

STATEWIDE COORDINATED
STATEMENT OF NEED

2017-2021

Office of Infectious Disease
Washington State Department of Health

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A. Epidemiologic Overview

Abbreviations

AARTH: African Americans Reach and Teach Health Ministry	MMP: Medical Monitoring Project
AETC: AIDS Education Training Center	MSM: Men Who Have Sex with Men
AI/AN: American Indian or Alaska Native	MWAETC: Mountain West AIDS Education Training Center
AIDS: Acquired Immune Deficiency Syndrome	NHBS: National HIV Behavioral System
ACS: American Community Survey	NHOPI: Native Hawaiian or Other Pacific Islander
CAPP: Care and Antiretroviral Promotion Program	OSPI: Washington State Office of the Superintendent of Public Instruction
CBO: Community Based Organization	PHIMS STD: Public Health Information Management System for Sexually Transmitted Diseases
CDCHC: Country Doc Community Health Center	PHSKC: Public Health - Seattle & King County
CDC: U.S. Centers for Disease Control and Prevention	PLWH: People Living with HIV Infection
CHC-Tacoma: Community Health Center - Tacoma	PLWDH: People Living with Diagnosed HIV Infection
DBHR: DSHS Division of Behavioral Health and Recovery	PrEP: Pre-Exposure Prophylaxis
DOH: Washington State Department of Health	PWID: Person Who Injects Drugs
DSHS: Washington State Department of Social and Health Services	QM: Quality Management
eHEPC: Enhanced Hepatitis C Reporting System	RWPA: Ryan White Part A
FPL: Federal Poverty Level	SAMSHA: Substance Abuse and Mental Health Services Administration
HCV: Hepatitis C Virus	SUD: Substance Use Disorder
HMC: Harborview Medical Center	STD: Sexually Transmitted Disease
HPSG: HIV Planning Steering Group	TGA: Transitional Grant Area
HOPWA: Housing Opportunities for Persons with AIDS	TSM: Transgender Women Who Has Sex with Men
HRSA: U.S. Health Resources and Services Administration	VL: Viral Load
IDU: Injection Drug User	WIC: Women, Infants, and Children Nutrition Program
LGBT: Lesbian, Gay, Bisexual, and Transgender	YVFWC: Yakima Valley Farmworkers Clinic
LHJ: Local Health Jurisdiction	
LOOC: Locating Out-of-Care Cases Data System	

Definitions

AIDS: Acquired Immune Deficiency Syndrome. This is the advanced stage of HIV infection and is defined by a specific immune system deficiency in CD4+ lymphocyte cells (<200 per μL) and/or the diagnosis of specific opportunistic illnesses.

Case: A person with HIV disease who has been diagnosed and reported to the health department while living in Washington.

Case Rate: The number of reported cases divided by the number of people residing in a given area and presumed to be at risk for disease, based on population estimates. In this report, rates are described as cases per 100,000 residents.

CD4 Count: The concentration of a certain type of white bloodcell circulating within a person's body. CD4 count provides a good indication of a patient's stage of HIV illness.

Confidence Interval (CI): A range of values within which the true value is likely to exist. In this report, we use 95% confidence intervals to describe the reliability of disease rates.

Cumulative HIV Cases: The total number of HIV cases ever reported, as of a specific point in time. Cumulative cases include people who are both living and deceased.

Engagement in HIV Care: At least one HIV medical care visit within a 12 month period; usually based on laboratory evidence (CD4 or viral load result).

Exposure Category: The manner in which a case was most likely to have been infected by HIV, based on reported risk behaviors. Categories are arranged in a hierarchy. A case can only be assigned to one exposure category at any give time.

Foreign-Born: This term is used to describe people born outside the United States.

Gender (or Gender Identity): One's innermost concept of self as male, female, both or neither; can be the same or different than sex assigned at birth

Health Disparity: A difference in health status or health care access which is often caused by a lack of fairness of social justice (i.e. **health inequity**).

Human Immunodeficiency Virus: The virus that causes HIV disease, including AIDS.

HIV Incidence: The number of new HIV infections within a specified period of time. (We can only estimate incidence, but we often use new HIV diagnoses to as proxy measure for incidence.)

HIV Prevalence: The total number of people living with HIV disease at a specific point in time. We can only estimate HIV prevalence.

HIV Surveillance: The ongoing and systematic collection, evaluation, and dissemination of population-based information about people diagnosed with HIV disease.

Late HIV Diagnosis: This describes the event in which a case is diagnosed with AIDS within 12 months of HIV diagnosis. A late HIV diagnosis indicates that a person was probably not getting routinely tested for HIV before the diagnosis occurred.

Linkage to HIV Care: Successful referral to a HIV medical provider within 30 days of HIV diagnosis.

Living HIV Case: A prevalent case of HIV infection that has been reported to the health department and is presumed living in Washington as of a specific point in time.

New HIV Case: A newly diagnosed case of HIV infection; also described as a **new HIV diagnosis**.

Reporting Delay: This refers to the length of time between when a case is diagnosed and when the case is reported to the health department. In Washington, most cases are reported within 3-6 months.

Sex at Birth: The sex (male or female) listed on a person's birth certificate.

Viral Load (VL): This is the concentration of viral copies circulating within a person's body.

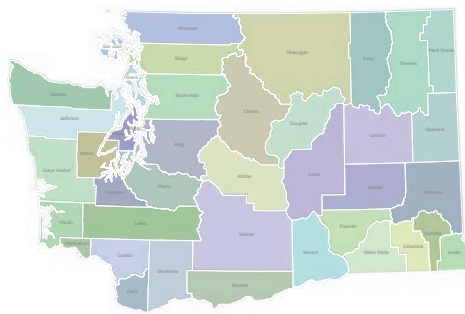
Virologic Suppression: Indication that a person's last reported VL result in a 12-month period was less than or equal to a 200 copies per milliliters of human plasma; evidence of effective HIV treatment.

Washington State

Located in the heart of the Pacific Northwest, Washington contains over 7 million people, about two-thirds of whom reside on the state's western side.

The state of Washington is located in the Pacific Northwest region of the United States, north of Oregon and west of Idaho. The state has 39 counties and 36 local health jurisdictions. With roughly 71,000 square miles, Washington ranks 18th largest in the nation by area. The Cascade Mountain range runs the length of the state from north to south, separating eastern and western Washington. All but one of Washington's seven largest cities are located in the western Washington, including Seattle and Tacoma. Eastern Washington is comparatively rural, but contains some of the largest and most productive agricultural regions on the West Coast.

Washington population is slightly above 7 million, roughly 2% of the population of the United States. From 2000 to 2014 the state's population grew by almost 17%, primarily in urban areas. The state's population distribution by age and gender resembles that of the country overall. County populations in 2014 varied from less than 3,000 to more than 2,000,000.



The state population is predominantly white (71%), followed by Hispanic (12%), Asian (8%), black (4%), and American Indian/Alaska Native (AI/AN; 1%). There are 29 federally-recognized American Indian tribes located in Washington. The tribes are sovereign nations but may interact with local health jurisdictions (LHJs) and with DOH on matters of public health.

The median household income for Washington in 2014 was approximately \$60,000, which was slightly higher than the national median income of \$54,000. Among Washington counties, the median

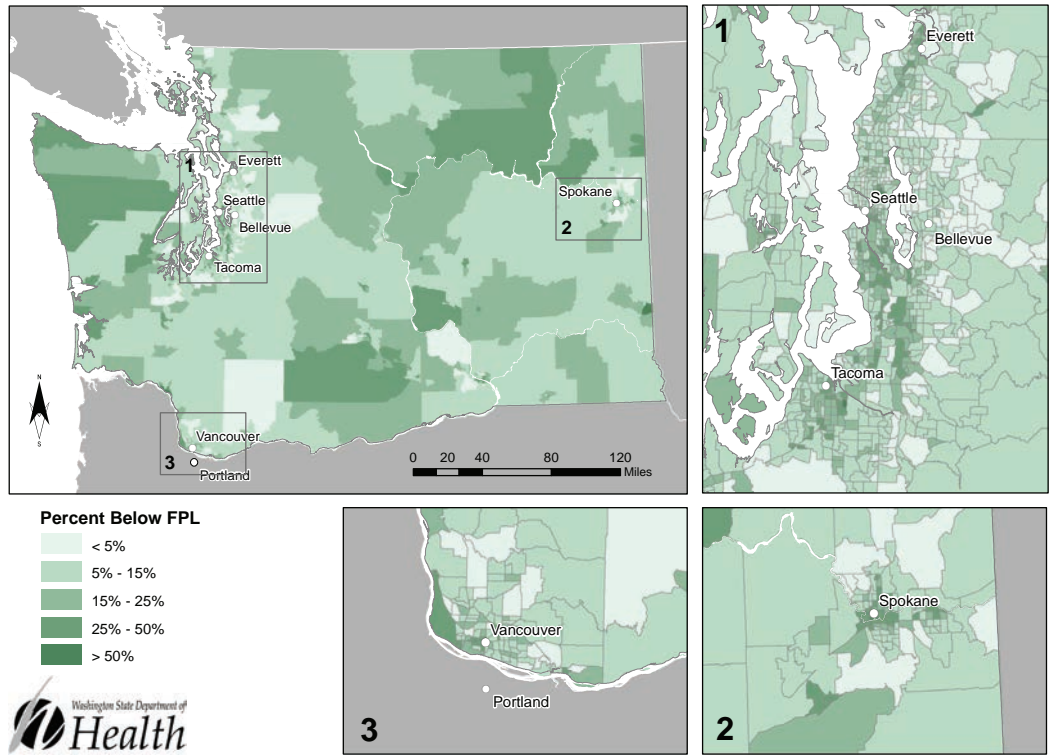
income varied considerably, with a nearly two-fold difference between the lowest and highest (range: \$35,000 to \$75,000). Counties with higher median incomes tended to be in the western part of the state.

In 2014, 14% of the state population lived in poverty, which was defined as an annual income of less than \$11,770 for a single person or \$24,250 for a family of four. Counties with the highest rates of poverty (over 20% of the county population) were located in south-central and eastern Washington. Nationally, 15% of the population was living in poverty in 2014.

In the United States, lack of health insurance coverage was 10% in 2014. The percentage of the population lacking health insurance coverage in 2014 varied by county and region. The counties with over 12% of residents lacking health insurance were located primarily in north-central and southeastern Washington while most western counties had fewer than 10% of residents with no health insurance.

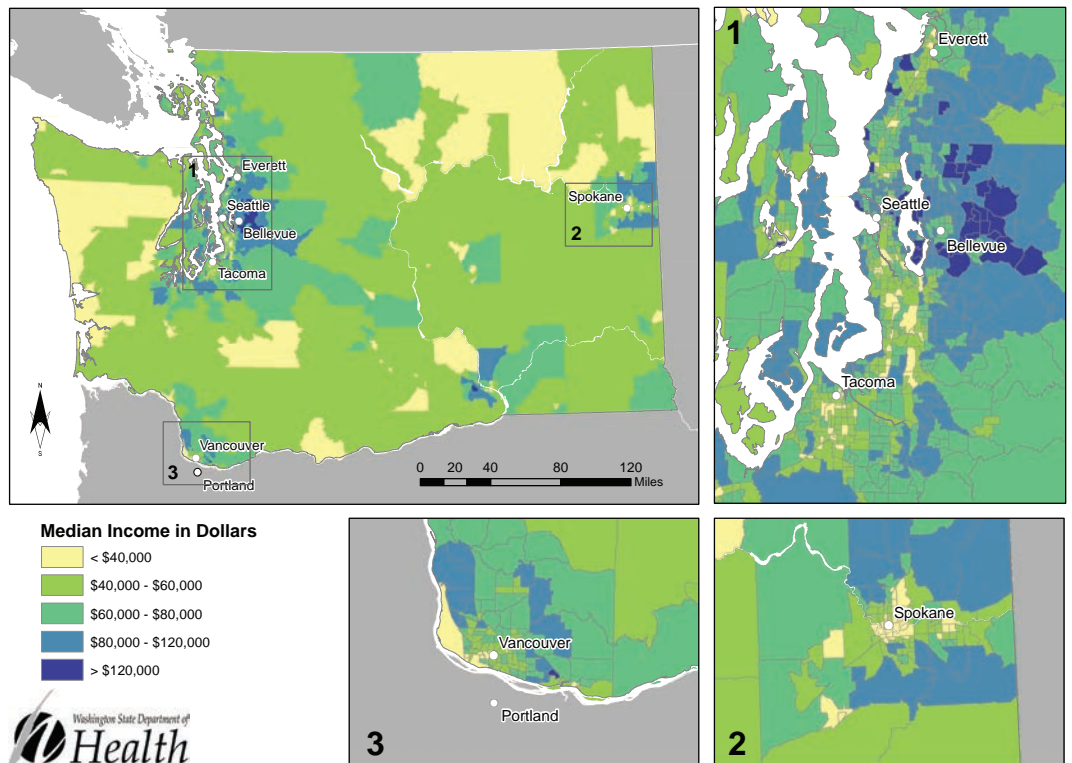
Most of Washington's poorest Census tracts are actually located in urban or suburban areas of the state. Among Census tracts in which at least 25% of residents were living below the Federal Poverty Line, about two-thirds were either within or very near one of the state's 10 largest cities.

Percent of Census Tract Residents Living Below Federal Poverty Line, WA State, 2010-2014

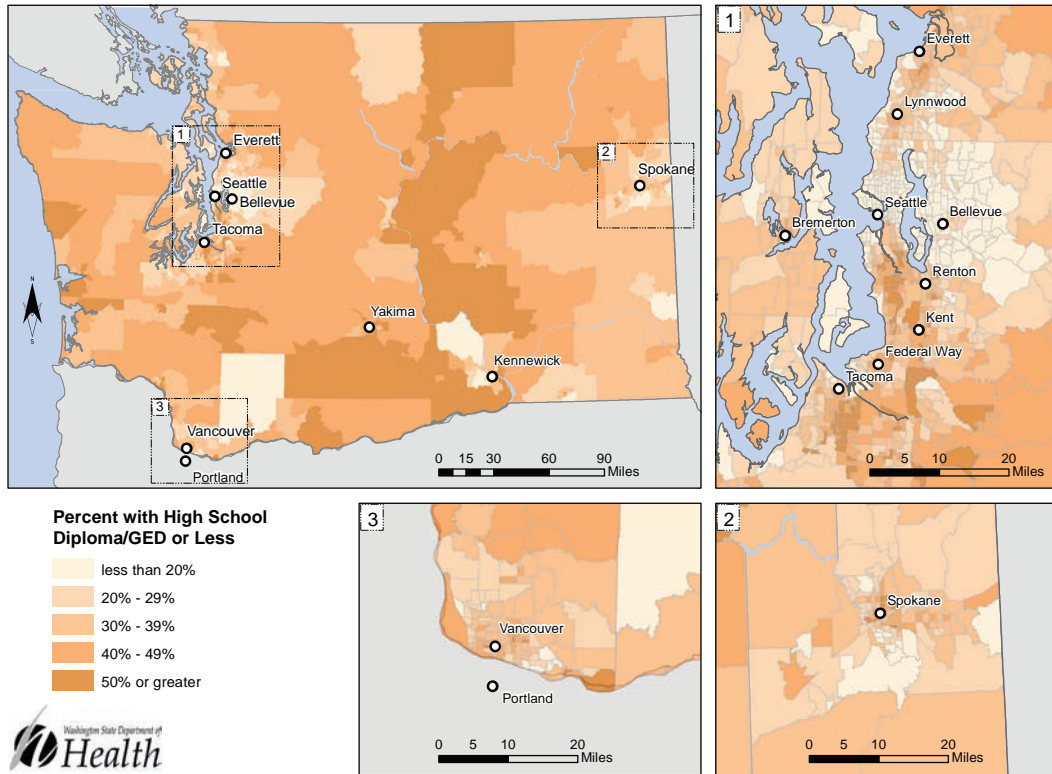


Statewide, median household income was approximately \$60,000. Lower income areas exist both inside and outside urban areas. Rural Census tracts tend to be larger, which makes them stand out more.

Median Household Income by Census Tract, WA State, 2010-2014

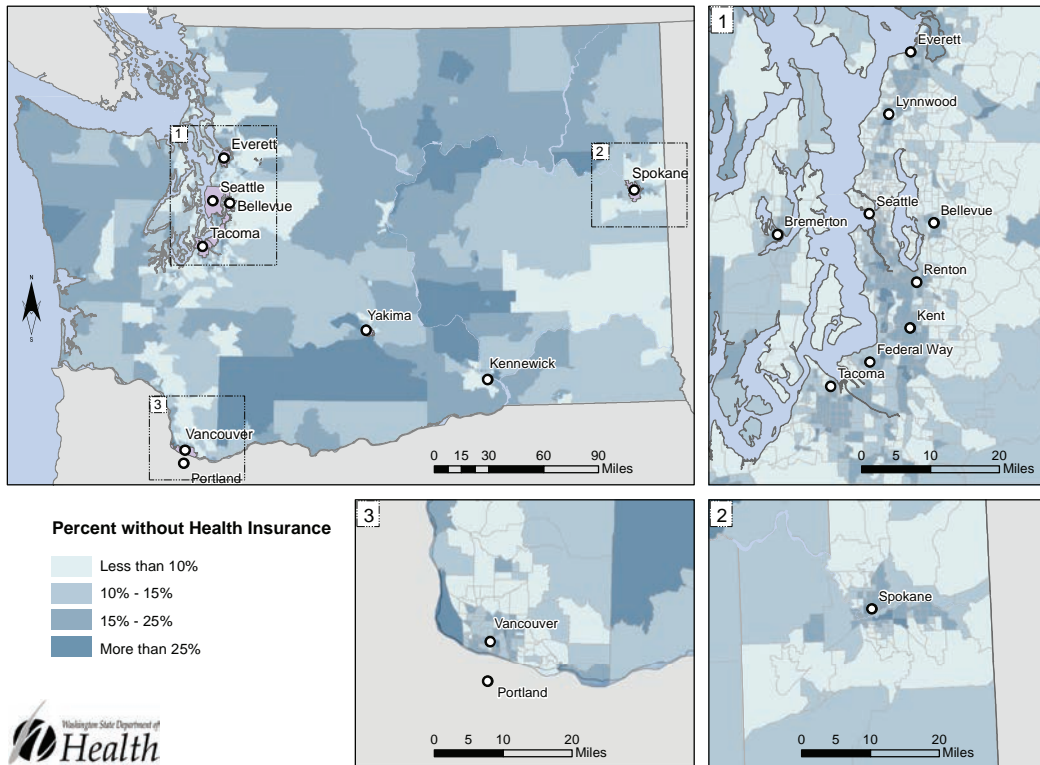


Percent of Census Tract Residents Ages 25+ with H.S. Diploma/GED or Less, WA State, 2010-2014



Statewide, 34% of Washington residents have less than or equal to a high school education. Census tracts with relatively lower levels of educational achievement exist in both urban and rural areas across the state.

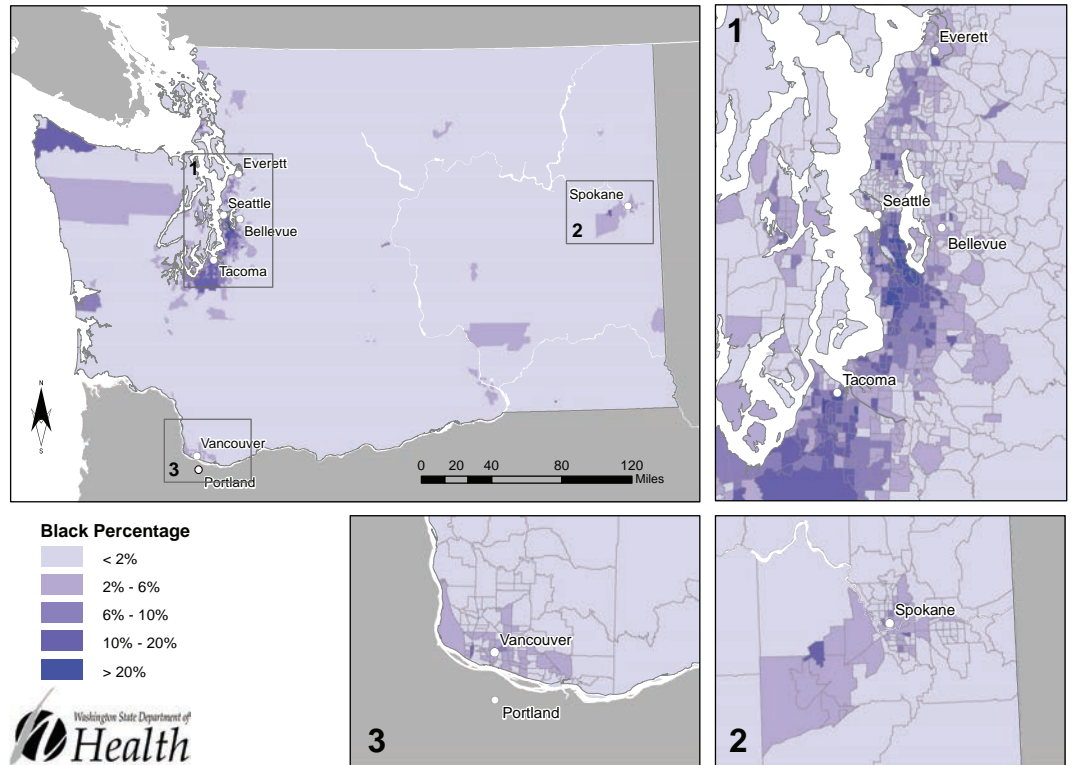
Percent of Census Tract Residents Living without Health Insurance, WA State, 2010-2014



About 90% of Washington residents have health insurance. Residents of rural areas are less likely to be covered.

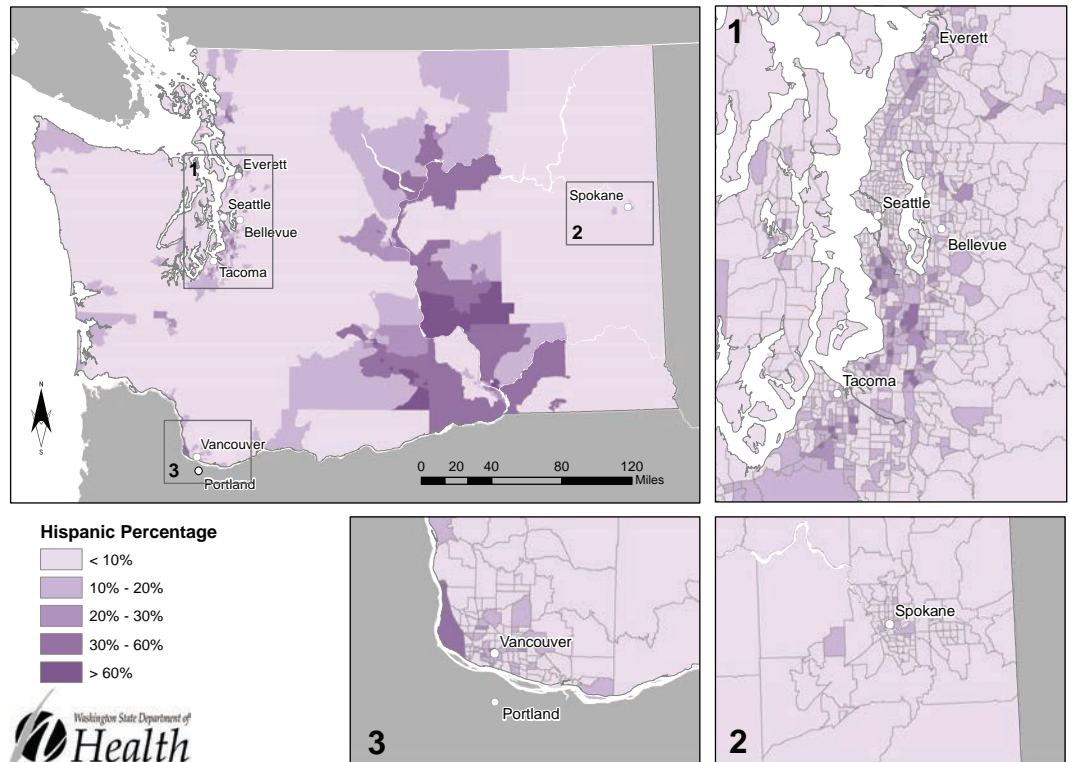
Most Black residents of Washington live within the Puget Sound region, in or near the cities of Seattle and Tacoma.

Percentage of Census Tract Residents Who Are Black, WA State, 2010-2014



Relatively speaking, Census tracts located in central Washington contain a higher proportion of Hispanic residents. However, roughly half of the state's Hispanic residents live in the Puget Sound area.

Percentage of Census Tract Residents Who Are Hispanic, WA State, 2010-2014



Geography of HIV

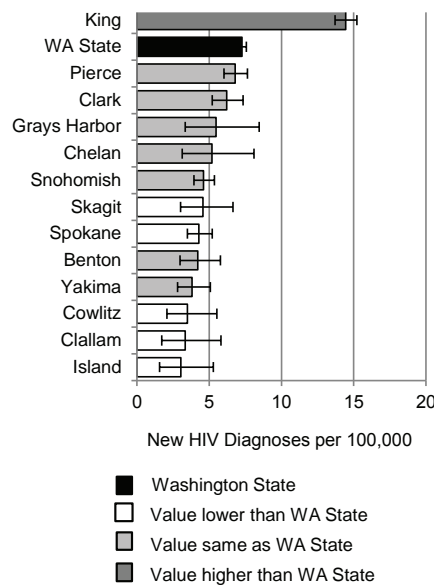
The HIV epidemic in Washington is heavily concentrated in the state’s urban areas, most of which are located in the Puget Sound region. Cases of HIV infection tend to be concentrated most in areas with higher levels of poverty, lower levels of median household income, and lower levels of educational achievement.

Both HIV incidence and prevalence are strongly correlated with residence in Washington’s largest cities and urban areas. Although less than a third (29%) of the state’s general population resides in King County, more than half (55%) of people living with diagnosed HIV infection (PLWDH) are King County residents; 37% live in the city of Seattle. In fact, according to the U.S. Census Bureau, Washington contains seven cities with populations of more than 100,000 people: Seattle, Tacoma, Everett, Bellevue, Kent, Spokane, and Vancouver. Collectively, these cities comprised about 1.5 million people in 2014, or 22% of all people living in Washington. Yet, the same seven cities accounted for 59% of all new HIV cases reported between 2010 and 2014.

