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Office of Infectious Disease
Washington State Department of Health



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Integrated HIV Prevention and Care Plan

Goals

Governor Inslee’s Proclamation to End AIDS in Washington

Washington State is in an exciting position to build on the strong foundation of public and private investment to keep people living with HIV (PLWH) healthy and prevent new HIV infections. We can address the social determinants of health and substantially reduce racial and ethnic disparities in health outcomes. By maintaining our state’s efforts to deliver treatment and care to everyone living with HIV, by focusing our efforts on breaking down silos between systems and removing barriers to care, by prioritizing communities of color and other underserved populations, and by inspiring communities to put these recommendations into action Washington will cut the HIV diagnosis rate in half by 2020, reduce HIV-related disparities, and significantly improve the health and wellbeing of PLWH.



On World AIDS Day (December 1, 2014), Governor Inslee issued a proclamation to End AIDS in Washington, and set a goal of reducing new HIV diagnoses by 50% by 2020 and reducing disparities in health outcomes for PLWH. The proclamation builds on the National HIV/AIDS Strategy (NHAS) and seeks to leverage opportunities within the Healthier Washington framework. NHAS is the nation’s first-ever comprehensive, coordinated HIV/AIDS roadmap with clear and measurable targets. Healthier Washington is an initiative focused on helping people experience better health throughout their lives and receive better—and more affordable—care when they need it.

Without a cure it is not possible to completely eradicate HIV in our state. A significant reduction in new diagnoses and in HIV-related disparities, along with an increase in percentage of people diagnosed with HIV who have suppressed viral loads will greatly reduce the impact of AIDS in Washington State, while improving the quality of life for those living with HIV. Governor Inslee’s proclamation is a bold commitment to expediting an end to the HIV epidemic, improving the health and quality of life for PLWH, reducing new diagnoses, and reducing disparities in health outcomes.

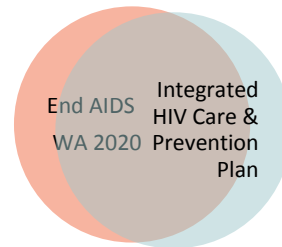
NHAS 2020

1. Reduce New Infections
2. Increase Access to Care and Improve Health Outcomes for People Living with HIV
3. Reduce HIV-Related Health Disparities and Health Inequities
4. Achieve a More Coordinated National Response to the HIV Epidemic

End AIDS Initiative Relationship to the Integrated Plan

The proclamation tasked the HIV Planning Steering Group (HPSG), the statewide HIV care and prevention planning body, with overseeing a task force to put forward a set of recommendations on how the state can achieve the goals of the proclamation. The HPSG established the End AIDS Steering Team (“Steering Team”) to engage in a community input process and draft the initial set of recommendations. The Steering Team included PLWH, staff members of Community-Based Organizations (CBOs), CBOs, an HIV medical provider, a representative of the Seattle Transitional Grant Area (TGA) HIV Planning Council, public health representatives, and community members from Eastern and Western Washington.

The End AIDS Initiative became the foundation of the Integrated HIV Care and Prevention Planning Process. The Initiative focuses on change at the broad based systems level and the Plan focuses on implementation at the programmatic level. They share the same goal and are organized around the same eleven concepts. Successful implementation of the Plan’s strategies creates a synergistic response which will bring us closer to ending the HIV epidemic in Washington State.



End AIDS Washington represents the investments required from multiple sectors. The Integrated HIV Care and Prevention Plan represents the investment contributed by the HIV Prevention and Care Service Delivery System at the Washington State Department of Health and the Seattle TGA. Successful implementation of End AIDS Washington will require collaboration across sectors and groups. The Recommendations identify the following agencies and communities as leaders for the work:

- PLWH and members of communities affected by HIV
- Governor’s Office
- Washington State Legislature
- Washington State Department of Health (DOH)
- Healthcare Organizations and Systems
- Health Care Authority (HCA)
- Office of the Insurance Commissioner (OIC)
- Office of the Superintendent of Public Instruction (OSPI) and Local School Districts
- Housing Opportunities for People with AIDS (HOPWA) grant program
- Affordable Housing Sector
- Local Health Jurisdictions (LHJs), Local Governments, and Service Providers
- Seattle TGA HIV Planning Council (Planning Council)
- Washington HIV Planning Steering Group (HPSG)

The end of AIDS is possible. Until there is a cure, Washington State is committed to innovative and collaborative public and private sector interventions to reach every person living with and at high risk for HIV to provide the tools and resources needed to protect their health and wellbeing, to measurably reduce HIV-related disparities, and to prevent new HIV diagnoses. Washington will continue to be a model for other states and jurisdictions as they tackle their HIV epidemics.

This plan will rely on passionate and inspired leadership from all sectors and communities, the willingness and capacity for self-reflection, and a commitment to honoring the fundamental humanity of every person touched by HIV to end the epidemic. Washington State has these key ingredients and looks forward to the day when we can all celebrate the end of AIDS.

End AIDS WA 2020 | Integrated HIV Prevention and Care Plan

1. Reduce by 50% the rate of new HIV diagnoses
2. Increase to 80% the percentage of people living with HIV who have a suppressed viral load
3. Reduce by 25% the age-adjusted mortality rates among people living with HIV
4. Reduce HIV-related health disparities among people living with HIV
5. Improve quality of life among people living with HIV



The goals of Integrated HIV Care Plan align with the goals of the End AIDS 2020 Initiative.

Objectives

End AIDS WA 2020 | Integrated HIV Prevention and Care Plan

1. Reduce by 50% the rate of new HIV diagnoses
2014 baseline: 6.3 new HIV diagnoses per 100,000
2020 target: ≤ 3.2 new HIV diagnoses per 100,000
2. Increase to 80% the percentage of people living with HIV who have a suppressed viral load
2014 baseline: 68% suppressed
2020 target: $\geq 80\%$ suppressed
3. Reduce by 25% the age-adjusted mortality rates among people living with HIV
2014 baseline: 2.2 deaths per 100,000
2020 target: ≤ 1.7 deaths per 100,000
4. Reduce HIV-related health disparities among Black and Hispanic people living with HIV, and PLWH aged 45 and older
 - a. Reduce by 50% the absolute difference between HIV diagnosis rate among U.S. born Black residents and the statewide HIV diagnosis rate
2014 Baseline: Rate difference of 14.6 cases per 100,000
2020 Target: Rate difference of ≤ 7.3 cases per 100,000
 - b. Reduce by 50% the absolute difference between HIV diagnosis rate among foreign born Hispanic residents and the statewide HIV diagnosis rate
2014 Baseline: Rate difference of 8.9 cases per 100,000
2020 Target: Rate difference of ≤ 4.5 cases per 100,000
 - c. Reduce by 50% the absolute difference between the average inter-test interval among newly-diagnosed foreign born Black residents and the interval among all new HIV diagnoses
2012-2014 Baseline: Inter-test interval difference of 729 days
2020 Target: Inter-test interval difference of ≤ 365 days
 - d. Reduce by 50% the absolute difference between the average inter-test interval among newly-diagnosed individuals ages 45 and older and the interval among all new HIV diagnoses
2012-2014 Baseline: Inter-test interval difference of 708 days
2020 Target: Inter-test interval difference of ≤ 354 days
 - e. Reduce by 50% the absolute difference between the percentage of newly diagnosed U.S. born Black residents who are linked to HIV medical care within 30 days of diagnosis and the percentage linked among all new HIV diagnoses
2012-2014 Baseline: Difference in percentage linked of 4.1%
2020 Target: Difference in percentage linked of ≤ 2.0

- f. Reduce by 50% the absolute difference between the percentage of foreign born Hispanic people living with HIV who are engaged in HIV medical care and equivalent percentage among all people living with HIV
 - 2014 Baseline: Difference in percentage engaged in care of 14.5%
 - 2020 Target: Difference in percentage engaged in care of $\leq 7.3\%$

- g. Reduce by 50% the absolute difference between the percentage of U.S. born Black people living with HIV who have achieved viral load suppression and the percentage among all people living with HIV
 - 2014 baseline: Difference in percentage suppressed of 8.1%
 - 2020 target: Difference in percentage suppressed $\leq 4.0\%$

- h. Reduce by 50% the absolute difference between the percentage of foreign born Hispanic people living HIV who have achieved viral load suppression and the percentage among all people living with HIV
 - 2014 baseline: Difference in percentage suppressed of 10.5%
 - 2020 target: Difference in percentage suppressed $\leq 5.2\%$

- 5. Improve quality of life among people living with HIV
 - a. Improve general health indicators: Percentage of people living with HIV who rate their overall health as good, very good, or excellent
 - 2014 Baseline: 81.1%
 - 2020 Target: $\geq 82.0\%$

 - b. Decrease health-related disability days: Mean number of days in which poor physical or mental health prevented normal activities among people living with HIV
 - 2014 Baseline: 3.6 days
 - 2020 Target: ≤ 3.0 days

 - c. Increase number of healthy days. Summary index of healthy days: Mean number of healthy days reported over past 30 day period
 - 2014 Baseline: 19.8 days
 - 2020 Target: ≥ 22.0 days

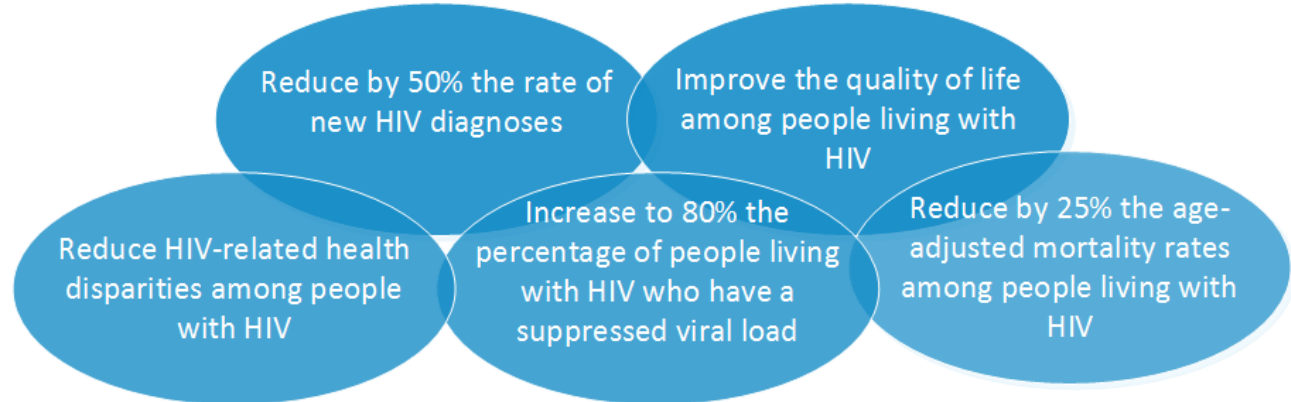
Calendar year 2017-2020 is implementation of plan

