients across service providers, and to develop a detailed profile of service utilization by race, gender and other factors. The statewide Quality Management Planning and Evaluation Group (QMPEG) which is overseeing implementation of the data system has entered into a contract with the University of Washington Center for Health Informatics to research the manner in which the various agencies record data elements, so that specific and accurate translations can be performed. Providers already collect the needed data elements, and will begin reporting them in January, 2009. The statewide database is slated to be in place by July, 2009. Running tests on the data to ensure accuracy will be done periodically by the Part A and B Grantees. As the data for Outpatient/ Ambulatory Medical Care becomes set, the system will be expanded to other services, beginning with Core Services.

It is expected that, when the Council convenes its prioritization and allocation committee in April of 2010, there will be at least two quarters of reliable data on client utilization, delineated by gender, race, geographic location and other factors, which the committee will be able to use.

B. USING DATA FOR EVALUATION

This Plan describes many ways in which data are used in planning, monitoring and making changes to services. The Council and Grantee have a well-established system by which the work of agencies, the Grantee and the Council are evaluated.

<u>The Work of Agencies:</u>

The Grantee will receive quarterly reports from agencies on their progress toward meeting their goals and objectives, and use these data to evaluate the programs. Programs having difficulties will be

given prompt technical assistance. As it becomes available, the Grantee will use client-level data for this purpose. The QM Manager will conduct quality assurance reviews, develop an improvement plan for each and monitor work on the improvement plan. These data will be reported (by service category, not by agency) to the Council for use in the prioritization and allocation process. Additionally, as part of the RFP process, the Grantee will conduct a technical review of the proposal and provide QM and contract-monitoring data to the panel for use in reviewing proposals.

<u>The Work of the Grantee:</u>
The Council will conduct an assessment of the administrative mechanism of the Grantee every other year (the next one will be in 2010) which includes recommendations for changes. The Grantee will make the changes where possible and outline barriers where changes are not possible. The results of the changes made will then be evaluated in the next administrative mechanisms assessment.

<u>The Work of the Council:</u>
The Council will evaluate its processes through satisfaction and effectiveness surveys. These data will be used in making changes to processes. Additionally, the Council will use needs assessment and, in the future, client-level data to determine the impact of their decisions on both the effectiveness of the service-delivery system and on PLWH.

C. Measuring Clinical Outcomes

Clinical outcomes are currently measured in a variety of ways, and, in the course of carrying out this Plan, those methods will improve. To date, the majority of the work on this issue has been conducted by the QM program and agencies, which will continue to look at a variety of clinical indicators across the range of patients. Goal 4, Objective 3 outlines three clinical outcomes slated for system-wide improvement in 2009 through an awareness campaign. Needs assessment data will evaluate the effectiveness of this campaign. As client-level data become available, the ability to measure clinical outcomes will be improved, and these data will be used in setting future improvement goals.

D. IMPLEMENTATION AND EVALUATION PLAN

GOAL 1: THE COUNCIL AND GRANTEE WILL KNOW THE HIV-RELATED NEEDS, GAPS, BARRIERS AND SERVICE UTILIZATION OF PLWH AND THE SERVICE CAPACITY IN THE SERVICE AREA.

NEW INITIATIVES:

OBJECTIVE 1: Obtain a complete picture of utilization of services through client-level data.

ACTIVITY 1: Begin collecting client-level data for Medical care in January 2009.

ACTIVITY 2: Institute statewide database in the second quarter of 2009.

ACTIVITY 3: Add more services to the database over time, beginning with Core Services.

ACTIVITY 4: Use information about under-utilization of services by specific populations of consumers to set allocation levels, sub-priorities and caveats in the prioritization process in spring 2010.