Given the location of Washington’s largest cities, it makes sense that rates of new HIV diagnoses were highest within counties located in western Washington. King County, which contains the city of Seattle, had the highest diagnosis rate at 14.3 cases per 100 residents.

The spatial distribution of prevalent HIV cases strongly resembles that of incident cases, although incident cases are slightly less likely to reside in King Co.

Figure 1. Rates of New HIV Diagnoses by County of Residence, WA State, 2010-2014 (Source: eHARS)

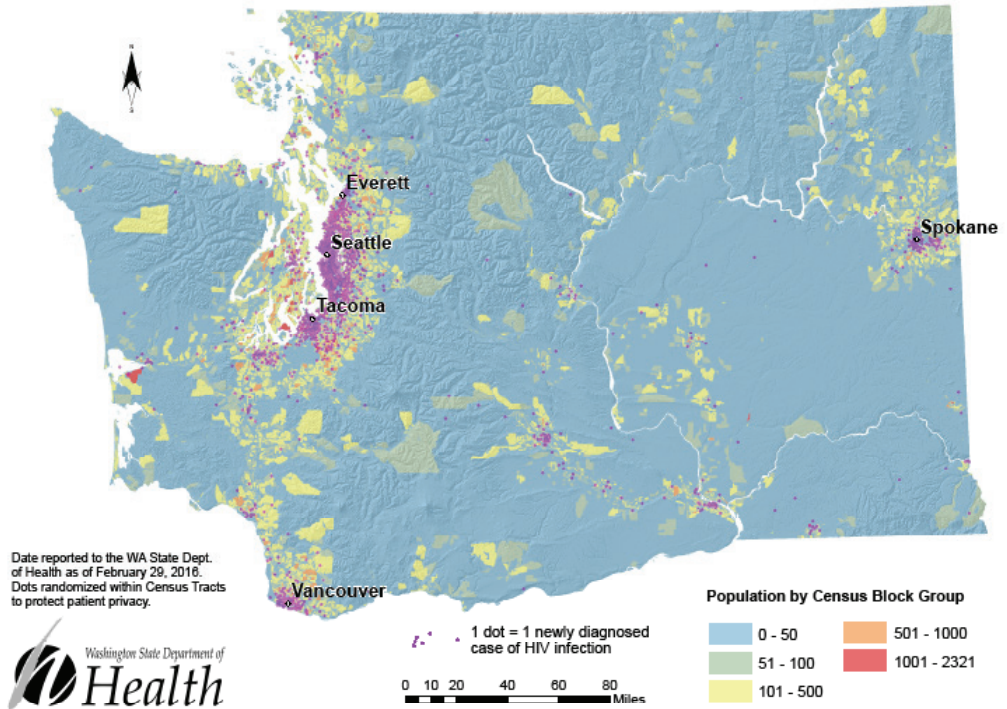


Similar to the larger black communities, most black PLWDH in Washington reside within the Puget Sound region. U.S.-born black PLWDH, who account for about 60% of all black HIV cases, tend to be concentrated within the cities of Tacoma and Seattle, whereas the majority of foreign-born black PLWDH live either in Seattle, select suburban communities in northern and southern King County, as well as southern Snohomish County.

The majority of Hispanic PLWDH live in western Washington, near the Puget Sound. Nevertheless, a substantial proportion of Hispanic cases also reside in the central part of the state, especially in agricultural areas near the cities of Yakima and Kennewick (Tri-Cities). Nearly two-thirds of Hispanic PLWDH were born outside the U.S. However, the ratio of cases born inside vs. outside the U.S. does vary from place to place around Washington. For example, most Hispanic cases residing near Spokane appear to be native to the U.S., while most cases living near Yakima are foreign-born.

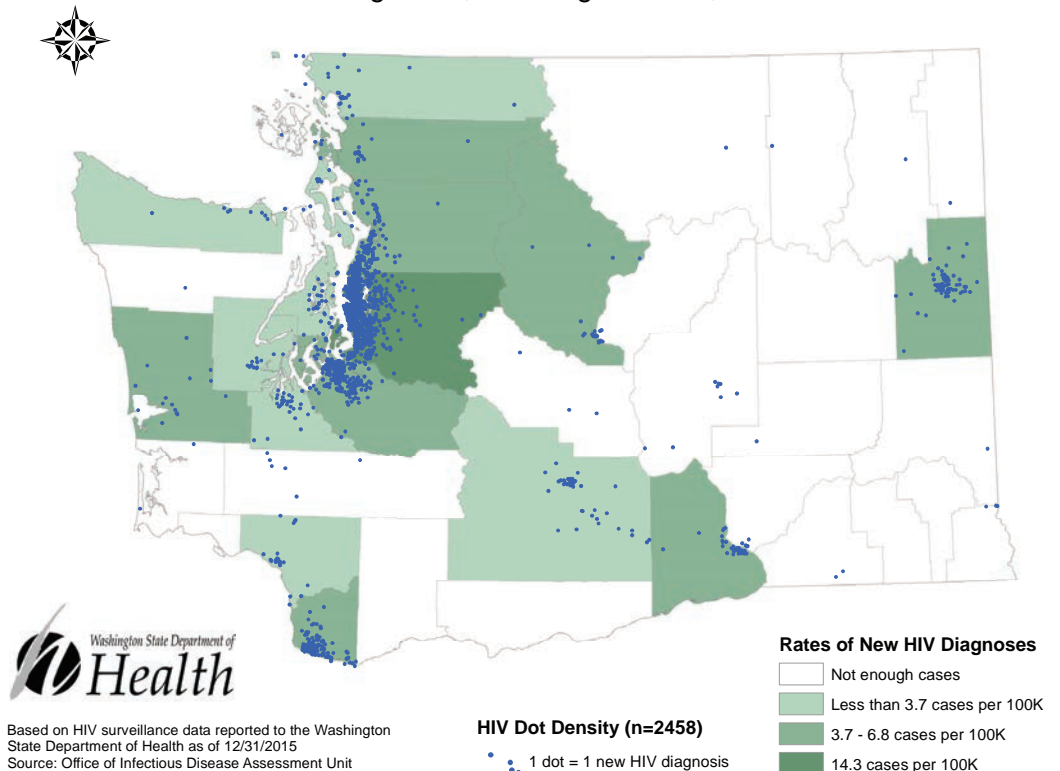
Most newly diagnosed cases of HIV infection reside in Washington's largest cities and urban areas, despite the fact that these cities only contain about a third of the state's general population.

**New HIV Diagnoses in Relation to Population Density
Washington State, 2010-2014 (n=2,460)**



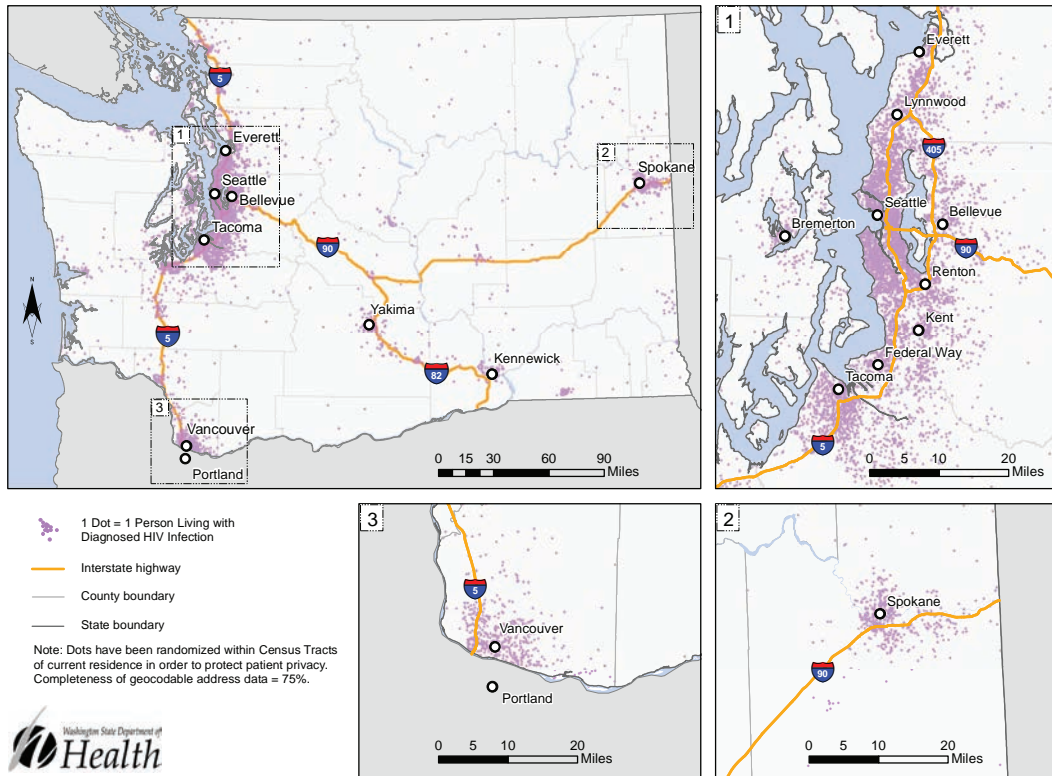
Between 2010 and 2014, King County (shaded in dark green) had the highest HIV diagnosis rate at 14.3 cases per 100,000 residents. About 55% of all new HIV diagnoses occurred among King County residents.

New HIV Diagnoses, Washington State, 2010-2014



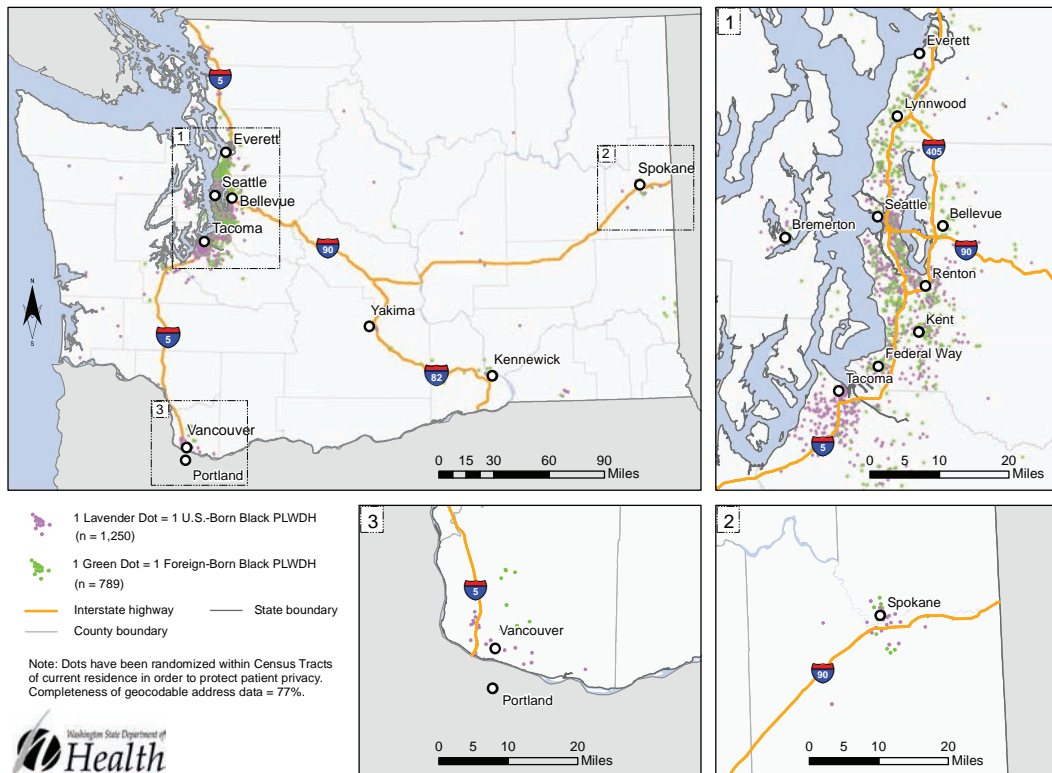
Based on HIV surveillance data reported to the Washington State Department of Health as of 12/31/2015
Source: Office of Infectious Disease Assessment Unit

People Living with Diagnosed HIV Infection, Washington State, Year-end 2014 (n=12,567)



Similar to new HIV diagnoses, most PLWDH reside in counties adjacent to the Puget Sound. King County had the highest HIV prevalence rate at 344 cases per 100,000 residents.

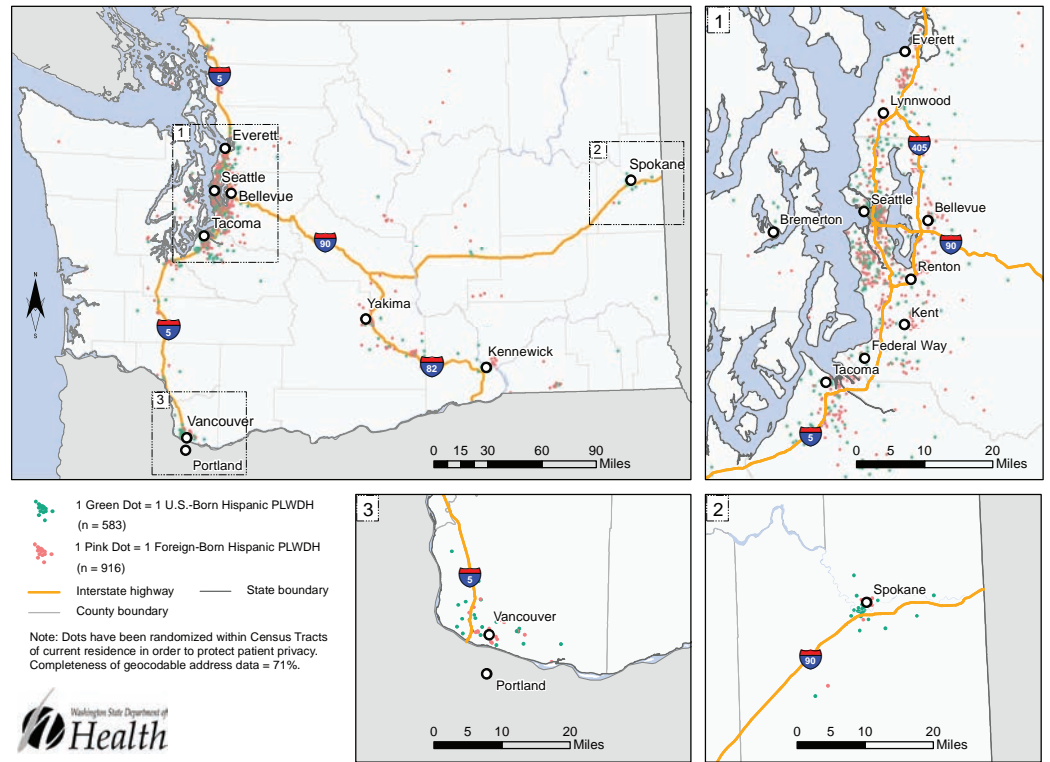
Black People Living with Diagnosed HIV Infection, by Place of Birth, Washington State, Year-end 2014 (n=1,648)



Within the Puget Sound region, the spatial distribution of black PLWDH varies by whether individuals were born inside vs. outside the U.S. For example, black cases residing in Tacoma are mostly U.S.-born, while cases in Kent are mostly foreign-born

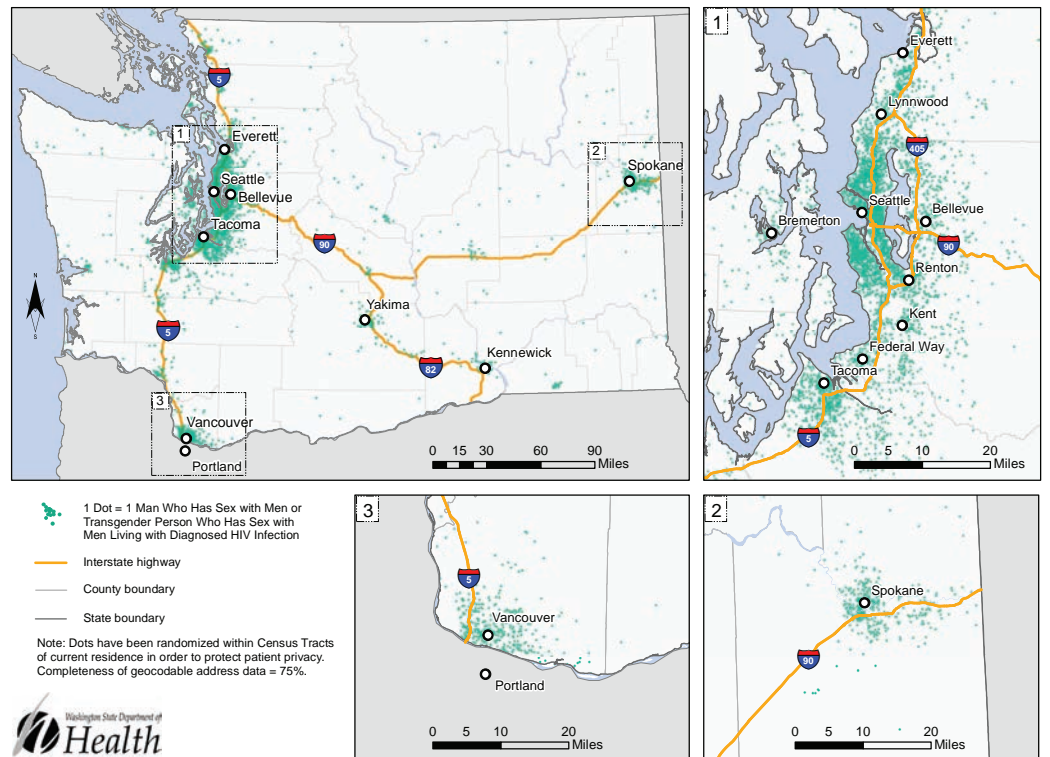
Similar to other racial/ethnic groups, the majority of Hispanic PLWDH reside in cities located near the Puget Sound. Regardless of where they live, approximately two-thirds of Hispanic HIV cases are foreign-born.

Hispanic People Living with Diagnosed HIV Infection, by Place of Birth, Washington State, Year-end 2014 (n=1,648)

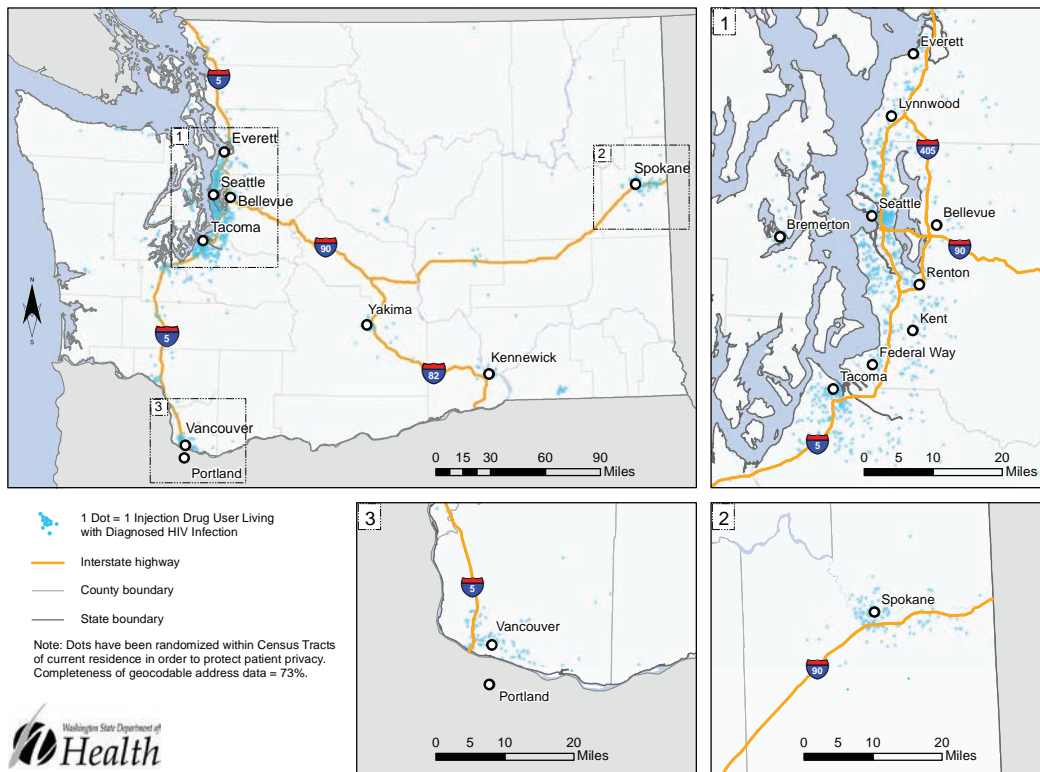


Approximately 75% of PLWDH in Washington are men or transgender women who have sex with men (MSM/TSM). This risk population predominantly resides in the Seattle and Tacoma metro areas, as do most prevalent cases among MSM/TSM.

MSM/TSM Living with Diagnosed HIV Infection, Washington State, Year-end 2014 (n=9,391)

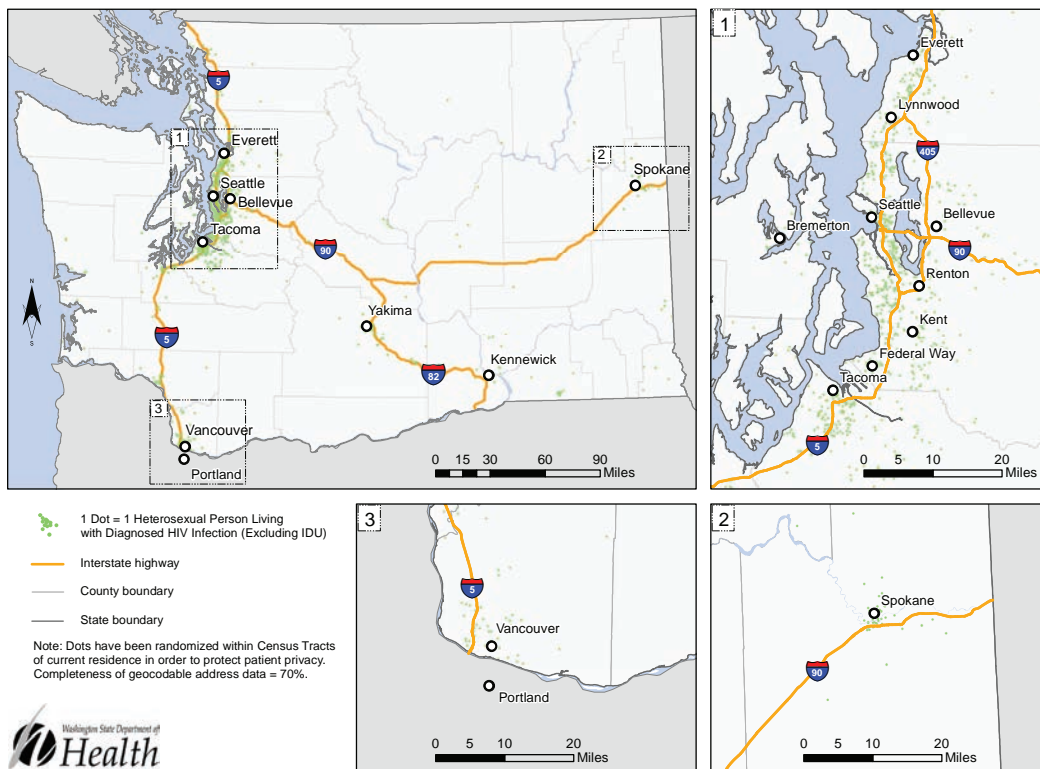


Injection Drug Users Living with Diagnosed HIV Infection, Washington State, Year-end 2014 (n=2,225)



Injection drug users (IDU) account for about 17% of PLWDH in Washington. The spatial distribution IDU cases is similar to that of other HIV risk populations.

Heterosexual Persons Living with Diagnosed HIV Infection, Washington State, Year-end 2014 (n=2,225)






Most (non-IDU) heterosexual PLWDH reside in the Puget Sound region, similar to other HIV risk populations. However, the association between HIV risk and urban residence is somewhat less pronounced compared to MSM/TSM or IDU.

People Living with Diagnosed HIV Infection,
Seattle TGA, Year-end 2014 (n=7,929)



Note: Dots have been randomized within Census Tracts of current residence in order to protect patient privacy. Completeness of geocodable address data = 75%.

-  1 Dot = 1 Person Living with Diagnosed HIV Infection
-  Seattle TGA (3 counties)
-  County boundary



Demographics and Social Determinants of Health

No demographic group has been more disproportionately affected by Washington's HIV epidemic than gay and bisexual men. However, HIV-related health disparities persist among persons of color, especially those who were born outside the United States.

In recent years, males have accounted for about 85% of all people newly diagnosed with HIV. Most new HIV cases are diagnosed among adults in their twenties or thirties, but more than a quarter are diagnosed among adults ages 45 and older. HIV is extremely rare among children in Washington.

Between 2010 and 2014, 55% of all people newly diagnosed with HIV in Washington were white, excluding those of Hispanic origin. Yet, racial/ethnic minorities continue to be disproportionately affected by the HIV epidemic in our state. Although black residents make up only 4% of the state's general population, nearly one in five PLWDH is black, and black HIV diagnosis rates are nearly 7-times higher than those of whites. HIV rates among both the Hispanic and Native Hawaiian and Other Pacific Islander (NHOPI) populations are roughly twice those of whites. In addition to race/ethnicity, nativity--or whether someone was born inside vs. outside the U.S. can have a large affect on both risk for infection and as well as access to and utilization of HIV-related services.

Demographic and behavioral survey data suggest that gay and bisexual men account for between 3% and 4% of Washington's male residents, based on sex assigned at birth. Despite being a small part of the general population, gay and bisexual men make up nearly three-quarters of the state's HIV epidemic. Because not all men who have sex with men (MSM) consider themselves gay or bisexual, CDC-supported HIV surveillance programs have traditionally preferred the behaviorally-based term MSM. Unfortunately, the CDC -developed definition of MSM also incorrectly captures transgender women who have sex with men (TSM). Therefore, the Washington State Department of Health (DOH) now uses the label MSM/TSM to describe this critical HIV risk population, of which >95% are likely to be gay and bisexual men. DOH estimates that at least 8% of MSM/TSM are HIV-infected statewide, including those who have not been diagnosed.

Although they comprise less than 14% of Washington's total black population, foreign-born black people have become an increasingly larger part of Washington's

HIV epidemic in recent years. During 2010–2014, black residents born outside the U.S. made up about half (51%) of all new HIV diagnoses among black residents, statewide. The majority of foreign-born black cases are attributed to either heterosexual or perinatal exposures which occurred outside the U.S., mostly in Sub-Saharan Africa.