Calendar year 2021 is reviewing progress and revising plan as necessary



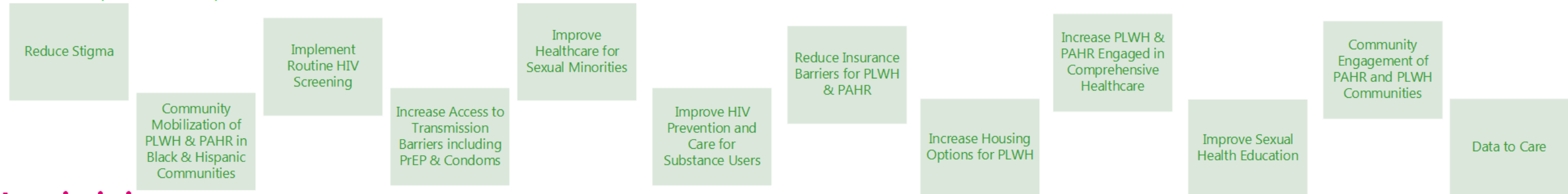
Goals

If we are successful we will



Strategies

We will implement these policies and actions



Activities

We will complete these tasks

<p>Implement We-R- One Campaign</p> <p>Implement quality improvement to identify and measure stigma.</p> <p>Allocate funding for stigma project(s)</p> <p>Promote inclusion of gender identity and sexual orientation into routine medical history</p> <p>Prioritize and allocate resources to programs of, by and for the populations experiencing the greatest levels of stigma-induced disparities (TGA)</p>	<p>Allocate Funding (DOH) Prioritize Funding (TGA) for US Born Black, Foreign Born Black, & Foreign Born Hispanic PLWH Targeted</p> <p>Testing & Linkage program for Foreign Born Hispanics</p> <p>Technical assistance on NQC disparity tool</p> <p>Specific linkage to care services for justice involved PLWH</p> <p>DOH & PHSKC dedicate staff</p> <p>Position inside DOH/OID dedicated to HIV -related health disparities and stigma</p> <p>OID level SEW Foreign Born Black-Foreign Born Hispanic & US Born Black</p> <p>Increase work against institutional racism</p> <p>Ensure that programmatic decisions are driven by diverse PLWH and PAHR</p>	<p>Allocate funding for HIV testing in non-clinical sites</p> <p>Provide guidance and resources related to the HIV Opt Screening legislation (SSB 5728).</p> <p>Educate patients and providers regarding HIV screening in conjunction with STD screening</p> <p>Use HIV surveillance data to optimize outreach services</p> <p>Utilize Outreach and EIS to reach disproportionately affected, historically underserved communities and bring them into testing (TGA)</p>	<p>Administer PrEP DAP</p> <p>Implement case management for PAHR</p> <p>Recruit PrEP providers</p> <p>Train external partners on "Paying for PrEP"</p> <p>Develop statewide PrEP referral system</p> <p>Increase PrEP training and consultation through ProjectECHO</p> <p>Maintain PrEP provider database</p> <p>Provide integrated HIV/ STD field services</p> <p>Develop a new condom distribution plan</p> <p>Convene OID level SEW for gay and bi Black men to address lack of PrEP access.</p> <p>Conduct PrEP DAP evaluation as well as statewide PrEP evaluation to understand barriers, knowledge, usage, risk factors.</p>	<p>Ensure that DOH funded medical services are culturally relevant for Gay/Bi/Trans (GBT) PAHR & PLWH</p> <p>Fund Open Access Clinic(s)</p> <p>Allocate funding for health care navigation for PLWH & PAHR</p> <p>Promote/advocate for GBT cultural competency for providers</p> <p>Provide integrated HIV/ STD field services</p> <p>Promote/Advocate for GBT safety in behavioral health providers agencies (TGA)</p>	<p>Support Syringe Services Programs</p> <p>Allocate funding for substance abuse out patient treatment outside TGA</p> <p>Provide integrated HIV/ STD field services</p> <p>Ensure ADAP formulary is inclusive of opioid replacement therapies</p> <p>Allocate funding for harm reduction, pre-treatment and post-treatment support to PLWDH (TGA)</p>	<p>Administer Early Intervention Program ADAP</p> <p>Administer PrEP DAP</p> <p>Identify and link EIP (ADAP) clients who are eligible to Medicaid</p> <p>Provide integrated HIV/ STD field services</p> <p>Allocate funding for health care navigation for PLWH & PAHR.</p> <p>Advocate for reduction on copayment costs for HIV and PrEP related medical care.</p> <p>Ensure health plan formularies include all HIV ARVs as well as PrEP medications.</p> <p>Collaborate with OIC to ensure health plans formularies, practices and fees are non-discriminatory</p>	<p>Allocate PLWH funding for housing</p> <p>Work collaboratively with HOPWA grantee to provide the best mix of housing options and services throughout the TGA</p> <p>Allocate funding for Stable Housing to DV Survivors living with HIV</p> <p>Provide targeted housing funding to PLWH for populations experiencing HIV related health disparities in Pierce County</p> <p>Allocate funding for Housing Case Management (NMCM) in the TGA</p> <p>Transitional and Emergency Housing (TGA)</p>	<p>Administer Early Intervention Program ADAP</p> <p>Variable intensity case management services based on need for PLWH & PAHR</p> <p>Allocate funding to NMCM to locate PLWH out of care(TGA)</p> <p>Allocate funding to comprehensive oral health care (TGA)</p> <p>Allocate funding for wraparound services</p> <p>Title XIX Case Management</p> <p>Recruit PLWH co-infected with HCV into HCV treatment</p> <p>Satellite clinics for geographic diversity</p> <p>Provide integrated HIV/ STD field services</p> <p>Provide targeted services for PLWH over 50</p> <p>Healthcare navigation for PAHR & PLWH</p>	<p>Staff DOH HIV/STD phone line.</p> <p>Provide technical assistance to LHJs</p> <p>Provide integrated HIV/ STD field services</p> <p>Increase LGBTQ youth sexual health education programming</p> <p>Review and certify curricula for medical accuracy</p>	<p>Convene OID level SEW Foreign Born Black-Foreign Born Hispanic & US Born Black</p> <p>Outreach to Black & Hispanic PLWH to link to EIP (ADAP) and third party insurers</p> <p>Improve We-R- One Campaign</p> <p>Promote leadership of PLWH and communities disproportionately impacted by HIV</p> <p>Ensure that programmatic decisions are driven by diverse, unaligned PLWH & PAHR</p>	<p>Use HIV surveillance data to identify and locate persons not receiving optimum HIV care</p> <p>Use HIV surveillance data to link or re-engage PLWH to care</p> <p>Provide integrated HIV/ STD field services</p>
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Health Disparities – Implement strategy specific activities related to reducing HIV-related health disparities

Stigma – Implement strategy specific activities related to reducing stigma

Synergy

The goals, objectives, strategies, and activities were developed through a concerted community effort engaging all components of the Washington State HIV Planning System as well as consumer/customer surveys, focus groups, and town hall meetings. The result was a plan which relies heavily on the execution of recommendations, which will allow us to achieve a total of five goals and their associated objectives. It is our hypothesis that achieving these goals will end the HIV epidemic in Washington State.

syn·er·gy

'sinərdʒi/ Noun

The interaction of two or more agents to produce a combined effect greater than the sum of their separate parts

Strategies/Activities

Reduce Stigma Experienced by PLWH and PAHR

People living with HIV and individuals from communities affected by HIV often experience HIV-related stigma, as well as a number of other stigmas including those related to race, sexuality, gender identity, poverty, mental health status, or substance use. Stigma can be experienced in social and family settings, schools, health care systems, faith-based organizations, communities, social service agencies, the criminal justice system, and more. While HIV-related stigma may be on the decline, a significant number of End AIDS survey respondents reported that stigma in multiple forms remains a significant barrier to HIV testing, staying retained in care, disclosing HIV status, initiating and sustaining Pre-Exposure Prophylaxis (PrEP) use, and overall quality of life.

In order to implement this strategy a serious effort must be made by government, health care providers, behavioral health providers, community-based organizations, faith communities, and the broader society to address and reduce stigma experienced by PLWH and individuals at risk for HIV. We must do more to create environments and services that support lesbian, bisexual, gay, and transgender (LGBT) individuals, persons in some highly affected communities of color, and other persons affected by the various forms of stigma which foster HIV transmission.

In many historically underserved and disproportionately affected communities, stigma can be a significant barrier to testing, getting into and staying engaged in care, and addressing co-occurring issues such as substance use. Services created early in the epidemic which focused on reducing stigma in some communities have not been successful in addressing stigma in other communities. Identifying new partners who are imbedded in these disproportionately stigmatized communities is key to reducing disparities in health outcomes in populations where they are seen the most: foreign born Blacks, African Americans, and Hispanics.

Activities

- **Implement We Are 1 Campaign**

We Are 1 is a regional health and wellness brand focusing on Men Who Have Sex with Men (MSM) in King, Pierce, and Snohomish Counties. DOH and the rest of the health collaborative take a holistic, health wellness messaging approach to address what amounts to a staggering disparity in health status for this population. The We Are 1 brand goals include:

- Respond to DOH Strategic HIV Prevention Framework
 - 25% reduction in HIV incidence in WA State
 - 50% reduction in incidence in MSM in Seattle and secondary urban areas
 - Respond to CBO needs
 - Respond to holistic health needs of MSM
 - Create continuity of messages between counties
 - Create synergies to increase efficiency, impact, and outcomes
 - Add supplemental/enhanced value to campaigns

Participating agencies include Center for Multicultural Health, Entre Hermanos, Lifelong, Gay City, Gender Justice League, Pierce County AIDS Foundation, Public Health–Seattle & King County (PHSKC), Seattle Counseling Service, Snohomish Health District, Tacoma-Pierce County Health Department, and Washington State Department of Health.

Campaigns have included a brand launch, Affordable Care Act and health insurance enrollment, PrEP, and HPV vaccine.

- **Implement quality improvement to identify and measure stigma**

DOH will work with clinics and case management agencies to implement a standardized tool for measuring stigma among health service staff. Complete information about the tool and how it works to reduce stigma and discrimination in health facilities is located at <http://www.healthpolicyproject.com/index.cfm?id=stigmabpackage>

- **Allocate funding to stigma projects**

Allocate funding for projects specifically designed to address different types of stigma in impacted communities.

- **Promote inclusion of gender identity and sexual orientation into routine medical history**

- Conduct SEW group to better understand HIV related stigma issues from community members.
- Accumulate existing and most relevant stigma related research and data to inform work in Washington State.
- Partner with national organizations conducting stigma efforts in order to incorporate these efforts in Washington State.
- Create a position inside DOH/Office of Infectious Disease (OID) dedicated to addressing HIV related health disparities and stigma.
- Develop an implementation plan for stigma reduction, based on current research and national efforts.

- Promote “best practice” examples of appropriate language and forms validated by community representatives to clinical provider groups, health plans, and private providers.
 - Make new curricula on orientation and gender identity available for continuing education to targeted providers.
 - Work with the clinical provider community to consider the value of a “center of excellence” approach to provide culturally appropriate whole person health care to individuals who identify as gay or transgender.
- **Allocate resources to programs of, by and for the populations experiencing the greatest levels of stigma-induced disparities in the Seattle Transitional Grant Area (TGA).**
 - Allocate resources to Outreach programs focused on foreign born Blacks from Ethiopia and Eritrea, countries which account for 62% of foreign born Black diagnoses in the TGA. This service works within these high prevalence communities to make HIV testing normative and associated with other positive health behaviors. After testing positive and getting linked to care, foreign born Blacks are highly engaged.
 - Allocate resources to Early Intervention Services (EIS) focused on justice involved African Americans. Based on statistics in King County and Washington State, U.S. born Blacks are five to six times more likely to have involvement with the criminal justice system, and men are much more likely to be justice involved than women. U.S. born Blacks in the TGA are three times more likely to have HIV than their White counterparts, and men comprise the majority of HIV cases.
 - Allocate resources to Psychosocial Support Services focused on women with HIV. While women are only 13% of PLWH in the Seattle TGA, their demographic characteristics are quite different from men. Over half of women living with HIV in the TGA are Black, and one third of Blacks living with HIV in the TGA are women. Stigma is a factor in seeking and staying in care for women, women are less likely to know other people with HIV and, upon diagnosis are much less likely to have information about the disease. Psychosocial Support helps women with HIV make connections with each other for support, community and information.

