WASHINGTON STATE INTEGRATED HIV PREVENTION AND CARE PLAN CY 2022-2026

Addressing Inequity to Improve HIV Outcomes

DECEMBER 6, 2022

THE WASHINGTON STATE DEPARTMENT OF HEALTH
Office Of Infectious Disease

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I. Executive Summary 4
1) Executive Summary of Integrated Plan and SCSN 4
a. Approach 4
b. Documents Submitted 5
II. Community Engagement & Jurisdictional Planning Process 6
1) Jurisdiction Planning Process 6
Timeline of Activities 8
a) Entities Involved in the Process 9
b) RWHAP Part A Planning Council Role 11
c) Role of Planning Bodies & Other Entities 12
d) Collaboration with RWHAP Parts 14
RWHAP Part B: 14
RWHAP Part C: 14
RWHAP Part D: 14
e) Engagement of People Living with HIV 15
f) Priorities 15
g) Updates to Other Strategic Plans 17
King County EHE Plan 17
Hepatitis C Free Washington 17
STI & Hepatitis B Legislative Advisory Group Recommendations 17
III) Contributing Data Sets and Assessments 18
1) Data Sharing and Use 18
2) Epidemiologic Snapshot 20
General Population 20
HIV Trends 21
Populations Disproportionately Impacted by HIV 21
Populations Disproportionately at Risk of Exposure and Infection 21
3) HIV Prevention, Care, and Treatment Resource Inventory 23
a) Strengths and Gaps 27
b) Approaches and partnerships 28
4) Needs Assessment 29

a) Priorities 29
b) Action Taken 30
c) Approach 30
RWHAP Part C: 31
IV) Situational Analysis Overview 32
1) Situational Analysis 32
a) Diagnose 38
b) Treat 39
c) Prevent 40
d) Respond 40
V) CY 2022-2026 Goals and Objectives 42
Goal 1 44
Goal 2 45
Goal 3 46
Goal 4 47
Goal 5 48
Goal 6 49
Goal 7 50
Goal 8 51
Goal 9 52
Goal 10 53
Goal 11 54
Goal 12 55
Goal 13 56
VI) Implementation, Monitoring, And Jurisdictional Follow Up 57
1) 2022-2026 Integrated Planning Implementation Approach 57
a. Coordinating Partners 58
b. Coordinating 62
2) Monitoring 63
3) Evaluation 68
4) Improvement 70
5) Reporting and Dissemination 71
6) Coordination with Other Plans 72

Appendices

Appendix 1: Glossary of Terms and Abbreviations 75

Appendix 2: WSPG Letter of Concurrence 82

Appendix 3: Seattle TGA Letter of Concurrence 84

Appendix 4: Office of Infectious Disease - Logic Model 85

I. EXECUTIVE SUMMARY

1) Executive Summary of Integrated Plan and SCSN

a. Approach

The HIV Integrated Plan Steering Committee coordinated and managed this integrated state/city prevention and care plan. Members are representatives from:

- The Washington State Department of Health (DOH) Office of Infectious Diseases (OID), including the principal investigator for Ryan White Parts B, C, and D grants, and the principal investigator for all CDC prevention grants related to HIV, viral hepatitis, and sexually transmitted infections (STIs).
- Public Health Seattle & King County (PHSKC), including the principal investigator for its Ryan White Part A grant.
- Multnomah County Health Department, including the principal investigator for its Ryan White Part A grant.
- The Seattle Transitional Grant Area (TGA) HIV Planning Council, the RWHAP Part A planning body.
- The Portland Transitional Grant Area (TGA) HIV Planning Council, the RWHAP Part A planning body.
- The King County Ending the HIV Epidemic Planning Committee (EPC).
- A team of consultants supported the Steering Committee.

At the start of 2022, the Steering Committee assembled and reviewed all current state and local needs assessments, data reports, and strategic plans related to HIV, viral hepatitis, and STIs, including the 2020 Plan to Support Ending the HIV Epidemic in King County and the 2017–2021 Washington Statewide Coordinated Statement of Need (SCSN) and Integrated Plan. The Steering Committee identified overarching priorities and common strategies across plans. These shared priorities informed initial research on national and statewide best practices and promising approaches for a literature review. This Steering Committee distributed the literature review to the agencies and community planning bodies involved in the integrated planning process.

Epidemiologists from OID and PHSKC worked together to develop an initial draft of the SCSN using data from the state's Enhanced HIV/ADS Reporting System (EHARS), as well as data collected as part of OID's additional surveillance projects, which include Molecular HIV Surveillance (MHS), HIV Incidence Surveillance (HIS), and the Medical Monitoring Project (MMP). This comprehensive SCSN provided the Steering Committee with population-level data on the demographic, geographic, physical health, behavioral health, and social determinants of health characteristics of people living with HIV (PLWH), people newly infected with HIV, and people at higher risk for HIV infection in the state between 2017 and 2021. The Steering Committee reviewed and analyzed all aggregated data from the SCSN and grouped findings under six high-level categories to

illustrate key population-level strengths, challenges, and disparities across the HIV care continuum.

The Steering Committee held a series of meetings and focus groups with the Seattle TGA, the Portland TGA, the King County EPC, RWHAP Part A, B, C, and D funded providers, PLWH, and individuals representing communities at higher risk of HIV infection to review the findings of the SCSN; discuss their met and unmet needs related to HIV prevention, treatment, and care; and solicit recommendations of goals.

Having assessed the needs of these critical stakeholders, The Steering Committee consolidated all recommended goals into 13 draft goals, which Seattle TGA, the Portland TGA, and the WSPG reviewed and refined. After confirming these final goals, the Steering Committee developed a set of implementation, monitoring, and evaluation activities for the Integrated Plan and submitted the final draft plan to the WSPG, EPC, Seattle TGA, Portland TGA, and OID, and DOH leadership. The result is a new plan that complements but does not duplicate existing planning efforts.

b. Documents Submitted

- Washington State Integrated Prevention and Care Plan CY2022–2026 – *Addressing Inequity to Improve HIV Outcomes*
- CY 2022–2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

II. Community Engagement and Jurisdictional Planning Process

I) Jurisdiction Planning Process

A Steering Committee coordinated and managed this integrated state/city prevention and care plan. Representatives are:

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Timeline of Activities

Jan 2022
- Steering Committeee is assembled and develops integrate planning methodology.
- Steering Committee conducts research on current national, state, and local HIV strategies and interventions.

Feb 2022
- OID and PHSKC compile epidemological data for analysis.
- OID and PHSKC gather information on HIV prevention, treatment, and care resource inventory.

Mar 2022
- OID and PHSKC analyze epidemiological data for SCSN.
- Seattle TGA reviews research on current national, state, and local HIV strategies and interventions.

Apr 2022
- Steering Committee reviews SCSN and identifies key themes to present to planning bodies.

May 2022
- Steering Committee sets up provider and community focus groups for input on priorities.

Jun 2022
- SCSN is presented to the Seattle TGA, Portland TGA, and other key stakeholders.
- WSPG is established.

Jul 2022
- SCSN is presented to the statewide planning body.
- Steering Committee completes needs assessment using previous assessments.
- Draft goals are compiled from the Seattle TGA, Portland TGA, and WSPG.

Aug 2022
- Steering Committee finalizes the Integrated Plan Goals.
- Seattle TGA, Portland TGA, and WSPG provide recommendations on implementation, monitoring, and evaluation activities.

Sep 2022
- Steering Committee finalizes the implementation, monitoring, and follow up activities and finishes a draft of the Integrated Plan.

Oct 2022
- Seattle TGA, Portland TGA, EPC, and WSPG review draft Integrated Plan and provide final feedback.

Nov 2022
- Integrated Plan is finalized and approved by DOH, PHSKC, and Multnomah County PH.
- WSPG, Seattle TGA, provide Letters of Concurence.

Dec 2022
- Final Integrated HIV Prevention and Care Plan, 2022–2026 is submitted to CDC and HRSA.

a) Entities Involved in the Process

Seattle TGA HIV Planning Council

The Seattle TGA Is one of the two RWHAP Part A planning bodies operating in Washington state. The council is responsible for determining the service needs of people living with HIV (PLWH) in King, Snohomish, and Island counties, prioritizing services to meet those needs, and allocating RWHAP Part A dollars to address those needs. The 16-member Seattle TGA has eight male and eight female participants, including 6 PLWH (5 male, one female). There are 4 White members, 6 Black members, 2 Hispanic members, 3 Asian members, and one multi-racial member. PHSKC staffs and supports the TGA Planning Council.

The Program Manager for the Seattle TGA was a member of the Steering Committee and assisted in coordinating the integrated planning process. The Program Manager also served as a liaison between the Steering Committee and TGA, bringing information and updates to both parties. The Seattle TGA engaged in the integrated planning process by:

- Reviewing the key findings of the SCSN, reviewing national best practices and innovations to address HIV.
- Providing input on the needs and priorities of PLWH in the Seattle TGA.
- Recommending a set of strategic goals to include in the Integrated Plan.
- Providing language accessibility features at meetings:
    - Live Captioning
    - Spanish interpreting and translation of materials
    - All written presentation materials were accessible and emailed in advance for review and preparation for the meeting.

The Seattle TGA also reviewed the final draft of the Integrated Plan and provided their Letter of Concurrence (Appendix 3).

Portland TGA HIV Services Planning Council

The Portland TGA is the second of two RWHAP Part A planning bodies operating in Washington state. The TGA includes Clark County, WA—Washington's fifth most populated county. The HIV Planning Services Council is dedicated to improving the quality of life for those infected and affected by HIV and ensuring that members of our community play lead roles in planning and assessing HIV resources. The 25-member Portland TGA has 11 males, 13 females, and one additional gender participant, including 10 PLWH (8 male; 2 female). There are 17 white members, 3 Black members, 1 Hispanic member, 1 Asian member, and three mixed-race members. The Multnomah County Health Department staffs and supports the TGA Planning Council.

The Planning Council administrator served as a member of the Steering Committee and exchanged information and updates on the integrated planning process between the Steering Committee and the Portland TGA. Like the Seattle TGA, the Portland TGA reviewed the key findings of the SCSN and national best practices and innovations to address HIV. Only Portland TGA members who lived or worked in Clark County, WA, provided input on the needs and priorities of PLWH in Clark County and recommended a set of strategic goals to include in Washington state's Integrated Plan. The Portland TGA reviewed the final draft of the Integrated Plan The Portland TGA also was involved in developing Oregon's Integrated Plan.

King County EHE Planning Council

The EPC is the only Ending the HIV Epidemic planning body that operates in Washington. The EHE was established in 2019 as part of the rollout of the national EHE campaign and is responsible for identifying gaps in HIV prevention and care services in King County, WA, and providing technical input on proposed EHE activities. The EPC released its first EHE strategic plan for King County in December 2020. Members include representatives with expertise in HIV prevention and care services, health care systems, epidemiology, substance use, and other social services, as well as affected community members. PHSKC staffs and supports the EPC.

The EHE planning, systems, and evaluation coordinator served as a member of the Steering Committee and exchanged information and updates on the integrated planning process between the Steering Committee and the EPC. The EPC also reviewed the key findings of the SCSN and national best practices and innovations to address HIV. The EPC conducted a needs assessment as part of its planning process in 2019 and 2020. The EPC contributed these data to the integrated planning process to speak to the needs of PLWH and people at higher risk of HIV infection in King County and the surrounding area.

Washington State RHWAP Part B Advisory Group

The Washington Syndemic Planning Group (WSPG) replaced Washington's HIV Planning Steering Group (HPSG), the state's RWHAP Part B advisory group, and CDC HIV planning body after they dissolved in December 2021. OID engaged in more than seven community conversations with DOH staff members, HPSG members, and the general public. OID held focus groups with individuals who represented specific key population groups related to HIV, viral hepatitis, and STIs in Washington, including:

- Monolingual Spanish speakers
- Asian people and other Pacific Islanders
- Unhoused people
- People with lived experience with viral hepatitis
- Providers serving people with lived experience with viral hepatitis

Community conversations focused on the needs of people with lived experience and people at higher risk of HIV, viral hepatitis, and STIs. The input gathered to form this community engagement process helped create the structure of the WSPG. The Steering Committee also reviewed the information to identify the needs and priorities to include in the Integrated Plan.

The Washington Syndemic Planning Group (WSPG) serves as the state's RWHAP Part B advisory group and CDC HIV planning body. Established in July 2022, its mission is to advise OID on statewide strategies, funding priorities, communications, research, and evaluation activities to address the syndemic of HIV, viral hepatitis, and STIs. The 22-member WSPG has twelve male, six female, and five additional gender participants, including 5 PLWH (5 male). Six are white, 9 Black, 4 Hispanic, 1 Native American, Indigenous or Native Alaskan, and two undisclosed members. Staff from OID support the WSPG.

b) RWHAP Part A Planning Council Role

RWHAP Part A

The Seattle TGA Is one of the two RWHAP Part A planning bodies operating in Washington state. The council is responsible for determining the service needs of people living with HIV (PLWH) in King, Snohomish, and Island counties, prioritizing services to meet those needs, and allocating RWHAP Part A dollars to address those needs. The 16-member Seattle TGA has eight male and eight female participants, including 6 PLWH (5 male, one female). There are 4 White members, 6 Black members, 2 Hispanic members, 3 Asian members, and one multi-racial member. PHSKC staffs and supports the TGA Planning Council.

The program manager for the Seattle TGA was a member of the Steering Committee and assisted in coordinating the integrated planning process. The program manager also served as a liaison between the Steering Committee and TGA, bringing information and updates to both parties. The Seattle TGA engaged in the integrated planning process by:

- Reviewing the key findings of the SCSN.
- Reviewing national best practices and innovations to address HIV.
- Providing input on the needs and priorities of PLWH in the Seattle TGA.
- Recommending a set of strategic goals to include in the Integrated Plan.

The Seattle TGA also reviewed the final draft of the Integrated Plan and provided their Letter of Concurrence (Appendix 3).

PHSKC administers all RWHAP Part A funds in the Seattle TGA, and the Multnomah County Health Department administers all RWHAP Part A funds in the Portland TGA. RWHAP Part A providers and recipients are members of the Seattle TGA and Portland TGA engaged in the integrated planning process by participating in these

groups. The Seattle TGA reviewed the key findings from the SCSN with PHSKC, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and used the EHE four pillars as a framework to suggest potential goals to include in the Integrated Plan. PHSKC summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

c) Role of Planning Bodies and Other Entities

AIDS Education and Training Center (AETC)

The Washington AETC delivers innovative education, training, clinical consultation, and technical assistance to improve access to care and outcomes along the HIV care continuum for people living with or at risk for acquiring HIV. The Washington AETC engaged in community conversations with OID as part of the integrated planning process. In this focus group, participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and used the EHE four pillars as a framework to suggest potential goals to include in the Integrated Plan. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

Housing Opportunities for Persons with AIDS (HOPWA)

DOH administers all HOPWA funds to local government and nonprofit agencies throughout the state. HOPWA funds cover tenant-based rental assistance; permanent housing placement; short-term rent, mortgage, and utility assistance; and other support services, including housing, counseling, transportation assistance, nutritional benefits, and resource identification services. Twelve agencies and organizations receive HOPWA funds in Washington state.