Who does it*? DOH will oversee implementation of software and house and manage all client-level data throughout the state. The Part A Grantee will contribute resources to the creation of the statewide database, follow up with providers regarding appropriate reporting and prepare reports for use by the Grantee, the Council and QM staff. The Council will review utilization of each Ryan White service and compare it with the demographics of the epidemic in terms of gender, race, age, ethnicity, country of origin, mode of exposure and geographic location.*

Markers that will show the TGA has successfully achieved this objective:

- *Medical care providers will be collecting all identified data elements beginning in January 2009.*
- *Database will be in place for Medical care by July 2009.*
- *Data that has been collected for Medical care will be 80% complete and accurate by December 2009, and improvements will be seen each quarter thereafter.*
- *Data will be used by the Council in the prioritization and allocation process March through June 2010.*
- *In March 2010, medical case management (MCM) programs and ADAP will be added to the database.*
- *MCM and ADAP data will be 80% complete and accurate by September 2010, and improvements will be seen each quarter thereafter.*
- *Oral health care programs will be added to the database in June 2010.*
- *Oral health care data will be 80% complete and accurate by December 2010, and improvements will be seen each quarter thereafter.*
- *Mental health services will be added to the database in September 2010.*
- *Mental health services data will be 80% complete and accurate by March 2011, and improvements will be seen each quarter thereafter.*
- *Substance abuse treatment program data will be added to the database in December 2010.*

- *Substance abuse treatment data will be 80% complete and accurate by June 2011, and improvements will be seen each quarter thereafter.*
- *Data for medical care, ADAP, MCM, oral health care, mental health services and substance abuse treatment will be used by the Council in June 2011 to make adjustments to the second year (2012) of the two-year prioritization and allocation plan.*
- *Medical nutrition therapy (MNT) data will be added to the database in March 2011.*
- *MNT data will be 80% complete and accurate by September 2011, and improvements will be seen each quarter thereafter.*
- *Housing program data will be added to the database in June 2011, as the first support service to be added.*
- *Housing data will be 80% complete and accurate by December 2011, and improvements will be seen each quarter thereafter.*
- *Additional services will be added to the database going into the next Comprehensive Plan period.*

OBJECTIVE 2: Assess PLWH beginning or increasing drug abuse and determine their specific HIV-related needs.

ACTIVITY 1: Conduct 200 interviews with MSM PLWH in January 2009 regarding the initiation of drug abuse and factors surrounding their lives at the time of initiation.

ACTIVITY 2: Conduct eight key informant interviews with providers who can provide insight into the specific factors that may influence consumers in beginning drug abuse and what they are currently doing to address this problem.

ACTIVITY 3: Analyze this data and present it to the Council, Grantee, QM Manager, service providers and the community. Include findings in subsequent prioritization and allocation processes.

Who does it*? Council Needs Assessment Workgroup will develop questions and brainstorm ways to reach a diverse number of clients. Public Health Epidemiologist will create the interview tool and analyze the data. Council staff will conduct key informant interviews, analyze qualitative data and present results.*

Markers that will show the TGA has successfully achieved this objective:

- *The assessment tool will be finalized by the second week of January 2009.*
- *200 interviews will be completed by the second week of February 2009.*
- *8 key informant interviews will be completed by the last week of January 2009.*
- *Data will be analyzed by the end of February 2009.*
- *Data will be presented to the Council, SPWG, QMPEG and Quality Management Advisory Group in mid-2009, followed by discussions of how the data can be used by those groups to reduce the number of PLWH starting to abuse substances after diagnosis.*

- *These data will be used in 2010 to create the prioritization and allocation plan for grant years 2011 and 2012.*
- *The Council's prioritization and allocation plan will reflect the use of these data.*

OBJECTIVE 3: Assess if and why there is under-utilization of some high-ranking Core Services by historically underserved and/or disproportionately affected communities.

ACTIVITY 1: Complete additional analysis to update those local populations with the highest disease burden, hence "disproportionately affected communities."

ACTIVITY 2: Control for payment sources besides Ryan White, review local HIV service utilization since the beginning of the epidemic and determine what populations have been historically underserved. In absence of direct HIV data, use surrogate markers.

ACTIVITY 3: Use client-level data as it becomes available for each service and identify groups of people with a certain demographic characteristic in common who are disproportionately under-utilizing highly ranked services (after eliminating those who are getting these services from other systems besides Ryan White).

ACTIVITY 4: Determine the barriers that cause this problem.

ACTIVITY 5: If needed, conduct additional assessment or add questions to comprehensive assessment to learn more about these barriers.