Community Mobilization of PLWH & PAHR in Black & Hispanic Communities

The HIV epidemic has affected some groups much more than others. To understand how these disparities affect people in Washington State, the Department of Health convened a Special Emphasis Workgroup on HIV-Related Disparities (SEW-D) to examine the statewide data in more detail. The SEW's report was published in February 2015.ⁱ

The SEW recognized the relationship of health disparities to the larger social context: *“HIV-related health disparities do not exist in isolation. They are part of a larger system of inequities that exists. They are compounded and exacerbated by one’s daily experience of injustice. As the...Health Disparities SEW...convened as part of the Washington State HIV Planning System we recognize our role in identifying and proposing strategies directly related to the provision of HIV related services. However, it is our belief that achieving the vision described in the National HIV /AIDS Strategy will require a paradigm shift. It will require a social justice approach that looks not only at specific indicators of inequality but also attempts to address issues broadly associated with the social determinants of health.”*

The SEW examined Washington’s HIV-related data associated with race and ethnicity, U.S.born v. foreign born, gay/bisexual men vs. heterosexual men and women, geography, age, and specified social determinants of health (income, education, and poverty). The SEW-D identified the following specific disparities:

1. Overall: gay and bisexual men of all races/ethnicities, compared to heterosexual men, experience a disparity for HIV infection of more than 150:1. This disparity is being addressed in detail in the work being done within the current HPSG framework.
2. U.S. born Black residents experience disparities in participation in prevention (including PrEP utilization) and testing, in being linked to care, in retention in care, and in viral load suppression. This tells us that the entire care continuum, starting with prevention, needs to be improved for U.S. born Blacks. Disparities for U.S. born Blacks compared to Whites are 4:1 for HIV infection. Seventy-seven percent of U.S. born blacks, once diagnosed, are linked to care, compared to 90 percent of Whites. The data show that U.S. born Blacks experience lower rates of retention in care and, as a result, are ten percentage points less likely to be virally suppressed than other groups.
3. Foreign born Black residents experience disparities in the number of late diagnoses. Foreign born Blacks are 100 times more likely to be infected than Whites and most likely to have been infected in their home countries, so testing as soon as possible after arriving in the U.S. would help address the disparity for HIV infection for foreign born Blacks.
4. Foreign born Hispanics also experience higher numbers of late diagnoses, lower levels of retention in care, and lower levels of viral load suppression (much of the care continuum).

5. Foreign born Hispanics are three times more likely to be infected than Whites and are at elevated risk for late HIV diagnosis (43% diagnosed with AIDS within 12 months of HIV diagnosis) and have a low level of viral suppression (55%) relative to non-Hispanic Whites. These facts prompt a new emphasis on HIV prevention, testing, and retention in care for this disproportionately affected population. There is enough qualitative data to suggest that enough of these infections take place in the U.S. to warrant added emphasis on prevention. People whose status in the U.S. is undocumented have greater challenges in accessing health care in general, which must be addressed if undocumented people are to have access to prevention and stay retained in care.
6. Younger adults (ages 18-35) show lower rates of retention in care. Approximately 51 percent of younger adults are retained in care, compared to 58 percent total.
7. In addition, specific geographic areas were identified as “hot spots” for HIV infection, related to education and income levels of residents. This geocoded information needs further analysis to verify “hot spots” for HIV infection, for use in targeting prevention/testing efforts.

The Seattle TGA, in tandem with the work of the SEW-D (which included Council members) has taken a deeper dive look at disparities along the care continuum within the TGA, and the barriers that exist in eliminating those disparities. Disparities within the TGA that differ from those within the State as a whole include:

1. All racial and ethnic groups besides Whites have significantly higher rate of late diagnosis.
2. The TGA itself is a “hot spot” of HIV infection in the State, but not all parts of the TGA are created equal. King County has the greatest burden of disease in the State, with 57% of new diagnoses 2010-2014, and 55% of prevalent cases in the state. The rate of new diagnosis in King County is 14.4 per 100,000, more than double the rate of the next most impacted county, and three times the rate of the other two counties in the TGA. King County has some of the wealthiest as well as some of the poorest census tracts in the State. As with the rest of the state, additional analysis of geocoded information is needed.

The Seattle TGA HIV Planning Council recognized that it needed to look at every aspect of the service system to make lasting change, starting with itself. While the Council has had trainings on social determinants of health for many years, the Council decided training on root causes was needed.

Activities

- **Allocate funding for US Born Black, Foreign Born Black, & Foreign Born Hispanic PLWH**
Annually, DOH allocates \$1,000,000 for case management and other services that target HIV-positive populations experiencing health disparities: U.S. born Blacks, foreign born Blacks, and foreign born Hispanics. For persons at high risk for HIV infection, DOH will allocate funds proportionately to populations experiencing disparate outcomes across the care continuum. These populations include all races and ethnicities of men who have sex with men, including transgender persons who have sex with men, U.S. born Blacks, foreign born Blacks, and foreign born Hispanics.

- **Allocate funding in the Seattle TGA for US and Foreign Born Blacks and Hispanics in grant years 2017 and 2018, and expand to additional populations in future years, based on data and lessons learned.**

Foreign-born Blacks have a significant late diagnosis rate, but once tested and connected to care stay engaged and get rapidly to viral suppression. The Seattle TGA has funded Outreach for foreign born Blacks to address the stigma that prevents these communities from testing. One strategy that is being and will continue to be used in the foreign born Black communities in the TGA is community-based health councils. Through pairing Ryan White Part A funding with other funding sources, community-based health councils have been created. This is a strategy for investing communities with the authority and resources to address public health issues in the ways that are most successful for them.

U.S. born Blacks have poorer outcomes across the care continuum. The Seattle TGA has allocated funds to Early Intervention Services for U.S. born Blacks to normalize testing, and Non-Medical Case Management (NMCM) for U.S. born Blacks to re-engage those who are out of care and keep them retained in care.

The TGA will look at the possibility of creating EIS or Outreach programs for U.S. and foreignborn Hispanics in future years.

Targeted NMCM works with U.S. and foreign born Hispanics who are in and out of care to increase and normalize engagement in care and treatment adherence. It also finds people who fall out of care, and re-engages them.

- **Allocate Targeted Testing & Linkage program in Central Washington for Foreign Born Hispanics.**

Annually, DOH allocates \$50,000 to address health disparities in foreign born Hispanics living in Yakima, Richland, Pasco, and Kennewick. With these funds, DOH is primarily focusing on testing and linkage to care services for foreign born Hispanics in these areas.

- **Provide technical assistance on implementing and adapting NQC disparity tool.**

The National Quality Center (NQC) has developed an Excel-based tool to help HIV care providers identify disparities in their client population. The tool can help providers prioritize program activity to areas of highest disparity. DOH will work with HIV care providers to implement this new epidemiologically-based tool.

- **Provide specific linkage to care services for justice involved PLWH.**

DOH contracts with Washington State Department of Corrections (DOC) to fund DOC's Community Linkage and Coordination Program. The goal of this program is to improve coordination of care for HIV-positive inmates transitioning into the community. The Community Linkage and Coordination Program Coordinator links inmates to primary medical care and case management services in the community, helps a releasing inmate complete his or her Medicaid and ADAP applications, and provides HIV prevention counseling.

In the Seattle TGA, an Early Intervention Service (EIS) initiative will be funded focused on justice involved African Americans. Partnering with another program for those who are justice involved, participants will receive HIV education and testing. Those testing positive will be immediately linked to care. Key to this strategy is using a variety of funding sources in addition to HIV funding, so that HIV education and testing can be provided within the context of whole person health to reduce the effects of stigma. Having these services provided by agencies that are part of the African American community, even if HIV work is new to them, will be key to developing trust. Additionally, City of Seattle dollars are used to provide specialized release planning for PLWH in the King County jail system to ensure a strong pre-release connection is made with medical providers, case managers and others.

- **DOH and Public Health – Seattle & King County (PHSKC) dedicate staff**
DOH will allocate staff time specifically focused on the implementation of community mobilization plan activities with People of Color Living with HIV and People of Color at High Risk of HIV infection.

- **Ensure that programmatic decisions are driven by diverse, unaligned PLWH**
In the Seattle TGA, the Planning Council will continue to include greater than 33% unaligned PLWH, and those consumer members (and the Council as a whole) will reflect the epidemic in the area, with special emphasis given to historically underserved populations. While Ryan White does not ask Planning Councils to report on nativity, the Seattle Planning Council has determined that, especially in the Black population, this is important. Therefore, the Council tracks U.S. and foreign born Black Council members separately, and ensures that both are proportionately represented. To improve consumer participation and success, additional outreach and training will be provided to create interest among consumers in participating, and help them to be more successful in the process. Unaligned consumers bring a perspective to assessment, prioritization, allocation and service design that is essential for the success of programs. While we have much data, and much of it comes from consumers, it is critical to have consumers present to “truth” the data. The grantee will also ensure that consumers are participants in RFP review panels, once again bringing an on-the-ground reality check to the process. The TGA will update the visual representations of the data to make them more understandable to all Council members. In particular, additional analysis and design of data presentations related to socio-economic status and geocoding will be created to help the Council better target resources within the TGA.

- **Create a position inside DOH/OID dedicated to better understand and addressing HIV -related health disparities and stigma which have been identified among three select populations:**
 - foreign born Black residents
 - foreign born Hispanic residents
 - U.S. born Black residents of Washington State

To achieve this, OID will take advantage of the state’s HIV Planning System and convene a series of HIV Special Emphasis Workgroups (SEWs). These groups are informal, ad-hoc advisory bodies which are comprised of community members and subject matter experts. Their purpose is to identify specific and effective implementation strategies that add operational values to HIV prevention, care, and continuum activities. For example, in early 2015, the first HIV-Related Special Emphasis Workgroup met and produced a detailed (albeit high level) report identifying and prioritizing which inequalities DOH should address as soon as possible.

- **Increase knowledge about and work against institutionalized racism.**
 - The Seattle TGA Planning Council strives not only to reflect the epidemic within the TGA, but to over-represent disproportionately affected communities. Having these voices at the table in an ongoing way means that the focus on disparities is not lessened over time. However, it is also critically important for the Council, Council staff, health department staff, and all service providers to move beyond the limited “diversity” or “cultural competency” framework, and use an equity and social justice (ESJ) lens in order to address the underlying problems, and thereby lessen inequities. All PLWH have interactions with multiple service providers so each of those services must be welcoming, safe, and responsive to those populations which have been historically underserved in HIV care. Toward this end the Council has already taken several steps:
 - Set a requirement for ESJ training as part of the general standards of care Part A sub-recipient agencies and their staff.
 - Had trainings with the Council on social determinants of health, implicit bias, understanding the difference between diversity, cultural competence and equity, leading with a race lens, and other topics.
 - Formed an equity workgroup to create ongoing content on these topics for each Council meeting.
 - Requested disparity data presented in various visual formats for use in prioritization, allocation, and directive-setting.

Future actions will include utilizing the expertise that exists within King County:

- Institute within all Council processes a question at each decision point, “How will this decision impact disparities?”
 - Work with the King County Equity and Social Justice Initiative, and the City of Seattle Race and Social Justice Initiative to develop trainers who can assist sub-recipient agencies in on-going training for their staff. Council staff are currently trainers for these initiatives, and will adapt existing train-the-trainer curricula.
 - Develop specific curricula that “connect the dots” between other social determinants of health and HIV, which can be delivered throughout the state.
 - In year two of the plan, do a “business as usual” assessment, determining which processes, documents, bylaws, etc. in the Planning Council disadvantage non-dominant culture participants. Make adjustments to these things to make Council processes more equitable. Make a document showing the results, and encourage agencies to do a similar assessment related to their services.
- **Convene OID level SEW for gay and bi Black men to address lack of PrEP access**

Implement Routine, Standardized HIV Screening

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

One in Ten Washingtonians Living with HIV Are Undiagnosed

Too many PLWH are unaware of their infection. DOH estimates that approximately one in ten PLWH in the state are undiagnosed. These individuals face the adverse health effects of untreated HIV infection and have the potential to unknowingly transmit HIV to others. In many instances, undiagnosed persons may not identify themselves as being at high risk for HIV, or may encounter stigma that inhibits them from testing or revealing risk behaviors to medical providers.