HOPWA subrecipients are members of the Portland TGA, Seattle TGA, and the WSPG. In addition to participation in the integrated planning process through these groups, Several individuals from these agencies engaged in a focus group discussion with OID as part of the integrated planning process. In this focus group, participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and used the EHE four pillars as a framework to suggest potential goals to include in the Integrated Plan. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

Public Health Seattle & King County (PHSKC)

PHSKC manages RWHAP Part A funds for the Seattle TGA and provides county services. The RWHAP Part A program manager was a member of the Steering Committee and served as the liaison between the PHSKC HIV/STD Program staff and

the Steering Committee. Additionally, PHSKC HIV/STD Program Unit engaged in a focus group discussion with OID as part of the integrated planning process. In this focus group, participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and used the EHE four pillars as a framework to suggest potential goals to include in the Integrated Plan. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

Multnomah County Health Department

The Steering Committee included staff from the Multnomah County Health Department because—given the high amount of population exchange between Clark County, Washington, and Multnomah County, Oregon—OID and the Multnomah County Health Department frequently coordinated public health efforts related to HIV and other infectious diseases. The two health departments kept each other abreast of the priorities and strategies formed as part of the planning process. OID consulted the Multnomah County Health Department staff to refine the goals under the "Response" pillar for the Integrated Plan.

Washington state DOH Office of Infectious Disease (OID)

OID has five sections:

- Adult Viral Hepatitis and Drug User Health
- HIV Community Services
- Infectious Disease Assessment
- Sexually Health and Prevention
- Eligibility and Benefits (ADAP)

Collectively, these units oversee funding, contracts, and direct client services related to prevention, harm reduction, testing, case management, treatment, care, and surveillance of HIV, viral hepatitis, and STIs in the state.

OID served as the primary convener of the Steering Committee for the integrated planning process. Key staff from OID's five units served on the Steering Committee. In July 2022, OID hired an HIV community planner and syndemic community planner who joined the Steering Committee and contributed to planning development. OID assessment unit staff led the development of the SCSN and needs assessment and facilitated the discussions of these data with the key stakeholder groups across the state mentioned in this section. OID held two community conversations where stakeholders reviewed critical findings from the SCSN, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and suggested potential goals to include in the Integrated Plan, using the EHE four pillars as a

framework. The Ending the HIV Epidemic in the United States (EHE) initiative aims to reduce new HIV infections by 90% by 2030. The initiative includes four pillars: DIAGNOSE, TREAT, PREVENT, and RESPOND. For each pillar, the EHE initiative scales up science-based strategies that can end the epidemic. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

d) Collaboration with RWHAP Parts

RWHAP Part B

OID administers RWHAP Part B funds in Washington state and distributes funds through a competitive RFA process. RWHAP Part B funds provide case management and other support services to PLWH and support the Early Intervention Program (EIP) and Washington state's AIDs Drug Assistance Program (ADAP).

RWHAP Part B providers (Lifelong EHIP and POCAAN, AIDS Health Foundation, and Pierce County AIDS Foundation) are represented on the WSPG and engaged with the integrated planning process. Additionally, OID staff assembled a group of stakeholders for an integrated planning focus group. Participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and suggested potential goals to include in the Integrated Plan, using the EHE four pillars (Respond, as a framework. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

RWHAP Part C

RWHAP Part C providers (Country Doctors, Madison Clinic, CHC Takoma) engaged in the process by participating in TGA Planning Councils, WSPG, and community-integrated planning discussions. Participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and suggested potential goals to include in the Integrated Plan, using the EHE four pillars as a framework. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

RWHAP Part D

A RWHAP Part D provider (Madison Health Clinic) engaged in the process by participating in TGA Planning Councils, WSPG, and community-integrated planning discussions. Participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and suggested potential goals to include in the Integrated Plan, using the EHE four pillars

as a framework. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

e) Engagement of People Living with HIV

Dozens of people living with HIV participated in the integrated planning process. In addition to the PLWH being involved in the integrated planning process through their membership in one or more of the community planning bodies operating in Washington state, OID and its consultant team held further community conversations with PLWH in the summer of 2022. OID engaged 16 case managers, community-based partners (i.e., Entre Hermanos, youth shelters), and HIV residency programs to ensure adequate recruitment among PLWH communities. In these meetings, participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of results, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and suggested potential goals to include in the Integrated Plan, using the EHE four pillars as a framework. OID and its consultant team summarized these conversations for the Steering Committee, which then used this information to develop the plan's final draft goals

f) Priorities

- Colocation of syndemic services at OTP/SUD/SSP
- Embrace Phlebotomy
- Expand low- and no-barrier treatment options for PLWH
- Expand Self-Collected Testing Options
- Expand testing and treatment options and medication access
- Implement service delivery methods explicitly developed for rural populations
- Increase age-specific syndemic services (youth and elder)
- Increase HIV services provided in Spanish
- Increase peer support for people living with HIV
- Promote provider accountability
- Provide holistic HIV prevention care for gender-expansive and transgender people
- Provide holistic syndemic care for people who exchange sex for money or nonmonetary items.
- Support organizations in creating full-service, robust, regional MOU
- Use mobile services to reach people where they live and work

Screen shot of Jam Board priority setting exercise

g) Updates to Other Strategic Plans

King County EHE Plan

The Integrated Plan resulted in no updates to the plan. It was designed to be complementary.

Hepatitis C Free Washington

OID published Hepatitis C Washington in July 2019. The Hep C Free Washington coordinating committee is setting priorities for the next two years. Linkage to care services is a high priority. Based on Hep C Free Washington's feedback and the Integrated Plan, DOH is considering resourcing efforts to eliminate HCV among PLWH (e.g., DOH is considering a position to work on this issue).

STI and Hepatitis B Legislative Advisory Group Recommendations

OID, the STI, and Hepatitis B Legislative Advisory Group recommendations were submitted to the state Legislature on December 1, 2022. While the recommendations were not updated based on this planning process (they primarily were developed before the Integrated Plan was complete), many of the Advisory Group's recommendations complement the Integrated Plan, such as recommending the Legislature resource specialty sexual health services, including PEP and PrEP access; resourcing outreach and mobile STI and sexual health services to reach people in rural communities, and expansion of STI/HIV testing and treatment options.

III) Contributing Data Sets and Assessments

I) Data Sharing and Use

Data Source	Description of Use	Sharing Agreements
Name of data source and owner	*How was data used in SCSN/planning?*	*Who were the data shared with, and for what purpose?*
EHARS – DOH OID	Described demographics of PLWH, HIV outcomes, disparities, priority populations, mortality, undiagnosed fraction, linkage to care, births, and new HIV diagnoses	Shared summary information with the integrated planning community to provide an overall description of the HIV epidemic in Washington state and to highlight disparities and priority populations.
PHIMS STD – DOH OID (STI Registry)	Described rates of coinfection of gonorrhea and syphilis among PLWH and statewide rates for context	Shared summary information with the Integrated Planning Committee and community members as context for HIV prevention planning.
Medical Monitoring Project – DOH OID	Described provider satisfaction, experiences with HIV stigma, homelessness, substance use, quality of life, disability, incarceration, language barriers, health care utilization, unmet needs for services, and the impact of the COVID-19 pandemic among PLWH	Shared summary information with the Integrated Planning Committee and community members to describe the context in which PLWH live and their barriers to care.
National HIV Behavioral Surveillance – DOH/KC	Described PrEP Uptake and HIV testing in King County	Shared summary information with Integrated Planning Committee as context for HIV prevention programming.

Provide – DOH OID (Ryan White Administrative Database)	Described DOH Ryan White programs, populations served, and services administered	Shared summary information with the Integrated Planning Committee for awareness of current DOH programs.
Behavioral Risk Factor Surveillance System – DOH Agencywide	Estimates of lifetime HIV testing, the prevalence of HIV risk behavior, substance use by the general population, quality of life of the general population	Shared summary information with the Integrated Planning Committee and community members for comparison between characteristics of the general population and PLWH and for context for prevention programming.
PRIDE Survey – King County Public Health	Estimates of PrEP Uptake by demographic characteristics	Shared summary information about PrEP uptake with the Integrated Planning Committee.
SHC PrEP Clinic Enrollment – King County Public Health	Estimates demographic distribution of PrEP uptake	Shared summary information about PrEP uptake with the Integrated Planning Committee.
American Community Survey – Public	Description of demographics of Washington state general population. Description of rural-urban disparities in HIV outcomes. Description of the interaction between SES and HIV outcomes.	Shared summary information about the interactions between community characteristics and HIV outcomes with the Integrated Planning Committee and community members.
HIV Trace – DOH OID	Description of HIV clusters and the demographics of individuals within clusters	Shared summary information about cluster detection and response with the Integrated Planning Committee.
EvalWeb – DOH OID	Description of state-funded HIV tests and the demographics of individuals who received tests.	Shared summary information with the Integrated Planning Committee to provide awareness of DOH activities.

SSP Database – DOH OID	Description of drug user health programs in Washington state	Shared summary information about DOH programs with the Integrated Planning Committee for contextual awareness.
Center for Health Statistics Death Data – DOH Agencywide	Description of top causes of death among PLWH	Shared summary information about top comorbidities with the Integrated Planning Committee.
WDRS – DOH PHOCIS (COVID-19 Registry)	Description of COVID-19 incidence, morbidity, and vaccination among PLWH	Shared summary information with the Integrated Planning Committee for contextual awareness of the impact of the COVID-19 pandemic

2) Epidemiologic Snapshot

General Population

Washington state has a population of about 7.5 million, 78% concentrated in Western Washington east of the Cascade mountains. The majority of the state (64%) lives in urban areas. The largest racial groups in Washington state are White (69%), Hispanic/Latinx (13%), Asian (8%), and Black (4%). In total, 91% of Washingtonian adults have a high school diploma, 66% have a household income above $50,000, and 94% are insured.

Of the state's population, 42% live in the Seattle TGA and 6% in the Portland TGA. Compared to other parts of the state, the population in the Seattle TGA is more likely to be Black (5%) or Asian (15%) and less likely to be Hispanic/Latinx (10%) or White (63%). In the Seattle TGA, 93% of adults have a high school diploma, 72% have an income above $50,000, and 95% are insured. The population in the Portland TGA is more likely to be Hispanic/Latinx (15%) or White (78%) and less likely to be Black (3%) or Asian (3%). Of adults in the Portland TGA, 93% have a high school diploma, 68% have an income above $50,000, and 94% are insured.

HIV Trends

The rate of new HIV diagnoses in Washington decreased from 2010 to 2014 but has increased monotonically since 2016 (Figure 1). When looking at the 5-year average, rates of new HIV diagnoses from 2015–2019 were higher among people aged 25–34 (14 per 100,000) and those who identified as either Black (26.3 per 100,000) or Hispanic/Latinx (8.3 per 100,000). Average rates of new HIV diagnosis were higher in the Seattle TGA (7.1 per 100,000) and were stable between 2015 and 2019. The average rates of new HIV diagnoses were lower in the Portland TGA (4.6 per 100,000) but increased (2015 rate: 3.5, 2019 rate: 5.6).

Figures 2, 3, and 4 (on page 21) present each area's 2019 care continuum metrics.

Populations Disproportionately Impacted by HIV

As part of our planning process, we identified several populations with low engagement in HIV care. In our 2015–2020 MMP sample (88% are virally suppressed), we found low viral suppression among people who were homeless in the past 12 months (68% virally suppressed), people incarcerated in the past 12 months (66% virally suppressed), and people who injected drugs in the past 12 months (67% virally suppressed). We use surveillance data to find significant racial disparities in sustained viral suppression (all viral loads in a calendar year <200 copies/mL). In 2019, 68% of Washington PLWH had sustained viral suppression, including only 58% of AI/AN PLWH, 54% of Black PLWH, and 48% of NHOPI PLWH.

Populations Disproportionately at Risk of Exposure and Infection

We use various data sources to characterize the population at high risk of HIV exposure and infection in Washington. In general, the people at highest risk of HIV acquisition in Washington state are those who inject drugs, those who have been incarcerated, those who experience houselessness, those who participate in exchange sex, and those with recent or current infections with STIs or Hepatitis C.

We estimate that 6% of Washingtonians have injected nonprescription drugs, been treated for an STI, or participated in exchange sex in the past year. These behaviors were more common among young and male individuals. We estimate that 37,000 people were incarcerated and 23,000 people were homeless at any given time in Washington state in 2020. Among those homeless, 47% were unsheltered and living in an area that was not meant for human habitation.

Statewide gonorrhea and syphilis cases and rates increased sharply between 2015 and 2019. In 2015 the rate of gonorrhea was 105 per 100,000; in 2019, it was 151. In 2015 the rate of primary and secondary syphilis was 6; in 2019, it was 11. During this time, the highest rates for gonorrhea and syphilis were observed among cisgender men, individuals within the 25–34 age group, and black non-Hispanic people. The higher rate in cisgender men is partly due to high rates among MSM because this group is disproportionately affected by both STIs, especially syphilis. Hepatitis C surveillance is limited in Washington state, but most detected acute cases were among people injecting drugs (79%) and individuals younger than 35 (59%).