HIV diagnosis rates among foreign-born Hispanics are roughly 4-times higher compared to those born in the U.S. In addition, they are more likely to be diagnosed late, and less likely to be successfully engaged in HIV medical care.

Overall, there is evidence to suggest that HIV risk is inversely associated with socio-economic position, especially among heterosexual and IDU risk populations. HIV diagnosis rates are higher in Census tracts with relatively lower levels of income and higher levels of poverty. In addition, persons who are homeless, addicted to drugs, and/or have a history of incarceration not only carry more risk for infection, but are less likely to receive optimal HIV medical care once diagnosed.

Table 1. New HIV Cases, WA State, 2009-2014 (Source: eHARS)

Year of HIV diagnosis:	Newly Diagnosed Cases of HIV Disease							Late HIV Diagnoses		
	2009 No.	2010 No.	2011 No.	2012 No.	2013 No.	2014 No.	2010-2014 No. %	Rate	2009-2013* %	
Total	550	557	496	509	456	440	2,458 100%	7.2	33%	
Sex at Birth										
Male	461	486	428	422	383	364	2,083 85%	12.2	34%	
Female	89	71	68	87	73	76	375 15%	2.2	30%	
Age at HIV Diagnosis										
< 13	10	10	6	8	8	3	35 1%	0.6	---	
13 - 24	81	74	68	80	73	68	363 15%	6.6	16%	
25 - 34	157	169	147	158	129	136	739 30%	15.6	27%	
35 - 44	146	155	127	131	131	106	650 26%	14.3	35%	
45 - 54	109	104	91	89	84	90	458 19%	9.5	47%	
55+	47	45	57	43	31	37	213 9%	2.4	54%	
Race and Hispanic Origin										
White	319	320	282	287	245	226	1,360 55%	5.5	32%	
Black	92	79	89	95	87	96	446 18%	37.5	31%	
Hispanic (all races)	87	105	77	63	77	59	381 16%	9.5	36%	
Asian	25	26	24	31	24	38	143 6%	5.7	40%	
Native Hawaiian / Pacific Islander	3	1	5	7	7	5	25 1%	12.2	---	
American Indian / Alaska Native	6	8	5	5	4	6	28 1%	6.2	46%	
Multiple Race	18	18	14	21	12	10	75 3%	5.8	30%	
Hispanic only:										
- White	31	33	40	28	37	27	165 7%	4.8	31%	
- Black	3	0	1	0	2	0	3 0%	---	---	
- Multiple / Other Race	8	9	3	4	3	6	25 1%	---	---	
- Unknown Race	45	63	33	31	35	26	188 8%	---	41%	
Exposure Category by Sex at Birth										
Male only:										
- Male / Male Sex (MSM)	317	353	297	279	265	241	1,435 58%	---	30%	
- Injecting Drug Use (IDU)	18	24	17	15	14	12	82 3%	---	48%	
- MSM and IDU	44	28	47	41	33	28	177 7%	---	24%	
- Heterosexual Contact	13	17	9	6	5	9	46 2%	---	62%	
- Pediatric	4	7	4	1	3	2	17 1%	---	---	
- Transfusion / Hemophiliac	0	0	0	0	0	0	0 0%	---	---	
- No Identified Risk	65	57	54	80	63	72	326 13%	---	52%	
Female only:										
- Injecting Drug Use	9	9	14	7	6	8	44 2%	---	---	
- Heterosexual Contact	61	49	30	32	31	23	165 7%	---	33%	
- Pediatric	7	3	2	2	1	1	9 0%	---	---	
- Transfusion / Hemophiliac	0	0	0	0	0	0	0 0%	---	---	
- No Identified Risk	12	10	22	46	35	44	157 6%	---	31%	

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of Dec 31, 2015.

*Late HIV diagnoses based on new HIV cases diagnosed between 2009 and 2013

Table 2. Comparing Socio-Demographic Characteristics of People Diagnosed with HIV Infection to Those of the General Population (Source: eHARS and ACS)

	New HIV Diagnoses, 2010-2014		People Living with HIV, 2014		General Population	
	No.	%	No.	%	No.	%
Total	2,460	100%	12,578	100%	6,968,170	100%
Sex at Birth						
Male	2,084	85%	10,773	86%	3,472,417	50%
Female	376	15%	1,805	14%	3,495,753	50%
Age						
< 13	35	1%	47	0%	1,150,196	17%
13 - 24	364	15%	305	2%	1,099,488	16%
25 - 34	739	30%	1,593	13%	967,013	14%
35 - 44	650	26%	2,832	23%	909,682	13%
45 - 54	459	19%	4,530	36%	951,587	14%
55+	213	9%	3,271	26%	1,890,205	27%
Race and Hispanic Origin						
White	1,360	55%	7,966	63%	4,932,640	71%
Black	446	18%	2,039	16%	247,417	4%
Hispanic (all races)	383	16%	1,647	13%	850,276	12%
Asian	143	6%	416	3%	525,664	8%
Native Hawaiian / Pacific Islander	24	1%	64	1%	43,756	1%
American Indian / Alaska Native	28	1%	155	1%	90,314	1%
Multiple Race / Unknown	76	3%	291	2%	278,103	4%
Area-Based Percent with Bachelor's Degree***						
< 10%	273	13%	1,146	12%	639,926	14%
10% - 20%	671	31%	3,035	33%	1,968,104	42%
20% - 30%	477	22%	2,189	24%	1,088,980	23%
30% - 40%	494	23%	2,095	23%	693,777	15%
> 40%	253	12%	905	10%	255,017	5%
Area-Based Median Household Income***						
< \$40,000	423	20%	1,732	19%	900,228	13%
\$40,000 - \$60,000	747	34%	3,503	38%	2,474,904	36%
\$60,000 - \$80,000	644	30%	2,583	28%	1,948,404	28%
\$80,000 - \$100,000	240	11%	1,103	12%	990,224	14%
> \$100,000	114	5%	449	5%	585,363	8%
Area-Based Percent Living Below Federal Poverty Line, Last 12 Months ** ***						
< 5%	174	8%	680	7%	965,573	14%
5% - 10%	528	24%	2,258	25%	2,071,791	31%
10% - 15%	382	18%	1,707	19%	1,458,580	22%
15% - 20%	506	23%	2,003	22%	915,556	14%
>20%	578	27%	2,722	30%	1,353,700	20%
Area-Based Percent with No Health Insurance						
< 10%	90	4%	379	4%	520,314	8%
5% - 10%	495	23%	2,255	25%	1,938,467	29%
10% - 15%	752	35%	3,128	34%	2,125,568	31%
15% - 20%	452	21%	1,999	22%	1,284,658	19%
20% - 25%	258	12%	1,174	13%	546,402	8%
>25%	121	6%	435	5%	349,791	5%

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of March 31, 2016.

* among those ages 25 and over

** last 12 months, among those for which poverty status was determined

*** based on aggregate, annualized Census data collected within census tracts of residence (2010-2014)

Table 3. New HIV Cases by Foreign-Born Status and Other Select Characteristics, 2010-2014
(Source: eHARS)

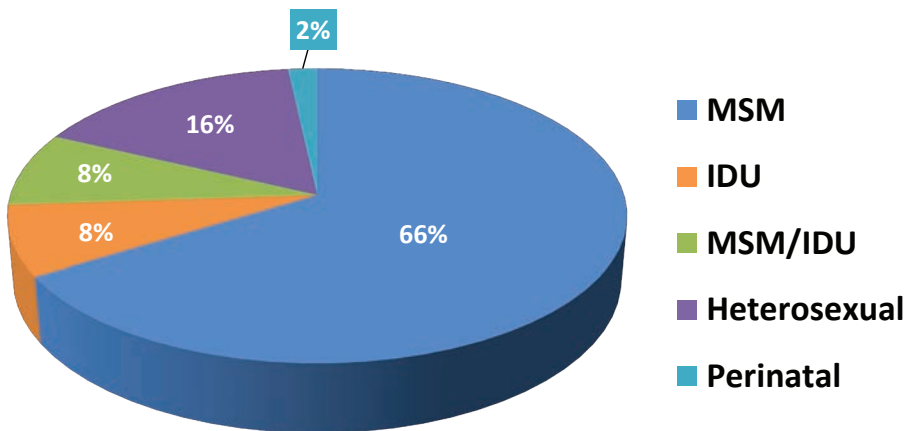
Characteristic:	Proportion of Cases with Select Characteristic at HIV Diagnosis						Total	
	Male %	Age > 34 years %	MSM %	Hetero- sexual %	Late HIV Diagnosis* %	Live in King Co. %	No.	%
U.S.-Born								
White	91%	57%	79%	6%	35%	58%	1,125	72%
Black	85%	37%	68%	15%	27%	61%	203	13%
Hispanic (all races)	92%	29%	85%	5%	26%	58%	110	7%
Asian	82%	41%	76%	0%	29%	82%	17	1%
Native Hawaiian / Pacific Islander	70%	40%	70%	30%	60%	40%	10	1%
American Indian / Alaska Native	80%	56%	44%	16%	52%	40%	25	2%
Multiple Race	94%	31%	81%	6%	30%	61%	64	4%
Total	90%	51%	77%	7%	33%	59%	1,554	100%
Foreign-Born**								
White	87%	54%	62%	12%	31%	81%	68	11%
Black	41%	64%	6%	18%	35%	67%	216	34%
Hispanic (all races)	90%	50%	62%	10%	45%	56%	218	34%
Asian	79%	55%	41%	10%	39%	68%	117	18%
Native Hawaiian / Pacific Islander	83%	33%	58%	17%	33%	58%	12	2%
American Indian / Alaska Native	---	---	---	---	---	---	0	0%
Multiple Race	50%	25%	25%	50%	50%	25%	4	1%
Total	71%	56%	39%	13%	39%	64%	635	100%

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of Dec 31, 2015.

*Late HIV diagnoses based on new HIV cases diagnosed between 2009 and 2013

**Section excludes 269 cases for which we do not have information about their foreign-born status.

Figure 2. New HIV Cases by Mode of HIV Exposure, Washington State, 2010-2014
(Source: eHARS)



MSM/TSM account for approximately 75% of all PLWDH in Washington State, including those who use injection drugs. (Note: Because the decision to use the label MSM/TSM was made recently, some tables and figures included in this report still use the label MSM by itself).

Table 4. Comparing Socio-Demographic Characteristics of MSM/TSM Diagnosed with HIV Infection to Those of the General Population, Washington State, 2010-2014 (Source: eHARS and ACS)

	New HIV Diagnoses, 2010-2014		People Living with HIV, 2014		General Population	
	No.	%	No.	%	No.	%
Total	1,462	100%	6,617	100%	6,968,170	100%
Area-Based Percent with Bachelor's Degree***						
< 10%	134	9%	658	10%	639,926	14%
10% - 20%	368	25%	1,871	28%	1,968,104	42%
20% - 30%	327	22%	1,535	23%	1,088,980	23%
30% - 40%	403	28%	1,731	26%	693,777	15%
> 40%	230	16%	822	12%	255,017	5%
Area-Based Median Household Income*						
< \$40,000	249	17%	1,103	17%	900,228	13%
\$40,000 - \$60,000	498	34%	2,458	37%	2,474,904	36%
\$60,000 - \$80,000	453	31%	1,871	28%	1,948,404	28%
\$80,000 - \$100,000	171	12%	831	13%	990,224	14%
> \$100,000	91	6%	354	5%	585,363	8%
Area-Based Percent Living Below Federal Poverty Line, Last 12 Months *** **						
< 5%	119	8%	493	7%	965,573	14%
5% - 10%	368	25%	1,685	25%	2,071,791	31%
10% - 15%	269	18%	1,207	18%	1,458,580	22%
15% - 20%	386	26%	1,530	23%	915,556	14%
>20%	320	22%	1,702	26%	1,353,700	20%
Area-Based Percent with No Health Insurance						
< 10%	63	4%	299	5%	520,314	8%
5% - 10%	356	24%	1,699	26%	1,938,467	29%
10% - 15%	568	39%	2,336	35%	2,125,568	31%
15% - 20%	283	19%	1,331	20%	1,284,658	19%
20% - 25%	134	9%	711	11%	546,402	8%
>25%	58	4%	241	4%	349,791	5%

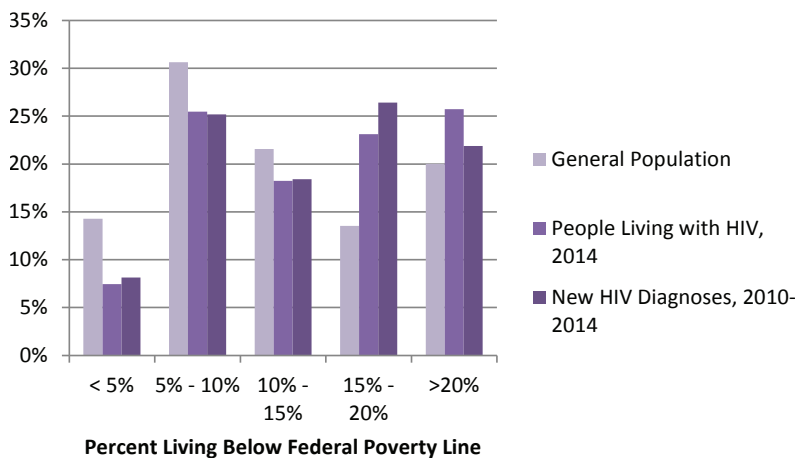
All HIV/AIDS surveillance data reported to the Washington State Department of Health as of March 31, 2016.

* among those ages 25 and over

** last 12 months, among those for which poverty status was determined

*** based on aggregate, annualized Census data collected within census tracts of residence (2010-2014)

Figure 3. Percent in Poverty: HIV-Positive MSM/TSM vs. the General Population, WA State, 2010-2014 (Source: eHARS and ACS)



MSM/TSM diagnosed with HIV are somewhat more likely than members of the general population (as a whole) to reside in Census tracts with higher rates of poverty.

Table 5. Comparing Socio-Demographic Characteristics of Non-MSM/TSM Diagnosed with HIV Infection to Those of the General Population, Washington State, 2010-2014 (Source: eHARS and ACS)

	New HIV Diagnoses, 2010-2014		People Living with HIV, 2014		General Population	
	No.	%	No.	%	No.	%
Total	705	100%	2,751	100%	6,968,170	100%
Area-Based Percent with Bachelor's Degree*						
< 10%	138	20%	487	18%	639,926	14%
10% - 20%	303	43%	1,164	42%	1,968,104	42%
20% - 30%	150	21%	654	24%	1,088,980	23%
30% - 40%	91	13%	363	13%	693,777	15%
> 40%	23	3%	83	3%	255,017	5%
Area-Based Median Household Income***						
< \$40,000	173	25%	629	23%	900,228	13%
\$40,000 - \$60,000	249	35%	1,044	38%	2,474,904	36%
\$60,000 - \$80,000	191	27%	712	26%	1,948,404	28%
\$80,000 - \$100,000	69	10%	272	10%	990,224	14%
> \$100,000	23	3%	94	3%	585,363	8%
Area-Based Percent Living Below Federal Poverty Line, Last 12 Months **						
< 5%	55	8%	187	7%	965,573	14%
5% - 10%	160	23%	572	21%	2,071,791	31%
10% - 15%	113	16%	500	18%	1,458,580	22%
15% - 20%	120	17%	473	17%	915,556	14%
>20%	257	36%	1,019	37%	1,353,700	20%
Area-Based Percent with No Health Insurance						
< 10%	27	4%	79	3%	520,314	8%
5% - 10%	139	20%	556	20%	1,938,467	29%
10% - 15%	184	26%	792	29%	2,125,568	31%
15% - 20%	168	24%	668	24%	1,284,658	19%
20% - 25%	124	18%	463	17%	546,402	8%
>25%	63	9%	193	7%	349,791	5%

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of March 31, 2016.

* among those ages 25 and over

** last 12 months, among those for which poverty status was determined

*** based on aggregate, annualized Census data collected within census tracts of residence (2010-2014)

Heterosexuals diagnosed with HIV (non-MSM/TSM) are much more likely than members of the general population (as a whole) to reside in Census tracts with higher rates of poverty.

Figure 4. Percent in Poverty: HIV-Positive Non-MSM/TSM vs. the General Population, WA State, 2010-2014 (Source: eHARS and ACS)

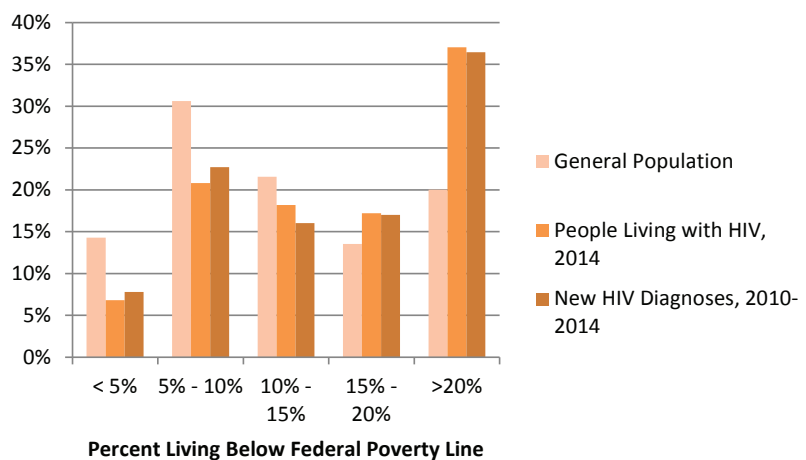


Table 6. HIV-Positive Persons in Care in Washington State, by Homelessness, 2009-2013 (Source: MMP)

Item	All Respondents	Homeless in prior 12 months		p-value
		No	Yes	
Age				<0.0001
18-34 years	12%	10%	27%	
35-44 years	25%	25%	27%	
45-54 years	40%	40%	36%	
55+ years	23%	25%	11%	
Race/ethnicity				<0.0001
White, non-Hispanic	68%	71%	40%	
Black, non-Hispanic	13%	12%	24%	
Hispanic or latino	10%	9%	18%	
Other	10%	9%	18%	
Sex at birth				0.1232
Male	87%	87%	81%	
Female	13%	13%	19%	
Nativity				0.3211
U.S.-born (incl. Puerto Rico)	87%	87%	84%	
Foreign-born	13%	13%	16%	
Sexual orientation (self-identified)				<0.0001
Homosexual	67%	70%	43%	
Heterosexual	23%	21%	45%	
Bisexual	8%	7%	10%	
Other/unclassified	2%	2%	3%	
Viral load suppression				<0.0001
All viral loads in the last 12 months undetectable, <=200	69%	72%	46%	
Injection drug use in prior 12 months				<0.0001
No	92%	94%	76%	
Yes	8%	6%	24%	
Unprotected anal sex in prior 12 months				0.2814
No	63%	64%	58%	
Yes	37%	36%	42%	

According to MMP survey data collected in Washington between 2009-2013, approximately 10% of the HIV-positive persons in care from 2009-2013 experienced homelessness at some point in the prior 12 months. Compared to individuals in care who were not homeless, those who were homelessness were younger, more

likely to be persons of color, more likely to be heterosexual, and more likely to have an unsuppressed viral load. About 24% of people who were homeless reported injecting drugs in the prior 12 months, compared to six percent of those who were not homeless. Thirty-one percent of homeless participants were co-infected

with hepatitis C virus (HCV), compared to 13% of non-homeless participants. The percentage of homeless participants with unsuppressed viral loads in the prior 12 months (54%) was nearly twice that of participants who were not homeless (28%).

Table 7. HIV-Positive Persons in Care in Washington State, by Poverty, 2009-2013 (Source: MMP)

Item	All in Care	Income as a percent of FPL			p-value
		<100%	100%-399%	>=400%	
Age					<0.0001
18-34 years	12%	17%	11%	6%	
35-44 years	25%	26%	25%	24%	
45-54 years	40%	41%	38%	41%	
55+ years	23%	16%	25%	29%	
Race/ethnicity					<0.0001
White, non-Hispanic	68%	51%	71%	82%	
Black, non-Hispanic	13%	23%	11%	4%	
Hispanic or latino	10%	14%	9%	7%	
Other	10%	13%	9%	7%	
Sex at birth					<0.0001
Male	87%	76%	89%	97%	
Female	13%	24%	11%	3%	
Nativity					<0.0001
U.S.-born (incl. Puerto Rico)	87%	80%	88%	94%	
Foreign-born	13%	20%	12%	6%	
Sexual orientation (self-identified)					<0.0001
Homosexual	67%	44%	73%	89%	
Heterosexual	23%	43%	17%	6%	
Bisexual	8%	10%	8%	4%	
Other/unclassified	2%	3%	2%	1%	
Viral load suppression					0.0002
All viral loads in the last 12 months undetectable, <=200	69%	61%	70%	77%	
Injection drug use in prior 12 months					<0.0001
No	92%	86%	94%	97%	
Yes	8%	14%	6%	3%	
Unprotected anal sex in prior 12 months					0.0007
No	63%	70%	64%	54%	
Yes	37%	30%	36%	46%	

MMP data also suggest that approximately one third (31%) of the HIV-positive persons who were in care in Washington between 2009-2013 had incomes which fell below the Federal Poverty Level (FPL). Compared to respondents with higher levels of income (400% of FPL or greater), the poorer respondents were more likely to be younger, persons of color, female, foreign-born, and heterosexual. Thirty nine

percent of those living below the FPL had an unsuppressed viral load in the prior 12 months, which is nearly twice the level of those living at 400% of FPL or above (23%).

Homelessness and poverty are important barriers which often prevent PLWDH from getting HIV treatment and achieving virologic suppression.

Table 8. New HIV Cases, Seattle TGA, 2010-2015 (Source: eHARS)

Year of HIV diagnosis:	Newly Diagnosed Cases of HIV Disease							Late HIV Diagnoses		
	2010 No.	2011 No.	2012 No.	2013 No.	2014 No.	2015 No.	2011-2015 No. %	Rate	2010-2014* %	
Total	359	304	328	283	309	272	1,496 100%	10.7	28%	
Sex at Birth										
Male	316	266	270	241	261	233	1,271 85%	18.2	28%	
Female	43	38	58	42	48	39	225 15%	3.2	30%	
Age at HIV Diagnosis										
< 13	3	3	4	5	2	3	17 1%	---	0%	
13 - 24	54	45	44	39	47	38	213 14%	---	16%	
25 - 34	116	95	112	82	97	96	482 32%	---	23%	
35 - 44	96	76	87	87	74	63	387 26%	---	28%	
45 - 54	67	54	55	51	63	49	272 18%	---	41%	
55+	23	31	26	19	26	23	125 8%	---	45%	
Race and Hispanic Origin										
White	217	165	189	148	152	126	780 52%	8.4	25%	
Black	50	61	70	59	73	69	332 22%	46.4	31%	
Hispanic (all races)	59	51	34	46	34	44	209 14%	15.9	29%	
Asian	18	17	21	16	35	29	118 8%	---	35%	
Native Hawaiian / Pacific Islander	1	3	1	4	4	2	14 1%	---	46%	
American Indian / Alaska Native	4	0	0	3	5	0	8 1%	---	58%	
Multiple Race	10	7	13	7	6	2	35 2%	---	26%	
Hispanic only:										
- White	23	28	8	18	12	14	80 5%	---	21%	
- Black	0	0	0	0	0	2	2 0%	---	0%	
- Multiple / Other Race	3	2	2	2	3	2	11 1%	---	20%	
- Unknown Race	33	21	24	26	19	26	116 8%	---	37%	
Exposure Category by Sex at Birth										
Male only:										
- Male / Male Sex (MSM)	251	195	194	178	187	166	920 61%	---	24%	
- Injecting Drug Use (IDU)	7	6	7	7	6	7	33 2%	---	42%	
- MSM and IDU	22	31	28	18	17	10	104 7%	---	20%	
- Heterosexual Contact	9	3	4	4	5	4	20 1%	---	64%	
- Pediatric	1	3	1	3	1	2	10 1%	---	11%	
- Transfusion / Hemophiliac	0	0	0	0	0	0	0 0%	---	0%	
- No Identified Risk	26	28	36	31	45	44	184 12%	---	48%	
Female only:										
- Injecting Drug Use	6	5	7	1	6	3	22 1%	---	20%	
- Heterosexual Contact	16	5	10	7	5	5	32 2%	---	30%	
- Pediatric	2	1	2	0	1	1	5 0%	---	33%	
- Transfusion / Hemophiliac	0	0	0	0	0	0	0 0%	---	0%	
- No Identified Risk	7	18	32	26	34	24	134 9%	---	29%	

All HIV/AIDS data reported to the Washington State Department of Health as of June 30, 2016

*Late HIV diagnoses based on new HIV cases diagnosed between 2010 and 2014

Table 9. People Living with Diagnosed HIV Infection, Seattle TGA, as of Year-end 2014
(Source: eHARS)

	HIV (not AIDS)			AIDS			All Cases of HIV Disease		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
Total	3,820	100%	133.9	4,337	100%	152.0	8,157	100%	286.0
Sex at Birth									
Male	3,335	87%	234.3	3,781	87%	265.6	7,116	87%	499.9
Female	485	13%	33.9	556	13%	38.9	1,041	13%	72.9
Current Age									
< 13	17	4%	---	1	0%	---	18	0%	---
13 - 24	139	19%	---	25	1%	---	164	2%	---
25 - 34	734	26%	---	311	7%	---	1,045	13%	---
35 - 44	990	31%	---	784	18%	---	1,774	22%	---
45 - 54	1,176	20%	---	1,738	40%	---	2,914	36%	---
55+	764	0%	---	1,478	34%	---	2,242	27%	---
Race and Hispanic Origin									
White	2376	0%	127.2	2,579	59%	138.0	4,955	61%	265.2
Black	694	4%	468.3	830	19%	560.1	1,524	19%	1028.4
Hispanic (all races)	465	19%	166.9	585	13%	209.9	1,050	13%	376.8
Asian	159	26%	---	191	4%	---	350	4%	---
Native Hawaiian / Pacific Islander	13	31%	---	18	0%	---	31	0%	---
American Indian / Alaska Native	26	20%	---	49	1%	---	75	1%	---
Multiple Race	86	2%	---	85	2%	---	171	2%	---
Hispanic only:									
- White	196	5%	---	167	4%	---	363	4%	---
- Black	5	0%	---	17	0%	---	22	0%	---
- Multiple / Other Race	28	1%	---	16	0%	---	44	1%	---
- Unknown Race	236	6%	---	385	9%	---	621	8%	---
Exposure Category by Sex at Birth									
Male only:									
- Male / Male Sex (MSM)	2,655	70%	---	2,668	62%	---	5,323	65%	---
- Injecting Drug Use (IDU)	81	2%	---	163	4%	---	244	3%	---
- MSM and IDU	266	7%	---	411	9%	---	677	8%	---
- Heterosexual Contact	71	2%	---	171	4%	---	242	3%	---
- Pediatric	19	0%	---	9	0%	---	28	0%	---
- Transfusion / Hemophiliac	5	0%	---	16	0%	---	21	0%	---
- No Identified Risk	238	6%	---	343	8%	---	581	7%	---
Female only:									
- Injecting Drug Use	44	1%	---	81	2%	---	125	2%	---
- Heterosexual Contact	274	7%	---	370	9%	---	644	8%	---
- Pediatric	22	1%	---	10	0%	---	32	0%	---
- Transfusion / Hemophiliac	4	0%	---	9	0%	---	13	0%	---
- No Identified Risk	141	4%	---	556	13%	---	697	9%	---

All HIV/AIDS data reported to the Washington State Department of Health as of June 30, 2016

HIV Rates, Trends, and Burden of Disease

Although the number of people living with HIV in Washington continues to rise, both HIV incidence and HIV-related mortality appear to be on the decline.