Determining how to utilize limited testing resources, and increasing overall testing, paid for by other funding sources is important in getting the State to its goals. While attention has historically been given to populations with the highest behavioral risk factors, and highest levels of seropositivity, looking at late diagnosis (defined as having an AIDS diagnosis within one year from HIV diagnosis) is also an important way to target limited resources. There is a statistically significant difference between foreignborn Black and foreignborn Hispanic Washington residents and their White counterparts with respect to late HIV diagnosis. The Special Emphasis Workgroup report on disparities noted that 43% of foreignborn Hispanics, and 40% of foreignborn Blacks had a late diagnosis compared to 33% of Whites. Similarly, older residents are also more likely to have a late diagnosis than their younger counterparts. Finally, income was closely related to both rates of HIV and with late diagnosis. Residents living in the lowest income census tracts had higher HIV rates, and higher instances of late diagnosis, regardless of other demographic characteristics. Within the Seattle TGA, where late diagnosis rates for White residents are lower than for the State as a whole (26%), all other racial and ethnic groups have a higher rate of late diagnosis, including Asian/Pacific Islanders (33%).

Additionally, HIV testing offers medical providers the opportunity to discuss and, if appropriate, prescribe PrEP to at risk HIV-negative individuals.

Activities

- **Allocate funding for HIV testing in non-clinical sites**
To reach populations at high risk for HIV infection, funded sites are expected to employ strategic targeting and recruitment efforts, reach targets for key program indicators, and monitor service delivery to ensure targeted testing is achieving program goals. Funded sites are expected to use HIV testing technologies that are the most sensitive, cost-effective, and feasible for use at their agency. Funded providers are expected to present confidential HIV testing as the default option for all persons requesting a HIV test. Funded providers are expected to establish partnerships with organizations that offer essential follow-up services.
- **Provide guidance and resources related to the HIV Opt-Out Screening legislation (SSB 5728)**
- **Educate patients and providers regarding HIV screening in conjunction with STD screening**

DOH will work collaboratively with the Mountain West AIDS Education and Training Center (AETC) to conduct webinars for clinical providers regarding HIV Opt out Screening legislation and STD screening guidelines. They will work with clinical mentors to ensure providers have knowledge of HIV and STD screening guidelines as well as practical application tools to best understand how to effectively incorporate these guidelines into clinical practice.

- **Use HIV Surveillance data to optimize outreach services**

The OIA Assessment Unit (AU) works closely with HIV prevention and care program staff and community planners to assess levels of service need to determine which populations have the greatest need. To achieve this, the AU epidemiologists attend programmatic and planning meetings, produce maps and other statistical data products, and provide technical consultation in order to inform decision-making and implementation of effective outreach activities.

- **Utilize Outreach and EIS in the Seattle TGA to reach disproportionately affected, historically underserved communities and bring them into testing**

Part A dollars are not used for testing within the TGA, as sufficient other resources exist. However, the Planning Council has identified PAHR who do not test due to stigma, discomfort with other testing programs, or lack of awareness of risk. Through narrowly targeted programs, those who do not know their status will be found, supported to learn their status, and helped to get into and stay in care using Outreach and EIS programs.

Increase Access to Transmission Barriers including PrEP & Condoms

PrEP

Over the last three decades, individuals at highest risk for HIV infection have substantially changed their behaviors in order to protect themselves and their sex partners. In particular, the emergence of the HIV epidemic led to a significant increase in condom use, particularly in the communities most affected by HIV. However, as with other behaviors that adversely affect health, consistent and sustained behavior change is difficult. Despite the adoption of safer sexual behaviors, HIV transmission has persisted.

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

In alignment with the NHAS and the CDC, the Integrated Plan emphasizes PrEP as a highly effective, scientifically proven intervention. Our strategy is to make PrEP widely available to individuals at high risk for HIV infection, and to promote the use of PrEP among those persons. Using PrEP provides people with the ability to take action to protect themselves from infection. It empowers HIV negative people to be in greater control of their lives and health.

Condoms

Making condoms widely available is integral to successful HIV prevention. Condom distribution is a cost-effective structural intervention that provides communities with the resources they need to prevent the spread of HIV. An effective condom distribution plan can change the way a community thinks about and engages in safer sex behavior.

In alignment with the NHAS and the CDC, the Integrated Plan recognizes condom distribution as an effective structural intervention. By making condoms more available, accessible, and acceptable, individuals at high risk for HIV infection will have the resources they need to stay negative.

Activities

- **Administer PrEP Drug Assistance Program (DAP)**

PrEP is a new HIV prevention method for people who do not have HIV. It involves taking a daily pill to reduce the risk of becoming infected with the virus. On July 16, 2012, the FDA approved Truvada as the only PrEP drug for HIV. Approval was based on research showing that **when adults took Truvada consistently, it was very effective at preventing HIV infection.** The drug works by stopping HIV from making copies of itself after it enters the body. **PrEP is most effective in combination with other HIV prevention methods, like condoms.**

PrEP DAP began in April 2014 to provide coverage for Truvada to prevent HIV to Persons at High Risk (PAHR). PrEP DAP is dependent upon funding from the State of Washington as federal dollars cannot be used for this purpose. DOH administers PrEP DAP and has designed it as a “payer of last resort” model. This means that individuals are referred to any other drug assistance programs that may be available to them first. For those who have no other options or who have exhausted their funding with the other resources, PrEP DAP can then assist.

DOH will continue to administer the program dependent upon state funding in the next biennium (July 1, 2017 to June 30, 2019). DOH will attempt to reach those that may be most in need of PrEP so that new infections can be prevented.

- Implement case management for PAHR**

Case management for PAHR includes both medical (MCM) and non-medical case management (NMCM) services. NMCM services have as their objective, providing guidance and assistance in improving access to needed services whereas MCM have as their objective improving health care outcomes. Case Management services for PAHR aim to provide customer centered activities that focus on PrEP access and utilization. This includes ensuring readiness for PrEP and/or providing treatment adherence support for PrEP. Case management for PAHR uses an Acuity Model as an engagement and retention in care process that informs the service provider about the appropriate service level and associated services for each customer. DOH based the PAHR Acuity Model concept on the HIV Care Acuity Model.
- Recruit PrEP providers**

We will increase the number of PrEP providers. Recruitment is mainly done outside of DOH through word of mouth or provider to provider. Once the interest is raised then we can provide training through Project ECHO or the AIDS Education Training Center (AETC).
- Train external partners “Paying for PrEP”**

Paying for PrEP training incorporates anticipated costs for insured, uninsured, and Medicaid (Apple Health) patients and all the different patient assistance programs available for the pharmacy costs. Patients with or without insurance will have out of pocket expenses for medical costs and labs. Trainees are shown how to identify which patient assistance program to apply for. As a payer of last resort, a patient can apply for PrEP DAP. Trainees will receive handouts for guidance.
- Develop statewide PrEP referral system**

Disease Intervention Specialists (DIS), Local Health Jurisdictions (LHJ), CBO, Syringe Service Program (SSP) outreach coordinators, and case managers will use a single referral process for PAHR. This will allow for follow-up and linkage-to-care. This system will need to be developed.
- Increase PrEP training and consultation through Project ECHO**

Increase provider training and consultation through Project ECHO. This can be done through the survey results sent out via the University of Washington (UW). Providers identify if they are interested in learning more information and clinical guidance on prescribing PrEP. Once identified, the provider is referred to Project ECHO for training and consultation. Consultation and training can happen via email, phone, telemedicine, and in-person.
- Maintain PrEP provider database**

This database is maintained within DOH and is updated when a new provider is identified through incoming PrEP DAP applications or as a prescriber through our pharmacy benefits manager. A questionnaire is sent to verify their clinic information and to request permission to display contact information on the web for potential new patients.
- Provide integrated HIV/STD field services**

DIS interview individuals diagnosed with HIV and/or STI, elicit partners, notify partners of exposure, refer for testing and treatment, and link patients to needed medical care. In the process, they identify people at risk for acquiring HIV and refer them for PrEP.

- **Develop a new condom distribution plan**
DOH will solicit community input into messages regarding condom usage and availability by inclusion of the topic in a special emphasis work group for gay and bisexual men, particularly Black men, regarding PrEP. DOH will meet with OSPI, adolescent health and reproductive health programs at DOH to understand condom distribution plans currently being provided and incorporate condom distribution deliverables into HIV Community Services contracts in collaboration with funded providers.
- **Convene OID level SEW for gay and bi Black men to address lack of PrEP access**
- **Conduct PrEP DAP evaluation as well as statewide PrEP evaluation to understand barriers, knowledge, usage, and risk factors**

Improve Healthcare for Sexual Minorities

In 2013, 67 percent of all new HIV diagnoses in the U.S. occurred in gay and bisexual men and other men who have sex with men (MSM), a group that includes approximately 2 percent of the U.S. population.^{viii} In Washington State, over 70 percent of persons living with HIV/AIDS are gay and bisexual men. However, the current health care system is ill equipped to adequately meet the needs of these men. A national survey conducted by the Kaiser Family Foundation in 2014 found that 47 percent of gay and bisexual men had never revealed their sexual orientation to a physician; 57 percent of gay and bisexual men reported that a medical provider had never suggested that they test for HIV.^{ix} Among 164 gay and bisexual men who responded to a Washington State internet-based survey, only 43 percent reported that they had a primary care medical provider who knew that they were a man who has sex with men.^x

Gay and bisexual men have specific healthcare needs and our success in ending the HIV epidemic requires a greater effort to meet those needs. While national guidelines recommend that all Americans test for HIV at least once in their lifetime, both CDC and local guidelines in Washington State recommend that most gay and bisexual men test at least annually, and that selected groups of gay and bisexual men test as often as four times a year.^{xi,xii} These guidelines also recommend that gay and bisexual men test frequently for other sexually transmitted infections.

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

Activities

- **Ensure that DOH funded medical services are culturally relevant for Gay/Bi/Trans (GBT) PAHR & PLWH**
 - Fund CBOs to provide culturally competent healthcare navigation and coordination services
 - Fund CBOs to partner with primary care physicians prescribing PrEP for GBT.
 - Fund Project ECHO to build capacity of primary care physicians to prescribe PrEP for GBT patients.

- **Fund Open Access Clinic(s)**

These are services to date that have been offered by an open access clinic.

- Focus is on those persons with extensive personal and social barriers to care
- Consists of NMCM, intensive outreach support, walk in or short interval appointments and other incentivized measures
- Walk-in medical care, five afternoons per week (in STD Clinic)
- Snacks and meal vouchers (each visit, up to once weekly)
- Cell phones and bus passes (contingent renewal)
- Cash incentives (every two months)

The MAX Clinic has approximately 80 patients, >50% of whom are virally suppressed. Ongoing efforts are needed to outreach and continue to engage this population in medical care.

- **Allocate funding for health care navigation for PLWH & PAHR**

DOH provides funding for health care navigation for PLWH and for PAHR. Health navigators work with case managers to serve the highest barrier clients, including those struggling with homelessness, mental illness, or substance abuse. Health navigators connect with community social service agencies and work with agency staff and medical care providers. They go with clients to appointments and other meetings with their case manager, mental health provider, HIV primary care providers. Navigators stay in contact with incarcerated clients, and provide street outreach. DOH funds agencies providing services for PAHR in high prevalence areas.