Figure 1. Rate and Number of New HIV Diagnoses, Washington State 2010-2019

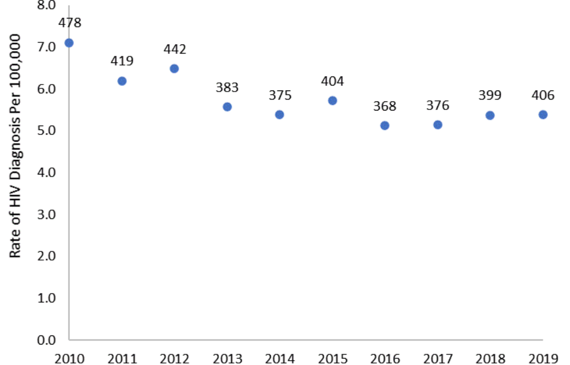


Figure 2. HIV Care Continuum, Washington State, 2019

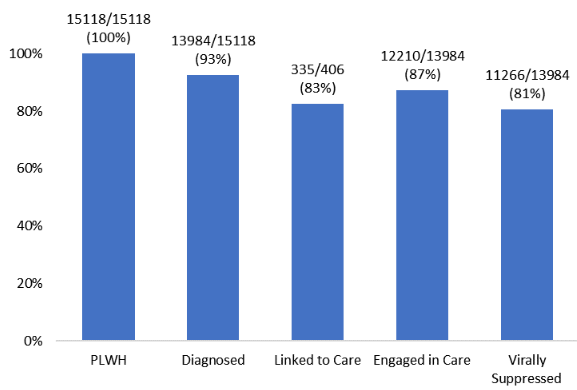


Figure 3. HIV Care Continuum for Seattle TGA, 2019

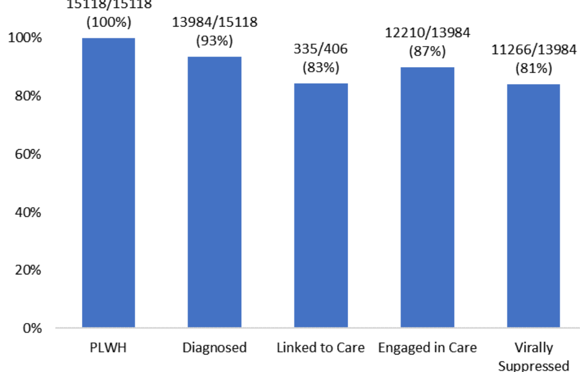
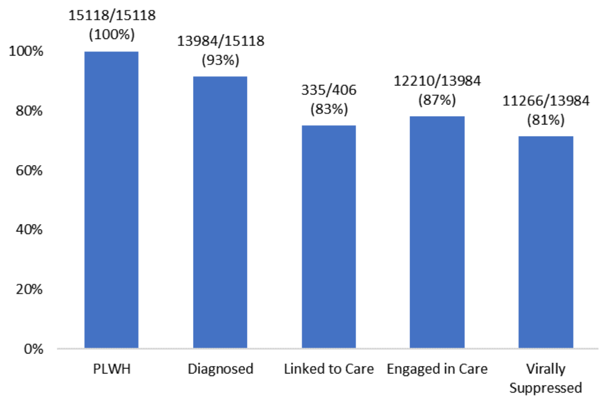


Figure 4. HIV Care Continuum for Portland TGA (Clark County), 2019



3) HIV Prevention, Care, and Treatment Resource Inventory

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression
CDC	PS212103	WA DOH	$636,761.00	Hepatitis Education Project, People's Harm Reduction Alliance	Community engagement, Surveillance, Hep C Testing and Linkage to Care			✓		
SAMHSA	Substance Abuse Block Grant	WA DOH	$864,000.00	none	Naloxone Purchase and Distribution			✓		
SAMHSA	Project to Prevent Prescription Drug/Opioid Overdose-Related Deaths	WA DOH	$702,512.00	Blue Mountain Heart to Heart, Dave Purchase Project, Willapa Behavioral Health, Phoenix Recovery Services, Spokane Regional Health District	Community engagement, Syringe services programs, Naloxone Purchase and Distribution, TA and Training			✓		
HRSA - RW Part C	Part C	Country Doc	$468,014.00	Country Doc	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services	✓	✓	✓	✓	✓
HRSA - RW Part B - Rebates	Rebates	WA State DOH	$16,472,985.00	Bailey Boushay House, Benton-Franklin Health District, Blue Mountain Heart to Heart, Cascade AIDS Project, Coastal Community Action Program, CHC Tacoma, Confluence Health, Country Doc, DOC, Entre Hermanos, Harborview, PHSKC, Kitsap Public Health District, Lifelong, POCAAN, PCAF, Spokane Regional Health District, UW Neighborhood Clinic, UW Satellite Clinics, Yakima Valley Farm Worker's Clinic	Medical Case Management, including Treatment Adherence Services, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Outreach Services, Psychosocial Support Services		✓	✓	✓	✓
HUD	HOPWA - Competitive	Washington State Department of Health	$1,222,025.00	Benton Franklin Community Action Committee, Confluence Health, Spokane Housing Authority, Spokane Regional Health District, Yakima Neighborhood Health Services	Leasing Transitional Short-Term Facilities, Tenant Based Rental Assistance, Short-Term Rent, Mortgage, and Utility, Supportive Services, Housing Information Services, Permanent Housing Placement			✓		
HUD	HOPWA - Formula	Washington State Department of Health	$1,301,249.00	AHAT, Blue Mountain Heart to Heart, Cascade AIDS Project, Coastal Community Action Program, Kitsap Public Health, Lifelong, PCAF, Sean Humphrey House, Spokane Housing Authority, Spokane Regional Health District, Yakima Neighborhood Health Services	Leasing Transitional Short-Term Facilities, Tenant Based Rental Assistance, Short-Term Rent, Mortgage, and Utility, Supportive Services, Housing Information Services, Permanent Housing Placement, Facility Based Housing			✓		

HUD	HOPWA - Competitive CARES	Washington State Department of Health	$145,149.00	Benton Franklin Community Action Committee, Yakima Neighborhood Health Services	Leasing Transitional Short-Term Facilities, Short-Term Rent, Mortgage, and Utility, Supportive Services, Permanent Housing Placement			✓		
HUD	HOPWA - Formula CARES	Washington State Department of Health	$177,035.00	Coastal Community Action Program, PCAF	Leasing Transitional Short-Term Facilities, Short-Term Rent, Mortgage, and Utility, Permanent Housing Placement			✓		
HUD	City of Seattle - Formula	City of Seattle	$3,357,136.00	Lifelong, Catholic Community Services. Bailey Boushay	Tenant Based Rental Assistance, Short-Term Rent, Mortgage, and Utilities, Supportive Services, Permanent Housing Placement			✓		
HUD	City of Seattle HIFA Grant	City of Seattle	$2,250,000.00	POCAAN, Center for Multicultural Health, Entre Hermanos	Resource ID, Short-Term Rent, Mortgage, and Utilities, Supportive Services, Housing Information Services			✓		
HRSA - RW Part A	HIV Emergency Relief Project Grants	Public Health - Seattle & King County	$7,281,709.00	AIDS Healthcare Foundation, Bailey Boushay House, Catholic Community Services, Center for MultiCultural Health, DOC, Downtown Emergency Service Center (DESC), Entre Hermanos, Lifelong, POCAAN, YWCA - BABES Network, PHSKC	Early Intervention Services (EIS) , Oral Health Care, Outpatient/Ambulatory Health Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing, Medical Transportation, Non-Medical Case Management Services, Psychosocial Support Services , Clinical Quality Management	✓	✓	✓		✓
City of Seattle	City of Seattle General Fund	City of Seattle	$267,296.00	Lifelong, Bailey Boushay House	Supportive Services			✓		
HRSA - RW Part C	RW Part C	Community Health Center - Tacoma	$266,952.00	CHC Tacoma	AIDS Pharmaceutical Assistance, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals , Medical Case Management, Including Treatment Adherence Services, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Linguistic Services, Medical Transportation, Non-Medical Case Management Services	✓	✓	✓	✓	✓
CDC	181802	WA DOH	$120,000.00	Thurston County Public Health	Non-Medical Case Management Services, Syringe services programs		✓	✓		
CDC	CDC CE191904	WA DOH	$165,500.00	Willapa Behavioral Health, SHARE, Spokane Regional Health District	Non-Medical Case Management Services, Hep C Testing and Linkage to Care, Syringe services programs		✓	✓		
CDC	OT212103	WA DOH	$695,930.00	Blue Mountain Heart to Heart, Cowlitz Family Health Center, Thurston County Public Health, Yakima Health District	Non-Medical Case Management Services, Hep C Testing and Linkage to Care, Syringe services programs		✓	✓		
HRSA - RW Part C	RW Part C	Harborview Medical Center	$450,939.00	HMC - Madison Clinic	Medical Case Management, Including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Health Education/Risk Reduction, Outreach Services	✓	✓	✓	✓	✓

HRSA - RW Part D	RW Part D	Harborview Medical Center	$357,932.00	HMC - Madison Clinic	Medical Case Management, including Treatment Adherence Services, Outpatient/Ambulatory Health Services, Health Education/Risk Reduction	✓	✓	✓	✓	✓
Harborview Medical Center	HMC - Madison Clinic	Harborview Medical Center	$2,899,252.00	HMC - Madison Clinic	Medical Case Management, including Treatment Adherence Services, Mental Health Services, Outpatient/Ambulatory Health Services	✓	✓	✓	✓	✓
CDC	Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States	Public Health - Seattle & King County	$2,047,588.00	Harborview Medical Center, Aurora Commons, Catholic Community Services of Western Washington, Health Point Community Health Center, Kaiser Permanente of Washington, International Community Health Services, Ballard Emergency Physicians, SeaMar Community Health Center, University of Washington Department of Emergency Medicine, PHSKC HIV/STD Programs	Medical Case Management, including Treatment Adherence Services, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Non-Medical Case Management Services, EHE Services, Capacity Building/Technical Assistance, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Social marketing campaigns, Social media strategies, Surveillance, Syringe services programs, Testing, Naloxone Purchase and Distribution	✓	✓	✓	✓	✓
HRSA - EHE	Ending the HIV Epidemic: A Plan for America — Ryan White HIV/AIDS Program Parts A and B	Public Health - Seattle & King County	$1,402,589.00	Harborview Medical Center, Aurora Commons, Catholic Community Services of Western Washington, CHI Franciscan Virginia Mason Bailey Boushay House, Kaiser Permanente Washington, International Community Health Services, SeaMar Community Health Center, Public Health - Seattle & King County HIV/STD Program Services	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Non-Medical Case Management Services, Outreach Services, EHE Services, HIV transmission cluster and outbreak identification and response		✓	✓	✓	✓
HRSA - RW Part B - ADAP	RW ADAP	WA DOH	$8,589,718.00	Ramsell Corporation, Lifelong (EHIP)	AIDS Pharmaceutical Assistance, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals			✓	✓	✓
HRSA - RW Part B - Base	RW Part B	WA DOH	$3,157,153.00	Lifelong (EHIP)	Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals			✓	✓	✓
HRSA - RW Part B - MAI	RW MAI	WA DOH	$81,523.00	WA DOH	Linkage to Insurance		✓	✓	✓	✓
HRSA - RW Part F	MWAETC	MWAETC	$3,098,654.00	WA AETC, AARTH	Capacity Building/Technical Assistance	✓	✓	✓	✓	✓
HRSA - RW Part B - Rebates	Local Rebates	WA DOH	$15,723,615.00	Lifelong (EHIP), Ramsell	AIDS Pharmaceutical Assistance, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals				✓	✓
HRSA - RW Part B - Rebates	Private Providers - 9299	WA DOH	$2,409,697.00	Private Providers	Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services		✓	✓	✓	✓

CDC	Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments	WA Department of Health	$4,656,564.00	Cascade AIDS Project, Center for Multicultural Health, Gay City, LifeLong AIDS Alliance, People of Color Against AIDS Network, Pierce County AIDS Foundation, Clark County Health Department, Public Health Seattle-King County, Snohomish Health District, Spokane Regional Health District, Tacoma Pierce County Health Department, Center for Disease Detection, National Council of STD Directors	HIV transmission cluster and outbreak identification and response, Partner services, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Surveillance, Testing, Linkage to care	✓	✓		
DOH GFS	State HIV Prevention, State STD Prevention, State Disease Control and Prevention	WA Department of Health	$3,669,920.00	Blue Mountain Heart to Heart, Cascade AIDS Project, Center for Multicultural Health, Entre Hermanos, Gay City, Harborview Medical Center, LifeLong AIDS Alliance, Pierce County AIDS Foundation, Benton Franklin Health District, Clark County Health Department, Public Health Seattle King County, Snohomish Health District, Spokane Regional Health District, Center for Disease Detection	Community engagement, Community mobilization, Condom distribution, HIV transmission cluster and outbreak identification and response, Partner services, Perinatal HIV prevention and surveillance, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Social marketing campaigns, Social media strategies, Surveillance	✓	✓		
HCA	Title XIX	HCA	$2,044,203.00	Title XIX Providers	Medical Case Management, Including Treatment Adherence Services		✓	✓	✓	✓

a) Strengths and Gaps

Washington state has many strengths. Washington is a Medicaid expansion state. Our ending the epidemic initiative was one of the first in the nation. There is much to be hopeful about when looking at the big picture of HIV in Washington. Medications are constantly improving, prolonging life for PLWH and reducing transmission.

Further, there are medications that HIV-negative people can take to prevent HIV, including pre-exposure and post-exposure prophylaxis (PrEP and PEP). We have various programs to help fund medication, housing, and other needs for PLWH. We have an ongoing project that is specifically looking to address HIV disparities. Most PLWHs in Washington are engaged in care and virally suppressed. This is good news!

However, we also have significant challenges.

- There are significant disparities across race categories for incidence. Black, Hispanic, and NHOPI communities have a disproportionately high incidence.
- Young people between the ages of 20 and 40 have about twice the risk of HIV infection than the general population. The peak risk of HIV infection is at 26–27 years of age, where we see an average of around 15 diagnoses per 100,000 person-years vs. 5.3 statewide).
- Between 2016 and 2019, 16% of new diagnoses of HIV involved injection drug use (PWID or PWID, who are also MSM). This points to the prominent role injection drug use play in perpetuating the HIV epidemic. Injection drug use drove the two largest HIV clusters in Washington.
- Many PLWH use meth, which is a significant barrier to their access to HIV care. 10% of PLWH self-report using meth at least weekly or have meth use documented in their medical records. Of these, 33% are not virally suppressed.
- Homelessness is a barrier to care that is similar in scope to substance use. About 10 percent of PLWH reported homelessness in the past 12 months. Specific populations of PLWH are more likely to be homeless than others. 20% of Black PLWH, 26% of PLWH with a transmission risk of IDU, and 30% of transgender PLWH reported being homeless in the past 12 months. The number of transgender individuals sampled in MMP is small, so that the estimate may be variable. However, homelessness is a documented burden on the transgender community, so there is reason to believe that it is a significant problem among transgender PLWH. It is worth noting that affordable housing is becoming increasingly rare in Washington and can be a driver of homelessness. Ryan White/HOPWA funding can help pay for housing for PLWH.