Who does it*? Epidemiologists will determine local disproportionately affected communities. A Workgroup, including Council members and the Grantee, will review service trends, assess client-level data and identify barriers. Epidemiologists and Council staff will conduct the assessment, if needed.*

Markers that will show the TGA has successfully achieved this objective:

- *In January 2009 the Epidemiologists will conduct analysis of the populations most greatly affected by the epidemic for the Council's prevention prioritization process. This analysis will include looking for disproportionately affected populations by sex, race, ethnicity, mode of transmission, age and geography.*
- *The Council will use this epidemiologic profile to update its list of disproportionately affected communities for care services.*
- *As client-level data becomes available (see Objective 1) it will be compared with information from the Medical Monitoring Project (MMP) and the Not in Care and Never in Care projects to determine which populations and sub-populations are under-utilizing services.*
- *These data will be presented to the Council by service category, as they become available.*
- *The Council will review other data sources, such as the comprehensive assessment(s) to see if they are able to identify barriers and solutions to them.*

- *If barriers cannot be identified through existing data sources, the Council will conduct an additional assessment in May 2011 (or include additional questions in the 2011 comprehensive assessment) to determine the barriers and/or solutions.*
- *The Council's prioritization and allocation plan will reflect the use of these data.*
- *As barriers for disproportionately affected and historically under-served populations are identified, the Council will include this information in the care prioritization and allocation processes, taking place in 2010 and 2012.*
- *After barriers have been addressed, client-level data will be assessed to determine the impact of funding changes.*

ONGOING, UPDATED INITIATIVES:

OBJECTIVE 4: Gain a clear picture of consumer needs and system capacity through the quantitative and qualitative assessment tools known as the Comprehensive Care Needs Assessment.

ACTIVITY 1: Revise the survey that identifies the needs, gaps and barriers of service for consumers. The survey will be administered in late spring of 2009, with a goal of getting responses from 10% of the TGA's PLWH and ensuring that responses are received from a representative sample of consumers. In addition to demographic information, the survey will also ask about newly identified issues.

ACTIVITY 2: Revise the survey that asks HIV service providers to identify the needs, gaps and barriers of the consumers they serve. Survey will be administered in early summer of 2009, with a goal of getting responses from 60% of providers and ensuring that responses are received from diverse types of providers who are seeing diverse types of clients with diverse needs. Survey will also collect data on size and demographics of provider case loads in order to identify system strains.

ACTIVITY 3: Analyze data from Activities 1 and 2 and determine themes and follow-up questions to be asked in focus groups and key informant interviews.

ACTIVITY 4: Conduct key informant interviews to gather additional qualitative data about barriers and system capacity strain in fall of 2009.

ACTIVITY 5: Conduct focus groups in with consumers that gather additional qualitative data about consumer needs, gaps and barriers fall of 2009.

ACTIVITY 6: Analyze all of the needs assessment data, compare it with data from the 2007 assessment and present findings to the Council, Grantee, QM Manager, service providers and the community in January 2010. Present data again to the Care Prioritization and Allocation Process including through the Categorical Data Reports (CDR) used in that process in April 2010.

ACTIVITIES 7-12: Repeat Activities 1-6 in 2011.

Who does it*? The Council Needs Assessment Workgroup will set plans, alter tools and brainstorm additional questions and ways to reach consumers who are least likely to fill out surveys. Public Health*

Epidemiologists will oversee the process and analyze data and help with presentations and CDRs. DOH staff will ensure that surveys are mailed to all ADAP clients and oversee distribution and analysis outside of King County. Council staff will handle logistics, distribute surveys, conduct interviews and focus groups, enter data, make presentations, create CDRs and conduct all qualitative and some quantitative analysis.

Markers that will show the TGA has successfully achieved this objective:

- *Consumer and provider needs assessment surveys will be distributed by April 2009 and April 2011.*
- *By July 2009, 670 consumer surveys (up from 506 in 2007) will have been received for King County (1,000 for the state as a whole), and they will reflect the epidemic, with the exception of over-representing smaller populations. One hundred and fourty King County provider surveys will be received during that time.*
- *By August 2009 (and again in 2011) all quantitative data will have been analyzed, providing additional guidance to the Needs Assessment Workgroup on questions for the qualitative portion of the assessment.*
- *By January 2010, key informant interviews and consumer focus groups will have been completed.*
- *By the end of February 2010, qualitative analysis of the data will be complete.*
- *By April of 2010 all of these data will be compiled into CDRs for the prioritization and allocation process starting that month.*
- *The 2011-12 prioritization and allocation plan will reflect the information provided in the CDRs.*

OBJECTIVE 5: Gain a clearer picture of programs, essential to PLWH, that are outside of the Ryan White Part A system.