- **Promote/advocate for GBT cultural competency for providers.**

DOH will promote existing and effective curricula on equity for GBT communities through AETC and offer provider continuing education as well as identify some “champions” for these efforts. DOH will create and publish a list of providers who are willing to identify themselves to patients as welcoming to individuals who are GBT while working closely with Group Health and Harborview on “best practice” models currently in process.

- **Provide integrated HIV/STD field services.**

DIS interview individuals who identify as sexual minorities diagnosed with HIV and/or STI, elicit partners, notify partners of exposure, refer for appropriate testing and treatment, and link patients to needed medical care.

Improve HIV Prevention and Care for Substance Users

Substance use in general continues to challenge HIV prevention, care, and treatment because it can impair decision-making around sexual safety, increase risk for HIV via syringe sharing, and interfere with the ability of PLWH to access and sustain HIV care and remain virologically suppressed. Drug use also compounds stigma and morbidity affecting PLWH and PAHR.

Cities in WA State were among the first in the U.S. to institute syringe service programs (SSP), and this successful effort has helped contain the HIV epidemic among persons who inject drugs (PWID). HIV surveillance data provided by the Infectious Disease Assessment Unit at DOH reported as of January 31, 2016 that roughly 18% of PLWH have a history of using injection drugs, and 16% of new HIV diagnoses between 2010-2014 occurred in PWID.

Non-injection drug use is also a critical factor driving the HIV epidemic in WA State. In particular, the use of methamphetamine by gay and bisexual men, including use through means other than injection, helps fuel the HIV transmission, as using methamphetamine is strongly associated with high risk sexual behavior. Data collected through Seattle's participation in the 2014 National HIV Behavioral Surveillance system suggest that 15% of gay and bisexual men have used methamphetamine in the prior year, and approximately one-third of gay and bisexual men with newly diagnosed HIV in King County report using methamphetamine in the prior six months.^{xiv} For King County, where the following data are tracked, HIV prevalence is nearly four times higher among gay and bisexual men who use methamphetamines (44%) versus gay and bisexual men who do not report methamphetamine use (12%) and local data suggest that using methamphetamine is the single strongest predictor of HIV acquisition.^{xv} PHSKC investigators estimate that 20% of all HIV infections in gay and bisexual men are attributable to methamphetamine use.^{xvi} Statewide data related to HIV and methamphetamine use are not available at this time. NHBS data describe a high risk sample and may not represent the entire population of gay and bisexual men in WA State.

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

For PLWH and PAHR who are ready to enter substance use treatment, especially GBT who use Meth, it is critical that they are able to be open about their sexual partners. Encountering facilities in which providers and fellow patients are not GBT friendly causes problems—from discomfort to lack of treatment success to physical danger for those who seek treatment.

Activities

- **Support Syringe Services Programs (SSP)**

Activities include purchasing and distributing injection equipment to all SSPs. We will work with diverse stakeholders (e.g. the Department of Social and Health Services (DSHS), the Health Care Authority (HCA)) to develop sustainable funding portfolios and directly fund ten SSPs for comprehensive services. The Determination of Need is complete. The CDC deems Washington State is at risk for an HIV/HCV outbreak due to injection drug use. We will work to verify and gain access to the use of federal funds to support this activity.

- **Allocate funding for substance abuse outpatient treatment outside TGA**

DOH provides funding for substance abuse outpatient services for PLWH. Services include screening, assessment, diagnosis, or treatment of substance use disorder. DOH only funds agencies providing services for PLWH who live outside the TGA.

- **Provide integrated HIV/STD field services**

DIS interview individuals diagnosed with HIV and/or STI, elicit partners, notify partners of exposure, refer for testing and treatment, and link patients to needed medical services including substance abuse treatment or needle exchange services.

- **Ensure ADAP formulary is inclusive of opioid replacement therapies**

DOH has reviewed its formulary and provides coverage for most opioid replacement therapies. DOH will work with the HPSG to identify any medications that may not currently be covered and add those to the formulary.

EIP also had an Advisory group and they will also be consulted regarding the need for any medication additions to the EIP formulary.

- **Allocate funding for harm reduction, pre-treatment, and post-treatment support to PLWH in the Seattle TGA**

Because not all PLWH who are chemically dependent are ready for treatment, the TGA uses a variety of harm reduction strategies (in addition to SSPs) to increase engagement in care and viral suppression. The Council allocates funding to Outpatient/Ambulatory Health Services (OAHS) – Treatment Adherence Support to provide medication management and directly observed therapy for PLWH who need this additional help. The Council also funds NMCM sub-prioritized to support a chemical dependency provider (CDP) to outreach to chemically dependent PLWH who are pre-assessment to help move them towards treatment, and conduct “on the fly” assessments. Additional NMCM supports other engagement and retention in care activities. Finally, the Council allocates funds to Psychosocial Support Services to help PLWH post chemical dependency treatment. All of these programs focus on the unique needs of substance users, especially methamphetamine users.

- **Promote/advocate for GBT safety in behavioral health agencies**

In the Seattle TGA, behavioral health is provided through insurance, Medicaid, state, and local funding, including a local tax specifically for behavioral health. Because of the significant relationship between methamphetamines and poor health outcomes for PLWH, the TGA is committed to influencing and supporting the behavioral health system to meet the needs of GBT people, both PLWH and PAHR, even though they do not directly fund substance use

treatment or mental health services. The Part A Grantee and Council will work collaboratively with the Department of Community and Human Services (DCHS), the King County agency responsible for allocating behavioral health funding, on initiatives to improve programs' abilities to provide safe, supportive, and effective services for GBT clients, and promote needed changes.

Reduce Insurance Barriers for PLWH & PAHR

The Affordable Care Act (ACA) has fundamentally altered the health care delivery system and increased Washington State residents' access to medical care. As of 2015 more than 90 percent of the state's residents had health insurance. However, even with the advances in comprehensive access to health care, some aspects of the healthcare system still present impediments to the state's goals of ending the HIV epidemic in Washington.

Because sexual health is a highly private matter, some individuals at high risk for HIV transmission prefer to receive HIV/STD services from a confidential STD Clinic. Receiving care at a provider other than their primary care provider often means that the preventive services are either not covered by health insurance at all, or are covered but with a cost to consumers. These costs present barriers to accessing effective preventive care and patients lose access to specialized care, diagnostic tests, and services that may not be available through their primary care providers.

Additional issues around confidentiality are also complicated by the Explanation of Benefits (EOB) documents provided by health plans following visits. There is considerable concern, particularly from young patients, that if they use their insurance for HIV/STD services, their insurance company will send an EOB statement to their homes, detailing the services, thus compromising their privacy.^{xviii} This fear is an impediment to patients seeking medical care for HIV/STD testing and treatment as well as PrEP.

Among persons with HIV infection, loss or interruption of insurance coverage frequently causes patients to discontinue taking medication that can save lives and prevent HIV transmission.^{xix} Although no one needs to go without HIV care in Washington State because of lack of insurance, many patients don't know that. When patients lose their insurance or have outstanding balances due to cost-sharing expenses, some simply stop taking their medications and stop going to their medical provider. At present, medical providers and case workers that serve persons with HIV infection have no way to know when their patients or clients lose their insurance, so they cannot help them find a way to continue the treatment they need. Currently there is not a system-level mechanism to address this problem, so there is not an Action Item recommended here, but since this also affects persons with other chronic medical conditions, it is raised as a way to draw attention to the need to solve it.

Finally, at present, many patients cannot access PrEP because their insurance does not cover the full costs of obtaining PrEP. Although the state's PrEP DAP provides co-pay assistance to some persons, allowing them to obtain medication, the program does not cover the costs of doctor visits or laboratory testing. Current funding for PrEP DAP is insufficient to meet the needs of all persons who can benefit from PrEP. PrEP is a cornerstone of Washington State's End AIDS Initiative. Ensuring that all Washington State residents at high risk for HIV infection have access to PrEP medications and medical services without co-pays or deductibles is consistent with how the ACA treats other preventive services, and will help bring about the end of the HIV epidemic in Washington State.

Activities

- **Administer Early Intervention Program (ADAP)**

EIP, which is Washington's ADAP program, serves over 3,000 clients. We estimate that EIP has a capacity to serve at least 4,200 clients. The program has cost savings from clients moving to Expanded Medicaid because of implementation of the ACA. This reduction in client numbers has increased our ability to serve additional clients reached through outreach efforts.

- **Administer PrEP DAP**

PrEP is a new HIV prevention method for people who do not have HIV. It involves taking a daily pill to reduce the risk of becoming infected with the virus. On July 16, 2012, the FDA approved Truvada as the only PrEP drug for HIV. Approval was based on research showing that **when adults took Truvada consistently, it was very effective at preventing HIV infection.** The drug works by stopping HIV from making copies of itself after it enters the body. **PrEP is most effective in combination with other HIV prevention methods, like condoms.**

PrEP DAP began in April 2014 to provide coverage for Truvada to prevent HIV to PAHR. PrEP DAP is dependent upon funding from the State of Washington as federal dollars cannot be used for this purpose. DOH administers PrEP DAP and has designed it as a "payer of last resort" model. This means that individuals are referred to any other funding sources that may be available to them first. For those who have no other options or who have exhausted other resources, PrEP DAP can assist.

DOH will continue to administer the program dependent upon state funding in the next biennium (July 1, 2017 to June 30, 2019). DOH will attempt to reach those that may be most in need of PrEP so that new infections can be prevented.

- **Identify and link EIP (ADAP) clients who are eligible to Medicaid**

For each client, EIP staff will review Automated Client Eligibility System (ACES) at enrollment and re-enrollment. Staff will also follow up on notifications from Evergreen Health Insurance Program (EHIP) when a client applying for a Qualified Health Plan (QHP) is indicated as Medicaid eligible due to income entered.

- **Provide integrated HIV/STD field services**

Disease intervention specialists interview individuals diagnosed with HIV and/or STI, elicit partners, notify partners of exposure, refer for confidential, low cost or free testing and treatment, and link patients to needed medical care.

- **Allocate funding for health care navigation for PLWH & PAHR**

- **Advocate for reduction on copayment costs for HIV and PrEP related medical care**

- **Ensure health plan formularies include all HIV ARVs as well as PrEP medications**

- **Collaborate with OIC to ensure health plans formularies, practices and fees are non-discriminatory**

Increase Housing Options for PLWH

Housing is an essential component of health, particularly for PLWH. Research has shown that housing assistance for PLWH is cost-effective^{xx} and improves health outcomes at each stage of the HIV care continuum^{xxi}; conversely, homelessness and housing instability are linked to inadequate HIV healthcare, high viral loads, poor general health, avoidable hospitalizations, and increased mortality.^{xxii} Stable housing improves health outcomes for PLWH and reduces the likelihood of HIV transmission. Yet the demand for temporary and long-term housing for PLWH far exceeds the supply. Nationally, more than 40 percent of PLWH will experience homelessness or housing instability over the course of their illness.^{xxiii} There are waitlists for housing support for PLWH throughout Washington State, and some areas lack any transitional housing services. The housing crisis is particularly acute within urban areas. Among Major City Continuums of Care [HUD 2015 AHAR], Seattle/King County has the third largest homeless population, behind only New York and LA. National estimates for people experiencing homelessness have been declining, but in Seattle/King County they have been increasing annually. The 2016 One Night Count summary of unsheltered people in selected areas of King County was 4,505, a 19% increase over 2015. Tacoma saw a similar increase in unsheltered people. In the Medical Monitoring Project, 15% of PLWH who receive their care in King County were unstably housed. Both Seattle Mayor, Ed Murray, and King County Executive, Dow Constantine, have declared a state of emergency related to homelessness, yet the problem persists. Increased costs of housing in Seattle have pushed low and middle income residents of Seattle both north, to Snohomish County (inside the TGA) and south to South King County, but also Pierce County (outside the TGA).