- Significant overlap exists between high-risk populations for HIV, syphilis, and gonorrhea. That is, compared to people without any STI, getting one sexually transmitted infection is related to an increased rate of diagnosis of another STI.
- Another health dimension affecting our work is the distinction between urban and rural parts of our state. Although most people have a concept of what "rural" and "urban" mean, there is no nationwide consensus on a precise definition. So, what made the most sense to us is to divide the state into "Rural," "Peri-Urban," and "Urban," using community factors that people generally associate with rural areas (see map). Using our classification system, 14% of Washingtonians live in rural areas, 21% live in peri-urban areas, and 64% live in urban areas. PLWH disproportionately live in urban areas; 6% of PLWH live in rural areas, 12% live in peri-urban areas, and 82% live in urban areas.
- Navigating the numerous systems involved in PrEP financing, insurance, and support programs is a significant barrier impacting prevention efforts

b) Approaches and partnerships

To complete the HIV Prevention, Care, and Treatment Inventory, DOH used the Resource Inventory Compiler tool provided by the technical assistance provider JSI. OID collaborated with internal programs and external partners to identify the various funding sources providing prevention, care, and treatment throughout the state. The compiler tool was shared as a resource for larger entities, or the information was given directly to DOH to incorporate into the tool. The following partnerships were identified:

- Ryan White Part A – Public Health Seattle & King County and Multnomah County Health Department
- Ryan White Part B – WA DOH ADAP and Care
- Ryan White Part C – CHC Tacoma, Harborview Medical Center, and Country Doctor
- Ryan White Part D – Harborview Medical Center
- Ryan White Part F – MW AETC, AARTH
- HOPWA – City of Seattle, WA DOH
- City of Seattle – General fund
- EHE – Public Health Seattle & King County
- Harborview Medical Center
- WA DOH – SAMSHA and CDC grants

4) Needs Assessment

a) Priorities

- Colocate syndemic services at OTP/SUD/SSP
- Embrace Phlebotomy
- Expand low- and no-barrier treatment options for PLWH
- Expand Self-Collected Testing Options
- Expansion of testing and treatment options and medication access
- Implement service delivery methods explicitly developed for rural populations
- Increase age-specific syndemic services (youth and elder)
- Increase HIV services provided in Spanish
- Increase peer support for people living with HIV
- Promote Provider Accountability
- Provide holistic HIV prevention care for gender-expansive and transgender people
- Provide holistic syndemic care for people who exchange sex for money or nonmonetary items.
- Support organizations in creating full-service, robust, regional MOU
- Utilize Mobile Services to reach people where they live and work

b) Action Taken

OID partnered with Health Management Associates in 2021 to host community conversations in town halls, focus groups, and stakeholder interviews. The sessions explored strengths, opportunities, and areas for improvement to develop a new planning body's structure, roles, and responsibilities. A comprehensive literature review helped inform and support these activities' findings. Community surveys were administered to determine priorities for planning body selection, highlighting the need to include people with lived experience and people of color. Therefore, a weighted scoring tool was developed to guide an equitable application process with these priorities in mind. Of 74 applications, 22 participants were selected to join the new planning group.

In July 2022, the WSPG began meeting to help OID end the STI, HIV, and viral hepatitis in Washington. The group created and accepted a charter and bylaws. WSPG was invited to several community presentations that shared syndemic epidemiological data with stakeholders to collect feedback and develop priorities for the integrative plan. OID used a JAM Board to document the collected priorities and synthesized the responses to create the goals and objectives outlined in this plan. WSPG reviewed the goals and plans for implementation and monitoring to finalize the Letter of Concurrence (Appendix 2).

c) Approach

Dozens of people living with HIV participated in the integrated planning process. In addition to the PLWH being involved in the integrated planning process through their membership in one or more of the community planning bodies operating in Washington state, OID and its consultant team held further community conversations with PLWH in the summer of 2022. OID engaged 16 case managers, community-based partners (i.e., Entre Hermanos, youth shelters), and HIV residency programs to ensure adequate recruitment among PLWH communities. In these meetings, participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of results, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and suggested potential goals to include in the Integrated Plan, using the Ending the HIV Epidemic (EHE) four pillars as a framework. OID and its consultant team summarized these conversations for the Steering Committee, which then used this information to develop the plan's final draft goals.

OID administers RWHAP Part B funds in Washington state and distributes funds through a competitive RFA process. RWHAP Part B funds provide case management

and other support services to PLWH and support the Early Intervention Program (EIP) and Washington state's AIDs Drug Assistance Program (ADAP).

RWHAP Part B providers (Lifelong EHIP and POCAAN, AIDS Health Foundation, and Pierce County AIDS Foundation) are represented on the WSPG and engaged with the integrated planning process. Additionally, OID staff assembled a group of stakeholders for an integrated planning focus group. Participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and suggested potential goals be included in the Integrated Plan, using the EHE four pillars as a framework. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

RWHAP Part C

RWHAP Part C providers (Country Doctors, Madison Clinic, CHC Takoma) were engaged in the process by participating in TGA Planning Councils and WSPG. Community-integrated planning discussions. Participants reviewed the key findings from the SCSN with OID, shared their insight and interpretation of findings as providers, identified their greatest met and unmet needs related to HIV treatment and care services in Washington, and suggested potential goals to include in the Integrated Plan, using the EHE four pillars as a framework. OID summarized these conversations for the Steering Committee, using this information to develop the plan's final draft goals.

IV)SITUATIONAL ANALYSIS OVERVIEW

1) Situational Analysis

Areas of Hope

There is much to be hopeful about when looking at the big picture of HIV in Washington. Medications are constantly improving and are prolonging life for PLWH and reducing transmission. Further, there are medications that people who are HIV-negative can take to prevent HIV, including pre-exposure and post-exposure prophylaxis (prep and pep). We have a variety of programs that can help fund medication, housing, and other needs for PLWH. We have an ongoing project that is specifically looking to address HIV.

These programs and scientific achievements result in the vast majority of PLWH in Washington engaged in care and virally suppressed.

Challenges - Health Disparities

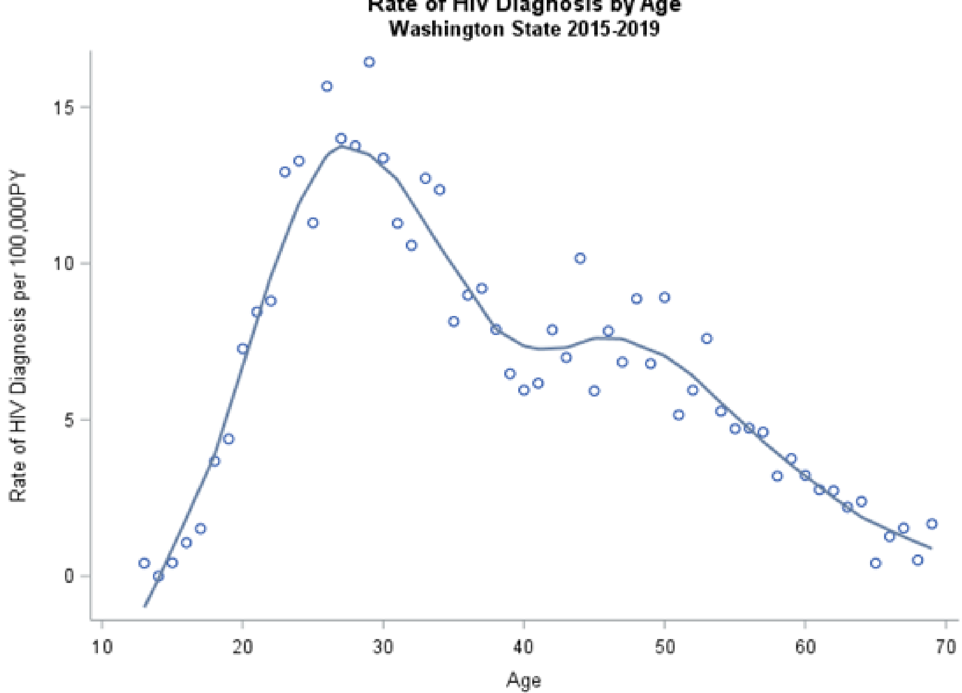
Race/Ethnicity.

There are significant disparities across race categories for incidence and access to HIV care. Black, Hispanic, and NHOPI communities have a disproportionately high incidence (rate per 100,000: Black 26, Hispanic 8, NHOPI 7). These populations, with the addition of AI/AN PLWH, are also slower to become virally suppressed after diagnosis and are less likely to be virally suppressed at a given time (Median Time to viral suppression in days: AI/AN 207, Black 104, Hispanic 92, NHOPI 108, state median 94; sustained viral suppression in 2019: AI/AN 58%, Black 61%, Hispanic 64%, NHOPI 48%, state average 68%.)

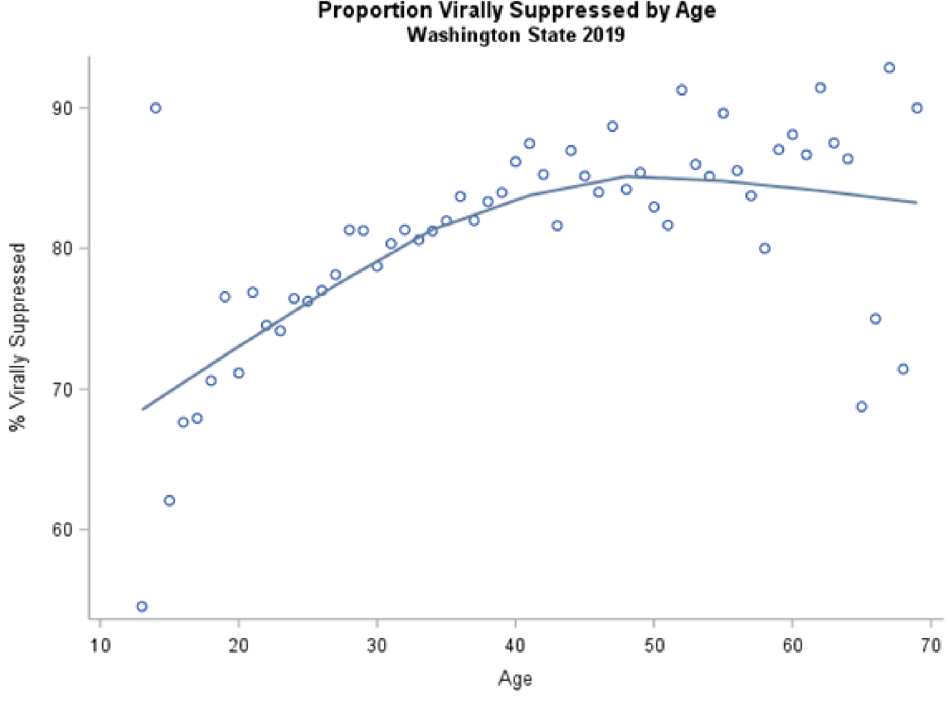
A deeper examination of these disparities points to differences in the social determinants of health. PLWH, people of color in Washington have lower income, worse insurance, more unemployment, lower quality of care, and higher rates of homelessness and incarceration. After adjustment for age, gender, and socioeconomic status, there are no differences in the prevalence of behaviors that carry a risk of HIV transmission.

Age

Young people between the ages of 20 and 40 have about twice the risk of HIV infection than the general population. The peak risk of HIV infection is at 26-27 years of age (15.0 diagnoses per 100,000 PY vs. 5.3 statewide).



Although this population links to care in a similar amount of time as other PLWH, younger PLWH are less likely to be virally suppressed.



Methamphetamine (and other drugs) use

Many PLWH use meth, which is a significant barrier to their ability to access HIV care. 10% of PLWH self-report using meth at least weekly or have meth use documented in their medical records. Of these, 33% are not virally suppressed.

Although heroin and off-label opiate use are also considerable barriers to HIV care (30% not virally suppressed in this population), it is much less common among PLWH. An estimated 4% of PLWH used heroin at least weekly or had heroin use or opiate use disorder documented in their medical records. Similar to the general population, PLWH who use heroin are likely also to use meth (43%), but people who use meth are not likely to use heroin (16%).

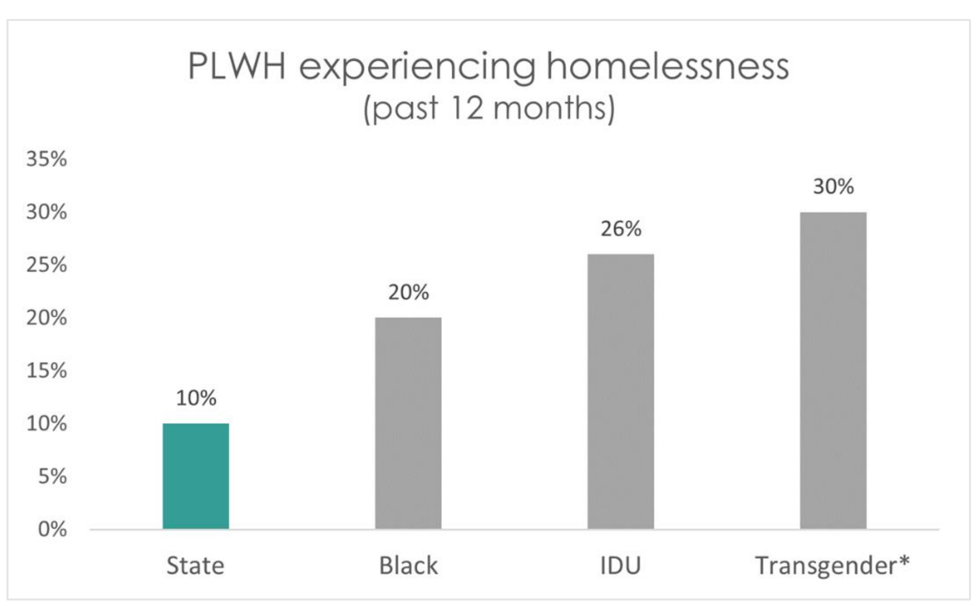
In addition to the information from MMP, we see similar trends from state death records. Between 2017 and 2019, PLWH were four times more likely to die from opioid overdose than the general Washington population and 11 times more likely to die from an overdose of psychostimulants. This points not only to the high prevalence of substance use among PLWH but also to the burden of the use on the health of PLWH.

Between 2016 and 2019, 16% of new diagnoses of HIV involved injection drug use (PWID or PWID, who are also MSM). This points to the prominent role injection drug use play in perpetuating the HIV epidemic. The proportion attributable to injection drug use decreased in 2020 (9%). However, the opinion of the DOH surveillance team is that this represents a decline in testing and access to services in marginalized groups rather than a decrease in transmission.

Homelessness

Homelessness is a barrier to care that is similar in scope to substance use. An estimated 10% of PLWH reported homelessness in the past 12 months. Of these individuals, 32% were not virally suppressed. Specific populations of PLWH are more likely to be homeless than others. For instance, 20% of Black PLWH, 26% of PLWH with a transmission risk of IDU, and 30% of transgender PLWH reported being homeless in the past 12 months. The number of transgender individuals sampled in MMP is small, so that the estimate may be variable. However, homelessness is a documented burden on the transgender community, so there is reason to believe that it is a significant problem among transgender PLWH.

From the 2020 Washington State Point in Time Homelessness count, only 29% of people who are homeless are chronically homeless. This suggests that the MMP participants who reported homelessness in the past 12 months do not represent the proportion of PLWH who are homeless at a given time. However, the low proportion virally suppressed in this population suggests that members of this population struggle to engage in care generally.


PLWH experiencing homelessness
(past 12 months)
35%
30%
25%
20%
15%
10%
5%
0%
10%
20%
26%
30%
State
Black
IDU
Transgender*

Other Sexually Transmitted Infections (STI)

Significant overlap exists between populations at high risk for HIV, syphilis, and gonorrhea. This presents an opportunity for HIV prevention among people diagnosed with syphilis and gonorrhea who do not yet have HIV. People diagnosed with gonorrhea are diagnosed with HIV at a rate that is 34 times that of the general population. This is driven by the remarkably high rate of HIV diagnosis among MSM with gonorrhea (614 cases per 100,000PY between 2015 and 2021). Still, the rate is also high among other men (66 cases per 100,000PY) and women (47 cases per 100,000PY, 2020 state average of 5 cases per 100,000). The same is valid for syphilis (all syphilis cases 470, MSM 725, other men 373, women 36).