ACTIVITY 1: Utilize the expertise of Council members to keep up to date on Medicaid, Ryan White Parts B, C, D & F, the substance abuse system, the mental health system, corrections, insurance, private providers and other programs affecting PLWH.

ACTIVITY 2: Seek additional information from and coordination with service systems outside of Ryan White-funded programs.

ACTIVITY 3: Compile information for use in the Council's prioritization and allocation process and the Grantee's work with service providers.

Who does it*? Council members will gain as much information as available from the programs and systems they work in and share this at Council meetings. The Council's Executive Committee will ensure that the opportunity for this type of update is available at Council meetings. The Grantee,*

Council staff and Council members will work together to bring in other experts. Council staff will compile the information in an easy to understand format for the Council's use.

Markers that will show the TGA has successfully achieved this objective:

- *A review of Council membership over the three-year period of this Plan will indicate that knowledgeable providers from each of these areas were members of the Council.*
- *A review of Council agendas over the three-year period of this Plan will show presentations on these systems.*
- *The CDRs will include information from other systems for the Council to use in decision-making.*
- *The Council's prioritization and allocation plan will reflect the use of these data.*

OBJECTIVE 6: Obtain technical assistance from HRSA to improve measures of cost effectiveness and outcome effectiveness.

ACTIVITY 1: Request Technical Assistance in March 2009.

ACTIVITY 2: Develop measures in summer of 2009.

ACTIVITY 3: Introduce methods into the Prioritization and Allocation process in April 2010 and the Procurement process in November 2010.

Who does it? *The Grantee will make a request for technical assistance to HRSA. A Council workgroup, including the Grantee and Council staff will work with the TA provider to develop better measures. The Council and Grantee will utilize the results in allocation and procurement, respectively.*

Markers that will show the TGA has successfully achieved this objective:

- *By June 2009 a TA provider will have been identified and contacted.*
- *By December 2009, updated measures of cost effectiveness and outcome effectiveness will be identified.*
- *These measures will be used to identify cost effective services providing effective outcomes for prioritization and allocation.*
- *The Council's prioritization and allocation plan will reflect these new measures.*

OBJECTIVE 7: Collect and organize all other available data for use by the Council.

ACTIVITY 1: Improve method for calculating the number of people not in care.

ACTIVITY 2: Research all available data sources and collect data.

ACTIVITY 3: Present data to the Council and the Prioritization and Allocation Committee.

Who does it? *The Grantee and local epidemiologists will work with DOH to refine Not-in-Care estimate. Council staff will organize data from previous and related assessments and materials gained from the Grantee and put it in a user-friendly format. The Grantee will provide service cost, expenditure, service*

provision, anticipated Part A award and Parity allocation information; the QM Manager will provide results of service reviews. The Epidemiologists will provide data.

Markers that will show the TGA has successfully achieved this objective:

- *A new, specific method of determining the number and demographic characteristics of those not in care will be presented to the Council in 2010 for use in the prioritization and allocation process.*
- *CDRs will include all available local data relevant to the prioritization and allocation process.*
- *The Council's Plan will reflect the use of these data in decision-making.*

GOAL 2: THERE WILL BE NO SIGNIFICANT GAPS IN THE HIGHEST RANKED CORE SERVICES.

ONGOING, UPDATED INITIATIVES:

OBJECTIVE 1: Utilize all available data to determine and fill gaps in the highest ranked services.

ACTIVITY 1: Create and distribute CDRs, presentations and other materials and present them to the Prioritization and Allocation Committee.

ACTIVITY 2: Consider services in order of priority in the allocation process, ensuring that a thorough discussion of any reported gap takes place and that plans are made for filling the gap.

ACTIVITY 3: To the extent possible within the confines of the legislation and the Council's ability to create and alter capacity, the Prioritization and Allocation Committee will fill any identified gaps in the highest ranked service (by allocation, sub-priority, caveat or identifying outside resources) before moving on to the next highest category.