CDC estimates that there are approximately 1.1 million people living with HIV infection in the United States; as many as 13% with HIV do not know they are infected. The Washington State Department of Health estimates HIV prevalence to be at least 14,000, or just over 1% of the national HIV burden. HIV prevalence in Washington is increasing about 3% per year, on average. Statewide, DOH estimates that about 10% of people living with HIV are not aware of their HIV status.

HIV incidence has steadily decreased over the past decade in Washington State. In 2006, the state's HIV diagnosis rate was 8.8 cases per 100,000 residents. In 2015, the state rate was 27% lower at 6.4 cases per 100,000. Similarly, the HIV transmission rate--the ratio of new cases compared to prevalent cases--has decreased more than 30% since the mid-2000s. There are likely many reasons for these decreases. However, most experts agree that the largest contributing factors are improved HIV testing behaviors in combination with better HIV treatment adherence resulting in more

PLWDH achieving virologic suppression.

Since the HIV epidemic began, nearly 7,000 people living in Washington have died as a result of their HIV illness. With effective treatment now widely available, HIV is considered to be a manageable, chronic disease. During 2010–2014, there were fewer than 100 HIV deaths per year in Washington, on average. During the 1990s, HIV deaths in Washington averaged more than 350 per year. The most common cause of death among people with HIV is liver failure, which often occurs as the result of co-infection with Hepatitis B or C.

The HIV epidemic has burdened some groups much more than others. To understand how HIV-related health disparities affect people in Washington State, the Department of Health convened a Special Emphasis Workgroup on HIV-Related Disparities (SEW-D) to examine the state-wide data in more detail. Published in February 2015, the SEW's report describes HIV-related health disparities with regard to race and ethnicity, U.S.-born vs. foreign

born, gay/bisexual men vs. heterosexual men and women, geography, age, and specified social determinants of health (income, education, and poverty). Based on these findings, the SEW-D identified the following specific disparities:

1. Overall: gay and bisexual men of all races/ethnicities, compared to heterosexual men, experience an actual disparity for HIV infection of more than 150:1. This disparity is being addressed in detail in the work being done within the current HIV Planning Steering Group (HPGS) framework.

2. U.S.-born Black residents experience disparities in participation in prevention (PreP) and testing, in being linked to care, in retention in care and in viral load suppression (basically the entire care continuum, starting with prevention, needs to be improved for U.S.-born Blacks). Disparities for U.S. Blacks compared to whites are 4:1 for HIV infection. Seventy-seven percent of U.S.-born blacks, once diagnosed, are linked to care, compared

to 90 percent of whites. The data show that U.S.-born Blacks experience lower rates of retention in care and, as a result, are ten percentage points less likely to be virally suppressed than other groups.

3. Foreign-born Black residents experience disparities in the number of late diagnoses. Foreign-born Blacks are 100 times more likely to be infected than whites and most likely to have been infected in their home countries, so testing as soon as possible after arriving in the U.S. would help address the disparity for HIV infection for foreign-born Blacks.

4. Foreign-born Hispanics also experience higher numbers of late diagnoses, experience lower levels of retention in care, and lower levels of viral load suppression (much of the care continuum).

Foreign-born Hispanics are three times more likely to be infected than Whites and are at elevated risk for late HIV diagnosis (43% diagnosed with AIDS within 12 months of HIV diagnosis) and have a low level of viral suppression (55%) relative to non-Hispanic Whites. These facts should prompt a new emphasis on HIV prevention, testing and retention in care for this disproportionately affected population. There is enough qualitative data to suggest that a number of these infections take place in the U.S. to warrant added emphasis on prevention.

People whose status in the U.S. is undocumented have greater challenges in accessing health care in general, which must be successfully addressed if undocumented people are to have access to prevention and stay retained in care.

5. Younger adults (ages 18-35) show lower rates of retention in care. Approximately 51 percent of younger adults are retained in care, compared to 58 percent total.

6. In addition, specific geographic areas were identified as “hot spots” for HIV infection, related to education and income levels of residents. This geocoded

information needs further analysis to verify “hot spots” for HIV infection, for use in targeting prevention/testing efforts.

Although age is not typically considered an HIV risk factor, it should be noted that nearly half of all PLWH are at least 50 years of age. Hence, in addition to dealing with

the need to treat and manage a chronic, life-threatening illness, these individuals also face vulnerabilities associated with aging and the development of other age-related health conditions.

Figure 5. Counts and Rates of New HIV Diagnoses, WA State, 1981-2014 (Source: eHARS)

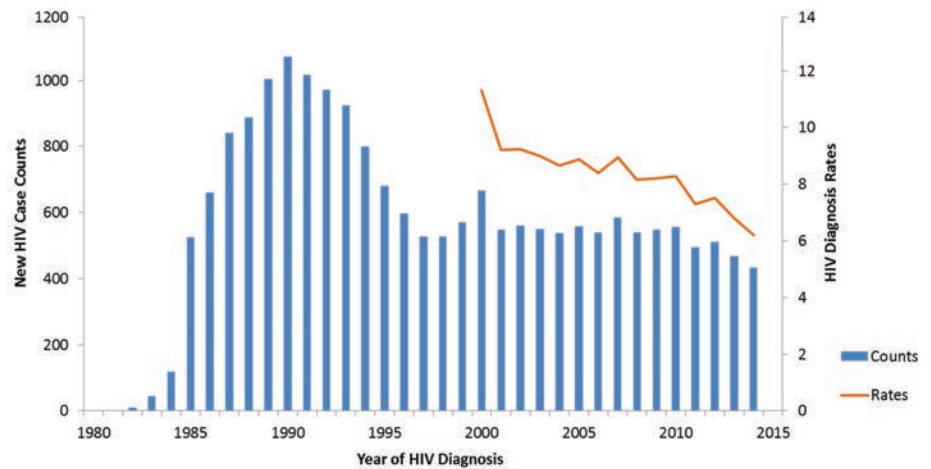


Table 10. Incident and Prevalent HIV Case Counts, WA State, 2007-2014 (Source: eHARS)

Year	New HIV Case	Diagnosed, Prevalent Cases (PLWDH)	Annual Percent Change among PLWDH	Transmission Rate
2007	581	10674	---	5.4%
2008	536	11021	3.3%	4.9%
2009	549	11365	3.1%	4.8%
2010	557	11726	3.2%	4.8%
2011	495	11730	0.0%	4.2%
2012	510	11877	1.3%	4.3%
2013	457	12228	3.0%	3.7%
2014	443	12532	2.5%	3.5%

Based on surveillance data reported to the Washington State Department of Health as of 6/30/2016

Over the past 10 years, HIV incidence has steadily declined in Washington. This encouraging trend suggests that HIV prevention efforts are working, and that the end of the HIV epidemic in our state could eventually become a reality.

Table 11. People Living with Diagnosed HIV Infection, WA State, as of Year-end 2014 (Source: eHARS)

	HIV (not AIDS)			AIDS			All Cases of HIV Disease		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
Total	5,647	100%	81.0	6,935	100%	99.5	12,582	100%	180.6
Sex at Birth									
Male	4,780	85%	137.7	5,997	86%	172.7	10,777	86%	310.4
Female	867	15%	24.8	938	14%	26.8	1,805	14%	51.6
Current Age									
< 13	46	1%	4.0	1	0%	0.7	47	0%	5.8
13 - 24	239	4%	25.9	66	1%	20.6	305	2%	89.2
25 - 34	1,096	19%	113.3	495	7%	91.0	1,591	13%	230.1
35 - 44	1,452	26%	159.6	1,381	20%	235.6	2,833	23%	418.0
45 - 54	1,731	31%	181.9	2,801	40%	263.7	4,532	36%	403.2
55+	1,083	19%	57.3	2,191	32%	80.2	3,274	26%	119.7
Race and Hispanic Origin*									
White	3,593	64%	72.8	4,377	63%	88.7	7,970	63%	161.6
Black	945	17%	381.9	1,095	16%	442.6	2,040	16%	824.5
Hispanic (all races)	702	12%	82.6	946	14%	111.3	1,648	13%	193.8
Asian	184	3%	35.0	232	3%	44.1	416	3%	79.1
Native Hawaiian / Pacific Islander	26	0%	59.4	39	1%	89.1	65	1%	148.6
American Indian / Alaska Native	58	1%	64.2	97	1%	107.4	155	1%	171.6
Multiple Race	134	2%	48.2	144	2%	51.8	278	2%	100.0
Hispanic only:									
- White	303	5%	41.6	311	4%	42.8	614	5%	84.5
- Black	13	0%	---	27	0%	113.0	40	0%	165.2
- Multiple / Other Race	48	1%	---	32	0%	---	80	1%	---
- Unknown Race	338	6%	---	576	8%	---	914	7%	---
Exposure Category by Sex at Birth									
Male only:									
- Male / Male Sex (MSM)	3,596	64%	---	4,060	59%	---	7,656	61%	---
- Injecting Drug Use (IDU)	177	3%	---	359	5%	---	536	4%	---
- MSM and IDU	459	8%	---	685	10%	---	1,144	9%	---
- Heterosexual Contact	131	2%	---	290	4%	---	421	3%	---
- Pediatric	33	1%	---	16	0%	---	49	0%	---
- Transfusion / Hemophiliac	7	0%	---	31	0%	---	38	0%	---
- No Identified Risk	377	7%	---	556	8%	---	933	7%	---
Female only:									
- Injecting Drug Use	110	2%	---	181	3%	---	291	2%	---
- Heterosexual Contact	524	9%	---	622	9%	---	1,146	9%	---
- Pediatric	41	1%	---	13	0%	---	54	0%	---
- Transfusion / Hemophiliac	5	0%	---	12	0%	---	17	0%	---
- No Identified Risk	187	3%	---	110	2%	---	297	2%	---

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of Dec 31, 2015.

* Section excludes 10 cases (5 with HIV, 5 with AIDS) for which we do not have information about race or ethnicity.

Table 12. People Living with Diagnosed HIV Infection, by County of Current Residence, WA State, as of Year-end 2014 (Source: eHARS)

	HIV (not AIDS)			AIDS			All Cases of HIV Disease		
	No.	%	Rate	No.	%	Rate	No.	%	Rate
Adams Co.	3	0%	---	10	0%	---	13	0%	67.0
Asotin Co.	9	0%	---	13	0%	59.2	22	0%	100.2
Benton Co.	63	1%	33.8	62	1%	33.2	125	1%	67.0
Benton-Franklin HD	88	2%	32.2	104	1%	38.1	192	2%	70.3
Chelan Co.	24	0%	32.3	28	0%	37.7	52	0%	70.0
Chelan-Douglas HD	29	1%	25.4	35	1%	30.7	64	1%	56.1
Clallam Co.	29	1%	40.0	37	1%	51.0	66	1%	91.0
Clark Co.	287	5%	64.8	351	5%	79.3	638	5%	144.1
Columbia Co.	3	0%	---	5	0%	---	8	0%	---
Cowlitz Co.	49	1%	47.3	65	1%	62.7	114	1%	109.9
Douglas Co.	5	0%	---	7	0%	---	12	0%	30.2
Ferry Co.	1	0%	---	5	0%	---	6	0%	---
Franklin Co.	25	0%	28.9	42	1%	48.5	67	1%	77.4
Garfield Co.	0	0%	---	0	0%	---	0	0%	---
Grant Co.	16	0%	17.2	33	0%	35.5	49	0%	52.7
Grays Harbor Co.	27	0%	36.8	50	1%	68.2	77	1%	105.0
Island Co.	34	1%	42.5	38	1%	47.5	72	1%	90.0
Jefferson Co.	13	0%	42.3	24	0%	78.2	37	0%	120.5
King Co.	3,223	57%	159.8	3,708	53%	183.8	6,931	55%	343.6
Kitsap Co.	123	2%	48.1	168	2%	65.7	291	2%	113.7
Kittitas Co.	5	0%	---	23	0%	54.6	28	0%	66.5
Klickitat Co.	8	0%	---	9	0%	---	17	0%	81.5
Lewis Co.	15	0%	19.7	38	1%	49.8	53	0%	69.5
Lincoln Co.	2	0%	---	4	0%	---	6	0%	---
Mason Co.	38	1%	61.3	48	1%	77.4	86	1%	138.7
NE Tri-County HD	12	0%	18.5	20	0%	30.9	32	0%	49.4
Okanogan Co.	13	0%	31.2	23	0%	55.2	36	0%	86.3
Pacific Co.	12	0%	56.9	18	0%	85.3	30	0%	142.2
Pend Oreille Co.	2	0%	---	7	0%	---	9	0%	---
Pierce Co.	647	11%	78.8	729	11%	88.8	1,376	11%	167.5
San Juan Co.	11	0%	---	16	0%	99.4	27	0%	167.7
Skagit Co.	39	1%	32.6	49	1%	41.0	88	1%	73.6
Skamania Co.	3	0%	---	3	0%	---	6	0%	---
Snohomish Co.	397	7%	53.6	550	8%	74.2	947	8%	127.8
Spokane Co.	215	4%	44.4	295	4%	60.9	510	4%	105.3
Stevens Co.	9	0%	---	8	0%	---	17	0%	38.7
Thurston Co.	119	2%	45.1	160	2%	60.6	279	2%	105.7
Wahkiakum Co.	1	0%	---	4	0%	---	5	0%	---
Walla Walla Co.	15	0%	24.9	33	0%	54.9	48	0%	79.8
Whatcom Co.	68	1%	32.8	116	2%	55.9	184	1%	88.6
Whitman Co.	7	0%	---	10	0%	---	17	0%	36.6
Yakima Co.	87	2%	35.0	146	2%	58.7	233	2%	93.6
Statewide Total	5,647	100%	81.0	6,935	100%	99.5	12,582	100%	180.6

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of Dec 31, 2015.

Note: Percentages (%) are rounded to the nearest whole number. Actual values may be less than they appear (e.g. 0.7% = "1%").

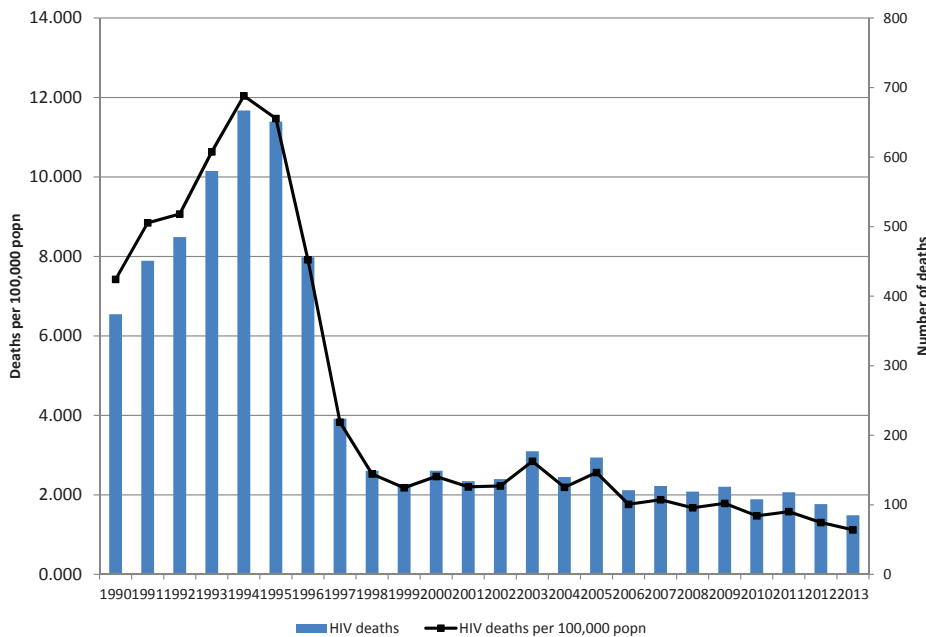
Table 13. Living HIV Cases by HIV Exposure Category, Sex at Birth, and Race/Ethnicity, WA State, as of Year-end 2014 (Source: eHARS)

Exposure category	White		Black		Hispanic		Asian		American Indian / Alaska Native	
	No.	%	No.	%	No.	%	No.	%	No.	%
Males:										
Male / Male Sex (MSM)	5,527	76%	672	50%	964	67%	221	67%	57	53%
Injecting Drug Use (IDU)	326	5%	104	8%	74	5%	9	3%	10	9%
MSM and IDU	846	12%	95	7%	125	9%	9	3%	21	19%
Heterosexual Contact	143	2%	168	12%	82	6%	13	4%	9	8%
Pediatric	11	0%	28	2%	4	0%	2	1%	1	1%
Transfusion / Hemophiliac	31	0%	4	0%	2	0%	0	0%	0	0%
No Identified Risk	348	5%	283	21%	195	13%	78	23%	10	9%
Total Males	7,232	100%	1,354	100%	1,446	100%	332	100%	108	100%
Females:										
Injecting Drug Use (IDU)	189	26%	54	8%	23	11%	2	2%	12	26%
Heterosexual Contact	455	62%	434	63%	139	69%	56	67%	31	66%
Pediatric	13	2%	32	5%	7	3%	2	2%	0	0%
Transfusion / Hemophiliac	5	1%	8	1%	1	0%	3	4%	0	0%
No Identified Risk	76	10%	158	23%	32	16%	21	25%	4	9%
Total Females	738	100%	686	100%	202	100%	84	100%	47	100%

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of Dec 31, 2015.

* Table excludes 65 Native Hawaiian and Pacific Islander cases due to small numbers. Also excluded are 278 cases reported as belonging to more than one racial or ethnic group, and 10 cases that are missing any information about race or ethnicity.

Figure 6. Age-Adjusted HIV Mortality, WA State, 1990-2013 (Source: eHARS)



Substantial decreases in age-adjusted HIV mortality over the past decade provide additional evidence that HIV is now considered by most experts to be a manageable, chronic condition.

Table 14. AIDS Cases and Deaths from HIV or AIDS, WA State, 1981-2014 (Source: eHARS)

	Recent AIDS Cases			Cumulative AIDS Cases		Cumulative HIV/AIDS Deaths	
	2010-2014			1981-2014		1981-2014	
	No.	%	Rate	No.	%	No.	%
Total	1,315	100%	3.8	14,338	100%	6,730	100%
Sex at Birth							
Male	1,107	84%	6.5	12,850	90%	6,206	92%
Female	208	16%	1.2	1,488	10%	524	8%
Age at AIDS Diagnosis						Age at Death	
< 13	0	0%	0.0	32	0%	15	0%
13 - 24	74	6%	1.4	580	4%	70	1%
25 - 34	304	23%	6.4	4,734	33%	1,594	24%
35 - 44	354	27%	7.8	5,451	38%	2,701	40%
45 - 54	390	30%	8.1	2,543	18%	1,478	22%
55+	193	15%	2.2	998	7%	872	13%
Race and Hispanic Origin							
White	748	57%	3.0	10,322	72%	5,336	79%
Black	235	18%	19.7	1,800	13%	640	10%
Hispanic (all races)	187	14%	4.7	1,335	9%	416	6%
Asian	65	5%	2.6	313	2%	77	1%
Native Hawaiian / Pacific	13	1%	6.3	52	0%	16	0%
American Indian / Alaska Native	23	2%	5.1	226	2%	103	2%
Multiple or Unknown Race	44	3%	3.4	290	2%	142	2%
Hispanic only:							
- White	77	6%	2.3	421	3%	156	2%
- Black	5	0%	---	42	0%	17	0%
- Multiple / Other Race	10	1%	---	51	0%	18	0%
- Unknown Race	95	7%	---	821	6%	225	3%
Exposure Category by Sex at Birth							
Male only:							
- Male / Male Sex (MSM)	694	53%	---	9,053	63%	4,503	67%
- Injecting Drug Use (IDU)	70	5%	---	903	6%	474	7%
- MSM and IDU	112	9%	---	1,444	10%	724	11%
- Heterosexual Contact	37	3%	---	414	3%	118	2%
- Pediatric	2	0%	---	16	0%	7	0%
- Transfusion / Hemophiliac	0	0%	---	156	1%	109	2%
- No Identified Risk	192	15%	---	864	6%	271	4%
Female only:							
- Injecting Drug Use	46	3%	---	397	3%	192	3%
- Heterosexual Contact	102	8%	---	872	6%	257	4%
- Pediatric	3	0%	---	23	0%	8	0%
- Transfusion / Hemophiliac	2	0%	---	49	0%	29	0%
- No Identified Risk	55	4%	---	147	1%	38	1%

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of Dec 31, 2015.

Behaviors and Risk Populations

Most new HIV infections in Washington are the result of unprotected sex among men or transgender women who have sex with men.

Although HIV can be transmitted in a variety of different ways, most HIV infections in Washington are attributed to unprotected anal intercourse. Anal sex is much riskier than vaginal sex, yet both anal and vaginal sex carry a greater risk than oral sex. Risk of HIV transmission is also greater

- if the HIV-negative partner is the receptive partner,
- if neither partner is wearing a condom,
- if the HIV-positive partner was infected recently,
- if the HIV-positive partner is not receiving anti-retroviral therapy (ART),
- if either partner has another sexually transmitted infection (STI), or
- if either partner is having a sexual relationship with more than one partner during the same time period.

MSM/TSM are at high-risk of HIV mainly due to the frequency with which they have unprotected anal sex. Studies conducted mainly in King County indicate that substantial proportions (>50%) of both positive and negative MSM/TSM have had unprotected anal sex in the past 12 months,

and often while under the influence of drugs such as methamphetamine or poppers. In the 2014 National HIV Behavioral Survey (NHBS), more than a third of MSM/TSM participants reported five or more sexual partners within the past year; and roughly one in five reported using drugs before or during sex with their last male partner. Additionally, a major HIV risk factor among MSM/TSM is co-infection with other sexually transmitted diseases such as gonorrhea or syphilis.

Sharing drug injection equipment is also a significant risk factor in the transmission of HIV. During 2010–2014, 15% of all new HIV diagnoses reported injection drug use, including those with other risk factors for HIV. Sharing HIV-contaminated needles and syringes and other injection equipment such as cookers and cottons can transmit HIV and other bloodborne diseases. Next to stopping the practice of injecting drugs, the consistent use of new or unshared equipment is the most effective method of reducing the risk of HIV infection among injection drugs users.

Methamphetamine (or “meth”) is a highly addictive stimulant that has increasingly become one of the most important risk factors for HIV, especially among MSM/TSM. Meth can be smoked, snorted or injected. Meth often causes users to be sexually aroused and increases sexual stamina. Research suggests that even when meth is not injected, its use can increase risk of HIV transmission, because meth users tend to be less likely to wear condoms during sex. They also appear to have sex more often, for longer periods of time, and with more partners.

Regardless of what kind(s) of recreational drugs people use, these substances, especially stimulants, often lead to impaired decision-making, which can result in unhealthy or unsafe sexual behaviors such as exchanging sex for drugs, having anonymous sex partners, not using condoms, and not seeking medical treatment for disease symptoms. Sexual partners of people who use recreational drugs are also often at increased risk for HIV and other STIs, regardless of whether they themselves use drugs.