Conversely, PLWH are at high risk of infection with other STIs. The rate of gonorrhea infection among PLWH from 2015-2019 was 271 per 10,000 person-years, approximately 20 times that of the general Washington population. The rate of syphilis is similarly high (53.6 vs. 1.65 per 10,000). This is driven by the high rate of these conditions among MSM PLWH; the rate among PLWH with other risk categories is more like the general population.

Our ability to describe the interaction between HIV and HCV is less complete, but there is reason to believe there is a significant overlap between PLWH and PLWHCV. From interviews with PLWH, we estimate that 16% of PLWH either were infected or had been previously infected with hepatitis C. This number was much higher among PWID (66%) and PWID who are also MSM (37%).

Rural vs. Urban

Another health dimension affecting our work is the distinction between urban and rural parts of our state. Although most people have a concept of what "rural" and "urban" mean, there is no nationwide consensus on a precise definition. For this report, we divided the state into "Rural," "Peri-Urban," and "Urban" using community factors that people generally associate with rural areas (see map). Using our classification system, 14% of Washingtonians live in rural areas, 21% live in peri-urban areas, and 64% live in urban areas. PLWH disproportionately live in urban areas; 6% of PLWH live in rural areas, 12% live in peri-urban areas, and 82% live in urban areas.

Transmission of HIV, syphilis, and gonorrhea is less common in rural areas; people in urban areas are four times more likely to be diagnosed with syphilis and HIV and three times more likely to be diagnosed with gonorrhea as compared to those in rural areas. However, diagnosis and treatment of these diseases can be more challenging in rural areas where people may have to travel further for healthcare and sexual health services.

Seventy-nine percent of PLWH living in urban areas of the state are virally suppressed, which is the highest of the three classifications. People who live in urban areas tend to

have access to a broader range of services than those in remote regions. In Washington, urban areas are also the areas with the highest diversity. Just under 50% of PLWH in urban areas identify as something other than white, as compared to 25% in rural areas. This may mean that services in urban areas need to be able to accommodate different cultural needs and the products of racism that disproportionally impact these populations

Seventy-eight percent of PLWH living in peri-urban areas of the state are virally suppressed, which falls between the values for urban and rural areas. PLWHs who live in peri-urban areas have markedly higher rates of poverty and the barriers to care associated with poverty. In peri-urban areas, 68% of PLWH have an income below the federal poverty level compared to 54% in other areas. PLWHs in peri-urban areas are 50% more likely to need or use emergency housing and 80% more likely to need or use substance use disorder treatment, domestic violence services, and mental health services than PLWHs in rural or urban areas.

Seventy-four percent of PLWH living in rural areas of the state are virally suppressed, which is the lowest of the three classifications. PLWHs who live in rural areas may have to travel a long distance to obtain HIV care and may have less access to support services. From MMP interviews, we also find that PLWH who live in rural areas experience a higher amount of stigma and have a more considerable unmet need for peer group support. This suggests that PLWH in rural areas may experience isolation and social barriers to HIV prevention and care.

Transgender Women

Despite a large amount of research on HIV in the Washington state community, we know very little about transgender women and HIV. In most research contexts, transgender women are classified by their sex assigned at birth, which ignores their identities and marginalizes their needs. Despite the limited evidence, studies of transgender women find staggeringly high rates of HIV infection. In King County, the HIV prevalence among transgender women was estimated at 20%, consistent with studies in other regions and internationally. Transgender women live in a society where they face significant stigma and discrimination, which can put them into situations that greatly increase their HIV risk and severely limit their ability to obtain adequate care. These situations are familiar to those working in HIV but include drug use, sex work, incarceration, homelessness, poor mental health, negative healthcare encounters, lack of familial support, and violence.

Combining ADAP claims, medical records, and self-report, we find that 3.1% of PLWH in Washington identify as transgender female or have undergone gender affirmation treatment. This may be an underestimate if transgender individuals are less likely to participate in MMP or enroll in ADAP, where much of the information about gender is derived.

Within this 3.1%, we see reflections of the marginalization of transgender women that has been described nationwide. Although the number of MMP participants are small (n=26), we estimate that transgender woman is 3.1 times more likely to be homeless (28% vs. 9%), 1.8 times more likely to face discrimination in a healthcare setting (50% vs. 28% in past 12 months), and 1.9 times as likely to have been coerced or threatened into having sex (48% vs. 26%) than other PLWH in Washington. Despite these barriers, transgender women report a quality of life that is equivalent to that of other PLWH (55% reporting "good" or "excellent" quality of life), and 96% are virally suppressed (87% of all others). These final statistics should be interpreted with caution, however, as they disproportionately reflect the experience of transgender women with the desire and means to undergo gender-affirming treatment.

a) Diagnose

- Race and structural racism negatively impact many BIPOC living with HIV, indicating a need for specific interventions in this pillar.
- Methamphetamine (and other drug use) contributes to suboptimal outcomes, indicating a need for specific interventions in this pillar.
- Housing is health care. Homelessness (using the broadest definition) has a significant negative impact. Interventions in this pillar must be implemented in a way that takes this impact into consideration
- Disproportionately high rates of HIV diagnosis among people who have gonorrhea and syphilis require an intense focus in this pillar.

- The distinction between rural, urban, and peri-urban is essential. This distinction requires a nuanced approach. Each intervention in this pilar should be evaluated for differences in outcomes and implemented to improve health outcomes regardless of geographic distinctions.
- Transgender women live in a society where they face significant stigma and discrimination, which can put them into situations that significantly increase their HIV risk and severely limit their ability to obtain adequate care. Population-specific intervention should be identified in collaboration with Transgender communities in this pillar.

b) Treat

- Race and structural racism negatively impact many BIPOC living with HIV, indicating a need for specific interventions in this pillar.
- Although young people are linked to care in a similar amount of time as other PLWH, younger PLWH are less likely to be virally suppressed.
- Methamphetamine (and other drug use) contributes to suboptimal outcomes, indicating a need for specific interventions in this pillar.
- Housing is health care. Homelessness (using the broadest definition) has a significant negative impact. Interventions in this pillar must be implemented to consider this impact.
- PLWH are at high risk of infection with other STIs requiring interventions in this pillar to include effective STI interventions.
- Transmission of HIV, syphilis, and gonorrhea is less common in rural areas; people in urban areas are four times more likely to be diagnosed with syphilis and HIV and three times more likely to be diagnosed with gonorrhea as compared to those in rural areas. However, diagnosis and treatment of these diseases can be more challenging in rural areas where people may have to travel further for health care and sexual health services.
- Transgender women live in a society where they face significant stigma and discrimination, which can put them into situations that significantly increase their HIV risk and severely limit their ability to obtain adequate care.

c) Prevent

- Race and the impacts of structural racism are negatively impacting many BIPOC living with HIV, indicating a need for specific interventions in this pillar.
- Methamphetamine (and other drug use) contributes to suboptimal outcomes, indicating a need for specific interventions in this pillar.

- Housing is health care. Homelessness (using the broadest definition) has a significant negative impact. Interventions in this pillar must be implemented to consider this impact.
- Disproportionately high rates of HIV diagnosis among people who have gonorrhea and syphilis present an opportunity for HIV prevention.
- Transmission of HIV, syphilis, and gonorrhea is less common in rural areas; people in urban areas are four times more likely to be diagnosed with syphilis and HIV and three times more likely to be diagnosed with gonorrhea as compared to those in rural areas. However, diagnosis and treatment of these diseases can be more challenging in rural areas where people may have to travel further for health care and sexual health services.
- Transgender women live in a society where they face significant stigma and discrimination, which can put them into situations that significantly increase their HIV risk and severely limit their ability to obtain adequate care.

d) Respond

- Race and the impacts of structural racism are negatively impacting many BIPOC living with HIV, indicating a need for specific interventions in this pillar.
- Methamphetamine (and other drug use) contributes to suboptimal outcomes, indicating a need for specific interventions in this pillar.
- Housing is health care. Homelessness (using the broadest definition) has a significant negative impact. Interventions in this pillar must be implemented to consider this impact.
- Disproportionately high rates of HIV diagnosis among people who have gonorrhea and syphilis present requires targeted interventions in this pillar.
- Transmission of HIV, syphilis, and gonorrhea is less common in rural areas; people in urban areas are four times more likely to be diagnosed with syphilis and HIV and three times more likely to be diagnosed with gonorrhea as compared to those in rural areas. However, diagnosis and treatment of these diseases can be more challenging in rural areas where people may have to travel further for health care and sexual health services.
- Transgender women live in a society where they face significant stigma and discrimination, which can put them into situations that significantly increase their HIV risk and severely limit their ability to obtain adequate care

V) CY 2022-2026 goals and objectives

		Diagnose	Treat	Prevent	Respond
Goal 1	**Embrace phlebotomy**	X			X
Goal 2	**Support organizations in creating full-service, robust, regional MOU**	X	X	X	X
Goal 3	**Provide holistic HIV prevention care for gender-expansive and transgender people**	X	X	X	
Goal 4	**Expand low- and no-barrier treatment options for PLWH**		X	X	
Goal 5	**Promote provider accountability**	X	X	X	
Goal 6	**Expand testing and treatment options and medication access**	X	X		
Goal 7	**Use mobile services to reach people where they live and work**	X	X	X	X
Goal 8	**Implement service delivery methods explicitly developed for rural populations**	X	X	X	
Goal 9	**Provide holistic syndemic care for people who exchange sex for monetary or nonmonetary items.**	X	X		
Goal 10	**Expand self-collected testing options**	X			

Goal 11	**Colocate syndemic services at OTP/SUD/SSP**	X	X	X	
Goal 12	**Increase HIV services provided in Spanish**	X	X	X	
Goal 13	**Increase age-specific syndemic services (youth and elder)**	X	X	X	

Goal 1	**Embrace phlebotomy**			
Objective 1	**Ensure that all nonclinical testing partners have robust phlebotomy capacity to perform high-quality integrated testing services, including HIV, STI, and viral hepatitis testing.**			
Objective 2	**Ensure that any preliminary positive/reactive test results determined by a point-of-care test get immediate follow-up with specimen collection to diagnose a current infection and accelerate linkage to care.**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, Ryan White subrecipients, HIV prevention community partners	Decrease new infections and improve health outcomes for PLWH by using the best test available.	Ryan White, Ryan White Rebates, CDC, GFS	Aligns with NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, and Hep C Free WA goals	June 2026
***Impact on the HIV Continuum**:* Projected impact is an improvement of Ever Diagnosed and New Cases Linked to Care within 30 days				
Advancement of Health Equity: Significant racial and ethnic disparities exist in Ever Diagnosed and New Cases Linked to Care within 30 days. Improvement in these bars overall will likely advance equity				

Goal 2	**Support organizations in creating full-service, robust, regional MOU**			
Objective 1	**Increase collaboration between subrecipient agencies**			
Objective 2	**Decrease the number of clients lost to care by increasing the number of warm hand-offs between agencies**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, Ryan White subrecipients, HIV prevention community partners	Increased engagement in care by creating a more effective referral process for people living with HIV	RW, CDC, GFS	Aligns with NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, and Hep C Free WA goals	January 2024
Impact on the HIV Continuum: Projected impact is a more robust service delivery system resulting in greater Engagement in Care				
Advancement of Health Equity: Significant racial and ethnic disparities exist in Engagement in Care. Improvement in these bars will likely advance equity				

Goal 3	Provide holistic HIV prevention and care for gender-expansive and transgender people			
Objective 1	**Create and fund HIV interventions designed to support gender-expansive and transgender people**			
Objective 2	**Create data product(s) that describe the impact of HIV on gender-expansive and transgender people**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, Ryan White subrecipients, gender-expansive and transgender community, HIV prevention community partners	Apply targeted universalism to advance equity in service delivery for gender-expansive and transgender people	CDC, RW, GFS	Aligns with NHAS, EHE, and STI National Strategic Plan	June 2024
Impact on the HIV Continuum: Challenges in data reporting, collection, and analysis do not provide enough information to make an informed impact statement				
Advancement of Health Equity: SCSN data identified gender expansive and transgender people are experiencing significantly more structural barriers. Specific programming with intentional involvement is likely to advance equity				

Goal 4	Expand low- and no-barrier treatment options for PLWH			
Objective 1	**Increase the number of low- and no-barrier clinics within WA State**			
Objective 2	**Support agencies funded under Outpatient/Ambulatory Health Services in reducing structural barriers to care**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, Ryan White subrecipients, Ryan White clinics, FQHC, DIS	Increase the availability of walk-in clinics and rapid start availability for PLWH	Ryan White, Ryan White rebates, CDC	Align with NHAS, EHE, and STI National Strategic Plan	June 2024
Impact on the HIV Continuum: Projected impact is a more robust service delivery system resulting in greater Engagement in Care and Viral Load Suppression				
Advancement of Health Equity: Significant racial and ethnic disparities exist in Engagement in Care and Viral Load Suppression. Improvement in these bars will likely advance equity				

Goal 5	Promote provider accountability			
Objective 1	**Increase provider engagement**			
Objective 2	**Measure provider success in core competencies and target follow-up education**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, clinicians, HIV providers, RW clinics, FQHC, Prevention Training Center, MWAETC	Motivating providers to change behaviors in patient care to increase their participation in infectious disease, prevention, and care priorities	RW, CDC, GFS	Aligns with NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, and Hep C Free WA	December 2025
Impact on the HIV Continuum: Provider relationship significantly impacts Engagement in Care and subsequent Viral Suppression. The projected impact is improvement in these bars				
Advancement of Health Equity: Significant racial and ethnic disparities exist in Engagement in Care and Viral Load Suppression. Improvement in these bars will likely advance equity				

Goal 6	Expansion of testing, treatment options, and medication access			
Objective 1	**Ensure access to long-acting HIV treatment options**			
Objective 2	**Maximize opportunities for STI, HEP C treatment for coinfected PLWH**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, clinicians, HIV providers, RW clinics, FQHC, Pharmaceutical companies, HIV prevention community partners	Increased viral suppression and quality of life for PLWH by providing effective and appropriate biomedical interventions	Ryan White, Ryan White rebates, ADAP, CDC	Aligns with NHAS, EHE, and Hep C Free WA	Dec 2025
Impact on the HIV Continuum: Projected impact is a more robust service delivery system resulting in greater Engagement in Care and Viral Load Suppression				
Advancement of Health Equity: Significant racial and ethnic disparities exist in Engagement in Care and Viral Load Suppression. Improvement in these bars will likely advance equity				

Goal 7	Use Mobile services to reach people where they live and work			
Objective 1	**Develop and fund mobile service options for HIV prevention and care**			
Objective 2	**Develop and fund services that target peri-urban locations**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, Ryan White subrecipients, communities, community-based providers, FQHC, HIV prevention partners	Increase engagement in care by locating or co-locating services in sites readily accessible	Ryan White rebates, GFS	Aligns with NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, and Hep C Free WA	Dec 2025
Impact on the HIV Continuum: Projected impact is the continuum. Our current service delivery system does not serve a subset of PLWH well				
Advancement of Health Equity: Significant racial and ethnic disparities exist across the continuum. Improvement will likely advance equity				