Who does it? *Council staff will compile data in an easy-to-use format. The Care Prioritization Steering Committee will set how and at what point different data elements will be introduced into the process. The Prioritization and Allocation Committee will use the data in creating their plan. The Grantee will use the data in the procurement process.*

Markers that will show the TGA has successfully achieved this objective:

- *The Council's prioritization plan will show a detailed account of how gaps in services were filled, starting with the highest priority.*
- *Subsequent needs assessments will show reduced or eliminated gaps in core services.*

GOAL 3: THERE WILL BE NO PLWH WITHOUT ACCESS TO THE HIGHEST RANKED CORE SERVICES, AND THE PROFILE OF SERVICE UTILIZATION WILL FAVOR HISTORICALLY UNDERSERVED AND DISPROPORTIONATELY AFFECTED POPULATIONS.

ONGOING, UPDATED INITIATIVES:

OBJECTIVE 1: Enroll those not in care into primary medical care and ADAP.

ACTIVITY 1: Through prioritization and allocation, ensure that capacity exists in these services for those who do not have other ways of paying for care.

ACTIVITY 2: Through prioritization, allocation and procurement, ensure that any barriers to access that *can* be removed *are* removed.

ACTIVITY 3: Utilize names-based reporting data to make direct contact with consumers considered to be Not-in-Care, and A) learn whether they are actually receiving care, and if not, B) help them to become engaged in care.

ACTIVITY 4: Outreach to find others lost to care and enroll them in care.

Who does it? *The Council will assess and assure capacity, and eliminate barriers within its ability. The Grantee will emphasize barrier elimination in the RFP and procurement process. Epidemiologists and QM staff will contact those Not-in-Care. All parts of the system will collaborate to find and enroll those not in care.*

Markers that will show the TGA has successfully achieved this objective:

- *All PLWH in the surveillance system who have not had a lab report within the last year will have been successfully found by the Not-in-Care staff.*
- *Those who are truly out of care will be helped to identify barriers to getting care.*
- *Those not-in-care will have been enrolled in care.*

OBJECTIVE 2: Eliminate disparities in care for disproportionately affected and historically underserved populations.

ACTIVITY 1: Review client-level data showing utilization patterns for these populations.

ACTIVITY 2: Review assessment data identifying barriers.

ACTIVITY 3: Review QM data indicating problems.

ACTIVITY 4: Compile all data and use in the Council's prioritization and allocation processes to reduce barriers through allocations, sub-priorities and funding caveats.

Who does it? *The Grantee, QM Manager, Council staff and Prioritization and Allocation Steering Committee will present data. The Prioritization and Allocation Committee will make the plan. The Grantee will ensure that the plan is put in place through the procurement process.*

Markers that will show the TGA has successfully achieved this objective:

- *Goal 1, Objective 1 will provide the data for this objective.*
- *The Council will be able to determine whether outcomes are not as good for some populations and sub-populations, controlling for equal access.*
- *The Council, QM Manager and Grantee will conduct additional assessments or analysis of existing data to determine reasons for differing outcomes.*

- *This information will be compiled and included on the CDRs for use in prioritization and allocation.*
- *The Council's prioritization and allocation plan will reflect the use of these data.*
- *Subsequent assessments will show a reduction in health outcome disparities.*

GOAL 4: SERVICES PAID FOR BY RYAN WHITE DOLLARS WILL BE OF HIGH AND EVER IMPROVING QUALITY.

ONGOING INITIATIVES:

OBJECTIVE 1: Continually assess the quality of Ryan White services.

ACTIVITY 1: Quality assurance reviews will take place regularly for all services at all agencies.

ACTIVITY 2: Client-level data will be integrated into the quality assurance review process.

ACTIVITY 3: An improvement plan will be made after each review.

ACTIVITY 4: Plans will be monitored and updated.

ACTIVITY 5: Service category-wide issues will be addressed at the system level, focusing on the highest priority services first.

Who does it? *QM staff will complete service audits and give feedback. Service provider agencies will develop an improvement plan with help of QM staff. The QM Manager and Grantee staff will monitor progress on plans. Grantee, QM program and Council will address service category-wide issues through regular processes.*

Markers that will show the TGA has successfully achieved this objective:

- *QM Manager will have copies of quality assurance reviews and improvement plans.*
- *QM Manager will have notes of progressmade on the plans.*
- *The Council will receive updates on these things, and service category-wide issues will be addressed in the prioritization and allocation process.*

OBJECTIVE 2: Review and update service standards and measures periodically.

ACTIVITY 1: Review the usability of standards and measures regularly.

ACTIVITY 2: Troubleshoot problems and update standards as needed.