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

The needs of PLWH experiencing or at risk for homelessness vary. Some individuals are in need of rental or mortgage assistance to get through a brief crisis, while others require long-term permanent supportive housing. Housing models should respond to this diversity of need in order to ensure that all PLWH and at-risk persons can be healthy and reduce the risk of HIV transmission.

Finally, substandard housing is an additional barrier for PLWH and other individuals in need of affordable housing options. Housing that is not well maintained, infested with vermin, or has environmental toxins, such as black mold, not only endangers residents' physical health, but evidence suggests it can also exacerbate mental health conditions.^{xxv} In order to get closer to ending HIV in Washington, the strategy must include safe, affordable housing options and homelessness prevention for PLWH and PAHR.

Activities

- **Allocate PLWH funding for housing**

DOH funds housing services outside of the Seattle TGA. Services include: providing limited short-term assistance to support emergency, temporary, or transitional housing to enable PLWH or families to gain or maintain outpatient health services. Housing-related activities include: assessment, search, placement, advocacy, and the fees associated with these services.

- **Work collaboratively with HOPWA grantee to provide the best mix of housing options and services throughout the Seattle TGA**

A representative of the HOPWA grantee serves on the Planning Council, allowing the group to work together to ensure the resources of each fund source was used optimally. Beginning in 2017, HOPWA will be used almost exclusively for permanent housing (and some Short Term Rent, Mortgage and Utilities-STRMU), and Part A dollars will cover the service component, as well as transitional and emergency housing. This will ensure that our limited resources are used optimally to address PLWH unmet housing needs. Because housing inventory is so limited within the Seattle TGA, the Council is also committed to providing resources to support PLWH while they are homeless. Programming includes drop in/on demand services, including NMCM and Treatment Adherence in a drop in center.

- **Allocate funding for Stable Housing to Domestic Violence (DV) Survivors living with HIV**

DOH contracts for housing services for PLWH who are domestic violence survivors. Services include providing limited, short-term assistance to support emergency, temporary, or transitional housing to enable customers or families to gain or maintain outpatient health services. DOH will only fund agencies providing services for PLWH who live outside the TGA.

Within the Seattle TGA, HOPWA and Part A dollars work collaboratively to provide a mix of housing services to meet the individual needs of the client. Services with DV expertise are among those options.

- **Provide targeted housing funding to PLWH for populations experiencing HIV related health disparities in Pierce County**

DOH will contract for housing services for PLWH experiencing health disparities in Pierce County, which has the second highest burden of HIV disease in the state. Services include providing limited short-term assistance to support emergency, temporary, or transitional housing to enable customers or families to gain or maintain outpatient health services. Housing-related activities include assessment, search, placement, advocacy, and the fees associated with these services.

- **Allocate funding for Housing Case Management (NMCM) in the Seattle TGA**

While providing housing itself is important for PLWH success, finding, accessing and maintaining is difficult for PLWH, in particular those with mental illness, chemical dependency and histories of trauma, incarceration, or eviction. The Council allocates funds to Housing Case Management to help PLWH with all three of these activities.

- **Allocate funds for Transitional and Emergency Housing in the Seattle TGA**

The Seattle TGA, particularly King County, has a severe housing crisis which disproportionately impacts low and moderate income residents. PLWH are severely impacted. Ten percent of PLWH in Washington reported being homeless in the past year, but this number was 15% in the TGA. Black men and women were more likely than other PLWH to say they needed, but could not get housing. The TGA provides funds for in transitional and emergency housing. In combination with the permanent housing provided through HOPWA the TGA hopes to reduce homelessness for PLWH.

Increase the Number of PLWH & PAHR Engaged in Comprehensive Healthcare

Twenty-five years ago, the Federal government enacted legislation that created a program to provide services exclusively to PLWH – the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, now known as the Ryan White Program. This program was established with the recognition that people with HIV, especially those with limited resources, needed a coordinated and comprehensive system of care and treatment. At the time the program was established, the main goal of the program was to provide people with the services and support they needed over the relatively limited time they would survive.

Since that time, tremendous advances in treatment have allowed people to live longer, healthier lives with HIV, as long as they stay engaged with care and adherent to medication. Multiple studies have shown that access to interdisciplinary care improves engagement and retention in care and adherence to medications^{xxvi,xxvii,xxviii}. A study of nine clinical sites funded by the Ryan White HIV/AIDS Program suggests that successful delivery of interdisciplinary care includes:

- Patient-centered, one-stop-shop approaches with integrated or co-located services,
- Diverse teams of clinical and non-clinical providers,
- A site culture that promotes a stigma-reducing environment for clients,
- The availability of a comprehensive array of medical, behavioral health, and psychosocial services,
- Effective communications strategies, including electronic medical records (EMRs) and,
- A focus on quality.^{xxix}

While the characteristics of a coordinated system of care for people with HIV have been described and some clinics in the state have successfully established systems that integrate diverse services, other providers continue to experience challenges in creating this type of system and some clients continue to experience barriers to getting the care they need. The fragmented system sometimes leads to delays in seeking medical care, reduced adherence to HIV treatment, and increased HIV transmission through risk behaviors. The need for an integrated system of HIV care that provides truly comprehensive services is now more important than ever.

These barriers also affect HIV risk. Gay and bisexual men, transgender/non-binary individuals, communities of color, persons with behavioral health conditions, people who use drugs, and others have complex healthcare needs that require an integrated system. Additionally, individuals who are incarcerated or recently released face a number of challenges in staying connected to HIV treatment or prevention services.

It will not be possible to end the HIV epidemic in Washington without addressing these barriers. Fortunately, the Healthier Washington initiative calls out a specific focus on “ensuring health care focuses on the whole person” and places major emphasis on removing barriers to providing interdisciplinary care in our health system. Systems are integrating payment models so that the care team has financial incentives to look holistically at patients. Plans are being put in place to develop the workforce, increasing the numbers of both clinical (physical and behavioral health) and non-clinical providers to address the needs of the increased number of people using the healthcare systems. Technology is being developed so that providers can more easily share information and provide support to clients in remote locations via telemedicine/telehealth.

- **Administer Early Intervention Program (ADAP).**

EIP, which is Washington’s ADAP program, serves over 3,000 clients. We estimate that EIP has a capacity to serve at least 4,200 clients. The program has cost savings from clients moving to Expanded Medicaid because of implementation of the ACA. This reduction in client numbers has increased our ability to serve additional clients reached through outreach efforts.

- **Provide variable intensity case management services based on need for PLWH**

To maximize the efficacy of case management overall, DOH has implemented and continues to refine an acuity model of service delivery that focuses on offering the right services to the right populations at the right time in the right dose. To maximize resources and minimize unnecessary and unproductive administrative barriers for those populations of PLWH needing low intensity services, DOH created a tier of case management services with minimal ongoing administrative requirements. By doing so, a greater number of clients can have their needs met at a reduced cost and time footprint, thereby freeing up resources targeted to those persons with higher and more intense needs. DOH is implementing an enhanced staffing continuum that includes peers, navigators, outreach workers, and intensive case managers to further realize this vision of variable intensity case management.

- **Allocate funding to NMCM to locate PLWH who are out of care or underserved in the Seattle TGA**

DOH funds case management throughout the state, and so the TGA has focused much of its funding on people who are not virally suppressed. The reasons for people who know their status to not be virally suppressed are varied, but in many cases, PLWH are lost to care because of homelessness, mental illness, and chemical dependency. Others simply do not feel comfortable within the care systems they have encountered. By funding services which help to find PLWH, and then spend time unpacking and responding to the reasons for this, the TGA has seen positive outcomes. Using harm reduction methods NMCM staff find those out of care and intervene to support them in getting and staying in care.

- **Allocate funding to provide a comprehensive system of oral health care in the TGA**

While the ACA provides comprehensive medical and behavioral health to PLWH throughout the State of Washington, Exchange plans to not provide dental care, and the dental care provided by Medicaid is very limited. As a result, this is the only significant core service gap for PLWH. Problems with Oral Health are correlated to other poor health outcomes. The TGA created a dental program in 2014 which uses many providers throughout the TGA and provided dental

care to 618 PLWH in 2015. Through dental case management, an additional 938 were appointed into dental services paid for by other sources. This system of care will continue to grow.

- **Allocate funding for wrap-around services**

DOH provides PLWH funding for mental health. Mental health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services. Contracted providers base services on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional. The Department only funds agencies providing services for PLWH who live outside the TGA.

- **Implement case management services based on variable need for PAHR.**

Case management for PAHR includes both MCM and NMCM services. NMCM services have as their objective providing guidance and assistance in improving access to needed services whereas MCM services have as their objective improving health care outcomes.

- **Administer Title XIX Targeted HIV MCM**

Washington's Medicaid program contracts with DOH to administer its Title XIX Targeted HIV MCM program. Title XIX Targeted HIV MCM is an intervention offered to those receiving Medicaid benefits that takes a holistic, wrap-around approach to chronic disease management. The intention of this intervention is to assist those eligible to live as independently as possible by achieving and maintaining improved health, reducing risky behaviors that put ongoing stability in jeopardy, and by assisting beneficiaries to gain access to needed medical, social, and educational services. Through ongoing assessment of needs and barriers, individualized service plans that articulate client centered goals, and regular coordination of benefits and systems, Title XIX Targeted HIV MCM assists PLWH to achieve health and stability.

- **Recruit PLWH co-infected with HCV into HCV treatment**

EIP is sending all of its clients (~3,400) a letter notifying them that hepatitis C virus (HCV) is now curable and the medications used to cure are on EIP's formulary. EIP can either pay the full cost of the medication regimen if the client is uninsured or can pay the co-pay/co-insurance for those with insurance.

EIP will also work with HIV case managers around the state to notify them of the availability and to talk with their clients about their options for treatment and cure of HCV if co-infected.

- **Contract with satellite clinics for geographic diversity**

DOH contracts with the Harborview Medical Center to provide outpatient and ambulatory medical services in satellite clinics located in Kitsap, Thurston, King, and Snohomish Counties. These satellite clinics improve access to primary and medical care for PLWH. The satellite clinics also serve HIV negative persons with the goal of increasing access for Post-Exposure Prophylaxis/PrEP clients.

- **Provide integrated HIV/STD field services**

DISs interview PLWH and PAHR depending on diagnosis of HIV and/or STI, elicit partners, notify partners of exposure, refer for testing and treatment, and link patients to needed medical care. This is a wrap-around health service, which helps to improve health through detection, treatment, and prevention of disease.

- **Allocate funding to wrap-around services that engage and retain PLWH in for health care and promote positive health outcomes in the Seattle TGA**

Because of the State's amazing EIP and MCM programs, the Seattle TGA has been able to focus its resources on those factors which, when missing, detract from positive health outcomes including NMCM, Housing, and Oral Health, listed above.

Another needed service for PLWH in the TGA is Food Bank/Meals services. In addition to having a housing crisis, the TGA also has a very high overall cost of living. Having consistent access to good quality food that meets dietary needs has been a key factor in maintaining health, and increasing quality of life and independence for low income PLWH. In addition to a food bank and kitchen which supplies packaged meals, groceries, and household supplies, there are drop off locations throughout the TGA for clients to get these needed items.

The Seattle TGA is a very large geographic area, and housing costs are much higher within the City of Seattle, which is where many services are located. As a result, transportation assistance is key to maintaining care. Dollars are allocated to provide bus tickets and bus passes.

In some cases, PLWH who are not part of the most affected populations can experience increased stigma and social isolation. As a result, the TGA funds Psychosocial Support to address these issues.