Goal 8	Implement service delivery methods explicitly developed for rural populations			
Objective 1	**Develop and fund interventions designed specifically for rural populations**			
Objective 2	**Maximize the effectiveness of linkage to care activities in rural areas**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, Ryan White subrecipients, communities, community-based providers, FQHC, HIV prevention partners	Apply targeted universalism to advance equity in service delivery for people in rural and frontier counties	Ryan White, CDC, GFS, Ryan White rebates	Aligns with NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, and Hep C Free WA.	Dec 2025
Impact on the HIV Continuum: Projected impact is the continuum. Service density is significantly less than in urban areas				
Advancement of Health Equity: Significant racial and ethnic disparities exist across the continuum. Improvement will likely advance equity				

Goal 9	Provide holistic syndemic care for people who exchange sex for monetary or nonmonetary items			
Objective 1	**Broaden condom distributions as a structural intervention for sex workers and people who exchange sex for nonmonetary items**			
Objective 2	**Solicit and incorporate feedback from people who exchange sex for monetary or nonmonetary items into implementing the Integrated Plan**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, RW subrecipients, people who exchange sex for monetary or nonmonetary items, community clinics, and providers	Increase the availability, accessibility, and acceptability of condoms for sex workers and people who exchange sex for nonmonetary items	CDC, GFS, RW, RW rebates	Aligns with NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, Hep C Free WA	June 2026
Impact on the HIV Continuum: Data is not collected in a way to provide enough information to make an informed impact statement				
Advancement of Health Equity: The social determinants of health significantly affect people who exchange sex for monetary or nonmonetary items. Strengthening services to this population will likely advance equity				

Goal 10	Expand self-collected testing options			
Objective 1	**Assess community interest in self-collected testing options**			
Objective 2	**Evaluate the feasibility of a statewide syndemic self-collected testing program**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, RW subrecipients, community-based providers, and HIV prevention community partners	Decrease new infections and improve health outcomes by using the best test available.	CDC, GFS, RW, RW rebates	Align with NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, Hep C Free WA	July 2023
Impact on the HIV Continuum: Projected impact is an improvement in Ever Diagnosed				
Advancement of Health Equity: Home testing is likely to reduce stigma as well as increase accessibility; both factors are likely to advance equity				

Goal 11	Colocation of syndemic services at OTP/SUD/SSP			
Objective 1	**Increase access to syndemic services for people who use drugs**			
Objective 2	**Create and fund services explicitly designed for PLHWs who use drugs.**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
HIV workforce, OTP workforce, SUD workforce, SSP workforce, DOH, FQHC, HCA, LHJ	Apply targeted universalism to advance equity in service delivery for people who use drugs and improved health outcomes for PLWH who also use drugs	Ryan White and Ryan White rebates, GFS, CDC	Aligns with NHAS, EHE, Viral Hepatitis National Strategic Plan, Hep C Free WA	Jan 2025
Impact on the HIV Continuum: Projected impact will improve the entire continuum				
Advancement of Health Equity: People who use drugs experience significant disparities in HIV outcomes. Population-specific interventions are likely to advance equity				

Goal 12	Increase HIV services provided in Spanish			
Objective 1	**Increase the number of dual-language (Spanish) employees in the WA state HIV workforce**			
Objective 2	**Increase access to medical interpreters for HIV-care appointments**			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
HIV workforce, DOH	Improved health outcomes for PLWH who are monolingual Spanish speakers	Ryan White, Ryan White rebates, CDC	Align with NHA and EHE	Dec 2024
Impact on the HIV Continuum: Projected impact will improve the entire continuum				
Advancement of Health Equity: Hispanic or Latina/o/x communities experience significant disparities in HIV outcomes. Population-specific interventions are likely to advance equity				

Goal 13	Increase age-specific syndemic services (youth and elder)			
Objective 1	Develop and fund interventions designed specifically for youth and elders			
Objective 2	Maximize the effectiveness of peer navigation for long-term survivors			
Key Partners	**Intended Outcomes**	**Funding Sources**	**Alignment Across Plans**	**Target Timeline**
DOH, LHJs, Ryan White subrecipients, communities, community-based providers, HIV prevention partners	Apply targeted universalism to advance equity in service delivery for youth and elders	Ryan White, CDC, GFS, Ryan White rebates	Aligns with NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, and Hep C Free WA	Dec 2025
Impact on the HIV Continuum: Projected impact will improve the entire continuum. Differences in HIV outcomes occur based on age and have varying impacts on different continuum bars (Diagnosed, Linked to Care, Engaged in Care, Virally Suppressed)				
Advancement of Health Equity: Significant racial and ethnic disparities exist across the continuum. Improvement will likely advance equity				

VI. Implementation, Monitoring, and Jurisdictional Follow Up

1) 2022-2026 Integrated Planning Implementation Approach

In this section, the infrastructure, procedures, systems, and tools that will support the key phases of integrated planning will demonstrate how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases:

1. Implementation

2. Monitoring

3. Evaluation

4. Improvement

5. Reporting and Dissemination

In 2022, the Washington State Department of Health (DOH) Office of Infectious Diseases (OID), Public Health Seattle & King County (PHSKC), the HIV Integrated Plan Steering Committee, and the Washington Syndemic Planning Group, partnered with consultants and key community stakeholders representing assembled committees and reviewed all current state and local needs assessments, data reports, and strategic plans related to HIV, viral hepatitis, and sexually transmitted infections. Overarching priorities and common strategies across plans were identified through review and revision as part of the planning process.

Dozens of People Living with HIV (PLWH) participated in the integrated planning process through membership in one or more community planning bodies. In addition to the PLWH being involved in the integrated planning process in Washington state, OID and its consultant team held more community conversations with PLWH in the summer of 2022. OID engaged 16 case managers, community-based partners, and HIV residency programs to ensure adequate recruitment among PLWH communities. In these meetings, participants reviewed key findings, shared their insight, identified their greatest met and unmet needs related to HIV treatment and care services in Washington State, and suggested potential goals to include in the Integrated Plan, using the Ending the HIV Epidemic (EHE) initiative that center and scale community-driven solutions to leverage science-based strategies in a four-pillar approach: Diagnose, Treat, Prevent, and Respond, as a framework. OID and its consultant team summarized these conversations for Washington's HIV Planning Steering Group (HPSG), which then used this information to develop the plan's final draft goals.

The Office of Infectious Diseases (OID) partnered with Health Management Associates in 2021 to host community conversations through town halls, focus groups, and stakeholder interviews. The sessions explored the strengths, opportunities, and areas for improvement in developing a new planning body's structure, roles, and responsibilities. A comprehensive literature review helped guide and support these activities' findings. Community surveys were also administered to determine priorities in selecting the planning body and demonstrated the importance of

including people with lived experience, people at higher risk of HIV, viral hepatitis, and STIs and underrepresented groups to engage in statewide strategies, funding priorities, communications, research, and evaluation activities to address the syndemic of HIV, viral hepatitis, and STIs effectively and comprehensively. A weighted scoring tool was developed to guide an equitable application process with these priorities in mind. Of 74 applications, 22 participants were selected to join the new planning group. This established the Washington Syndemic Planning Group (WSPG).

In July 2022, the WSPG began meeting to advise OID on programs that were supporting communities and individuals impacted by STIs, HIV, viral hepatitis, and drug user health in Washington. The group created and accepted a charter and bylaws. WSPG was invited to several community presentations where syndemic epidemiological data was shared with stakeholders to collect feedback and develop priorities for the integrated plan. OID used a JAM Board to document the collected priorities and synthesized the responses to create the goals and objectives outlined in this Integrated Plan. In October 2022, the WSPG members reviewed the thirteen goals and plans for implementation and monitoring. Language accessibility features were provided at meetings through live captioning and all written presentation materials were accessible in English and Spanish and emailed in advance for review and preparation for the consensus meeting. Using a polling feature, the WSPG arrived at full concurrence with the plan and the Letter of Concurrence (Appendix 2) was formally submitted by the tri-chairs.

A) Coordinating Partners

In 2019, a review of published plans showed consistent theme areas among initiatives and programs working to end HIV, STI, and HCV epidemics. A focused effort to end the epidemics of HIV, STIs, HCV, and overdose requires cross-collaboration to maximize resources and reach common priority populations, such as gay and bisexual men, women of transgender experience, people who use drugs, and communities disproportionately impacted by these issues, such as African Americans, Latina/o/x and Native Americans. Recognizing the advantages of community engagement and stakeholder involvement being integral to advancing the goals and removing silos within the critical priority conditions, the newly formed Washington Syndemic Planning Group (WSPG) was launched in the Summer of 2022 to support the goals and objectives of moving along a synergized continuum of care. Members of WSPG reflect the high-priority communities and are subject matter experts in one or more conditions: HIV, HCV, STI, SUD/OUD.

Members of the WSPG engage in activities to provide and apply their expertise in meaningful support of the goals and objectives to move forward in bi-directional information exchange. The WSPG is also used to engage with at-risk communities, offer feedback on strategies and objectives, and offer input with solicitation planning. OID is responsible for clearly describing and defining the state’s priorities, goals, and for obtaining information from the planning body to advise the state’s interpretation of data to make meaningful, impactful, and localized data-driven decisions that can be made, supported, and measured.

In 2022, OID began the planning process for a new Request for Applications to be released in the spring of 2023. The goals and objectives in this integrated plan align with program expectations and deliverables aiming to improve health outcomes, integrate HIV, STIs, HCV and drug user health, and address documented health disparities. This plan is grounded in the overarching goal to link key populations to clinical care that prevents and manages disease transmission. The upcoming solicitation announcement will focus on centering new partnerships that are currently active in serving communities experiencing health and care disparities, such as African American/ Black and Latina/o/x communities. There is also interest in contracting with agencies serving or able to serve rural communities, urban, and peri-urban areas.

Partnerships will be inclusive of and not limited to:

- Community-based organizations
- Local health jurisdictions across Washington State
- People with lived experience in conditions prioritized by OID
- Clinical partners including Ryan White Part C and Ryan White Part A
- Partners at Public Health Seattle & King County
- Academic partners at the University of Washington including Project ECHO
- The Prevention Training Center
- The Mountain West AIDS Education and Training Centers.

Contracted agencies will partner with OID to provide clinical and community services across Washington State. These agencies will perform the necessary community-facing duties that help link communities served by OID programs to stay connected to clinical care by providing case management and care support services for Persons Living with HIV (PLWH) across our state and to enhance access to HIV testing, condoms, and Pre-Exposure Prophylaxis (PrEP) for Persons at High Risk for HIV (PAHR) in the areas of the state with the highest rates of HIV infection. Contracted and partnered activities will also increase efforts to address health disparities among PLWH and PAHR, including an increased emphasis on engaging Gay, Bisexual and Other Men Who Have Sex with Men (MSM) of all races and ethnicities. Efforts to address HIV-related stigma and to invigorate meaningful community engagement work which results in remarkable localized progress will also be prioritized.

Overall, partners at multiple levels of engagement will coordinate their activities to align with the goals and objectives in this integrated plan (section V). Implementation activities will ensure the planning process, member recruitment, steering group, workgroups, and caucuses are centered on equitable practices and include active participation from communities disproportionately impacted by conditions.

Selected implementation sites will be committed to the promotion of population health by advancing systems, social, and environmental factors impacting the EHE four pillars framework

(diagnose, treat, prevent, respond) of health and health disparities. The sites will support the department's mission to protect and improve the health of Washingtonians by ending HIV, STI, and HCV epidemics in addition to the varied co-occurring conditions for people who use drugs in the state.

Contractors will work with OID to coordinate with peer leaders in all conditions and sections within OID to ensure balanced attention is provided to conditions and populations most impacted, particularly for individuals who have been historically marginalized and underserved by traditional systems, institutions, and programs.

An integrated plan and our current Syndemic Planning group were developed through synergistic efforts to align strategies of six program areas at OID in partnership with contracted partners and planning bodies made up of subject matter experts in several areas to promote community learning:

- Adult Viral Hepatitis & Drug User Health
- HIV Community Services
- Infectious Disease Assessment
- Sexual Health and Prevention
- Eligibility & Benefits (ADAP)
- Business Development

The Integrated Plan's goals, listed below, and accompanying objectives were developed in collaboration with people living with HIV (PLWH) and other stakeholders and partners across Washington State. Implementation of the plan, outlined within the 13 goals and objectives defined in Section V, will prioritize actions and coordinate the use of resources in communities and groups affected by HIV, to identify common goals and align strategies and evaluation around these goals:

- Embrace Phlebotomy
- Support organizations in creating full-service, robust, regional MOU
- Provide holistic HIV prevention care for gender-expansive and transgender people
- Expand low & no barrier treatment options for PLWH
- Promote Provider Accountability
- Expansion of testing and treatment options and medication access
- Utilize mobile services to reach people where they live and work
- Implement service delivery methods explicitly developed for rural populations

- Provide holistic syndemic care for people who exchange sex for money or non-monetary items
- Expand self-collected testing options
- Co-location of syndemic services at OTP/SUD/SSP
- Increase HIV services provided in Spanish
- Increase age-specific syndemic services (youth & elder)

The multi-tiered approach to communication, using individuals with lived experience, is a large advantage of this program's design. Each community and social network type can inform the work of the others in a cross-collaborative effort. The creation of the new Syndemic Planning Group includes individuals with lived experience from several conditions and perspectives.

The Washington Syndemic Planning Group (WSPG) will also connect with community members and groups to lead in the launch of three subgroup functional committees. The functional committees' focus will be to further support, test and refine the activities promoting the Integrated Plan's goals and objectives, with measures to promote inclusivity during the development and implementation phases:

- Collaboration in the development of a statewide solicitation process
    - Contracted partners will work collaboratively to create a synergized approach to the four pillars (Diagnose, Treat, Prevent, Respond)
- Development of a Washington State Syndemic Planning Group (WSPG)
    - Three leads: one governmental, one community, one provider
    - Further refined into three internal functional committees:
        - **Strategy and Priority Setting**
            - Review research, data, and information gathered on HIV, viral hepatitis, and STIs to inform plan activities
            - Develop recommendations of goals, objectives, and strategies that use a syndemic approach to address HIV, viral hepatitis, and STIs
            - Recommend priorities for OID to consider in its funding of vendors, contractors, and activities related to HIV, viral hepatitis, and STIs
            - Embed health equity and racial justice focus in all recommendations
        - **Research, Evaluation, and Monitoring**
            - Inform OID research, data collection, and analysis activities conducted by OID in support of the WSPG using a health equity lens

        - Support plans and activities, including metrics, to monitor and evaluate statewide progress concerning WSPG goals, objectives, and strategies.
        - In partnership with OID, develop annual progress updates and reports for the WSPG
    - **Implementation and Communication**
        - Act as a liaison between other state and jurisdictional planning bodies addressing HIV, viral hepatitis, and STIs
        - In partnership with OID, develop communications to publicize the work of the WSPG
        - Support the development of an implementation plan to operationalize the work needed to accomplish the recommended goals, objectives, and strategies of the WSPG that embeds health equity and racial justice
        - With the Research, Evaluation, and Monitoring Committee, enhance implementation and communication efforts based on annual progress
- Formation of focused caucuses to ensure inclusion of community stakeholders in the process of exploring and refining the goals and objectives. Initially, the meetings will focus on the following community groups:
    - **Long-term HIV survivors**
    - **Persons who use drugs**
    - **Cognitive/Behavioral Health**
    - **Transgender/Gender Expansive**

B) Coordinating Funding

The Washington Department of Health (WA DOH) receives funding from federal grants, state legislative-designated funds, and restricted and unrestricted pharmaceutical rebate revenue. We recognize that federal and restricted funds come with specific deliverables, activities, and requirements. WA DOH will comply with those expectations and requirements while also integrating services for HIV, STIs, HCV, and Drug User health in a way that allows funded partners to serve the needs of community members in an innovative, integrated, and comprehensive way to reduce funding and service delivery silos.