Table 15. People Living with Diagnose HIV infection by Race/Ethnicity and Mode of Exposure, WA State, as of Year-end 2014 (Source: eHARS)

Race/ ethnicity	Mode of HIV Exposure							
	Total MSM		(Non-MSM) IDU		Heterosexual		Other	
	no.	row %	no.	row %	no.	row %	no.	row %
White	6718	84%	582	7%	620	8%	113	1%
Black	849	41%	227	11%	864	42%	130	6%
Hispanic	1223	74%	118	7%	276	17%	36	2%
Asian	270	64%	21	5%	104	25%	25	6%
Haw/PI	45	67%	4	6%	17	25%	1	1%
AI/AN	84	54%	30	19%	37	24%	4	3%
Multi	221	80%	26	9%	22	8%	7	3%
Total	9410		1008		1940		316	

Figure 7. HIV Testing History (Time Since Last Negative Test) among Heterosexuals, Men Who Have Sex with Men (MSM), and Injection Drug Users (IDU), Seattle-Area National HIV Behavioral Surveys, 2011-2013 (Source: NHBS)

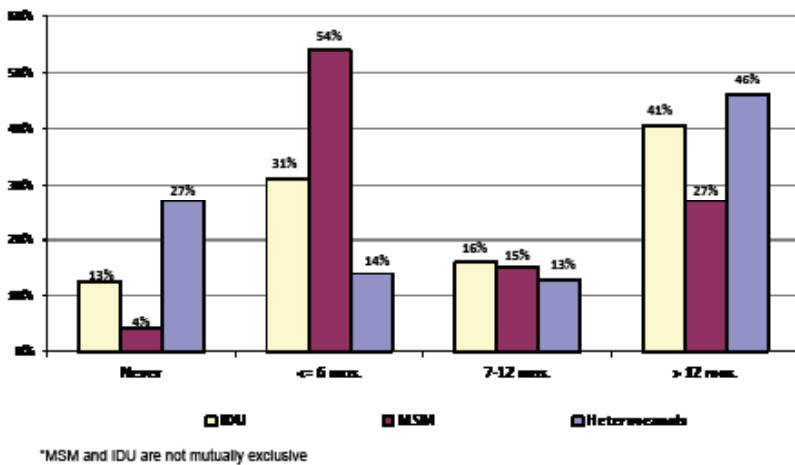
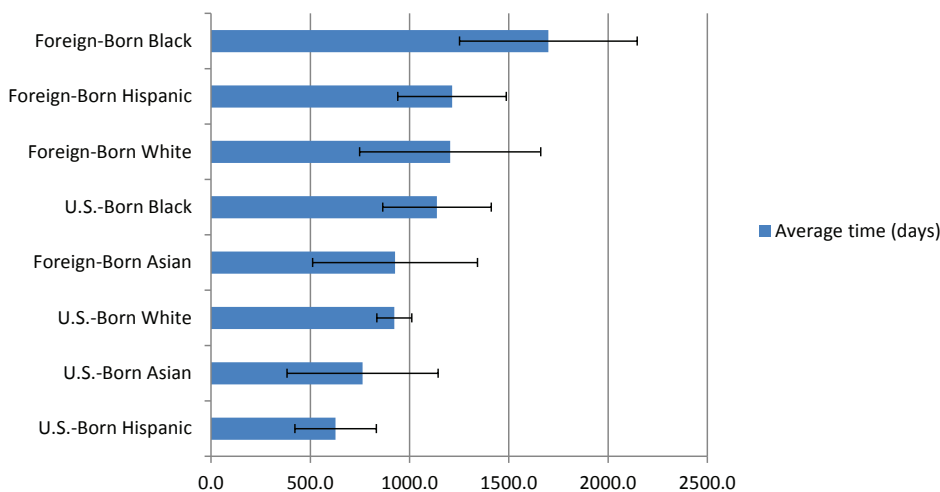
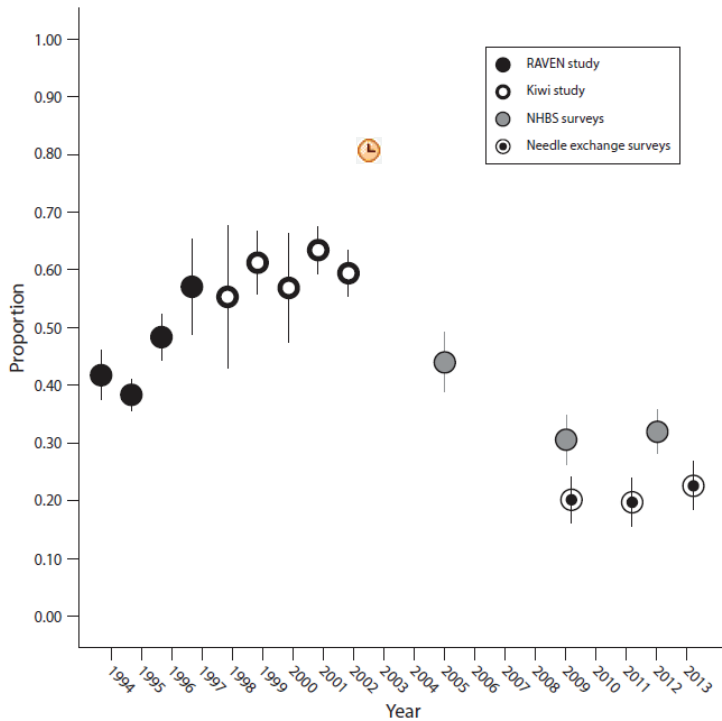


Figure 8. Average Time (in Days) Between Date of HIV Diagnosis and Date of Last Reported HIV-Negative Test Result, Washington State, 2010-2014



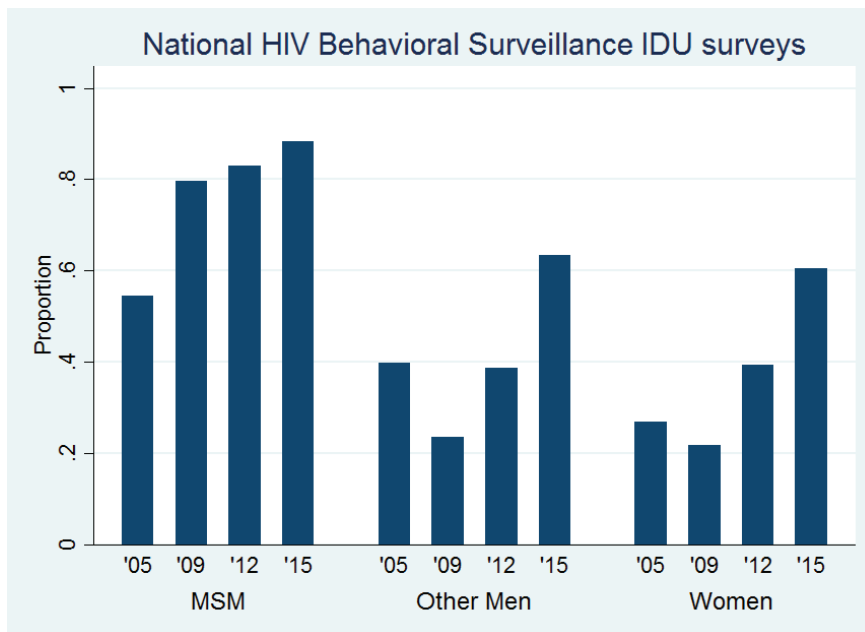
Regardless of race/ethnicity, foreign-born individuals newly diagnosed with HIV are less likely to report a previous test within the past 12 months. Knowing one's status is an important step towards initiating treatment and protecting partners

Figure 9. Time Trends in the Proportion of Participants Reporting Sharing Needles Across Seattle-Area Surveys of Injection Drug Users, 1994-2013 (Source: NHBS)



Local data collected from multiple Seattle-area surveys conducted during approximately the last 20 years suggest that the percentage of IDU who share needles has decreased dramatically over time. This helps explain why the proportion of new HIV diagnoses attributed to IDU has also decreased over time, and reinforces the continued need for syringe services programs.

Figure 10. Methamphetamine Use among Persons Who Inject Drugs, 2005-2015 (Source: NHBS)



While fewer persons who inject drugs are sharing needles, the percentages of both male and female IDU who report using meth has steadily increased in recent years.

Table 16. Characteristics Associated with HIV Prevalence among Participants in Seattle-area National HIV Behavioral Surveys, 2012-2014 (Source: NHBS)

	2015		2014		2013	
	Injection Drug Users (IDU)		Men who have sex with men (MSM)		Heterosexuals	
Total N	535		503		401	
HIV seropositive	5% (26/533)		17% (81/479)		1% (3/401)	
MSM/IDU HIV positive	22% (13/59)		48% (15/31)		n/a	
HIV + unaware of status*	15% (4/26)		7% (6/81)		33% (1/3)	
	Total	% HIV+	Total	% HIV+	Total	% HIV+
Age (years)						
18-29	24%	2%	33%	8%	25%	0%
30-39	23%	9%	28%	18%	20%	2%
40-49	23%	6%	20%	23%	29%	1%
50+	29%	4%	20%	23%	26%	0%
Gender						
Male	64%	6%	100%	17%	62%	<1%
Female	36%	3%	n/a	-	38%	1%
Race/ethnicity						
White, non-Hispanic	66%	5%	62%	18%	16%	0%
Black, non-Hispanic	9%	6%	8%	13%	64%	1%
Hispanic	9%	4%	17%	13%	6%	0%
Other race	4%	0%	5%	18%	5%	0%
Multiracial	12%	8%	8%	27%	10%	0%
Previous 12 months						
Number of sex partners:						
0	18%	3%	n/a	-	n/a	-
1	32%	4%	18%	13%	18%	1%
2 to 4	34%	5%	30%	18%	37%	0%
5 to 9	8%	0%	22%	8%	18%	1%
10+	9%	15%	31%	25%	27%	1%
Male-male sex	11%	22%	100%	17%	n/a	-
STD diagnosis	5%	15%	17%	32%	8%	0%
Popper use	n/a	-	33%	26%	n/a	-
Amphetamine use (non-injection)	60%	5%	15%	44%	8%	0%
Amphetamine injection (any)	65%	6%	5%	54%	n/a	-
Injection drug use	100%	5%	6%	48%	n/a	-
Drug most frequently injected						
Heroin	67%	3%	30%	25%	n/a	-
Speedball	7%	3%	0%	0%	n/a	-
Cocaine	<1%	0%	0%	0%	n/a	-
Amphetamine	19%	10%	70%	63%	n/a	-
Other drug (mostly Heroin + meth)	6%	9%				
Receptive needle sharing	38%	3%	19%	50%	n/a	-

* By self-report

Statewide, DOH estimates that the proportion of MSM/TSM who are HIV-positive is at least 8%. However, NHBS data suggest the proportion is much higher among younger, sexually-active MSM/TSM living in the Seattle area. This is especially concerning considering the relatively high prevalence of additional HIV risk behaviors within this group, including substance use and multiple sexual partners. Nevertheless, it's encouraging that only a small percentage (7%) were infected but unaware.

Table 17. HIV-Positive Persons in Care in Washington State by Unprotected Sex, Prior 12 Months, 2009-2013 (Source: MMP)

Item	All Respondents	Unprotected sex, prior 12 months		
		No	Yes	p-value
Age				<0.0001
18-34 years	12%	8%	18%	
35-44 years	25%	20%	34%	
45-54 years	40%	42%	35%	
55+ years	23%	30%	12%	
Race/ethnicity				0.0035
White, non-Hispanic	68%	64%	74%	
Black, non-Hispanic	13%	16%	8%	
Hispanic or latino	10%	10%	9%	
Other	10%	9%	10%	
Sex at birth				<0.0001
Male	87%	83%	92%	
Female	13%	17%	8%	
Sexual orientation (self-identified)				<0.0001
Homosexual	67%	59%	80%	
Heterosexual	23%	30%	14%	
Bisexual	8%	9%	5%	
Other/unclassified	2%	2%	1%	
Income				0.0007
<100% FPL	31%	34%	25%	
>=100% FPL - <400% FPL	45%	45%	44%	
>=400% FPL	24%	21%	31%	
Stigma				0.7869
Experience no stigma	22%	22%	23%	
Experience any stigma	78%	78%	77%	
Nativity				0.0008
U.S.-born	87%	84%	92%	
Foreign-born	13%	16%	8%	
Viral load suppression				0.0005
All viral loads in the last 12 months undetectable, <=200	69%	73%	63%	
Injection drug use in prior 12 months				<0.0001
No	92%	96%	86%	
Yes	8%	4%	14%	

Approximately 37% of the HIV-positive persons in care from 2009-2013 engaged in unprotected anal intercourse during the prior 12 months. Compared to those

who did not have unprotected anal sex, these individuals were younger and more likely to be White, non-Hispanic. About 37% of those who engaged in unprotected

anal sex had an unsuppressed viral load, compared to 27% of the individuals who did not have unprotected sex.

Table 18. HIV-Positive Persons in Care in Washington State by Injection Drug Use, Prior 12 Months, 2009-2013 (Source: MMP)

Item	All Respondents	Injection drug use prior 12 months		p-value
		No	Yes	
Age				0.0113
18-34 years	12%	11%	19%	
35-44 years	25%	25%	34%	
45-54 years	40%	40%	31%	
55+ years	23%	24%	16%	
Race/ethnicity				0.0007
White, non-Hispanic	68%	67%	72%	
Black, non-Hispanic	13%	13%	6%	
Hispanic or latino	10%	10%	4%	
Other	10%	9%	19%	
Sex at birth				0.0023
Male	87%	86%	97%	
Female	13%	14%	3%	
Sexual orientation (self-identified)				0.0016
Homosexual	67%	67%	75%	
Heterosexual	23%	24%	10%	
Bisexual	8%	8%	9%	
Other/unclassified	2%	1%	6%	
Viral load suppression				<0.0001
All viral loads in the last 12 months undetectable, <=200	69%	71%	43%	
ANY viral load in the last 12 months >200 copies/ml or Missing/unknown	31%	29%	57%	
HIV/HCV co-infection				<0.0001
No, HIV only	85%	88%	59%	
Yes, HIV/HCV co-infection	15%	12%	41%	
Unprotected anal sex in prior 12 months				<0.0001
No	63%	66%	33%	
Yes	37%	34%	67%	

According to MMP survey data collected between 2009-2013, approximately 8% of the HIV-positive persons receiving HIV care had injected drugs during the prior 12 months. Compared to persons who did not inject drugs, those who did were more likely to be young, of 'Other' race/ethnicity, and to be living below the Federal Poverty Level.

Approximately 30% of people who injected drugs were also homeless within the prior 12 months, compared to 8% of those who did not. About 57% of those who injected drugs had an unsuppressed viral load, compared to 29% of those who did not. In addition, 41% of participants who injected drugs in the prior 12 months were co-infected with hepatitis C compared

to only 12% of those who had not. Also, approximately two-thirds of people who injected drugs reported having engaged in unprotected anal intercourse during the prior 12 months, compared to one-third of individuals who did not inject drugs.

Co-Morbidities

The presence of Hepatitis C or another STD can increase a person's chance of acquiring HIV and vice versa. Being co-infected can make treatment for both conditions more challenging, and greatly increases the risk of spreading HIV to sexual and needle-sharing partners.

HIV AND HEPATITIS C

Hepatitis C virus (HCV) and human immunodeficiency virus (HIV) are both spread through blood and body fluids and can be transmitted through shared injection drug equipment and sexual transmission. When injection drug equipment is shared between partners, the transmission risk is much higher for HCV compared to HIV. However, HIV is easier to transmit sexually compared to HCV. Most coinfections result from injecting drugs, but MSM/TSM are also at increased risk for HCV/HIV coinfection via unprotected sex. Around 250,000 to 300,000 persons in the United States have HCV/HIV coinfection.

An estimated 8% of persons with HCV also have HIV, while 15% of those with HIV also have HCV. Health outcomes are usually poorer with HCV/HIV coinfection. A person with existing HIV infection is only one-fourth as likely to clear a new HCV infection. Liver disease progresses faster with HCV/HIV coinfection and survival is poorer if liver failure occurs.

Liver cancer may be more common and a coinfecting pregnant woman is more likely to transmit HCV to the infant.

HIV AND OTHER STDs

Some STDs are more closely linked to HIV than others. In the United States, people who get syphilis, gonorrhea, and herpes often also have HIV, or are more likely to get HIV in the future. This is especially true among gay and bisexual men.

Activities that can put people at increased risk for both STDs and HIV include:

- Having anal, vaginal, or oral sex without a condom;
- Having multiple sex partners;
- Having anonymous sex partners;
- Having sex while under the influence of drugs or alcohol can lower inhibitions and result in greater sexual risk taking

HIV-negative sex partners are at greater risk of getting HIV from someone who is HIV-positive and acquires another STD. Being co-infected can overwhelm a

person's immune system, causing a person have more virus circulating in their blood, which makes them more infectious.

Ways to reduce risk of getting HIV and/or another STD include:

- Choosing less risky sexual behaviors;
- Using condoms consistently and correctly;
- Reduce the number of sex partners;
- Limiting or eliminating drug and alcohol use before and during sex;
- Having an honest and open talk with healthcare provider and ask whether they should be tested for STDs and HIV.
- Talking with their healthcare provider and find out if pre-exposure prophylaxis, or PrEP, is a good option for them to prevent HIV infection

Table 19. Comparing Characteristics of People Living with Diagnosed HIV Infection Who Do or Don't Have a Hepatitis C Diagnosis, Washington State, as of Year-end 2014 (Sources: eHARS and eHEPC)

	Hepatitis C Diagnosis?				Total PLWH	
	Yes		No		No.	%
	No.	%	No.	%		
Total	1,011	100%	11,556	100%	12,567	100%
Stage of Disease						
HIV	359	36%	5,280	46%	5,639	45%
AIDS	652	64%	6,276	54%	6,928	55%
Sex at Birth						
Male	835	83%	9,926	86%	10,761	86%
Female	176	17%	1,630	14%	1,806	14%
Age						
< 13	0	0%	47	0%	47	0%
13 - 24	13	1%	292	3%	305	2%
25 - 34	72	7%	1,521	13%	1,593	13%
35 - 44	192	19%	2,637	23%	2,829	23%
45 - 54	428	42%	4,099	35%	4,527	36%
55+	306	30%	2,960	26%	3,266	26%
Race and Hispanic Origin						
White	685	68%	7,271	63%	7,956	63%
Black	146	14%	1,893	16%	2,039	16%
Hispanic (all races)	92	9%	1,556	13%	1,648	13%
Asian	25	2%	391	3%	416	3%
Native Hawaiian / Pacific Islander	2	0%	62	1%	64	1%
American Indian / Alaska Native	26	3%	129	1%	155	1%
Multiple Race / Unknown	35	3%	254	2%	289	2%
Mode of HIV Exposure						
MSM / TSM	301	30%	7,354	64%	7,655	61%
IDU	310	31%	516	4%	826	7%
MSM / TSM / IDU	269	27%	873	8%	1,142	9%
Heterosexual	60	6%	1,510	13%	1,570	12%
Blood / Pediatric / Other	20	2%	134	1%	154	1%
No Identified Risk	51	5%	1,169	10%	1,220	10%
County of Current Residence						
Clark Co.	24	2%	400	3%	424	3%
King Co.	455	45%	5,357	46%	5,812	46%
Pierce Co.	108	11%	859	7%	967	8%
Snohomish Co.	40	4%	613	5%	653	5%
Spokane Co.	48	5%	336	3%	384	3%
Other	336	33%	3,991	35%	4,327	34%
HIV Care Outcomes						
Engaged in Care	876	87%	9,282	80%	10,158	81%
Retained in Care	634	63%	6,323	55%	6,957	55%
Virologically Suppressed	718	71%	8,030	69%	8,748	70%

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of May 31, 2016.

Table 20. New HIV Diagnoses by Presence vs. Absence of a Concurrent STD Diagnosis, Washington State, 2010-2014 (Source: eHARS and PHIMS STD)

	Concurrent HIV-STD Diagnosis?				Total PLWH	
	Yes		No		No.	%
	No.	%	No.	%		
Total	408	100%	2,053	100%	2,461	100%
Sex at Birth						
Male	397	97%	1,689	82%	2,086	85%
Female	11	3%	364	18%	375	15%
Age						
< 13	0	0%	35	2%	35	1%
13 - 24	94	23%	269	13%	363	15%
25 - 34	149	37%	592	29%	741	30%
35 - 44	98	24%	552	27%	650	26%
45 - 54	55	13%	405	20%	460	19%
55+	12	3%	200	10%	212	9%
Race and Hispanic Origin						
White	246	60%	1,114	54%	1,360	55%
Black	48	12%	398	19%	446	18%
Hispanic (all races)	71	17%	313	15%	384	16%
Asian	20	5%	123	6%	143	6%
Native Hawaiian / Pacific Islander	4	1%	20	1%	24	1%
American Indian / Alaska Native	5	1%	23	1%	28	1%
Multiple Race / Unknown	14	3%	62	3%	76	3%
Mode of HIV Exposure						
MSMT	328	80%	1,114	54%	1,442	59%
IDU	4	1%	123	6%	127	5%
MSMT / IDU	55	13%	123	6%	178	7%
Heterosexual	5	1%	208	10%	213	9%
Blood / Pediatric / Other	0	0%	26	1%	26	1%
No Identified Risk	16	4%	459	22%	475	19%
County of Residence at Dx						
Clark Co.	16	4%	117	6%	133	5%
King Co.	290	71%	1,113	54%	1,403	57%
Pierce Co.	31	8%	241	12%	272	11%
Snohomish Co.	21	5%	147	7%	168	7%
Spokane Co.	12	3%	89	4%	101	4%
Other	38	9%	346	17%	384	16%
Late HIV Diagnosis						
	72	18%	704	34%	776	32%
Linkage to Care						
	280	69%	1,274	62%	1,554	63%

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of April 30, 2016.

Table 21. HIV-Positive Persons in Care in Washington State by HIV/HCV Co-Infection, 2009-2013 (Source: MMP)

Item	All Respondents	HIV/HCV Co-infection		p-value
		HIV Only	HIV/HCV coinfection	
Sex at birth				0.0974
Male	87%	88%	83%	
Female	13%	12%	17%	
Income				<0.0001
<100% FPL	31%	26%	59%	
>=100% FPL - <400% FPL	45%	47%	32%	
>=400% FPL	24%	27%	9%	
Sexual orientation (self-identified)				<0.0001
Homosexual	67%	71%	48%	
Heterosexual	23%	20%	39%	
Bisexual	8%	7%	11%	
Other/unclassified	2%	2%	3%	
Homeless				<0.0001
Not homeless prior 12 months	90%	92%	79%	
Homeless prior 12 months	10%	8%	21%	
Viral load suppression				0.0204
All viral loads in the last 12 months undetectable, <=200	69%	70%	61%	
Care in the past 6 months				0.0206
Yes, received care in past 6 months	94%	93%	98%	
No care in past 6 months	6%	7%	2%	
Injection drug use in prior 12 months				<0.0001
No	92%	95%	78%	
Yes	8%	5%	22%	
Unprotected anal sex in prior 12 months				0.0131
No	63%	62%	72%	
Yes	37%	38%	28%	

Approximately 15% of the HIV-positive persons in care from 2009-2013 were co-infected with hepatitis C virus (HCV). Compared to persons who were not co-infected, these individuals were more likely to be younger, of 'Other' race/ethnicity, have income under the Federal Poverty Level, heterosexual and homeless. Almost 40% of the co-infected persons had an unsuppressed viral load, compared to 30% of those who were not co-infected. About two-thirds of the HIV/HCV co-infected

experienced at least one unmet need, and approximately 22% of co-infected individuals used injection drugs in the prior 12 months, compared to 5% of those who were not co-infected.

Table 22. HIV Mortality among People Living with Diagnosed HIV Infection, by Whether Cases were Co-Infected with Hepatitis C, Washington State, 2010-2014 (eHARS and eHEPC)

Year of Death	HIV Only			HIV + Hepatitis C Co-Infected			Total Deaths among PLWDH	% of Total Deaths Co-Infected with Hepatitis C
	Deaths	PLWDH	Death Rate	Deaths	PLWDH	Death Rate		
	No.	No.	%	No.	No.	%		
2010	170	10627	1.6%	44	1107	3.8%	214	20.6%
2011	160	10658	1.5%	61	1082	5.3%	221	27.6%
2012	149	10850	1.4%	56	1038	5.1%	205	27.3%
2013	116	11225	1.0%	57	1026	5.3%	173	32.9%
2014	134	11556	1.1%	44	1011	4.2%	178	24.7%
	Average:		1.3%	Average:		4.7%	Average:	26.6%

All HIV/AIDS surveillance data reported to the Washington State Department of Health as of May 31, 2016.

Table 23. STD Diagnoses and HIV Co-Infection among MSM, Washington State, 2010-2014 (Source: eHARS and PHIMS STD)

	Gonorrhea	Syphilis
Total interviewed MSM cases	4548	1164
MSM cases screened for HIV (excluding prev. positives)	2504	505
Total no. of MSM cases reported as HIV-positive	1200	618
• previously HIV-positive	1064	540
• new HIV cases found via screening	116	61
• concurrent HIV diagnoses*	20	17
Screening yield	5%	12%
Missed screening opportunities	980 (22%)	119 (10%)

* HIV diagnoses within 30 days (plus or minus) of STD diagnoses

The diagnosis of a bacterial STD continues to be an important, sentinel event indicating both a history of risky sexual behaviors and the need for HIV screening, especially among MSM/TSM. As many as 12% of those screened are newly diagnosed with HIV infection. As more health care providers recognize and take advantage of these HIV screening opportunities, fewer MSM/TSM remain HIV infected but unaware. Nevertheless, missed screening opportunities continue to occur.

B. HIV Care Continuum

Getting to Suppression

Washington is leading the nation towards ensuring all people living with HIV are aware of their infection and are receiving optimal HIV medical treatment.

In keeping with the National HIV/AIDS Strategy, DOH is dedicated to assuring that all people living with HIV are diagnosed; linked to consistent, optimal HIV medical care; and receive the full benefits of antiretroviral treatment, including viral suppression. To this end, all HIV-positive individuals are considered the top priority from both an HIV prevention and care perspective. In order to monitor progress and assure these goals are met, DOH recently developed a statewide HIV care continuum (Figure 1). Also referred to as the HIV care cascade, this “dash board” figure is used to show both the number and proportion of people living with HIV disease (PLWH) who are engaged at each stage of HIV care.

The care continuum is a useful way to look at how successfully the HIV system is engaging and retaining PLWH in care, and at which points individuals fall out of care. The goal of the HIV care system is to optimize engagement at each step of the care continuum, which would mean that all PLWH are diagnosed, retained in care and virally suppressed. The primary clinical outcome of interest is virologic

suppression, which occurs when the concentration of virus circulating within an HIV-positive person’s body falls below 200 copies per milliliter. Individuals who achieve suppression are not only much healthier and able to survive longer, but also less infectious, making them less able to transmit the virus to uninfected sexual or needle-sharing partners.

Washington’s care continuum was developed by DOH, and debuted at a July 2014 meeting of the state’s HIV Planning Steering Group. Its design is similar to those developed by both the U.S. Centers for Disease Control and Prevention, as well as the White House Office of National AIDS Policy and other state and local health departments across the U.S.

Most care continua begin by displaying the number or percent of PLWDH who have been diagnosed and are living with HIV disease. In addition, these figures describe important care and treatment-related milestones, such as the percent of PLWDH linked to care (usually limited to recently diagnosed cases), the percent

engaged or retained in care within the past 12 months, and the percent with a suppressed viral load. The Washington model does contain some important differences. Washington’s continuum is somewhat unique in that it does not include an estimate of the number of PLWH who have been prescribed antiretroviral therapy (ART). This is because DOH does not have what it considers to be a timely, reliable source for this information. Also, DOH prefers the metric “engaged in care” vs. “retained in care”. While both indicators can be useful, we feel the first is easier to both calculate and easier to understand for less data-savvy stakeholders.

Follow-up investigations with PLWDH who appear to be out-of-care based on missing laboratory surveillance data (CD4 or viral load results) suggest that 30%-40% of these individuals no longer reside in Washington. Hence, DOH is considering adjusting the methods used to produce future care continua to take these findings into account (see proposed continuum, next page).