Although it is ideal for PLWH to be housed, wait lists may significantly delay entry into housing. Homelessness, often combined with mental illness and/or chemical dependency, can be a barrier to adherence. In response, the Council has funded Treatment Adherence through Outpatient/Ambulatory Medical Services. This program provides various interventions, such as putting together medisets for clients, to storing medication, to directly observed therapy.

- **Allocate funding for health care navigation for PLWH & PAHR**

DOH provides funding for health care navigation for PLWH and for PAHR. Health navigators work with case managers to serve the highest barrier clients, including those struggling with homelessness, mental illness, or substance abuse. Health navigators connect with community social service agencies and work with agency staff and medical care providers. They go with clients to appointments and other meetings with their case manager, mental health provider and HIV primary care providers. Navigators stay in contact with incarcerated clients, and provide street outreach. DOH funds agencies providing services for PAHR in high prevalence areas.

- **Provide targeted services to PLWH over 50**

As the population of PLWH ages a greater proportion is over the age of fifty. This creates new challenges and unique set of health concerns. In order to determine the most effective service delivery strategies a significant effort must be made to engage and learn about the unique needs of this group. This is a priority. It is likely that the meaningful inclusion of PLWH over 50 will impact the current Stigma, Disparities, and Health Care System for Sexual Minorities, Housing, and Community Engagement strategies.

In the Seattle TGA, needs assessments conducted by the Council showed both increased needs among older PLWH, as well as increased isolation and depression. The Council has allocated funding to peer programming and psychosocial support to address these issues. Currently 36% of the unaligned consumers on the Planning Council are over age 50. They bring the issues of this population to the table, and at their urging, additional age-based analysis of data was done, and an interview project with just older PLWH will be conducted in 2017.

Improve Sexual Health Education

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

The AIDS Omnibus Act^{xxx} requires annual instruction in an HIV curriculum for students in Washington public schools, grades 5-12. In 2007 the Washington Legislature passed the Healthy Youth Act (HYA), which requires that sexual health education taught in Washington public schools be comprehensive, age-appropriate, and medically accurate.^{xxxi} The law does not, however, **require** that schools provide sex education for students. Currently, sex education curricula and practices are randomly surveyed by OSPI on a bi-annual basis to determine what curricula are being used, what topics taught, time allotted, etc. Because the surveys are random and voluntary on the part of school districts, they do not reflect a comprehensive review of compliance with the HYA. Currently there is neither an enforcement mechanism nor funding to ensure that curricula comply with the requirements of the Act. Consequently, the implementation of the Healthy Youth Act has been uneven across school districts.

More could be done in all districts to ensure that the curricula and instruction are updated with current science and are truly inclusive of the needs of LGBT youth, including gay and bisexual young men – who are the population at greatest risk for HIV infection. From 2010-2014, 16 percent of newly diagnosed PLWH in Washington were under the age of 25.^{xxxii} Improved curricula, stronger oversight and enforcement, and more support are all needed to help schools provide innovative, state of the art instructional materials such as Working to Institutionalize Sexual Health Education (WISE), Exemplary Sexual Health Education (ESHE), and Personal Responsibility Education Program (PREP). These improvements will help ensure the young people of Washington are getting the information they need to make healthy decisions and prevent STDs (including HIV) and unintended pregnancies. Additionally, comprehensive sexual health education programs must reach young people who have left the school system because they have graduated, dropped out, are experiencing or at risk of homelessness, or are in the juvenile justice system.

Activities

- **Staff DOH HIV/STD phone line**

- **Provide technical assistance to LHJs**

Upon request, WA DOH staff assists LHJ program staff in preparing and providing information and education to members of the community.

- **Provide integrated HIV/STD field services**

DISs interview PLWH and PAHR depending on diagnosis of HIV and/or STI, elicit partners, notify partners of exposure, refer for testing and treatment, and link patients to needed medical care. This is a wraparound health service which helps to improve health through detection, treatment, and prevention of disease.

- **Increase LGBTQ youth sexual health education programming**

- **Review and certify curricula for medical accuracy**

Educational materials funded by DOH including: pamphlets, brochures, flyers, booklets, audiotapes, videotapes, DVDs, posters, billboards, curricula/training guides, TV/radio PSAs, web pages, periodicals, and questionnaires/survey instruments must be submitted for a Materials Review Process. This includes approval through a Program Materials Review Panel who review materials according to the following criteria:

1. Scientific and technical accuracy,
2. Compliance with the Basic Principles listed in the document, *Content of AIDS-Related Written Materials, Pictorials, Questionnaires, Survey Instruments, and Education Session in Center for Disease Control and Prevention Assistance Programs (1992)*,
3. Appropriateness for target audiences.

A minimum of five (5) reviewers are needed for the review to be completed. Following the completion of review, literature will be assigned one of the following statuses:

- Approved as submitted: Met review requirements as submitted.
- Approved with suggested changes: Met review requirements but Panel members have offered suggestions to strengthen the materials.
- Conditionally approved with required changes: Identified changes must be made in order to meet review requirements. Once changes are made, materials are approved.
- Not approved as submitted: Did not meet the review criteria and must be revised. Must go through Program Review Panel again.

Community Engagement by At-Risk and PLWH Communities

PLWH have been at the forefront of policy and programmatic interventions since the beginning of the epidemic. These efforts have directly contributed to a dramatic increase in HIV awareness, and access to and retention in HIV-related medical care. Many planning bodies, including Ryan White Planning Councils, require representation of PLWH. Yet survey responses and comments in community forums during the End AIDS Project thus far indicate that our public and private sector HIV services could do more to more fully engage and empower PLWH and communities disproportionately affected by HIV. This request for inclusion and leadership opportunities in design and decision-making is not only about community empowerment – a worthwhile goal in itself – but also about making all HIV community services more responsive to community needs and therefore more effective in achieving the goals of End AIDS Washington.

Using HIV-related disparities and the multiple forms of stigma as the lens, there are many opportunities to strengthen “community engagement” as a key element of ending the HIV epidemic in our state. A Steering Team member noted: *I think we want a genuinely collaborative process, one that involves PLWH and affected communities, but also involves medical and social service providers, government, and healthcare organizations.* One of the key early conversations with each community (see definition below) will be to come to a shared understanding of what a “genuinely collaborative process” means and what behaviors and actions can make this happen effectively.

Getting the “communities” to engage more fully and effectively could be defined by HIV status, sexual orientation, geography, racial-ethnic background, age, mental health status, gender identity, or other factor that describes or defines why they may be stigmatized or experience disparities. The word “community” will have many meanings. And even though some community members may have been involved in the past, there are additional community members who will likely wish to participate in the future.

Members of many communities often prefer that the engagement takes place on their “turf” and include leadership roles by leaders in their group. “Turf” could be a community center, church, restaurant, home, or other venue where members of the community feel at home. Members of the community would have many options for providing their ideas including: speaking, writing comments, recording comments, being interviewed, etc. Multiple languages are supported by interpreters and translated materials. The goal is to offer many pathways to participation by members of the community.

Activities

- **Convene OID level SEW**
DOH is committed to better understanding and addressing HIV-related health disparities which have been identified among three select populations:
 - Foreign born Black residents,
 - Foreign born Hispanic residents, and
 - U.S.born Black residents of Washington State.

To achieve this, OID will take advantage of the state’s HIV Planning System and convene a series of HIV SEWs. These groups are informal, ad-hoc advisory bodies which are comprised of community members and subject matter experts. Their purpose is to identify specific and effective implementation strategies that add operational values to HIV prevention, care, and continuum activities. For example, in early 2015, the first HIV-Related SEW met and produced a detailed, high level report identifying and prioritizing which inequalities DOH should address as soon as possible.

- **Outreach to Black & Hispanic PLWH to link to EIP (ADAP) and third party insurers**

DOH provides outreach services to identify racial and ethnic minorities who are out of care. This includes PLWH who know their status and have never entered care or who have dropped out of care, as well as HIV positive persons who do not know their status. The Department’s Minority AIDS Initiative Coordinator will work with newly diagnosed clients from the time they test positive until they enroll into ADAP or other medication assistance programs. This position will also work with out-of-care clients from re-linkage activities to enrollment in ADAP or other medication adherence programs.

- **Improve We Are 1 Campaign**

We Are 1 is a regional health and wellness brand focusing on MSM in King, Pierce, and Snohomish Counties. DOH and the rest of the health collaborative take a holistic, health wellness messaging approach to address what amounts to a staggering disparity in health status for this population. The We Are 1 brand goals include:

- Respond to DOH Strategic HIV Prevention Framework
 - 25% reduction in incidence in WA State.
 - 50% reduction in incidence in MSM in Seattle and secondary urban areas.
 - Respond to CBO needs.
 - Respond to holistic health needs of MSM.
 - Create continuity of messages between counties.
 - Create synergies to increase efficiency, impact, and outcomes.
 - Add supplemental/enhanced value to campaigns.
- Participating agencies include: Center for Multicultural Health, Entre Hermanos, Lifelong, Gay City, Gender Justice League, Pierce County AIDS Foundation, PHSKC, Seattle Counseling Service, Snohomish Health District, Tacoma-Pierce County Health Department, and Washington State Department of Health.

Campaigns have included: a brand launch, Affordable Care Through Utilizing All Available Data Tools (Act and Health Insurance Enrollment, PrEP, and HPV Vaccine).

- **Promote leadership of PLWH and communities disproportionately impacted by HIV (DOH)**

- **Promote leadership by PLWA and ensure that programmatic decisions are driven by diverse, unaligned PLWH & PAHR (TGA)**

Seattle TGA Planning Council consumers are committed to fully participating in decision-making processes, recruiting others to participate, and pushing for seats at the table. There is concern that some decision-makers do not understand the unique value that PLWH who receive services and *are not aligned with any organization* bring to the conversation. Council consumers are committed to showing the value added, increasing their numbers and increasing their knowledge base through:

- Create additional trainings and revitalize current curricula on how to effectively participate in planning work, and make it available to PAHR as well as PLWH—specifically those who are not already engaged with the Council’s work,
- Have specific topic trainings on topics such as Trauma Informed Care and Social Determinants of Health,
- Pushing for the inclusion of unaligned PLWH & PAHR on the HPSG and other groups,
- Re-energize consumers through a re-dedication to the Denver Principles,
- Have “hot topic” meetings to draw those who have not previously participated.

- **Identify funding to create and maintain an interactive website for PLWH, community members, and providers in the Seattle TGA.**

The issue of PLWH and PAHR-- especially those who are not of the majority population—continuing to be ill informed about services, opportunities for input, and about their disease is troubling, and while providers are required to advertise their services, information still does not get out to all. By creating a website which:

- has a simple, easy to remember and well-advertised URL,
- provides universal information for PLWH, PAHR, providers, and others who care about HIV,
- gives the opportunity to give general feedback, and
- has a periodic “what do you think about this” question.

The Seattle TGA hopes to increase engagement throughout the system through the website and the training leadership program.

Data to Care

In support of CDC-sponsored activities, which attempt to locate and re-engage PLWH who appear to be out-of-care, OI developed the Locating Out-of-Care (LOOC) electronic data system. LOOC is used to support and document the statewide, surveillance-based re-investigation of potentially out-of-care cases. These are presumed prevalent cases (living cases of HIV infection in WA) for which DOH has not received a CD4 or viral load (VL) test result within the past 18 months (excluding persons newly diagnosed with HIV within the period).

Each LOOC investigation involves a manual review of multiple data systems including eHARS, Accurant, statewide laboratory surveillance data (Lab Tracker), ADAP data system, the state's STD reporting system (PHIMS STD), and multiple remote electronic medical record data linked to several of the state's largest medical facilities. When appropriate, cases are electronically assigned to local DIS who are able to make direct contact with last known providers and/or the patients themselves. Patients who are contacted, confirmed out-of-care, and willing to participate are referred to the state's Care and ART Promotion Program (CAPP).