There are two approaches to consider for funding integration and coordination: blending and braiding.

- Blending refers to wrapping funds from two or more funding sources to fund a specific part of a program or initiative. Coded costs are not necessarily allocated and tracked by individual funding sources.
- Braided funds bring two or more funding sources together to support the total cost of a service. Revenues are allocated, and different categories of funding sources track expenditures. In braiding, cost-allocation methods are required to ensure that there is no duplicated funding of service costs and that each funding source is charged its fair share across the partners.

WA DOH expects to use the braided funding process to adhere to restricted funding requirements and to stretch limited unrestricted General Fund State resources.

Funded partners will have comprehensive contracts with work statements that separate deliverables by funding codes. For services not eligible for federal funding or in the instances where federal funds are insufficient for the disease burden, general state funds will be used to fill gaps and ensure comprehensive care. WA DOH contracts have been integrated for several years. Still, continued work will be necessary to provide assistance and technical support needed to streamline partners' invoicing and contracting processes, and ensure standard budget balancing and deliverable reporting formats.

WA DOH currently has three program positions for contract management and a five-member fiscal team. The Operations and Infrastructure Manager will oversee the bidding process, the development of integrated budgets, and the scope of work and deliverables. Contract Managers and fiscal staff initially craft the budgets with partners, then monitor monthly invoices and submit deliverables. Routine budget planning and monitoring reports will guide program integrity, recognition, the celebration of milestone achievements, and the instillation of technical support.

2) Monitoring

The Office of Infectious Disease is committed to reducing disparities and improving health equity and outcomes related to HIV, STIs, and HCV. The methods to be used for monitoring progress on the Integrated Plan’s goals and objectives will include a multi-layered approach outlining the stages in development, testing and refining, and dissemination of updated process measures among multiple stakeholders such as contracted partners, whole planning groups, steering and internal committees such as the Research, Evaluation and Monitoring Committee, and the larger community.

A Steering Committee coordinated and managed this integrated state/city prevention and care plan. Representatives are:

- The Washington State Department of Health (DOH) Office of Infectious Diseases (OID), including the principal investigator for Ryan White Parts B, C, and D grants and the

principal investigator for all CDC prevention grants related to HIV, viral hepatitis, and sexually transmitted infections (STIs).

- Public Health Seattle & King County (PHSKC), including the principal investigator for its Ryan White Part A grant.
- Multnomah County Health Department, including the principal investigator for its Ryan White Part A grant.
- The Seattle Transitional Grant Area (TGA) HIV Planning Council, the RWHAP Part A planning body.
- The Portland Transitional Grant Area (TGA) HIV Planning Council, the RWHAP Part A planning body.
- The King County Ending the HIV Epidemic Planning Committee (EPC).
- A team of consultants supported the Steering Committee.

At the start of 2022, this Steering Committee assembled and reviewed all current state and local needs assessments, data reports, and strategic plans related to HIV, viral hepatitis, and STIs, including the 2020 Plan to Support Ending the HIV Epidemic in King County and the 2017–2021 Washington Statewide Coordinated Statement of Need (SCSN) and Integrated Plan. The Steering Committee identified overarching priorities and common strategies across plans. Epidemiologists from OID and PHSKC worked together to develop an initial draft of the SCSN using data from the state's Enhanced HIV/ADS Reporting System (EHARS), as well as data collected as part of OID's additional surveillance projects, which include Molecular HIV Surveillance (MHS), HIV Incidence Surveillance (HIS), and the Medical Monitoring Project (MMP).

Having assessed the needs of critical stakeholders, the Steering Committee consolidated recommended goals into 13 draft goals and objectives, which the Seattle TGA, the Portland TGA, and the WSPG reviewed and refined. After confirming these final goals and objectives, the Steering Committee developed a set of implementation, monitoring, and evaluation activities for the Integrated Plan and submitted the final draft plan to the WSPG, EPC, Seattle TGA, Portland TGA, and OID and WA DOH leadership.

Outcomes development on Integrated Plan goals and information regarding needs, benefits, and monitoring procedures will be used to compare the efficacy, equitable access, and experience with treatments and interventions in areas of consumer recruitment and retention, clinical and social resource center performance, and evaluation of the additional impact of the plan’s process and outcomes indicators of the thirteen goals and objectives of the integrated plan.

This approach includes using peer navigators and linkage to care specialists that provide enhanced regional support, aiming to link Black American/African Born and Hispanic/Latina/o/x

individuals living with HIV with access to medical care, case management, supportive services, and partner services.

Performance measures such as annual retention in care, HIV viral load testing/suppression, and quality of life will be tracked, monitored, and evaluated to determine optimal health outcomes. Training and technical assistance will be offered to ensure performance measures are tracked and monitored appropriately. Agencies will continue monitoring HIV/AIDS Bureau (HAB) performance measures using the data provided to assist with inter-agency identified Quality Management Plans. Funded entities use the clinical quality management plan template to develop their individual plans. Reports are submitted quarterly using a quarterly reporting template. The reports are reviewed, and coaching and technical assistance is provided based on need.

The HIV Client Services Internal Quality Improvement Committee (QI Committee) includes members from each program area within HIV Client Services (Table 1). The QI Committee re-examines prior indicators, previously stated quality improvement needs, and the revised HAB performance measures. The HIV Quality Improvement Group meets quarterly.

Table 1: 2022 Quality Improvement Internal Committee Members

Affiliation
Washington State Department of Health (DOH)
Benton-Franklin Health District
Blue Mountain Heart to Heart
Cascade AIDS Project (CAP)
Coastal Community Action Program
Confluence
Country Doctor
WA State Department of Corrections
Entre Hermanos
Harborview Medical Center
Kitsap Public Health District
Lifelong
Pierce County AIDS Foundation (PCAF)

People of Color Against AIDS Network (POCAAN)
Spokane Regional Health District
Yakima Farm Workers/New Hope Clinic

The HIV Client Services Programs includes several funding sources and provides a variety of services. Funding sources include:

- State: General Funds State
- Federal: Ryan White Part B (base)
- Federal: AIDS Drug Assistance Program (ADAP)
- 340B rebates

Monitoring will be an ongoing collaborative process between funded partners, WSPG, and DOH. Some metrics for the identified goals are still to be determined in collaboration with community groups. There are also goals without baseline data, which will be measured in the plan's first year. Once fully documented, the monitoring process will measure progress toward the goals and objectives, establish specific guidelines for monitoring, establish procedures for course correction, select strategies for collecting information and analyze data to inform decision-making and improve HIV prevention, care, and treatment efforts to ensure that the results are fairly presented. Deliverables updates will be provided to the WSPG for consideration before public release through external and social media platforms. Budgets, work plan milestones, and landscape reviews will occur in a regular cadence to be determined. Information, input, and recommendations received through these processes will inform OID activities to update plans and materials and will be distributed at regular intervals. The plan will be a living document that will be adjusted as new information becomes available or new input is provided.

Highlights of monitoring activities include:

- This data is aggregated and represents all efforts toward the goals and objectives. The monitoring will also be included in partner contracts and reported through monthly data systems, combined with DOH-generated work and deliverables. All will feed up to a comprehensive dashboard for tracking and reporting.
- Based on the timeframe of surveillance data and program reporting among partners and stakeholders, the dashboard will be updated semi-annually. OID and WSPG will work with the Surveillance team for assistance in developing and updating the data dashboard.
- Program technical assistance is provided to reroute the work to ensure that contract-level monitoring is also accomplished or when outcomes are not achieved.

- A logic model (Appendix 4) provides evaluation benchmarks, which implementation and outcomes can be monitored and measured against.
- Presentations to key stakeholders and the WSPG will include progress reports from caucus meetings.
- A public-facing dashboard may be developed showing goals, deliverables, and progress charts.

HIV Care Monitoring - DOH's performance measures showing progress and identifying improvement areas are available for each funded service category. Detailed descriptions of performance measures are available in the quarterly report template and from the DOH Clinical Quality Management Program Coordinator. Additional performance measures may be tracked based on identifying disparate impact or other identified disparities defined by the funded programs and WSPG data. Potential focus areas are youth, people over 50 living with HIV, transgender persons, women, and justice involved. HIV Client Services will focus on quality improvement measures that align with the National HIV/AIDS Strategy and HAB Measures, Washington state-wide measures using data from the Enhanced HIV/AIDS Reporting System (eHARS), National Quality Center In+Care Measures, National Quality Forum (NQF) Endorsed Measures. HIV Client Services requires all sub-recipients and contracted providers to track performance measures identified in the Clinical Quality Management Plan.

The sub-recipient's Clinical Quality Management/Improvement program will report quarterly on the following performance measures:

HAB Clinical Performance Measures - Core

- 1. HIV Viral Load Suppression (95%) – Percentage of HIV+ persons with an HIV viral load suppressed to <200 copies/mL. The denominator is all diagnosed HIV+ persons who received any service from the sub-recipient.
- 2. Prescription of HIV Antiretroviral Therapy (95%) – Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy1 for the treatment of HIV infection during the measurement.
- 3. HIV Medical Visit Frequency (90%) – Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit every six months of the 24-month measurement period with a minimum of 60 days between medical visits.
- 4. Gap in HIV Medical Visits (5%) – Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year.
- 5. Annual Retention in Care (80%) – Percentage of patients, regardless of age, with a diagnosis of HIV who had at least two (2) encounters within the 12-month measurement year.

HIV Community Services monitors the care plan during site visits. Each sub-recipient will be responsible for a local indicator based on an assessment of local improvement needs.

At DOH, the six section leads will convene quarterly to discuss the plan's updates and adjustments. These accomplishments and pivots will be shared with the WSPG committees and caucuses based on the priority topic area for each. Contract monitoring will be conducted monthly as activities supporting deliverables are submitted into internal data systems. Working with programs and contracted partners, our surveillance team and program leads will create a deliverable grid to capture updates and pivots for dissemination.

Annual iterations of the plan will be reviewed by the full WSPG membership during scheduled meetings for updates, led by the steering committee. Meetings will regularly add agenda items to support and review the plan's progress through discussion and reporting activities, including feedback forms that may be shared between meeting times. Progress will also be disseminated through presentations and publications shared internally and externally. Regular email correspondence and partner and stakeholder check-ins will also provide an opportunity for strengthening plan goals and objectives.

Three functional committees will further refine and carry out the work of the WSPG. The Research, Evaluation & Monitoring Committee is tasked with informing DOH research, data collection, and analysis activities supporting the WSPG, including needs assessments and formal evaluations. They will develop a plan to monitor and evaluate statewide progress in alignment with the goals, objectives, and strategies set in the Integrated Plan and review it annually.

WSPG members have a standing deliverable to review and offer feedback to update the HIV Integration Plan goals and objectives with each iteration.

3) Evaluation

DOH Assessment, Clinical Quality Management (CQM), and program teams will develop new interventions and build from existing interventions. They will use programmatic data designed to incorporate continuous learning and improvement into all phases and know how and when to pivot.

Additionally, the results of our environmental scan, particularly information gathered from Health Management Associates, have helped us understand different intervention readiness of communities and general attitudes towards a Syndemic approach in various geographic areas. This helps us determine our baseline community for project monitoring and improvement.

Assessment needs to monitor and measure impact are consolidated into thirteen draft goals and objectives. Once these final goals were confirmed, a set of outcome measures that would align with other strategic plans (such as NHAS, EHE, STI National Strategic Plan, Viral Hepatitis National Strategic Plan, & Hep C Free WA). The goals were developed for the Integrated Plan and the final draft plan was submitted for approval by the WSPG, Epidemic Planning Committee, Seattle Transitional Grant Area, Portland Transitional Grant Area, OID and DOH.

As outlined in the Goals and Objectives chart in Section V, continuous quality improvement throughout the implementation period will determine success rates towards the goals, focus on prevention, diagnosis, treatment, and response, including the development, testing, and adaptation of interventions and fidelity to chosen interventions and outcomes, and will be a dynamic document that will be updated as needed through process and outcomes measures that will be evaluated every six months or more and outcome measures will be evaluated yearly. Programmatic activities and discussions will be presented to the full WSPG in the form of agenda items, presentations, resource sharing, and training opportunities for progress review and discussions recommending statewide strategies, funding priorities, communications, research, and evaluation activities to enhance prevention, diagnosis, treatment, care, and the response of HIV, viral hepatitis, and sexually transmitted infections (STIs) supporting a syndemic approach to statewide coordination of prevention and care.

Process and outcome indicators would be represented in the following table (Table 2), outlining key areas for development and improvement that support these thirteen goals and objectives from Section V:

1. Embrace Phlebotomy
2. Support organizations in creating full-service, robust, regional MOU
3. Provide holistic HIV prevention care for gender expansive and transgender people
4. Expand Low & No Barrier treatment option for PLWH
5. Promote Provider Accountability
6. Expansion of testing and treatment options and medication access
7. Utilize Mobile Services to reach people where they live and work
8. Implement service delivery methods explicitly developed for rural populations
9. Provide holistic syndemic care for people who exchange sex for money or non-monetary items
10. Expand Self-Collected Testing Options
11. Co-location of syndemic services at OTP/SUD/SSP
12. Increase HIV services provided in Spanish
13. Increase age-specific syndemic services (youth & elder)

Table 2: Outcomes Indicators Table

Goal /Objective
Process Indicators

Indicator(s):		Data Sources	Reporting Frequency
Description:			
Baseline:	Goal:		
Outcomes Indicators			
Indicator:		**Data Sources**	**Reporting Frequency**
Description:			
Baseline:	Goal		

4) Improvement

Overall, updates will be made to the plan on an annual basis. HIV Community Services implements at least one quality improvement project each calendar year, which can be extended to meet outcome goals. This annual objective is further broken out into focused components and activities on a quarterly timeline based on the deliverables of programs, committees, and caucus meetings that will support continuous program development and adjustments, measuring participant reach and demographics. DOH will use Continuous Quality Improvement to support plan implementation, including developing, testing, and refining goals, and facilitate monitoring activities to ensure fidelity to chosen interventions and outcomes.