Figure 11. HIV Care Continuum, Washington State, 2015 (Source: eHARS)

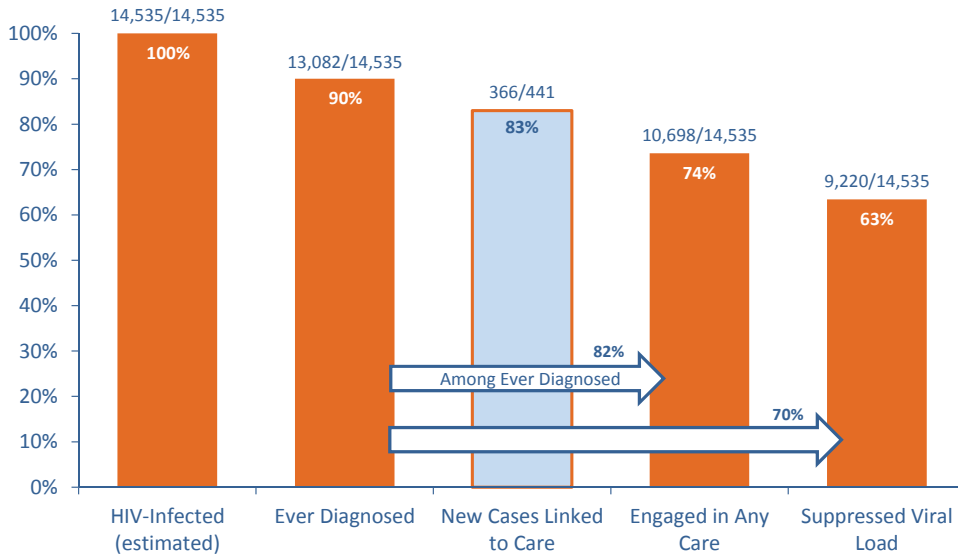
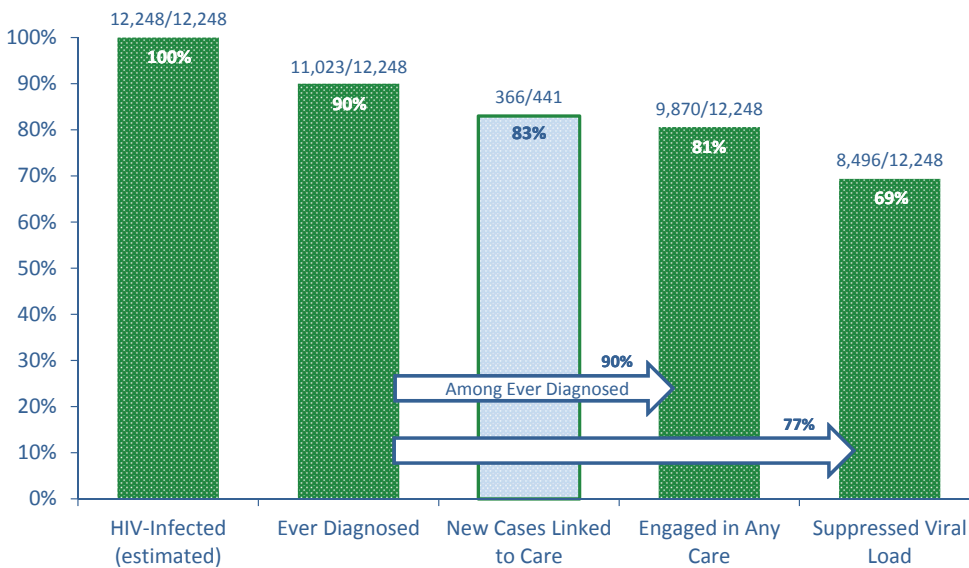


Figure 12. Proposed HIV Care Continuum in Which Recent Laboratory Evidence and the Results of Data to Care Investigations are Used to Determine Current Residence and Vital Status, Washington State, 2015 (Source: eHARS and LOOC)



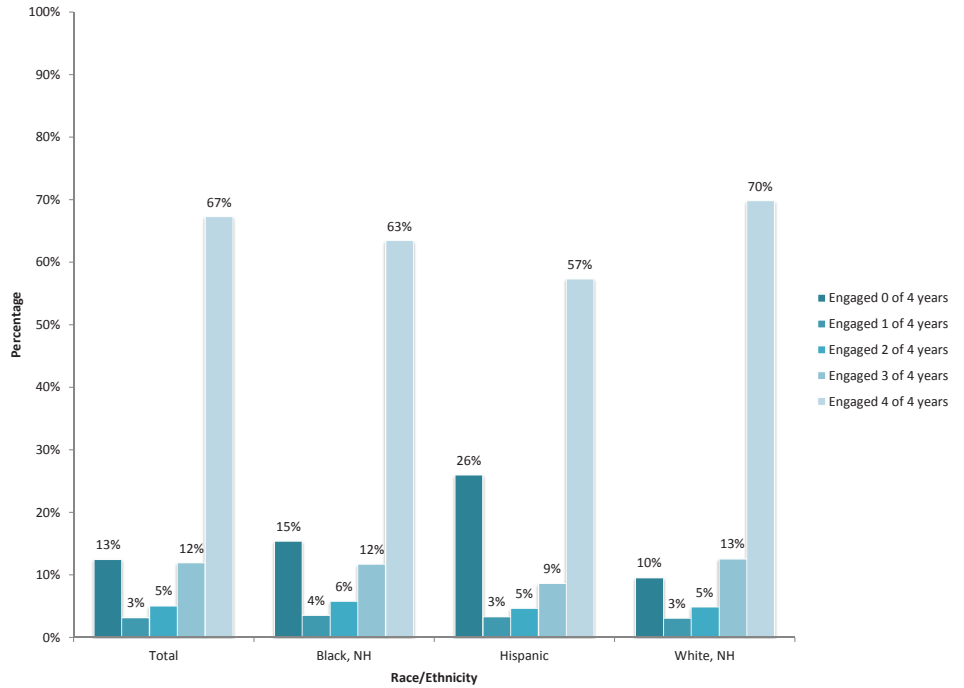
One goal established by End AIDS Washington is for at least 80% of PLWDH to achieve virologic suppression by the year 2020. In 2015, approximately 70% of PLWDH appeared to be suppressed. However, the actual percentage might be higher.

When DOH takes the results of Data to Care investigations into account, the estimated number of PLWH drops 16%, and the proportion of those individuals who appear to be suppressed increases roughly 10%, suggesting that we might be closer to achieving the End AIDS Washington goal than previously thought.

DOH has developed useful variations of the HIV care continuum which describe outcomes within key demographic sub-groups as well as over longer periods of time. These figures help further characterize HIV-related health disparities, such as those affecting persons of color.

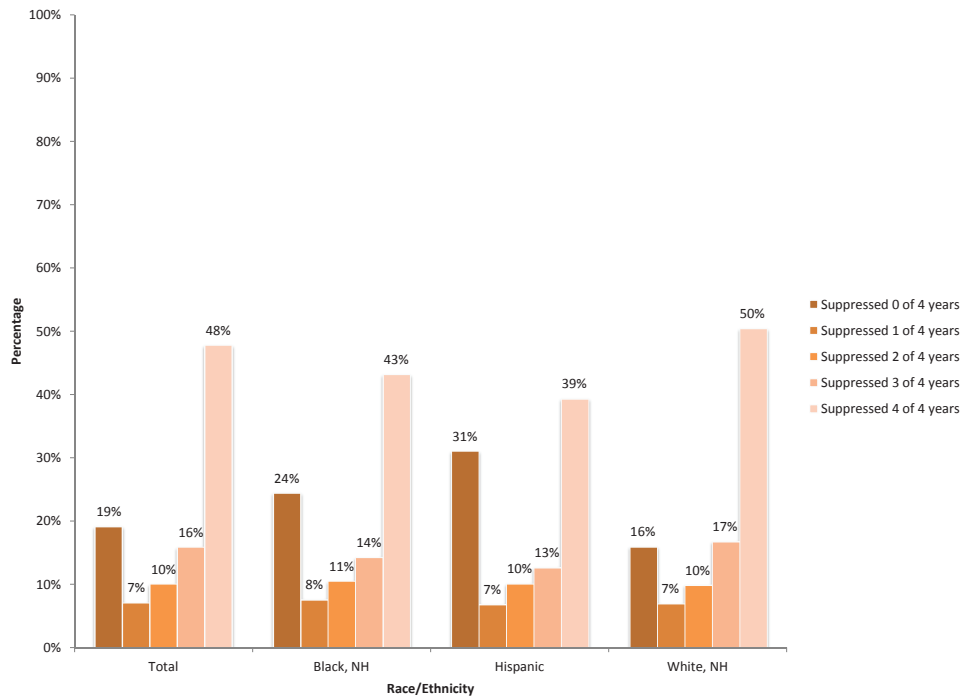
Between 2011 and 2014, nearly one-third (31%) of Hispanic PLWDH did not have any evidence of virologic suppression in any year within the four-year period.

Figure 13. Number of Years Engaged in HIV Care among People Living with Diagnosed HIV, Washington State, 2011-2014 (Source: eHARS)



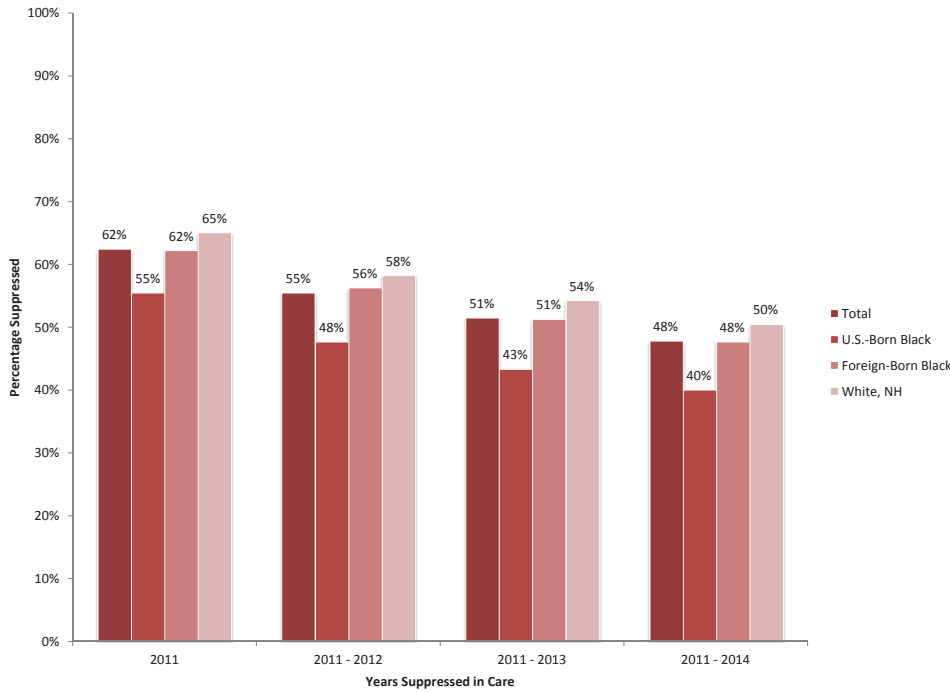
* among cases who were diagnosed prior to 2011 and presumed to residing in Washington each year between 2011 and 2014

Figure 14. Number of Years Virologically Suppressed among People Living with Diagnosed HIV, Washington State, 2011-2014 (Source: eHARS)



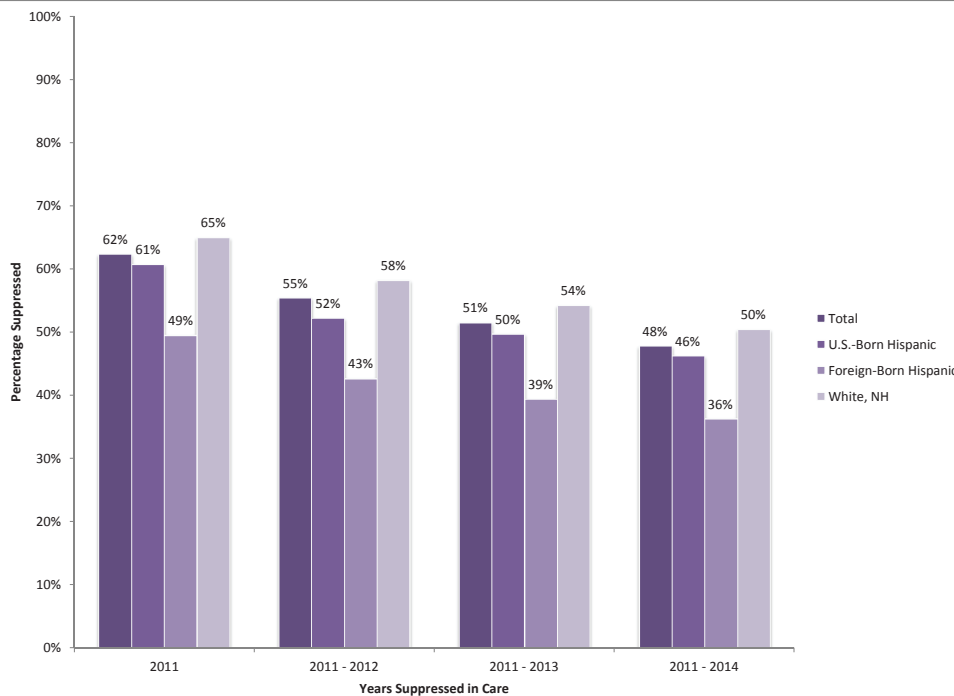
* among cases who were diagnosed prior to 2011 and presumed to residing in Washington each year between 2011 and 2014

Figure 15. Consistent VL Suppression among U.S- vs. Foreign-Born Black People Living with Diagnosed HIV, Washington State, 2011-2014 (Source: eHARS)



* among cases who were diagnosed prior to 2011 and presumed to residing in Washington each year between 2011 and 2014

Figure 16. Consistent VL Suppression among U.S- vs. Foreign-Born Hispanic People Living with Diagnosed HIV, Washington State, 2011-2014 (Source: eHARS)



* among cases who were diagnosed prior to 2011 and presumed to residing in Washington each year between 2011 and 2014

In addition to stratifying care outcomes among PLWDH by race/ethnicity, it is also important to control for nativity, or whether individuals were born inside vs. outside the U.S. Between 2011-2014, foreign-born Black PLWDH were more likely to consistently achieve virologic suppression (across multiple years) compared to their U.S. born counterparts.

U.S.-born Hispanic cases seem to be more able to remain consistently suppressed compared to those who are foreign-born. The opposite is true among Black cases.

Table 24. HIV-Positive Persons in Care in Washington State by Virologic Suppression during Prior 12 Months, 2009-2013 (Source: MMP)

Item	All Respondents	Suppressed viral load prior 12 months		
		All VL <=200 copies/mL	Any VL >200 copies or missing	p-value
Age				<0.0001
18-34 years	12%	9%	18%	
35-44 years	25%	23%	31%	
45-54 years	40%	42%	36%	
55+ years	23%	27%	16%	
Race/ethnicity				0.0633
White, non-Hispanic	68%	70%	63%	
Black, non-Hispanic	13%	11%	16%	
Hispanic or latino	10%	9%	11%	
Other	10%	10%	10%	
Sex at birth				0.5348
Male	87%	87%	86%	
Female	13%	13%	14%	
Income				0.0002
<100% FPL	31%	27%	39%	
>=100% FPL - <400% FPL	45%	46%	43%	
>=400% FPL	24%	27%	18%	
Homeless				<0.0001
Not homeless prior 12 months	90%	93%	82%	
Homeless prior 12 months	10%	7%	18%	
Unmet need in prior 12 months				0.0002
No unmet need	49%	53%	40%	
Any unmet need	51%	47%	60%	
Injection drug use in prior 12 months				<0.0001
No	92%	95%	86%	
Yes	8%	5%	14%	
Unprotected anal sex in prior 12 months				0.0005
No	63%	67%	56%	
Yes	37%	33%	44%	

According to MMP survey data collected between 2009-2013, among HIV-positive participants receiving HIV medical care, several demographic and risk factors were associated with having an unsuppressed viral load during the prior 12 months. The odds of persons with income under the Federal Poverty Level being unsuppressed were 2.1 times greater than the odds of

persons with income four or more times the Federal Poverty Level being unsuppressed. The odds of 18-34 year olds not being suppressed were 3.4 times greater than the odds of those 50 and older not being suppressed and the odds of 35-44 year olds not being suppressed were 2.2 times greater than the odds of those 50 and older not being suppressed. The

odds of homeless individuals not being suppressed were 2.9 times greater than the odds of those not homeless not being suppressed. The odds of persons who injected drugs not being suppressed were 3.3 times greater than the odds of those who did not inject drugs.

Figure 17. VL Suppression among HIV-Positive Persons by Homelessness in the Past 12 Months, Washington State, 2009-2013 (Source: MMP)

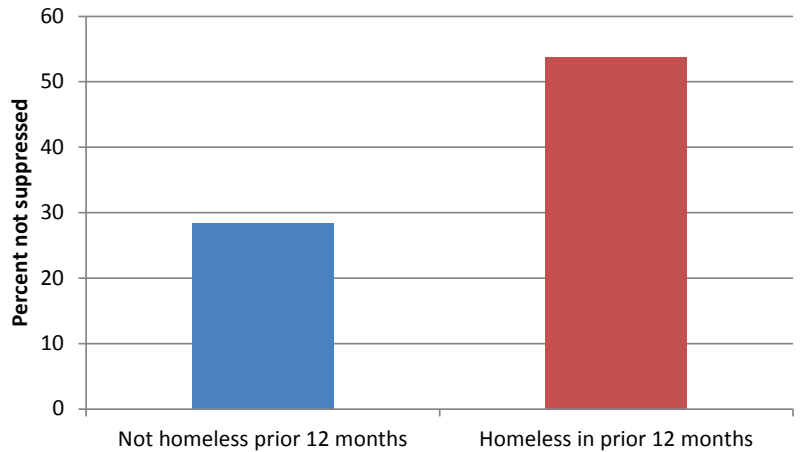


Figure 18. VL Suppression among HIV-Positive Persons by Incarceration in the Past 12 Months, Washington State, 2009-2013 (Source: MMP)

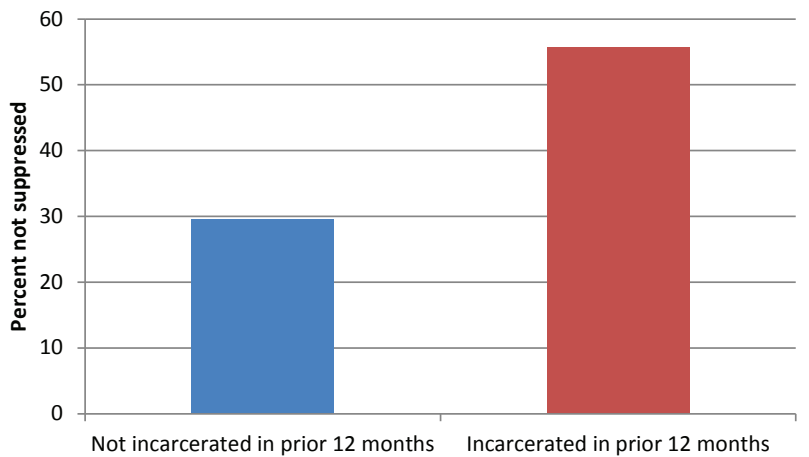
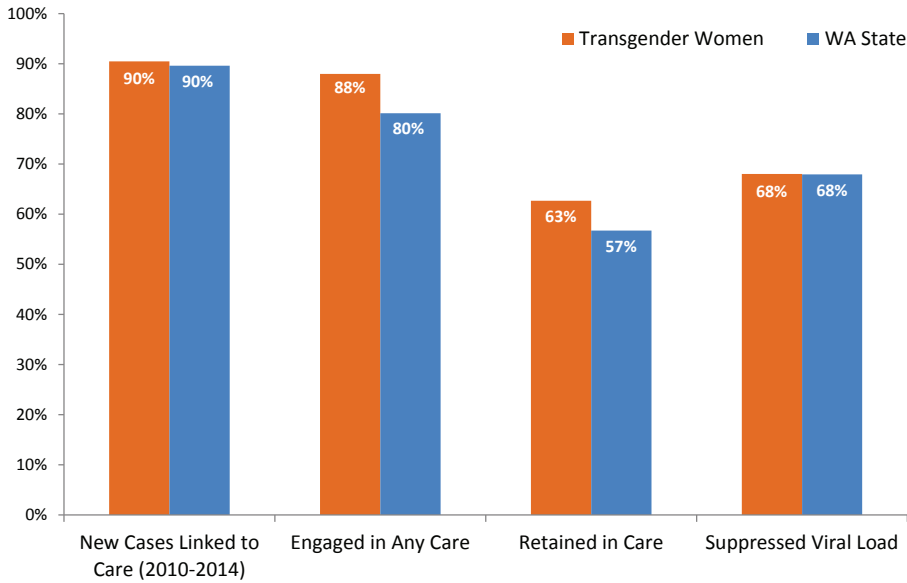


Figure 19. VL Suppression among HIV-Positive Persons by Injection Drug Use (IDU) in the Past 12 Months, Washington State, 2009-2013 (Source: MMP)



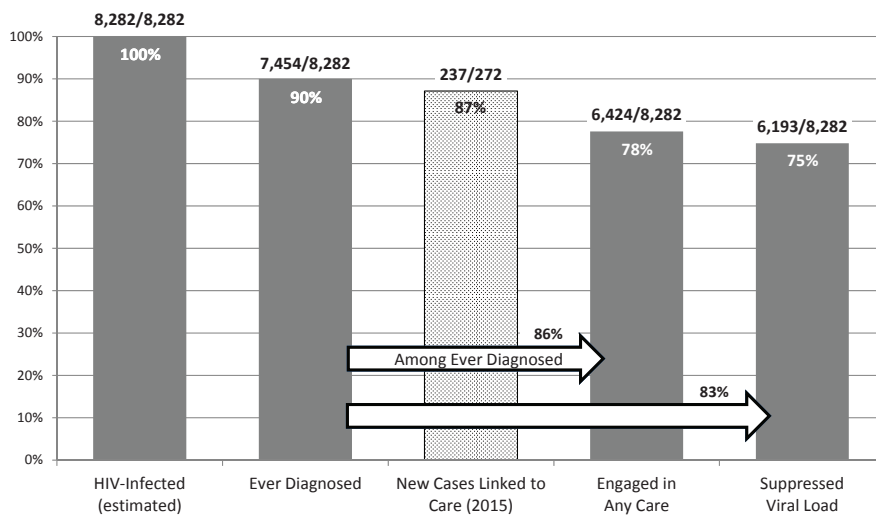
MMP findings help characterize potential barriers which can prevent PLWDH from initiating or adhering to HIV treatment or achieving virologic suppression. Even among survey participants thought to be receiving HIV care, the presence of factors such as homelessness, incarceration, or injection drug use within the prior 12 months seem to have a substantial negative affect on their ability to achieve virologic suppression.

Figure 20. HIV Care Continuum among Transgender Women Living with HIV, Washington State, 2010-2014 (Source: eHARS)



Seventy-six transgender women appeared to be living with HIV as of year-end 2014. The percentages of cases with laboratory evidence of HIV care engagement, retention in care, and viral load suppression were 88%, 63%, and 68%, respectively. While there is room for improvement, these percentages are similar to those among all PLWDH in Washington.

Figure 21. HIV Care Continuum, Seattle TGA, 2015 (Source: eHARS)



Nearly two-thirds of Washington's HIV epidemic exists within the three counties (King, Snohomish, and Island) which make up Seattle's Ryan White Part A Transitional Grant Area (Seattle TGA). PLWDH who reside within the Seattle TGA are more likely to be engaged or suppressed vs. those who reside elsewhere.