ACTIVITY 3: Set priorities for improvement year by year.

Who does it? *QM staff will determine the usability of standards and measures and note problems. The Standards of Care Committee (which includes QM Manager, Grantee and Council members) will review potential adjustments and set improvement priorities.*

Markers that will show the TGA has successfully achieved this objective:

- *Standards will used by the QM Manager in reviewing programs.*
- *The QM Manager will update the Council on any problems at least biannually.*

- *Service standards will be revised as needed, in order of priority.*

OBJECTIVE 3: Engage in system-wide quality improvement.

ACTIVITY 1: Assess system-wide clinical indicators.

ACTIVITY 2: Ensure that clinical indicators are collected as part of the statewide client-level data system.

ACTIVITY 3: In 2009, make improvement in four key clinical indicators through a client awareness campaign:

- Increase the rate of PAP tests among female PLWH;
- Increase the percentage of PLWH who know their CD4 cell and viral load counts;
- Increase the percentage of PLWH who renew with the Early Intervention Program (EIP) on time and therefore have no lapse in coverage; and
- Increase the rate of adherence to medication regimen among PLWH.

ACTIVITY 4: Offer monthly educational updates for providers to improve and sustain professional competence.

ACTIVITY 5: The Comprehensive Care Needs Assessment will include questions to assess the effectiveness of the consumer awareness campaign.

Who does it? *The QM Manager will ensure that indicators are included in the statewide client-level data collection. QM staff will review charts to assess indicators. The QM and Grantee staff will develop and implement client awareness campaign. The QM program will identify and schedule provider educational updates. The QM Manager will ensure that questions related to the awareness campaign are included in the needs assessment survey.*

Markers that will show the TGA has successfully achieved this objective:

- *Improvement is shown in the four indicators listed in Activity 3 above through needs assessment, client-level data and/or subsequent QM reviews.*
- *Records of educational updates are kept.*

OBJECTIVE 4: Providers will engage in program-level quality improvement activities.

ACTIVITY 1: QM requirements will be integrated into all of the TGA's processes

- Programs will be required to submit annual QM plans that include quality assurance, client satisfaction and quality improvement goals and activities.
- Programs will report their QM activities quarterly.

ACTIVITY 2: Trainings on QM will be provided for providers, consumers and planners to develop and increase capacity on the program level.

Who does it? *The Grantee and QM Manager will include QM requirements in the RFP and contracts. Agency staff will create QM plans for their programs, implement and report progress on them to the QM Manager. The QM Manager will provide trainings.*

Markers that will show the TGA has successfully achieved this objective:

- *There will be a QM plan submitted by every funded agency/program that includes quality assurance, client satisfaction and quality improvement goals and activities.*
- *There will be quarterly QM reports submitted by every funded agency.*

OBJECTIVE 5: Obtain client feedback on Ryan White services.

ACTIVITY 1: Feedback from consumers will be collected online, and providers will be contacted about concerns and compliments.

ACTIVITY 2: Focus groups will be held to gather client input.

ACTIVITY 3: Program-level client feedback will be collected.

Who does it? *QM staff will monitor client feedback website, take out client-identifying information and contact providers with the information. QM staff will conduct focus groups with clients. Providers will obtain client feedback on their services.*

Markers that will show the TGA has successfully achieved this objective:

- *The QM Manager will present a synopsis of information gathered from these activities to the Council biannually.*

GOAL 5: TO THE GREATEST EXTENT POSSIBLE, THERE WILL BE SEAMLESS COORDINATION BETWEEN RYAN WHITE PART A CARE AND OTHER SERVICES.

ONGOING INITIATIVES:

OBJECTIVE 1: Ensure coordination between all Ryan White Parts in Washington State.

ACTIVITY 1: The Part A Grantee and Council representatives will participate in developing the Statewide Coordinated Statement of Need (SCSN).

ACTIVITY 2: Part B, C, D and F Grantees or representatives will serve on the Council.

ACTIVITY 3: All Parts will collaborate on a statewide client-level data system, housed at the Part B Grantee's office.

ACTIVITY 4: All Parts will participate in a statewide Quality Management Planning and Evaluation Group (QMPEG).

ACTIVITY 5: All Parts will look for collaboration in other assessments, including the coordinated Part A & B Comprehensive Care Needs Assessments.