Data

Data is collected to monitor performance and measure impact. The measures were chosen to demonstrate the project's impact by supporting the indicators defined by measurable goals in the vital EHE strategies:

- **Diagnose** all people with HIV as early as possible.
- **Treat** people with HIV rapidly and effectively to reach sustained viral suppression.
- **Prevent** new HIV transmissions using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

In addition to data collection, systemic gaps identified via direct services will be included as the context in consideration of these reports. Collaboration between epidemiologists and direct

service staff ensures that epidemiological reports are both contextually comprehensive and centered around community members. Direct service staff are trained and stationed in such a way that allows for multiple perspectives: from the individual clients' perspectives, the community perspective, which includes the local health care systems and local health authority, and the statewide perspective that involves how community members may move through the jurisdictions to best serve their needs. This unique ability to observe and identify gaps within the system to the clients served often allows direction for future data reporting and surveillance. This integration of direct services and data surveillance and assessment is just one example of how OID strives to improve service in rural communities, urban, and peri-urban areas.

Communities

Caucus meetings have been held centering key priority communities: Long term HIV survivors, Substance Use Affected, Cognitive and Behavioural health, and Transgender/Gender Expansive people to make a measurable, systemic, and sustained impact on the plan's goals and objectives and influence programs. DOH and WSPG will work with community participants to understand service gaps, access barriers, and ineffective interventions. Community caucus meetings will also influence progress towards developing, testing and refining, and measuring the effectiveness of interventions by exploring innovative approaches to meet the needs of underrepresented populations.

Planning Bodies

The WSPG will lead in promoting organic collaboration among communities through human-centered design. They will connect at least bi-monthly to discuss and offer feedback and support on relevant, comprehensive syndemic topics in a peer setting where their feedback informs the direction of the integrated plan and overall effort to end the epidemics. WSPG can use its influence to inform the work of legislation, administrative policies, and leadership to enhance efforts happening at the programmatic and ground levels.

5) Reporting and Dissemination

Reporting on impact in terms of marginality and inclusion indices will identify where further work is needed to support trauma-informed care, equitable practices, and stigma reduction, outlining negative spaces among consumer and provider (clinicians, case managers) experiences. Regular meetings and check-ins among contracted partners are scheduled to provide updates and gain feedback on improvements to the plan. Email correspondence is used to share information and materials such as posters/flyers and other engagement opportunities. Materials are also shared out on an external-facing website and distributed through a listserv. OID accommodates the use of Culturally and Linguistically Appropriate Services (CLAS) standards to share information in English and Spanish.

HIV Community Services – Clinical Quality Management (HCS-CQM)

All HIV Community Services sub-recipients must submit data into Provide by Groupware Technologies, Inc (GTI) on services provided and HIV clinical quality measures. All HIV Community Service sub-recipients must report their impact on HIV clinical quality performance

measures for all services to patients diagnosed quarterly. The CQM Program Coordinator is required to conduct CQM Committee meetings with all sub-recipients to discuss performance measures, benchmarks, client satisfaction surveys, and technical assistance. Sub-recipients use internal Quality Management Meetings or Client Advisory Boards (CAB) to share and discuss information from quarterly CQM Meetings and any agency-specific information to ensure both clients/consumers and staff are aligned.

6) Coordination with Other Plans

Jurisdictions across the country, including Washington state, have documented a demographic shift in new HIV, STIs, and HCV cases. For HIV, there is an increase in infections among people who inject drugs and continued disparities in outcomes for people who are non-white.

For STIs, Washington is experiencing an increase in syphilis among heterosexuals, including among those who have unprotected sex, have reoccurring STI diagnoses, or experience intimate partner violence, and has also led to a significant increase in cases of congenital syphilis. Increased reported cases of syphilis among people with opposite-sex partners include many instances related to methamphetamine use. This is in addition to continuing increases in reported cases of syphilis among gay, bisexual, and other men who have sex with men. This community has been disparately affected by syphilis and other STIs in the past two decades.

For HCV, the number of cases in younger people is increasing primarily due to injection drug use. In addition, deaths related to overdose have shifted – heroin, fentanyl, and stimulant-related overdose deaths are on the rise. It is essential to address these issues in a coordinated and strategic way, centering key priority populations and where they live, work, and socialize.

Synergistic interaction of the Integrated Plan's implementation, monitoring, evaluation, and improvement activities with the Ending the HIV Epidemic (EHE), Hepatitis C Free Washington, and Washington Statewide STI recommendations outline significant alignment of crucial issues in public health, fulfilling a four-pillar approach that moves toward ending these epidemics: Diagnose, Treat, Prevent, and Respond. In collaboration with partners, OID aims to:

- Promote trauma-informed practices among providers and community agencies to reduce stigma.
- Improve the health and well-being of populations most affected by HIV, STIs, HCV, and drug-related harms (e.g., overdose).
- Promote sexual health and prevent new HIV, STI, and HCV infections.
- Diagnose HIV, STI, and HCV infections early and engage people in timely care.
- Improve health, longevity, and quality of life for people living with HIV, STIs, and HCV and people who use drugs.
- Ensure the quality, consistency, and effectiveness of all OID-funded HIV, STI, HCV, and drug user health programs and services.

Some critical areas of integration among these approaches include recognizing our responses to how implementation, monitoring, evaluation, and improvement of the Integrated Plan is synergistic with those of other plans (Ending the HIV Epidemic, Hepatitis C Free Washington, Statewide STI Recommendations) and is an integral part of the Evidence-Based Practice (EBP) process to compliment the other plans and avoid duplication of efforts. We approach this by identifying our goals and objectives outlined in section V.

Establishing our research questions helps identify methodologies to observe clusters of priority conditions that may be observed through qualitative and quantitative assessments illustrating observations made by the programs and planning groups, epidemiology, and clinical measures. Selecting the best EBP Tools to reflect outlined indicators using a CQI process can further be used to test and refine the Integrated Plan. For example, a tool could be a dashboard or database only addressing treatment and prevention questions. Other databases may address feedback on treatment, prevention, diagnosis, response, quality improvement, and health equity using Targeted Universalism, an approach to setting universal goals and using targeted processes to achieve those goals.

There are many challenges for fidelity to the Integrated Plan, coming from a variety of sources and directions. These challenges include:

- Staff turnover
- Lack of funding
- Staff capacity limits
- Other priorities (I.e., new condition response, the resurgence of COVID-19 or MPV)
- Lack of successful community engagement for those with the greatest disparities
- Public health workforce losses
- Public health workforce morale and competing priorities
- Lack of community trust
- Planning group member turnover
- Increase of social vulnerability with stigmatization and racist behaviors among those associated with same-sex sexual practices, HIV, STI, drug use, sex work, and sexual and gender minorities

Synchronization across the three strategic plans—Ending the HIV Epidemic, Hepatitis C Free Washington, and Statewide STI Recommendations—identifies coordination of crucial priority areas inclusive of:

- Reducing stigma
- Increasing education and awareness

- Effectively engaging and empowering disproportionately impacted communities to reduce disparities
- Enhancing workforce capacity and culturally affirming care
- Increasing routine screening, rapid linkages, and comprehensive care
- Increasing access and linkage to social supports
- Removing policy, insurance, and financial barriers to care
- Enhancing data systems for detection, engagement, and response
- Increasing prevention efforts, especially for populations at high risk of infection

While a trauma-informed approach to direct services works well within populations experiencing the highest levels of need and is commonly well received by individual clients and moderately to other direct service providers supporting the local continuum of care, systemic level policy changes are not often impacted at this level. With continued attention to building meaningful and effective community engagement combined with active participation with the WSPG, OID direct service providers significant systemic change can produce transformational health outcomes.

Appendix 1: Glossary of Terms and Abbreviations

ABBREVIATIONS

AARTH: African Americans Reach and Teach Health Ministry

AETC: AIDS Education Training Center

AI/AN: American Indian or Alaska Native

AIDS: Acquired Immune Deficiency Syndrome

ACS: American Community Survey

ADAP: AIDS Drug Assistance Programs

CAPP: Care and Antiretroviral Promotion Program

CBO: Community Based Organization

CDCHC: Country Doc Community Health Center

CDC: U.S. Centers for Disease Control and Prevention

CHC-Tacoma: Community Health Center – Tacoma

DBHR: DSHS Division of Behavioral Health and Recovery

DOH: Washington State Department of Health

DSHS: Washington State Department of Social and Health Services

EHE: Ending the HIV Epidemic

eHEPC: Enhanced Hepatitis C Reporting System

FPL: Federal Poverty Level

FQHC: Federally Qualified Health Center

GFS: General Fund State

HCV/Hep C: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

HMC: Harborview Medical Center

HPSG: HIV Planning Steering Group

HOPWA: Housing Opportunities for Persons with AIDS

HRSA: U.S. Health Resources and Services Administration

IDU: Injection Drug User

LGBT: Lesbian, Gay, Bisexual, and Transgender

LHJ: Local Health Jurisdiction

LOOC: Locating Out-of-Care Cases Data System

MMP: Medical Monitoring Project

MOU: memorandum of understanding

MSM: Men Who Have Sex with Men

MWAETC: Mountain West AIDS Education Training Center

NHAS: National HIV/AIDS Strategy

NHBS: National HIV Behavioral System

NHOPI: Native Hawaiian or Other Pacific Islander

OSPI: Washington State Office of the Superintendent of Public Instruction

OTP: Opioid Treatment Program

OUD: Opioid Use Disorder

PHIMS STD: Public Health Information Management System for Sexually Transmitted Diseases

PHSKC: Public Health - Seattle & King County

PLWH: People Living with HIV Infection

PLWDH: People Living with Diagnosed HIV Infection

PrEP: Pre-Exposure Prophylaxis

PWID: Person Who Injects Drugs

QM: Quality Management

RWHAP: Ryan White HIV/AIDS program

RWPA: Ryan White Part A

SAMSHA: Substance Abuse and Mental Health Services Administration

SSP: Syringe Services Program

SUD: Substance Use Disorder

STD/STI: Sexually Transmitted Disease/Sexually Transmitted Infection

TGA: Transitional Grant Area

TSM: Transgender Women Who Has Sex with Men

VL: Viral Load

WIC: Women, Infants, and Children Nutrition Program

YVFWC: Yakima Valley Farmworkers Clinic

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 mL) 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 blood cell 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 given time.

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

Four Strategies- Diagnose, Treat, Prevent, Respond:

- **Diagnose** all people with HIV as early as possible.
- **Treat** people with HIV rapidly and effectively to reach sustained viral suppression.
- **Prevent** new HIV transmissions by using proven interventions (e.g., PrEP and SSPs).
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

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).

Health Equity: (CDC) "Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

The aim of healthcare equity is to ensure that everyone can access affordable, culturally competent health care regardless of:

- Race
- Ethnicity
- Age
- Ability
- Gender identity or expression
- Sexual orientation
- Nationality
- Socioeconomic status
- Geographical location (i.e., rural or urban)

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

HIV Continuum: A public health model that outlines the steps or stages that people with HIV go through from diagnosis to achieving and maintaining viral suppression (a very low or undetectable amount of HIV in the body) through care and treatment.

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.

Holistic: A method that considers multidimensional aspects of wellness, utilizing a whole person approach in structural, social, economic, and environmental factors.

Integrated Plan (IP): Umbrella document that presents recommendations for care and prevention services.

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 to 6 months.

Opioid Treatment Program (OTP): Opioid treatment programs (OTPs) are licensed by the Department of Health (DOH) and use medications for opioid use disorder (OUD) that are approved by the U.S. Food and Drug Administration in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to individuals diagnosed with OUD.

Peri-Urban: is of or relating to an area immediately surrounding a city or town.

Phlebotomy: using a needle to take blood from a vein; drawing blood; venipuncture.

Ryan White HIV/AIDS Program (RWHAP): to improve the quality and availability of HIV care and treatment for low-income people with HIV

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

Syndemic: “A syndemic is a situation in which two or more interrelated biological factors(conditions) work together to make a disease or health crisis worse. The term syndemic was created by medical anthropologist Merrill Singer in the early 1990s”.

Targeted Universalism: A framework that supports the use of targeted approaches to achieve universal goals.

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.

Appendix 2: WSPG Letter of Concurrence

STATE OF WASHINGTON

DEPARTMENT OF
HEALTH

Office of Infectious Disease

P.O. Box 47840 • Olympia, Washington 98504-7840

December 8, 2022

Centers for Disease Control and Prevention, 1600 Clifton Road NE, Atlanta, GA 30333

DHHS/HRSA/DSHAP, 5600 Fishers Ln, Rockville, MD 20847

RE: Letter of Concurrence between Washington State Planning Group and Washington Department of Health

Dear HRSA/HAB and CDC Leadership:

The Washington State Planning Group concurs with the following submission by the Washington State Department of Health (WADOH) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The Washington Syndemic Planning Group (WSPG), comprised of twenty-three members, have reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The WSPG concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

Over the course of two meetings, opportunities were provided to reflect and review the goals and objectives outlined within the Integrated HIV Prevention and Care Plan, including the SCSN. Copies were sent out, in draft form, to all members for review and delivery of feedback, and two meetings were held to further discuss and provide clarifications to questions and comments from the WSPG. To gauge the members' consensus level, a poll was distributed twice, with one meeting dedicated to clarifications by WADOH staff.

The signatures below from the Washington State Planning Group tri-chairs confirm the concurrence of the full WSPG with the Integrated HIV Prevention and Care Plan.

Signatures:

JJ Baker		
JJ Baker	Monte Levine	Elizabeth Crutsinger-Perry

Washington Syndemic Planning Group Tri-Chairs

Thank you,

Elizabeth Crutsinger-Perry, MSSW, MA Director, Office of Infectious Disease Washington State Department of Health

Appendix 3: Seattle TGA Letter of Concurrence

Officers:
Katie Hara
Michael Louder

Members:
Andrew Ashiofu
Amber Casey
Hector Urrunaga Diaz
German Galindo
Ray Harris
Eve Lake
Patricia Ogunmola-Nazzal
Ron Padgett
Richard Prasad
John Rodriguez
Genie Sheth
Lina Stinson-Ali
Gladys Wiessner

Centers for Disease Control and Prevention
1600 Clifton Road NE
Atlanta, GA 30333

DHHS/HRSA/DSHAP
5600 Fishers Ln
Rockville, MD 20847

November 28, 2022

Dear HRSA/HAB and CDC Leadership:

We write on behalf of the Seattle Transitional Grant Area's HIV Planning Council. The Planning Council concurs with the submission of the Integrated HIV Prevention and Care Plan (Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The SCSN and Plan were created by a collaborative process of the HIV planning bodies in Washington State. The Planning Council had an opportunity to reflect and review the goals and objectives outlined within the Plan and SCSN.After reviewing the Plan and SCSN, the Planning Council can verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The Council also concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Ryan White HIV/AIDS Program legislation and program guidance.

Sincerely,

Katie Hara
Co-Chair

Michael Louder
Co-Chair

Appendix 4: Office of Infectious Disease – Logic Model