C. Financial and Human Resources Inventory

I. HIV Care Services

Ryan White Part A:

Seattle TGA

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
City of Seattle, Ryan White Part A	\$1,096,858	19%	Lifelong & various dental providers	1,500	Oral Health Care	Retention in Care
	\$186,624	19%	Lifelong, King County jail, Bailey-Boushay House, YWCA-BABES, PHSKC-STD Clinic	TBD	Medical Case Management	Diagnosis, Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
Ryan White Part A	\$ 95,399	2%	TBD	TBD	Early Intervention Services	Diagnosis, Linkage to Care
	\$ 1,089,346	18%	Country Doc	215	Non-Medical Case Management	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$ 112,427	2%	TBD	215	Non-Medical Case Management (Latino PLWH)	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$ 65,361	1%	Lifelong	46	Substance Abuse Services (Outpatient)	Linkage to Care, Retention in Care, Viral Suppression
	\$ 1,215,000	21%	Lifelong	850	Food Bank/Home-Delivered Meals	Retention in Care, Viral Suppression
	\$1,504,512	25%	Lifelong	715	Housing Services	Linkage to Care, Retention in Care, Viral Suppression
	\$ 35,447	1%	Lifelong, Bailey-Boushay House	350	Medical Transportation Services	Linkage to Care, Retention in Care, Viral Suppression
	\$ 95,398	2%	TBD	TBD	Outreach Services	Diagnosis, Linkage to Care
	\$ 37,402	1%	YWCA-BABES	100	Psychosocial Support Services	Linkage to Care, Retention in Care, Viral Suppression
	\$ 375,000	6%	Bailey-Boushay House	300	Treatment Adherence Counseling	Retention in Care, Viral Suppression
Total	\$5,908,774					

I. HIV Care Services

Ryan White Part A:

Portland TGA

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
Ryan White Part A	\$ 10,000	4%	Clark County Public Health – subcontract with New Day Community Dental	12-15	Oral Health	Retention in Care, Viral suppression
	\$ 29,775	12.5%	Clark County Public Health	35	Health Insurance Premium and Cost-Sharing Assistance	Retention in Care, Viral suppression
	\$ 6,000	2.5%	Clark Co Public Health - sub contract with Community Services Northwest	5	Mental Health Services	Retention in Care, Viral suppression
	\$ 130,000	55%	Clark County Public Health	330	Medical Case Management	Retention in Care, Viral suppression
	\$ 62,000	26%	Clark County Public Health	80	Housing Services	Retention in Care, Viral Suppression
Total	\$237,775					

Ryan White Part B:

Washington State Department of Health (DOH) - Care

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
Washington State General Funds	\$219,367	0.7%	Harborview Medical Center	720	Outpatient/ Ambulatory Medical Care	Prevention, Diagnosis, Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$114,124	0.4%	Kitsap Public Health District, CHC-Snohomish, SeaMar Olympia			
	\$91,322	0.3%	Washington State Department of Corrections	60	Outreach: Prison Re-entry	Linkage to Care, Retention in Care

I. HIV Care Services

Ryan White Part B:

Washington State Department of Health (DOH) - Care (continued)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step(s) impacted
Ryan White Part B - Base	\$3,369,264	11%	DOH Early Intervention Program	1,160	Health Insurance Premium Assistance	Retention in Care, Prescribed ART, Viral Suppression
Ryan White Part B - ADAP	\$8,383,774	26%	DOH Early Intervention Program	2,194	Health Insurance Premium Assistance	Retention in Care, Prescribed ART, Viral Suppression
Local Dollars	\$2,000,000	6%	Fee-for-Service – payment for services, co-pays, deductibles	TBD	Oral Health Care, Mental Health, Labs, Dental, Outpatient/ Ambulatory Services	Retention in Care
	\$10,500,000	33%	Fee-for-Service Pharmaceuticals	TBD	ADAP: Pharmacy Assistance	Retention in Care, prescribed ART, Viral Suppression
	\$139,185	0.4%	Spokane AIDS Network, Pierce County AIDS Foundation, Lifelong, Kitsap County Health District, Blue Mountain Heart to Heart	189	Mental Health Services	Retention in Care
	\$6,000	>0.1%	Pierce County AIDS Foundation	10	Medical Nutrition Therapy	Retention in Care
	\$14,600	>0.1%	Lifelong, Pierce County AIDS Foundation	10	Substance Abuse (Outpatient)	Retention in Care
	\$154,495	0.5%	Benton Franklin Health District, Clark County Public Health, Grant County Health Department, Kitsap County Health District, Lifelong, Coastal Community Action Program, Yakima Valley Farm Workers Clinic,	1,004	Food Bank/Home-Delivered Meals	Retention in Care

I. HIV Care Services

Ryan White Part B:

Washington State Department of Health (DOH) - Care (continued)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step(s) impacted
			Pierce County AIDS Foundation, Spokane AIDS Network			
	\$34,409	0.1%	Benton Franklin Health District, Blue Mountain Heart to Heart, Lifelong, Coastal Community Action Program, Spokane AIDS Network	292	Health Education/ Risk Reduction	Retention in Care
	\$111,592	0.4%	Grant County Health Department, Kitsap County Health District, Blue Mountain Heart to Heart, Pierce County AIDS Foundation, Spokane AIDS Network	203	Housing Services	Retention in Care
	\$66,981	0.2%	Benton Franklin Health District, Clallam County Health and Human Services, Clark County Public Health, Grant County Health Department, Kitsap County Health District, Spokane Regional Health District, Lifelong, Entre Hermanos, Harborview Medical Center, Coastal Community Action Program, Yakima Valley Farm Workers Clinic, Pierce County AIDS Foundation, Spokane AIDS	2,058	Medical Transportation Services	Retention in Care

I. HIV Care Services

Ryan White Part B: Washington State Department of Health (continued)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
			Network			
	\$122,555	0.4%	Benton Franklin Health District, Grant County Health Department, Blue Mountain Heart to Heart, Lifelong, Entre Hermanos, Coastal Community Action Program, Pierce County AIDS Foundation, Spokane AIDS Network	309	Outreach Services	Linkage to Care
	\$158,134	0.5%	Benton Franklin Health District, Clark County Public Health, Grant County Health Department, Spokane Regional Health District, Blue Mountain Heart to Heart, Lifelong, Entre Hermanos, Coastal Community Action Program, Spokane AIDS Network	262	Treatment Adherence Counseling	Retention in Care
	\$6,321,756	20%	Benton Franklin Health District, Clallam County Health and Human Services, Clark County Public Health, Grant County Health Department, Kitsap County Health District, Entre Hermanos, Harborview Medical Center, Spokane Regional Health District, Lifelong, Coastal	3,000	Medical Case Management	Linkage to Care, Retention in Care, Viral Suppression

I. HIV Care Services

Ryan White Part B:

Washington State Department of Health (continued)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
			Community Action Program, Blue Mountain Heart to Heart, Yakima Valley Farm Workers Clinic, Pierce County AIDS Foundation, Spokane AIDS Network, People of Color Against AIDS Network			
Ryan White Part B – Minority AIDS Initiative	\$66,755	0.2%	Department of Health	50	Outreach Services	Linkage to Care
Total	\$31,874,313					

I. HIV Care Services

Ryan White Parts C and D:

Community Health Center - Tacoma (CHC-Tacoma)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
Ryan White Part C	\$117,703	46%	Community Health Care - Tacoma Community	310	Outpatient/Ambulatory Medical Care	HIV Diagnosis, Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$15,470	6%		67	Local AIDS Pharmaceutical Assistance	Retention in Care, Prescribed ART, Viral Suppression
	\$15,000	6%		30	Oral Health Care	Retention in Care
	\$9,688	4%		80	Health Insurance Premium and Cost-Sharing Assistance	Linkage to Care, Retention in Care, Viral Suppression
	42,320	16%		40	Mental Health Services	Linkage to Care, Retention in Care, Viral Suppression
	8,135	3%			Medical Nutrition Therapy	Retention in Care
	7,000	3%		10	Substance Abuse Services (Outpatient)	Retention in Care
	20,592	8%			Case-Management Services (non-medical)	Retention in Care
	3,500	1%		10	Linguistic Services	Retention in Care
	2,900	1%		50	Medical Transportation Services	Linkage to Care, Retention in Care
	15,472	6%		50	Treatment Adherence Counseling	Retention in Care
Total	257,780					

I. HIV Care Services

Ryan White Parts C and D:

Country Doctor Community Health Center (CDCHC)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
Ryan White Part C	\$ 488,897	72%	Country Doctor	350	Outpatient/Ambulatory Medical Care	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$ 186,624	28%	Country Doctor	350	Medical Case Management	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
Total	\$ 675,521					

I. HIV Care Services

Ryan White Parts C and D:

Harborview Medical Center (HMC) - Care

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
Ryan White Part C	\$107,910	3.0%	HMC Madison Clinic	315	Outpatient/ Ambulatory Medical Care	HIV Diagnosis, Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$ 34,387	1.0%	HMC Madison Clinic	95	Mental Health Services	Linkage to Care, Retention in Care, Viral Suppression
	\$13,797	0.4%	HMC Madison Clinic	45	Early Intervention Services	HIV Diagnosis, Linkage to Care
	\$65,480	1.8%	HMC Madison Clinic	260	Medical Nutrition Therapy	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$117,732	3.3%	HMC Madison Clinic	550	Medical Case Management	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$13,797	0.4%	HMC Madison Clinic	90	Health Education/ Risk-Reduction	Linkage to Care, Retention in Care
	\$33,776	0.9%	HMC Madison Clinic	625	Outreach Services	HIV Diagnosis, Linkage to Care, Retention in Care

I. HIV Care Services

Ryan White Parts C and D:

Harborview Medical Center (HMC) - Care (continued)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step(s) impacted
Ryan White Part D	\$143,667	4.0%	HMC Madison Clinic, UW Maternal Infant Care Clinic	120	Outpatient/ Ambulatory Medical Care	HIV Diagnosis, Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$159,471	4.4%	HMC Madison Clinic	32	Medical Case Management	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$3,518	0.1%	HMC Madison Clinic	108	Health Education/ Risk-Reduction	Linkage to Care, Retention in Care, Viral Suppression
	\$526	0.0%	HMC Madison Clinic	20	Medical Transportation Services	Linkage to Care, Linkage to Care, Retention in Care
	\$3,518	0.1%	HMC Madison Clinic	18	Outreach Services	HIV Diagnosis, Linkage to Care, Retention in Care
Harborview Medical Center	\$2,418,265	67.2%	HMC Madison Clinic	2000	Outpatient/ Ambulatory Medical Care	HIV Diagnosis, Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$200,987	5.6%	HMC Madison Clinic	600	Mental Health Services	Linkage to Care, Retention in Care, Viral Suppression
	\$280,000	7.8%	HMC Madison Clinic	1028	Medical Case Management	Linkage to Care, Retention in Care, Viral Suppression
Total	\$3,596,831					

I. HIV Care Services

Ryan White Parts C and D:

Yakima Valley Farm Workers Clinic (YVFWC) - Care

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step(s) impacted
Ryan White Part C	\$329,949	46%	New Hope Clinic	270	Early Intervention Services	HIV Diagnosis, Linkage to Care, Engaged in Care, Prescribed ART, Viral Suppression
Washington State Department of Health	\$181,297	25%	New Hope Clinic	211	Medical Case Management	Engagement in Care, Prescribed ART, Viral Suppression
Ryan White Part D	\$119,818	17%	New Hope Clinic	30	Health Education/ Risk-Reduction	Diagnose & Engage in Care
University of Washington AETC	\$90,201	13%	New Hope Clinic	165	Other – Training Health Providers and Staff	Diagnose & Engage in Care
Total	\$721,265					

Ryan White Part F:

Mountain West AETC - Care

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of providers to receive services	Number of providers to receive services
Ryan White Part F	\$2,943,523	100%	Mountain West AETC	1,615 providers	1,615 providers
			Washington State Local Partners within the Mountain West AETC: AARTH (African American Reach and Teach Health) = \$132,000 Yakima Valley Farm Workers Clinic (YVFWC) = \$90,000 Washington State AETC = \$117,000		
Total	\$2,943,523				

I. HIV Care Services

Ryan White Part F:

Housing Opportunities for Persons with AIDS (HOPWA): Washington State and City of Seattle

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services delivered	HIV Care Continuum step (s) impacted
HOPWA (State Grant)	\$ 861,231	30%	Yakima Neighborhood Health Services, Housing Authority of the City of Bellingham, Pierce County AIDS Foundation, Spokane Housing Authority, Lifelong, Benton Franklin Community Action Committee, Okanogan County Community Action Council, Spokane Coalition of the Responsible Disabled	285	Housing Services	Retention in Care
	\$ 195,069	7%	Yakima Neighborhood Health Services, Housing Authority of the City of Bellingham, Pierce County AIDS Foundation, Lifelong, Benton Franklin Community Action Committee, Okanogan County Community Action Council, Spokane Coalition of the Responsible Disabled	225	Case Management (non-medical)	Retention in Care
HOPWA (City of Seattle Grant)	1,770,821	63%	City of Seattle – Lifelong; Catholic Community Services	165	Short term rent, mortgage & utility assistance; tenant-based rental assistance; Project-based rental assistance	Retention in care; viral load suppression
Total	\$2,827,121					

I. HIV Care Services

Medicaid:

Washington State Health Care Authority (HCA)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
Medicaid	\$4,912,208	72%	Fee-for-service providers	2,279	Outpatient/Ambulatory Medical Care	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$1,906,045	28%	Fee-for-service providers	2,565	Medical Case Management	Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
Total	\$ 6,818,253					

SAMSHA:

Department of Social and Health Services/Division of Behavioral Health and Recovery

The Department of Social and Health Services/Division of Behavioral Health and Recovery (DBHR) is the Single State Authority for Substance Use Disorders and Mental Health Services. DBHR administers the Substance Abuse Block Grant and Mental Health Block Grant received annually from Substance Abuse and Mental Health Administration (SAMSHA). DBHR is also proactive in applying for SAMSHA Substance Use Disorder and Mental Health Discretionary Grants for Prevention, Intervention, Treatment and Recovery Support Services. Grant funding supports our community-based prevention work in schools and communities, including the implementation of evidence-based practices targeting individuals and families. Funds also support early intervention as

well as screening and brief intervention in primary care facilities. DBHR dedicates SAMSHA funds to support outpatient and inpatient residential services for individuals with substance use disorders who are not eligible for Medicaid. DBHR also fund Recovery Support services for individuals with Substance Use Disorders and Mental Health conditions. The Mental Health Block Grant is to provide services to individuals with a confirmed diagnosis of Severe Mental Illness or children with Serious Emotional Disturbances.

HHS Affordable Care Act Funding for Substance Abuse Services

In March 2016, HHS announced awards to health centers to help treat the prescription opioid abuse and heroin epidemic. In Washington, the following received funding under this announcement: Wenatchee, Spokane, Tacoma, Seattle, Bremerton, and Yakima. These awards will increase the

number of patients screened for substance use disorders and connected to treatment, increase the number of patients with access to MAT for opioid use and other substance use disorder treatment, and provide training and educational resources to help health professionals make informed prescribing decisions.

II. HIV Prevention Services

Washington State Department of Health - Prevention

Private and public funding source(s)	Dollar amount in FY2015 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
State Prevention; Category A; STD AAPSS	\$400,000	4%	Cascade AIDS Project; Spokane AIDS Network	479 (CTR)	Targeted HIV Testing; Outreach; Linkage to Care; Retention in Care; Condom Distribution; PrEP Linkage & Retention; Health Insurance Enrollment; Medication Adherence	Prevention; Diagnosis; Linkage to Care; Retention in Care; Viral Suppression
State Prevention; Category A; Category C	\$302,185	3%	Lifelong	537 (CTR)		
State Prevention; Category A; Category C; STD AAPSS	\$212,973	2%	Pierce County AIDS Foundation	264 (CTR)		
State Prevention; Category C; STD AAPSS; AVH Sur Pt B	\$326,471	3%	Clark County Public Health	1,400 (SSP)		
State Prevention; Category A; Category C; STD AAPSS; STD State PPHF HPV	\$7,592,154	70%	Public Health Seattle King County	4,550 (O&R); 37,000^ (SSP)		
State Prevention, Category A; Category C; STD AAPSS; AVH Sur Pt. B	\$721,994	7%	Spokane Regional Health District; Snohomish Health District	1,700 (SSP); 318 (CTR)		
State Prevention, Category A; Category C; STD AAPSS; AVH State; AVH Sur Pt. B	\$698,401	6%	Tacoma Pierce County Health Department	596 (CTR)		
State Prevention	\$345,970	3%	Blue Mountain Heart to Heart; Point Defiance AIDS Project; Pacific Treatment Alternatives	15,855^ (SSP)		

II. HIV Prevention Services

Washington State Department of Health (continued)

Private and public funding source(s)	Dollar amount in FY2015 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
State Prevention; STD State; AVH Sur Pt. B	\$101,236	1%	Kitsap County	900 (SSP); 113 (CTR)		
State Prevention; AVH Sur Pt. B	\$ 91,224	1%	Thurston County; Whatcom County	2,995^ (SSP); 79(CTR)		
State Prevention; STD AAPPS; AVH Sur Pt. B	\$ 27,965	<1%	Yakima County	1400^ (SSP); 72 (CTR)		
Total	\$10,820,573	Unless otherwise noted, client numbers reflect number of outreach and referral contacts only for HIV testing clients (CTR) or syringe exchange clients (SSP) ^ indicates duplicated contacts are reported for Outreach and Referral (O&R)				

Public Health - Seattle and King County

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
City of Seattle	\$ 80,250	9%	Center for MultiCultural Health	135	HIV Testing; STI Screening; PrEP education/promotion; community mobilization (African American Men/MSM); HIV testing/promotion (African born Heterosexuals); insurance advocacy (all)	Primary Prevention, Case Finding, Retention in Care, Linkage to Care
	\$ 49,592	5%	Gay City Health Project	3350	HIV Testing / STI Screening; testing promotion, PrEP education / promotion / provision; community mobilization; statewide End AIDS Washington support (MSM focus)	Primary Prevention , Case Finding, Linkage to Care
Washington State	\$ 315,590	17%	Center for MultiCultural Health	400	HIV Testing; STI Screening; PrEP education/promotion; community	Primary Prevention, Case Finding,

II. HIV Prevention Services

Public Health - Seattle and King County (continued)

Private and public funding source(s)	Dollar amount in FY2016 (\$)	Percentage of total funds in FY2016 (%)	Provider(s) receiving funding to provide service	Number of clients to receive services	Services	HIV Care Continuum step (s) impacted
					mobilization (African American Men/MSM); HIV testing/promotion (African born Heterosexuals); insurance advocacy (all)	Retention in Care, Linkage to Care
	\$680,032	36%	Gay City Health Project	2,800	HIV Testing; STI Screening; PrEP education/promotion; community mobilization (African American Men/MSM); HIV testing/promotion (African born Heterosexuals); insurance advocacy (all)	Diagnosis, Linkage to Care, Retention in Care, Prescribed ART, Viral Suppression
	\$162,500	9%	Entre Hermanos	250	Testing promotion; PrEP promotion; community mobilization (Latino MSM); condom distribution	Primary Prevention, Case Finding, Linkage to Care
	\$246,098	13%	Lifelong	300	Linkage/re-linkage services, adherence support; testing promotion; condom distribution. Youth-focused community mobilization, outreach & risk-reduction	Primary Prevention, Case Finding, Retention in Care, Linkage to Care
	\$217,500	12%	Seattle Counseling Service	400	Peer outreach and prevention support (Meth/Injection Drug-using MSM); syringe exchange, treatment access; community mobilization; testing & PrEP promotion	Primary Prevention, Case Finding, Linkage to Care
Total	\$1,751,562					

*Also reported on Washington State Department of Health - Prevention

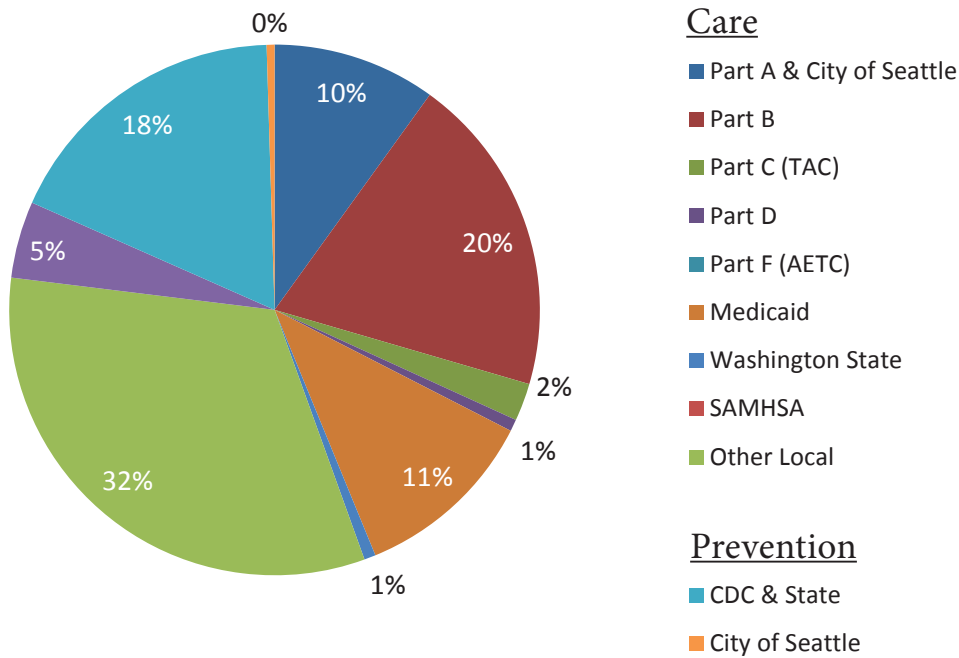
Washington State - Resource Inventory : Summary of Funded Care Services by Funding Source

Service Type	Care					Prevention					Total Dollar Amount		
	Ryan White Part:					Medicaid	WA State	SAMSHA	Other Local	HOPWA		CDC & State	City of Seattle
	A	B	C	D	F								
<i>Percentage of Total HIV \$\$:</i>	10%	20%	2%	1%		11%	1%		32%	5%	18%	0.5%	100%
Core Medical Services													
Outpatient/Ambulatory Medical Services			X	X		X	X		X				
AIDS Drug Assistance Program												X	
Oral Health Care	X											X	
Early Intervention Services	X		X										
Health Insurance Premium/ Cost-Sharing Assistance			X										
Mental Health services			X									X	
Medical Nutrition Therapy			X	X								X	
Medical Case Management	X		X	X		X						X	
Substance Abuse Services - Outpatient	X											X	
Supportive Services													
Non-medical Case Management	X									X	X		
Food Bank/Home-delivered Meals	X										X		
Health Education /Risk Reduction			X	X							X		
Housing Services	X									X	X		
Medical Transportation Services	X										X		
Outreach Services	X	X	X	X			X				X		
Psychosocial Support Services	X												
Prevention Services													
Target HIV Testing											X	X	
Outreach											X	X	
Linkage to Care											X		
Retention in Care											X		
Condom Distribution											X	X	
PrEP Linkage & Retention											X	X	
Health Insurance Enrollment											X		
Medication Adherence											X		
Total HIV Prevention and Care Dollars:												\$60,473,291	

Washington State - Resource Inventory: Dollars Allocated by Funding Source

Funding Source	Dollar Amount	% of total
CARE		
Part A & City of Seattle	\$6,022,527	10%
Part B	\$11,819,793	20%
Part C (TAC)	\$1,392,349	2%
Part D	\$430,518	1%
Part F (AETC)		
Medicaid	\$6,818,253	11%
Washington State	\$424,813	1%
SAMHSA		
Other Local	\$19,629,707	32%
HOPWA (State & Seattle)	\$2,827,121	5%
PREVENTION		
CDC & State	\$10,820,573	18%
City of Seattle	\$287,637	0.5%
Total HIV Prevention and Care Dollars	\$60,473,291	100%

Figure X. Prevention and Care Dollars by Funding Source



III. Additional Information

HIV Workforce Capacity and Its Effect on HIV Prevention and Care Service Delivery System

Public Health Seattle & King County (PHSKC): There is an adequate supply of the HIV workforce in the PHSKC jurisdiction. While PHSKC cannot definitively state the number of professionals who provide services to PLWH, we are certain that services are available within 30-days, which is the metric that warrants a Core Medical Services Waiver from HRSA.

Country Doc (CDCHC): CDCHC enjoys a positive reputation of being a good place to work, an organization dedicated to providing high quality care to the community, regardless of ability to pay. Competitive compensation (salary and fringe benefits) and progressive personnel policies enhance this reputation. The availability of well-trained professionals dedicated to provision of health care and HIV services means that CDCHC has not experienced a work force problem that has negatively affected access to care.

Yakima Valley Farm Workers and New Hope Clinic (YVFWC): New Hope Clinic has two licensed providers, six registered nurses (RNs), one data entry specialist, an office manager, and a clinic director. New Hope Clinic serves approximately 270 patients in Central and Eastern Washington (from Yakima to Walla Walla and northeast Oregon). Having staff members that provide medical case management and direct care has been instrumental in keeping patients in care and having a large percentage of PLWHA who are undetectable

Mountain West AIDS Education and Training Center (AETC): In 2015, the Northwest AETC and five of the Mountain Plains AETC states merged to become the Mountain West AETC (MWAETC). The new name reflects a new, expanded region covering 40% of the United States landmass. MWAETC serves 10 states: Alaska, Colorado, Idaho, North Dakota, Montana, Oregon, South Dakota, Utah, Washington, and Wyoming.

MWAETC is expanding and strengthening the HIV workforce by training and providing technical assistance to health care professionals, inter-professional health teams, and health care organizations on the prevention, diagnosis, and treatment of HIV disease. The Mountain West AETC will improve outcomes along the HIV care continuum, including diagnosis, linkage, retention and viral suppression, through the breadth of its programs:

- Interactive presentations
- Clinical preceptorships
- Clinical consultation
- Self study
- Coaching for organizational capacity building
- Communities of practice

The training arm of the Ryan White HIV/AIDS Program, the regional AETC Network supports health care professionals to counsel, diagnose, treat and medically manage people living with HIV. This effort aligns with the National HIV/AIDS Strategy goals to reduce new infections, increase access to care and improve health outcomes, reduce HIV-related health disparities and health inequalities, and achieve a more coordinated national response to the HIV epidemic.

As a vital partner in this national effort, the MWAETC works with clinics to transform their practices, offering in-person and distance-based programs to build organizational capacity to meet a clinic's HIV care and treatment goals. MWAETC provides innovative training and technical assistance to minority providers and minority-serving providers and institutions that serve racial and ethnic minorities living with HIV/AIDS. MWAETC develops inter-professional HIV educational programs and hands-on learning opportunities in the postgraduate setting.

Washington State Programs
MWAETC programming in Washington State is implemented through regional programs as well as the activities of three partner programs located in the state: African American Reach and Teach Health (AARTH); Yakima Valley Farm Workers Clinic (YVFWC); and the Washington State AETC program.

African Americans Reach and Teach Health (AARTH) Ministry is a faith-based capacity building nonprofit organization established to respond to HIV/AIDS and other major health issues affecting people of African descent. AARTH's MWAETC programs develop and implement culturally relevant HIV/AIDS early intervention and care curricula, training strategies and capacity-building activities for African American churches, faith-based institutions and health care professionals serving African American (native and African born) HIV positive patients in the MWAETC region. The Yakima Valley Farm Workers Clinic (YVFWC) is a community/migrant health center established in 1978, providing a variety of services (medical, dental, mental health, educational training, HIV/AIDS, substance abuse, WIC, and community health services) to Hispanic, Spanish-speaking, and migrant/seasonal farm workers in Washington and Oregon. The New Hope Clinic is a nurse-managed Ryan White HIV/AIDS Treatment Modernization Act, Part C clinic in Yakima, WA and is a division of YVFWC, providing medical, nursing and dental care, as well as nutrition support, counseling, outreach, and case management for people living with HIV/AIDS in Yakima and throughout central Washington. The main goal of New Hope Clinic's MWAETC program is to develop and provide HIV/AIDS training to clinic providers who primarily serve Latino migrant farm workers with HIV or who are at high risk for HIV infection and have limited access to medical care. This includes instructional clinical training programs, as well as a rural nursing preceptorship program.

The Washington State Office of the MWAETC, at the University of Washington, is affiliated with the HIV clinical center of excellence in Washington State, the Harborview Medical Center's Madison AIDS Clinic in Seattle. The Washington State AETC program offers trainings and capacity building assistance to healthcare providers and clinical sites throughout the state; a monthly AIDS Clinical Conference, an annual HIV/AIDS Care in the Correctional Setting conference and an annual Clinical HIV Update for Nurses conference.

Workforce Capacity: Prevention Services

Fragmentation of local healthcare delivery systems: Funded prevention agencies outside of King County face limitations in workforce capacity due to the fragmentation of local healthcare delivery systems and supportive services. A primary focus of HIV prevention activities, however, is to form a more comprehensive healthcare delivery system for customers.

Role of peers in reaching PAHR customers: The role of peers in HIV prevention activities helps to expand the reach of preventative services to more PAHR customers. The expansion of prevention workforce using peers as support staff allows greater reach to both high-risk, low-to-moderate acuity and higher-acuity, low-capacity populations in an effort to connect them with preventative healthcare services.

Adjusting workforce to address PAHR acuity: Funded prevention agencies have demonstrate success in facilitating healthcare access to prospective high-risk, low-to-moderate acuity clients. The capacity of agencies to expand reach to engage more higher-acuity, low-capacity populations is limited. For low-to-moderate acuity clients, the “promotion of an access to” model works in fostering utilization. Harder-to-reach populations, however, more nuanced models need to be adapted in order to ensure engagement across multiple access points.