Who does it? *Co-chairs of the Council, the Part A Grantee and Council staff will participate in SCSN creation and DOH staff write the plan. The Membership Committee of the Council will seek Part B, C, D*

& F grantees for Council membership. The Part B Grantee and assessment unit will lead the client-level data process with input and support from the other Parts. The Part B Grantee and Part A QM Manager will lead the QMPEG with representatives of all Parts. Part A Council staff and Part B planning staff will complete statewide comprehensive assessments collaboratively in 2009 and 2011.

- *The SCSN will reflect participation from the Part A Grantee, Care Co-Chairs and staff.*
- *A review of membership of the Council over the three-year period of this Plan will reflect that all provider slots are filled.*
- *The Statewide client-level data base will be in place by July 2009.*
- *QMPEG minutes will reflect participation by representatives of all Parts.*
- *The 2009 and 2011 comprehensive care needs assessments will be conducted using the same tools at the same time throughout the state. Part A Council staff and Part B staff will be able to analyse data by TGA or region.*

OBJECTIVE 2: Ensure coordination between HIV prevention, testing and counseling and early intervention services.

ACTIVITY 1: The Council will continue to plan for both Ryan White care services and 100% of CDC and 50% of Washington State AIDS Omnibus prevention services in the area.

ACTIVITY 2: Assess the effectiveness of testing and counseling providers in moving newly diagnosed PLWH into care services and make adjustments based on the results.

ACTIVITY 3: Assess the effectiveness of medical case managers and primary care providers in delivering prevention messages that are consistent with proven protocols and make adjustments based on the results.

Who does it? *The Membership Committee will ensure that Council members reflect both the HRSA and CDC required membership. The Prioritization and Allocation Committees will make sure that those with prevention expertise participate in care prioritization and allocation and those with care expertise participate in prevention prioritization and allocation. Epidemiologists and Council staff will conduct assessments. The Council will utilize results in setting guidance in the prioritization and allocation process.*

Markers that will show the TGA has successfully achieved this objective:

- *Council prevention and care prioritization and allocation plans will reflect coordination in planning, and not create gaps in service.*
- *All newly identified positives will be identified as being in care.*
- *On the 2009 assessment, consumers will be asked whether and how often providers delivered prevention messages to them.*

OBJECTIVE 3: Links will be established and/or strengthened between the HIV system and Substance Abuse Prevention, Substance Abuse Treatment, Mental Health, Corrections, Medicaid, Housing and other systems affecting the health of PLWH.

ACTIVITY 1: Experts from these fields will be brought in to present to the Council.

ACTIVITY 2: Providers conversant in these systems will continue to be members of the Council.

ACTIVITY 3: The HIV system will monitor the use of the new "1/10 of 1%" substance abuse treatment and mental health funding to ensure that PLWH and those at risk for HIV have access to those services.

ACTITIVY 4: The HIV system will educate service providers in other systems about the need for cultural competence for historically underserved and disproportionately affected PLWH.

Who does it? *The Council Executive Committee will arrange for speakers and time on the Council agenda. The Membership Committee will seek members for the Council with expertise in other systems. Care and Prevention Grantee staff and the Council Executive Committee will monitor and update the Council on the use of the "1/10 of 1%" dollars. The Council will educate service providers and systems about the challenges faced by PLWH in these other systems.*

Markers that will show the TGA has successfully achieved this objective:

- *A review of Council agendas over the three-year period of this Plan will reflect presentations by experts in each of these fields, as well as updates on the status of the "1/10 of 1%" services tax.*
- *Minutes of the meetings of provider workgroups for these services will indicate presentations by Council members, Council staff and/or Grantee staff.*

GOAL 6: THE PLANNING COUNCIL WILL BE AWARE OF AND RESPONSIVE TO CHANGES IN THE HIV+ POPULATION AND THE SURROUNDING FUNDING AND CARE ENVIRONMENT.

ONGOING INITIATIVES:

OBJECTIVE 1: Be aware of and responsive to emerging health trends in PLWH.

ACTIVITY 1: Continue to have at least one HIV primary care provider (PCP) on the Council who can bring information about new health trends.

ACTIVITY 2: Have medical updates presented to the Council.

ACTIVITY 3: Utilize this knowledge to inform Council processes.