Interaction with Different Funding Sources to Ensure Continuity of HIV Prevention, Care, and Treatment Service

Public Health Seattle & King County: The Part A program works closely with the TGA’s two Part C programs (Harborview Medical Center’s Madison Clinic and Country Doctor Community Health Centers). The Part A Grantee works closely with program directors at these sites to maximize Ryan White funding, and the Part A Quality Management (QM) staff has worked extensively with both programs in integrating their quality improvement processes into the larger QM system in the TGA.

Parts A and D Grantee staff work collaboratively to ensure adequate funding of HIV services targeting women, children and families, and that programs effectively track each of these funding streams separately. Additionally, the Washington State Department of Health convened the Washington State Cross-Parts Collaborative to develop the state’s Comprehensive Plan.

Housing Opportunities for Persons with AIDS Programs (HOPWA): The Part A and HOPWA Grantees work collaboratively with each other in order to maximize scarce housing resources for low-income PLWH with housing needs. Both participate in monthly meetings of local HIV Housing providers to discuss service delivery and develop policies and procedures across HOPWA and Part A. HOPWA staff participate on review panels for all Ryan White competitive housing proposals, and Part A provides funding information during the City of Seattle’s HOPWA allocation process. HOPWA shares funding information with the Planning Council and adjusts allocations, as necessary, in response to this information. For example, during 2015, the HOPWA Grantee made the decision to terminate investment in transitional housing programs. Ryan White Part A (RWPA) resources were available, and were able to fill the funding gap left by the decision of the City.

In October 2015, a team consisting of the HOPWA Grantee, the RWPA Grantee, an epidemiologist, and the TGA’s lead HIV housing agency, travelled to a Regional Meeting sponsored by the U.S. Department of Housing and Urban Development to complete a planning session to develop goals and strategies to develop a local HIV Housing Care Continuum. Efforts are underway to create a Care Continuum for clients who are served through permanent housing, transitional housing, and through HOPWA’s Short Term Rent, Mortgage, and Utility (STRMU) program in order to show how housing supports increase a client’s engagement and retention in care and boosts their ability to achieve viral suppression. SAMHSA: Resources programmed into the TGA from SAMHSA include a multitude of grants that provide

access to recovery resources and supports those with mental health and substance abuse disorders. While these are not specifically targeted to PLWH, it is unclear to what degree it directly affects PLWH.

A HOPWA Grantee staff member has joined the Part A’s Planning Council in early 2016.

Other state and local social service programs: Part A funds interact with several other funding streams in the TGA, including:

- City of Seattle General Fund, used for HIV case management funding for Seattle PLWH. Funding from this source is projected to remain at its current level in FY 2016.

- Part A uses a portion of Washington State’s Housing and Homeless Fund on a local level to increase support services for formerly homeless persons in public housing. Part A projects funding to remain stable in FY2016; although it is unclear, to what degree this will directly affect housing and service availability for PLWH.

- McKinney/Vento Homeless Assistance Act funds are used primarily for shelter programs, temporary housing and housing support services, including agencies that serve persons with HIV/AIDS. King County is forecasting that 2016 federal McKinney funds will stay the same as 2015, although the supply of housing resources has increased due to reallocations for supportive services-only grants. The overall impact of these homeless housing funds on PLWH is difficult to predict because WA state law excludes entering information about PLWH into the homeless management information system. • The HOPWA program works with a wide range of homeless housing advocacy and program development programs that work with local housing funders to develop new low-income housing projects, including several HIV-specific projects. Emergency, transitional and permanent “set-aside” units for PLWH are provided by Plymouth Housing Group, Downtown Emergency Services Center, Compass Center, Sound Mental Health, and Catholic Community Services of Snohomish County.

- The HOPWA program works with a wide range of homeless housing advocacy and program development programs that work with local housing funders to develop new low-income housing projects, including several HIV-specific projects. Plymouth Housing Group, Downtown Emergency Services Center, Compass Center, Sound Mental Health, and Catholic Community Services of Snohomish County provide emergency, transitional and permanent “set-aside” units for PLWH.

- Part A expects Washington State funding from discretionary state and Formula Grants to remain stable in FY2016. For FY2015, King County Mental Health and Chemical Dependency Division projects a 1% reduction in revenue for mental health and substance abuse services. The Planning Council will closely monitor the outcome of these budget cuts and projected revenue increases for potential impact on PLWH in the Seattle TGA.

- Public Health’s HRSA-funded Health-care for the Homeless Network (HCHN) programs conduct outreach and linkage into primary care for over 1,500 homeless TGA residents per year, many of them HIV-infected. Part A projects HCHN’s federal and local funding to remain stable in FY2016.

- Harborview Medical Center, the Northwest’s largest public health facility, is home to Madison Clinic, the region’s largest HIV-specific primary care outpatient medical program. Madison Clinic offers HIV-related outpatient primary and specialty care, medical nutrition therapy, medical case management, and HIV psychiatric services. Public Health’s HIV and STD testing services are primarily at Harborview.

- Country Doctor: The Ryan White Program - Parts A and C - are the primary funding sources for CDCHC’s HIV program. Part C funds the ambulatory care program - including two RN positions that monitor treatment plans, specialty referrals, medication adherence, and provide patient education regarding treatment plans. Other portions of CDCHC’s HIV program include rapid testing (funded in part by Public Health -

Seattle King County which purchases test kits for CDCHC), the PeEP program which is unfunded but supported by CDCHC’s general fund.

YVFWC: Different funding sources support New Hope Clinic by providing testing, linkage to care, medical case management, and educating health professionals on testing. Through the various funding sources, we have been successful at keeping a high percentage of PLWHA in care and suppressed viral loads. Through medical case management services, education on treatment adherence and condom use we believe we have made a large impact on the reduction of new cases in the areas we serve.

Mountain West AETC: The MWAETC receives Ryan White Part F funding to support the training and capacity-building assistance of health care providers serving persons living with and at risk for HIV across the 10-state region. MWAETC funding is comprised of Core Training and Technical Assistance programs, Minority AIDS Initiative programs, Practice Transformation Projects, and an Inter-professional Education Project.

Interaction with Different Funding Sources: Prevention Services

Limitation in scale of prevention services: Attempting to diversify funding sources for HIV prevention work is limited by the scale of HIV prevention services. This is particularly true for agencies with smaller workforces. Partnerships have helped in providing supportive prevention services to customers but have not expanded many agency scopes of work. By increasing the scale of prevention services or by creating more continuity between care and prevention programming, new opportunities for funding that were once not feasible can be explored including third-party billing. Expanding prevention services for PAHR: Expanding rendered prevention services outside of HIV/STI testing for PAHR is costly. Referrals to outside systems has worked but has proved insufficient to meet the entirety of need. While agencies strive to build partnerships with connec-

tive agencies, the funding for this type of workforce infrastructure does not exist limiting long-term growth opportunities. Co-locating with acute and primary care providers: To achieve economies-of-scale, models that station case managers out of highly-utilized providers are being explored across multiple geographies. Agency prevention and care footprints can be expanded through this strategy.

Needed Resources or Services not Provided

PHSKC: Re-engagement strategies are one place in which we could add resources/services. While we have invested heavily in the Care and Antiretroviral Promotion Project (CAPP) and the Max Clinic, which is an invitation-only, walk-in clinic for persons who had been out of care, this is a labor-intensive intervention and has a small caseload. Also needed is PrEP promotion for African-American MSM and Latino MSM, and increased routine screening of African immigrants.

HMC: There is a lack of permanent housing for low-income clients in the jurisdiction, both generally and for HIV+ clients. Rents in Seattle and the surrounding areas have skyrocketed in recent years, and homelessness is an increasing problem. The Mayor and the City have been looking at improving both emergency housing options (shelter) and access to permanent housing. Madison Clinic staff participate in local meetings aimed at maximizing housing resources for HIV+ people, and participate on the local RW Part A Planning Council, which looks at emergency and transitional housing options locally.

YVFWC: A need in the community is to provide in-depth prevention education on HIV/AIDS to adolescents. However, for this to happen there needs to be policy change at OSPI. At this time, students get minimal education in health education class as required by OSPI.

HOPWA: The largest challenge for the HOPWA program is finding affordable rental housing that will take the housing vouchers. Moreover, when an affordable rental is located, the HOPWA client is often

screened out due to his or her criminal or poor credit history. In addition to available, affordable housing, HOPWA clients need more mental health and substance abuse services. This will help them confront barriers and remain their housing.

Mountain West AETC: MWAETC provides capacity-building programs and training to expand and support the HIV workforce, targeting providers serving the needs of communities impacted by HIV.

CBO Prevention Services:

Lack of HIV and LGBTQ Providers: There is a notable lack of HIV Providers in non-King County jurisdictions. Additionally, there is a lack of providers who have demonstrated expertise or competence working with LGBTQ individuals and/or prescribing PrEP in many of these jurisdictions as well.

Integrating DIS and CBO Workforces: Local Health Jurisdictions and State DIS Staff need to share information more regularly and integrate better with the CBO workforce. Locating DIS at CBO locations is a strategy that can be explored.

Funding For Peers Outreach Workers: Maintaining funding for community outreach through peers should be prioritized.

D. Assessing Needs, Gaps, and Barriers

Service Need Listing from Brainstorm that Created Woordle (alphabetical)

- ACCESS TO MEDS
- CASE MANAGEMENT
- DENTAL: Should deal with whole person, not just what their insurance covers. For example, one client needed extensive dental work done, but plan would only cover teeth being pulled, so just the teeth were pulled and no other care was given.
- HOUSING : Not able to get affordable, low income housing. Some clients are not eligible for Section 8 housing. They were given a voucher for 2 months and then an extension, but then was kicked out of housing.

Rental assistance, then would like housing that is up to health codes.

Housing options were extremely limited for justice involved individuals

Housing with no income requirements. Clients would like special funding for last months rent and deposit rent so that they can get into housing.

Emergent situations. One example was partners/ two people whom separate...once person gets to stay in the housing and the other has to leave (become homeless).

Credit checks are an issue with getting housing.

- INSURANCE: Some clients still find it difficult to access and keep insurance coverage
- MENTAL HEALTH: Not enough visits per year are covered.
- LIFE INSURANCE
- PEER GROUP SUPPORT: Peers who have experience of HIV and how to get information out to others in the community.

Service Gaps

Routine Standardized HIV Screening for All Washington Residents

HIV testing is a cornerstone for HIV prevention and care, and a critical component of both the NHAS and Washington State's plan to End AIDS . Diagnosing people with HIV leads to long-term behavior change; allows at-risk HIV-negative persons the opportunity to consider PrEP, which can decrease the risk of transmitting HIV by 92 percent; and allows infected persons to initiate life-saving antiretroviral therapy, which can decrease the risk of transmitting HIV by 96 percent.

Stigma

One in Ten Washingtonians Living with HIV Are Undiagnosed Too many PLWH are unaware of their infection. The Washington State Department of Health (DOH) estimates that approximately one in ten PLWH in the state are undiagnosed. These individuals face the adverse health effects of untreated HIV infection and have the potential to unknowingly transmit HIV to others. In many instances, undiagnosed persons may not identify themselves as being at high risk for HIV, or may encounter stigma that inhibits them from testing or revealing risk behaviours to medical providers.

Access to Pre-Exposure Prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) offers at-risk individuals a new tool for taking an active role in keeping themselves HIV-negative. PrEP involves taking a single pill (Truvada® [emtricitabine/tenofovir]) every day to avoid HIV infection. When taken consistently, PrEP reduces the risk of HIV infection in people who are at high risk by up to 92 percent. Based on this high level of protection and in recognition of the need for additional effective interventions that protect people from HIV, the updated 2015 U.S. NHAS includes PrEP as one of its four pillars of HIV prevention. The CDC likewise recommends that PrEP be used as a prevention tool for people who are at substantial risk for HIV, including persons in serodiscordant relationships, gay and bisexual men who have sexual partners of unknown HIV status, and persons who inject drugs. The 2015 DOH and PHSKC PrEP Implementation Guidelines further define characteristics of patients at high risk for HIV infection who are potential candidates for PrEP.

Healthcare Systems that Meet the Needs of Sexual Minorities

Gay and bisexual men have specific healthcare needs and our success in ending the HIV epidemic requires a greater effort to meet those needs. While national guidelines recommend

that all Americans test for HIV at least once in their lifetime, both CDC and local guidelines in Washington State recommend that most gay and bisexual men test at least annually and that selected groups of gay and bisexual men test as often as four times a year. These guidelines also recommend that gay and bisexual men test frequently for other sexually transmitted infections.

Additionally, transgender/non-binary individuals have specific healthcare needs and providers and systems need to be better trained to provide responsive care in a welcoming environment. Furthermore, transgender/non-binary individuals, particularly transgender women of color, are disproportionately likely to be at risk for HIV. Integrating gender-affirming care and HIV prevention or treatment are essential to meeting the needs of the transgender/non-binary community.

Prevention, Care and Treatment Options for Substance Users, Including Persons Who Inject Drugs

Substance use undermines the success of HIV treatment. In King County, over half of all persons who are out of care use substances, and approximately 25% identify substance use a reason for their inability to receive care or for discontinuing their HIV medication. The failure to successfully treat persons who use substances perpetuates the cycle of HIV transmission and undermines the state's efforts both to prevent HIV transmission and avert the morbidity and mortality associated with HIV/AIDS.

Insurance Coverage and Affordable Healthcare for PLWH and Individuals at Risk for HIV

The Affordable Care Act (ACA) has fundamentally altered the health care delivery system and increased Washington State residents' access to medical care. As of 2014, an estimated 89 percent of the state's residents had health insurance. However, even with the advances in comprehensive access to health care, some aspects of the healthcare system still present impediments to the state's goals of ending the HIV epidemic in Washington.

Safe, Stable and Affordable Housing for People Living with and At Risk for HIV

Homelessness is a significant barrier to wellness for PLWH. When a person's primary focus is finding food to eat and a safe place to sleep, treating one's HIV becomes a lower priority. The lack of housing stability can lead to consequences including: missed medical appointments, lost or stolen medications, higher viral loads, worse health outcomes, and increased risk of transmission to others.

Whole Person Healthcare to PLWH

The need for an integrated system of HIV care that provides truly comprehensive services is now more important than ever. The PLWH who remain out of care and unsuppressed often confront tremendously difficult social circumstances exacerbated by complex medical conditions. Mental illness and substance use disorders (SUD) are common among persons living with HIV. Of those enrolled in Medicaid in 2007 who had HIV, fifty percent had a dual diagnosis with substance use disorders or mental illness. The structure of the health care system often creates barriers to successful, comprehensive care. These barriers include ; preconditions for entering some systems that make it impossible for whole-person health to be addressed (for instance, you need to be sober to get housing, or you need to have addressed your mental health issues before getting treatment for substance use disorders) structures that require patients to consistently attend appointments or comply with rules that they cannot comply with and stigma. Stigma associated with being HIV-positive, having mental health and/or substance use disorder issues, being gay, or being a person of color can compound the challenges for these individuals. PLWH over the age of 50 face the additional vulnerabilities of aging. Successfully meeting the needs of the most vulnerable patients requires a willingness and commitment to restructure the health care system. In some instances, this will also require new resources as existing federal programs are not designed to pay for the care of the most difficult-to-treat patients.

Comprehensive Sexual Health Education, and Interventions for Washington Youth

Young people need to have the information, tools, and resources to understand risks and make sound decisions about their sexual health throughout their lives. This is necessary to enable them to protect themselves against sexually transmitted diseases (STDs), including HIV, and unintended pregnancy. Comprehensive, medically-accurate and culturally relevant sexual health education that is LGBT-inclusive equips young people with this information.

Meaningful Community Engagement and Empowerment for People and Communities Disproportionately Affected by HIV-Related Disparities and Stigma

PLWH have been at the forefront of policy and programmatic interventions since the beginning of the epidemic. These efforts have directly contributed to a dramatic increase in HIV awareness, and access to and retention in HIV-related medical care. Many planning bodies, including Ryan White Planning Councils, require representation of PLWH. Yet survey responses and comments in community forums indicate that

our public and private sector HIV services could do more to more fully engage and empower PLWH and communities disproportionately affected by HIV. This request for inclusion and leadership opportunities (in design and decision-making) is not only about community empowerment – a worthwhile goal in itself – it is also about making all HIV community services more responsive to community needs and therefore more effective

- Lack of knowledge about HIV: Survey respondents and participants in community forums report a lack of knowledge about and awareness of HIV among affected communities as well as the public at large. This lack of knowledge was seen as contributing both to HIV risk and HIV-related stigma.

Service Barriers

HIV-related stigma and health disparities are most commonly identified as significant barriers to seeking and accessing HIV screening, accessing culturally appropriate healthcare and support services, utilizing HIV treatment or prevention regimens, and staying retained in care.

- Stigma: Stigma was the barrier most commonly identified through surveys and in community forums. The multiple stigmas that affect many PLWH and communities affected by HIV cut across all aspects of the care continuum.

People living with and at risk for HIV often experience multiple and overlapping stigmas. These many include stigma associated with HIV, HIV testing and pre-exposure prophylaxis (PrEP); sexual orientation or gender identity; race or ethnicity; poverty or homelessness; mental health conditions and substance use disorders (SUD); aging (especially for people over age 50 living with HIV) and others. Furthermore, persistent disparities, particularly disparities by race and ethnicity, related to HIV risk, diagnosis rates and health outcomes result in unacceptable health inequities.

- Social determinants of health, including poverty and its effects: PLWH and individuals at risk for HIV often live in poverty. Housing instability and homelessness, food insecurity, lack of transportation, and other issues related to poverty are significant barriers to accessing and staying in care.

- Healthcare access and costs: Many survey respondents noted the high cost of HIV-related healthcare, as well as challenges accessing culturally responsive HIV medical care providers (including LGBT-sensitive providers), mental healthcare and other specialists, particularly in rural areas.

- Substance use disorder and mental health care treatment needs: Many PLWH and individuals at risk for HIV are also facing challenges with substance use and mental health conditions, as well as challenges with the availability and cultural appropriateness of the services.

E. Data: Access, Sources, and Systems

Main Sources of Data

ENHANCED HIV/AIDS REPORTING SYSTEM (eHARS):

eHARS is the state's HIV surveillance registry. It contains demographic, geographic, behavioral, and clinical information (including laboratory results) about all people reportedly diagnosed with HIV or AIDS while residing in Washington State. All states and territories count HIV/AIDS cases in the same manner. An individual gets counted as an HIV case in the county in which he/she is residing at the time of his/her initial HIV diagnosis (not including a diagnosis made from an anonymous test). Once that person progresses to AIDS, he/she is counted as an AIDS case in the county in which he/she is residing at the time of his/her AIDS diagnosis. States are continually working with each other to ensure that cases are counted in only one state. Once a person is diagnosed with AIDS, he/she remains an AIDS case even if his/her health later improves. Within Washington State, county-level case counts can go down if we learn that a person's earliest diagnosis of HIV or AIDS actually occurred while he/she resided in another state or county. Also, a county's HIV case count can go down over time if their HIV cases progress to AIDS while residing outside the county. For epidemiologic purposes, it is helpful to evaluate all cases of HIV and AIDS as part of one combined group: people who have been diagnosed with HIV disease. For this report, geographic assignment of a new HIV case is based on residence at the time of a person's initial HIV diagnosis, regardless of whether he/she later progressed to AIDS. Living cases are geographically assigned based on best available data regardless of where they were diagnosed.

PHIMS STD:

PHIMS STD is the state's STD surveillance registry which is operated by DOH in collaboration with local STD control programs. It includes case report data related to several sexually-transmitted infections--all of which are notifiable conditions--including chlamydia, gonorrhea, and syphilis. PHIMS STD data support STD control and

prevention activities across Washington State including HIV-STD co-morbidity. These data are routinely reported to CDC as part of the National STD Surveillance System. Because of incomplete diagnosis and reporting, the number of STD cases documented in PHIMS STD is less than the actual number of cases occurring in Washington. PHIMS STD also contains data collected via HIV Partner Services, a prevention intervention which helps notify named sexual partners of possible HIV/STD exposures and supplements data collected via HIV case surveillance.

NATIONAL HIV BEHAVIORAL SURVEILLANCE SYSTEM (NHBS):

In 2003, CDC created NHBS to conduct behavioral surveillance among persons at high risk for HIV infection. Surveys are conducted in rotating, annual cycles in three different populations at increased risk for HIV:

- 1) Gay, bisexual and other men who have sex with men; known as the MSM cycle.
- 2) Persons who inject drugs (PWID); known as the injection drug use or IDU cycle, and
- 3) Heterosexuals at increased risk for HIV infection; known as the HET cycle.

Before each NHBS cycle, formative assessment is conducted to learn more about each local population and to inform operational procedures. Venue-based, time-space sampling (VBS) is used during the MSM cycles. Health department staff identify venues frequented by MSM (e.g., bars, clubs, organizations, and street locations) as well as days/times when men frequent those venues. Venues (and specific day/time periods) for recruitment are chosen randomly each month. Respondent-driven sampling (RDS) is used during the IDU and HET cycles. Health department staff select a small number of initial participants, or "seeds," who complete the survey and recruit their peers to participate. Recruitment and interviewing then continue until the target sample size is reached.

Trained interviewers in all NHBS project areas use a standardized, anonymous questionnaire to collect information on HIV-related

risk behaviors, HIV testing, and the use of HIV prevention services. HIV testing is offered to all participants. During each cycle, a minimum of 500 eligible persons from each participating project area are interviewed and offered HIV testing. The first full round of NHBS, which comprised all three cycles (MSM, IDU, and HET), was conducted from 2003–2007. The second round was conducted from 2008–2010, the third from 2011–2013, and the fourth round began in January 2014.

ENHANCED HEPATITIS C SURVEILLANCE SYSTEM (eHEPC)

In April 2015, DOH implemented statewide enhanced surveillance for Washington residents recently diagnosed with chronic HCV (excluding King County residents). Statewide sampling of chronic HCV cases was done on a monthly basis using laboratory data from the Public Health Reporting of Electronic Data (PHRED) system. Only patients with test results in PHRED meeting criteria for a confirmed diagnosis of chronic HCV were included in the group sampled as cases. Enhanced investigations involved contacting the primary care provider (or accessing electronic medical records) for medical management information and attempting to interview the case for missing demographic and risk factor information.

AMERICAN COMMUNITY SURVEY (ACS):

Operated by the U.S. Census Bureau, the ACS is a nationwide survey that collects and produces population estimates and related information on demographic, social, economic, and housing characteristics about our nation's population every year. This information provides an important tool for communities to use to see how they are changing. When people fill out the ACS form, they are helping to ensure that decisions about the future of their community can be made using the best data available. Decision makers require a clear picture of their population so that scarce resources can be allocated efficiently and effectively. ACS data are available at different levels of geography, from state-wide to Census tracts and block groups. These data are especially valuable towards

characterizing the way social determinants of health such as income and education affect public health outcomes.

Every year, the U.S. Census Bureau contacts over 3.5 million households across the country to participate in the ACS. To help those responding to the ACS, a booklet is available containing information on aspects of the survey aspects that affect the American public the most: ACS collection procedures, questions asked in the ACS, uses and importance of each question, and how to access the ACS estimates produced.

MEDICAL MONITORING PROJECT: (MMP)

The Medical Monitoring Project (MMP) is a surveillance project designed to learn about the experiences and needs of people who are receiving care for HIV. The federal Centers for Disease Control and Prevention (CDC) funds the project, and partners with 23 city, county and state health departments across the country to conduct it. The surveillance project uses a three-stage approach to develop a representative sample of approximately 400 individuals in Washington state who received medical care in a specific four-month period. After the sample is chosen, project staff work with the patients' health care facilities to attempt to interview them and review their medical records. The interview questionnaire asks for a variety of information related to a patient's demographics, access to care and prevention services, use of HIV antiretrovirals and health- and risk-related behavioral information. The purpose of the medical record review is to obtain important clinical information related to a patient's health status and HIV-related care.

The MMP data presented in this epidemiologic profile were collected from 2009 through 2013. During that period, there were 1081 HIV-positive individuals in care who were both interviewed and whose medical records were reviewed. When MMP viral load suppression data are presented in this document, HIV viral load suppression means all viral loads in the prior 12 months (not just the most recent) were less than or equal to 200 copies per milliliter.

MMP data are collected on individuals who were in HIV care and are not necessarily representative of those not in care. Due to the time it takes to collect, clean and weight the data, there is a delay of about two years before the data are available for analysis and dissemination, though that time delay is shrinking as the project matures and the Centers for Disease Control and Prevention return the data to the state more rapidly.

Data Policies

We aren't aware of policies which facilitated or served as barriers to the conduct of the needs assessment. However, the HIV care continuum is dependent on HIV surveillance data - the quality and completeness of which are influenced by a variety of legal, administrative, and programmatic policies which exist in Washington State. The reporting of both HIV infection and AIDS to the health department (as notifiable conditions) in Washington has long been mandatory. The implementation of name- and address-based HIV reporting in Washington in 2006 has improved the accuracy and reliability of incidence data, and improves the validity of performance metrics based on both newly diagnosed and prevalent case counts. Likewise, the implementation in 2006 of statewide, comprehensive HIV-related lab reporting helps with monitoring HIV care outcomes and maintaining up-to-date current residence information which is needed to calculate prevalence. DOH also has programmatic policies in place which require Disease Intervention Specialist (DIS) and Partner Services field staff to confirm and document initial care linkage among newly diagnosed cases, and which strives to conduct supplemental interviews with all newly diagnosed cases.

Using Data for Planning

Again, we feel the needs assessment was successfully able to collect data necessary to inform Integrated HIV prevention and care planning. We would have liked to collect a

large volume of data, but the types of data collected were sufficient.

As for the HIV care continuum, we would have preferred better completeness for certain data elements related to HIV testing and treatment history. Because true HIV prevalence cannot be measured directly, we use a back-calculation model to estimate prevalence. This model relies in part on the date of the last HIV negative test result. Unfortunately, we are only able to collect this date from about half of newly diagnosed cases. Likewise, we agree with CDC and other experts who feel that the initiation of anti-retroviral therapy (ART) is an important milestone which contributes strongly both to individual-level health outcomes and to population-level HIV prevention. Unfortunately, the timing of ART initiation is often not documented or reported by HIV care providers. Hence, we don't feel the data are complete enough to support the inclusion of a metric in our continuum which would describe the proportion of PLWH who have initiated ART.



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