Who does it? *The Membership Committee will seek PCP members who work with large numbers of PLWH. The Executive Committee will seek speakers and set time aside on the Council agenda. The Prioritization and Allocation Steering Committee will build information about health trends into the process.*

Markers that will show the TGA has successfully achieved this objective:

- *The Council's prioritization and allocation plan will reflect the emergence of new health trends.*

- *A review of Council agendas will show an annual medical update by the designated PCP member of the Council.*

OBJECTIVE 2: Be aware of and responsive to demographic and psychosocial changes in the epidemic.

ACTIVITY 1: Utilize service providers, testing and counseling providers and epidemiologists to update the Council on emerging trends.

ACTIVITY 2: Present this information to the Council.

ACTIVITY 3: Use this information to inform Council processes.

Who does it? *Providers on the Council and on the Service Providers Work Group (SPWG)will bring information to those bodies. Epidemiologists will regularly present information on emerging trends as part of both care and prevention prioritization and allocation processes.*

Markers that will show the TGA has successfully achieved this objective:

- *Council prioritization and allocation plan will reflect these emerging issues.*
- *A review of Council agendas will show annual presentations on this topic.*

OBJECTIVE 3: Be aware of and responsive to changes in local, state and federal funding and legislation that impacts PLWH.

ACTIVITY 1: Collect information from state and local funding sources.

ACTIVITY 2: Present this information to the Council's Executive Committee.

ACTIVITY 3: Determine whether there is a need for Council action and, if so, act.

Who does it? *Council members will collect information and bring it to the Executive Committee. The Executive Committee will determine whether action is called for and, if so, act.*

Markers that will show the TGA has successfully achieved this objective:

- *The Executive Committee, Council and Prioritization minutes will indicate the Council's response to external funding changes.*
- *Records will indicate instances in which the Council has responded to an issue in writing.*

GOAL 7: THIS PLAN WILL BE COMPLETED IN THREE YEARS.

ONGOING INITIATIVES:

OBJECTIVE 1: Have regular check-ins on the Comprehensive Plan.

ACTIVITY 1: Have quarterly updates on the plan presented at Council meetings.

ACTIVITY 2: Educate new members of the Council on the plan as part of New Member Orientation (NMO).

ACTIVITY 3: Begin the prioritization and allocation process with a review of the plan and how the committee's work will further its goals.

Who does it? *Council staff will track progress on the plan and present this to the Executive Committee, which will present it to the Council. Council staff will conduct NMO. The Prioritization and Allocation Steering Committee will present the plan to the Prioritization and Allocation Committee.*

Markers that will show the TGA has successfully achieved this objective:

- *The Council minutes will reflect quarterly updates on the plan from Council staff.*
- *Minutes of the Prioritization and Allocation Committee will indicate a presentation on the role of the plan in that committee's work.*

OBJECTIVE 2: Update the plan as needed.

ACTIVITY 1: Be aware of changes to Ryan White legislation and external factors that may drive changes to the plan.

ACTIVITY 2: Monitor progress in accomplishing the plan's tasks.

ACTIVITY 3: As needed, make adjustments.

Who does it? *The Grantee and Council staff will track Ryan White legislation. Council members will track other external factors. Council staff will track progress on the plan. The Executive Committee will make changes, if necessary.*

Markers that will show the TGA has successfully achieved this objective:

- *The Council agenda will indicate a presentation on changes to the Ryan White Act upon its renewal.*
- *Council minutes will reflect quarterly updates on the plan from Council staff.*
- *Council minutes and the plan itself will reflect adjustments made to the plan.*
- *The HRSA project officer will be updated about progress on the plan quarterly.*

OBJECTIVE 3: Write the 2012-14 Comprehensive Plan as new goals emerge.

ACTIVITY 1: As planning begins for the years 2012-14, begin the next plan's goals and objectives.

ACTIVITY 2: Refine these goals throughout the time of the 2009-11 plan.

ACTIVITY 3: Finish the 2012 Comprehensive Plan in late 2011.

Who does it? *Council staff will make note of emerging plans for future years as these things are created by the Council. A Council committee will form in June 2011 to write the 2012-14 plan.*

Markers that will show the TGA has successfully achieved this objective:

- *Council minutes will reflect instances in which plans extending into 2012 and beyond are made.*
- *The 2012-2014 Comprehensive Plan will be turned in to HRSA in January, 2012.*