Activities

- **Use HIV surveillance data to identify and locate persons not receiving optimum HIV care**
- **Use HIV surveillance data to link or re-engage PLWH to care**
- **Provide integrated HIV/STD field services**
DISs interview individuals diagnosed with HIV and/or STI, elicit partners, notify partners of exposure, and refer for testing and treatment, and link patients to needed medical care.

Conclusion

The goals, strategies, objectives, and activities presented were carefully developed to address both short-term and longer-term opportunities to achieve the goal of ending the HIV epidemic in Washington State. There is a strong commitment to reducing stigma and HIV-related disparities, and investing in new forms of community engagement. The effort to End AIDS is an active, ongoing, passionate effort. The work is iterative, meaning that as implementation begins and progresses, the voices of the communities most affected by HIV will be welcomed. Implementation will consider experience about what works and what doesn't, additional and new scientific or medical findings, and new information from others working to End AIDS.

Collaborations, Partnerships, and Stakeholder Involvement

A collaborative process was used to develop the Integrated Plan/SCSN. The process used to collect the data was developed by the SCSN Steering Committee. This committee consisted of consumers, HIV Planning Ryan White Part A Program staff, and WA State DOH Program Staff and Epidemiologists. Members of this team created a process to ensure consumer input representative of **all** of Washington State. Opportunities for input were provided by consumers receiving services from RW Part A & Part B as well as prevention services. Communities provided information regarding current HIV prevention and care services and those that are needed. In addition to seeking input from individuals familiar with the current HIV service delivery system we also attempted to gather information from

- PLWH who know their HIV status, but are not in care;
- Persons at higher risk for HIV infection;
- People experiencing HIV-related health disparities.

This community input process was in addition to data used by the PHSKC & WA State DOH Assessment Units to complete the Epidemiological Profile. It consisted of consumer interviews, consumer surveys,

case manager interviews, case manager surveys, regional focus groups, and End AIDS Initiative listening sessions. The End AIDS effort provided multiple opportunities to reach PLWH, individuals at risk for HIV, medical providers, supportive service providers, and other stakeholders, striving to hear from all parts of the state and all communities affected by HIV. Feedback methods included an open-ended survey, available in English and Spanish, online and in paper form, through which the Steering Team received a total of 137 responses. We held six community forums around the state, in Seattle, Tacoma, Everett, Spokane, Yakima and Vancouver, as well as targeted community conversations. Through all of these methods, approximately 350 people provided invaluable feedback.

The HPSG & the Planning Council each participated in developing the activities during their regular scheduled planning meetings. Ad-hoc work groups were convened to provide input on specific strategies. These groups comprised of HPSG members, Planning Council members, DOH staff, PHSKC staff, Multnomah County Health Department and external subject matter experts. The rough draft of the plan and SCSN was presented in a statewide community forum, and 23 individuals attended. Representatives were present from all Ryan White components. Input from this meeting was utilized to fine tune the final draft of the plan.

People Living with HIV and Community Engagement

The Integrated Plan was created through a variety of committees and workgroups over more than a year. Most of these groups were convened by the HPSG, the body tasked with planning for Ryan White Part B, Part B ADAP and related program income, CDC Prevention, and State prevention and care dollars. The Planning Council, the body responsible for Ryan White Part A dollars, created the parts of the plan related to Part A services inside the Seattle TGA. The Council as a whole also gave input to the End AIDS Washington plan, and one of its members represented the Council on the End AIDS Committee. While the HPSG does not have membership slots designated for Council representatives, two Council members, one an unaligned consumer, currently serve on the HPSG, and other current and former Council members have served on HPSG committees of SEWs.

Seattle TGA

- a. The Seattle TGA HIV Planning Council is responsible for assessing need, prioritizing, and allocating Part A funds in King, Snohomish, and Island Counties. The Council currently has 24 members and 45.8% of them are unaligned consumers of RWPA services. Both the consumers as a subset, and the Council as a whole are reflective of the epidemic, with the exception of Hispanic members. A new Council applicant who is Hispanic has been approved for membership by the Council, and should be appointed by the King County Executive within a month. Because U.S. born Blacks account for 10% of cases, and foreign born Blacks account for 8% of cases within the jurisdiction, the Council's membership committee ensures that both are proportionately represented on the Council. Council

and committee meetings are open to the public, are advertised and all have opportunities for public input.

In addition to those who were involved “in the room,” PLWH are represented through a variety of data sources that the Council uses for decision-making. Core surveillance and the Medical Monitoring Project are two key data sources for the Council, and PHSKC and DOH epidemiologists provide detailed analyses of these data for use by the Council. Other local data that was particularly important for the Council’s was from the CAPP and LOOC programs, both of which find people who are out of care or not virally suppressed, find out why they are out of care, and work to get them reengaged. While the information from these PLWH is not representative of the epidemic in the jurisdiction, it is representative of those PLWH who are in greatest need of help from Part A. CAPP includes information on the barriers for people staying in care and, as such are very valuable to Council in allocating funds and setting directives. King County is a site for the National HIV Behavioral Surveillance survey (NHBS), which provides information on PAHR, HIV prevalence, and testing behavior. The Council requests that additional local questions be added to MMP, which is the best random sample PLWH project to assess need. The Council itself conducts needs assessments with PLWH, to supplement these sources. Because open meetings and focus groups often do not provide a representative sample of consumers, the Council also conducts targeted interviews with PLWH.

Additionally, the Council and grantee reached out to existing community groups in communities that are disproportionately affected by HIV, such as ethnic media organizations. Many of these organizations and communities do not feel comfortable going to a meeting that is about HIV, but all were very welcoming, and gave very valuable perspectives, ideas and feedback when we went to them.

- b. In the Seattle TGA, the Council was involved in plan development in several places, and Council consumers often had great impact. Just a few specific examples include:
 1. Consumers pushed for “quality of life” to be added to End AIDS Washington, and emphasized the different needs of aging PLWH.
 2. Consumers pushed against “one-size-fits-all” programming, noting the diversity of need, identity and belief among PLWH. Specifically, consumers pushed for programming that addresses stigma.
 3. Consumers are the ones who refuse to accept the answer “it’s just impossible.” An example in the TGA is providing Oral Health programming. Without consumer activism, this service would not exist in the TGA. While this is a core service, some providers felt it was not important to HIV health. Consumers made compelling arguments about how this service supports HIV care, and how the lack of it can interrupt other care. They also researched and found dental models used in other Part A cities.
 4. Consumers who live outside of the city of Seattle have been very effective in advocating for the needs of other areas. These include demanding food drop off points in south King County and Everett, and adding dental providers in Snohomish County.

5. Consumers pushed for additional and coordinated funding around transitional and emergency housing, as well as for services that help PLWH find and maintain housing.
 6. Consumers pushed for the requirement that agencies do a better job of getting information about their services out to all consumers, and that, when demand exceeds funding that priority not just be “first come, first served,” noting that those consumers in-the-know are often not those with the greatest needs.
 7. Consumers pushed for equity and social justice work within the Council and the service system.
 8. Consumers are often the ones to ask uncomfortable questions, such as “how many at-risk African Americans and Women are enrolled in the (service type redacted) program.” Often just raising the issue helps to spur forward action.
 9. Consumers were the ones to identify the problem with GBT PLWH participating in substance use treatment due to the homophobia within programs. They also pushed for harm reduction programming.
- c. Methods for engaging PLWH in the Seattle TGA are listed above. In addition to advertising, Council members are asked to reach out to consumers and help them attend meetings. Periodic consumer-only meetings are a chance for both education and input. Because prevention and testing dollars are planned for at the State level, the Council has not worked much with people who do not know their HIV status. That is changing, and with the change comes the need to diversify the Council. The Council has always had representatives from high risk communities, whether PLWH, providers or other experts.
- d. As stated above, in the Seattle TGA impacted communities are involved throughout the process, and are often the ones to drive the conversation.

Washington State

- a. The WA State Planning System has three components; HPSG, Special Emphasis Workgroups and Village. PLWH and PAHR represent 16% of the HPSG and workgroup membership, Villages are convened in order to provide PLWH & PAHR multiple and varied opportunities for input. The planning system worked to provide-multiple opportunities to reach PLWH, individuals at risk for HIV, and other stakeholders, striving to hear from all parts of the state and all communities affected by HIV. Feedback methods included an open-ended survey, available in English and Spanish, online and in paper form, through which the Steering Team received a total of 137 responses. The Steering Team also held six community forums around the state, in Seattle, Tacoma, Everett, Spokane, Yakima and Vancouver, as well as targeted community conversations. Through all of these methods, approximately 350 people were engaged in the formation of these strategies.

- b. The impact of PLWH & PAHR on the plan was significant.

The comments received can be grouped into two broad categories, substantive and implementation. Different approaches were implemented for addressing these two broad categories. Implementation will be utilized by program staff to ensure successful implementation of the strategies

- **Substantive** “What”: What should be added to?
- **Implementation** “How”: How should these be implemented?

HPSG Response to Substantive Comments

Substantive comments focused primarily on three topics: PLWH over age 50, Transgender people, and HIV and Drug User Health. These comments share a common theme, “One size does not fit all.”

PLWH Over Age 50

Major themes

Comments related to this theme conveyed a sense of invisibility. People expressed feelings of invisibility in this report as well as the current HIV services delivery system. This was particularly profound given approximately half of the people living with HIV in Washington State are over the age of 50, some of whom are long term HIV survivors. In addition to the medical issues they face from taking earlier-generation medications (some with unanticipated side effects), they also are affected by limited incomes, housing issues and isolation experienced by many older Washingtonians.

Response

The HPSG strategized to address this issue in a way which demonstrates our understanding of the depth and breadth of these comments. We determined that significant effort must be made to engage and learn about the unique needs of this group before action steps can be developed that are relevant. We prioritized this as topic for future work. It is likely that the meaningful inclusion of PLWH over 50 will impact the current Stigma, Disparities, Health Care System for Sexual Minorities, Housing, and Community Engagement Recommendations (and perhaps others.) The broad impact of these comments and need for deep listening contributed to our decision to add it as an additional item rather than simply revise the existing recommendations.

Transgender People and HIV

Major themes

People raised concerns that the recommendations did not acknowledge transgender people as distinct. They are unique and cannot be “lumped together” with other groups at risk for HIV or living with HIV. The recommendations include transgender people throughout the report; however transgender women to be included with gay and bi men. Significant effort needs to be made to engage with and learn more about the needs and circumstances transgender people face, before action steps can be revised to determine what steps must be taken to make them relevant for transgender people.

Response

The comments eloquently expressed the need to talk to transgender people directly regarding their lived experience. They cautioned us to not assume a recommendation developed to respond to the need of a gay or bisexual man is applicable to a transgender woman. The HPSG recognized the need to engage the transgender community in a process to refine the recommendations to create transgender specific strategies. The need for deep listening and engagement with the transgender community contributed to our decision to add Transgender People and HIV as an additional item rather than simply revise the existing recommendations.

Drug User Health

Major Themes

Drug user health is an important issue and while People Who Inject Drugs (PWID) are included in many places in this Report; we received feedback that this group should be the focus of a separate Recommendation.

Response

The health care needs of PWID are complex and encompass a number of health risks beyond HIV. The current HIV framework and programming includes a significant focus on PWID. An additional strategy designed to promote and strengthen drug user health, particularly to reduce the risk of transmission of HIV infection was created

- c. DOH integrated HIV care and prevention planning in 2014 and implemented a new HIV planning system. The vision is to end the HIV epidemic in Washington State. We do this by preventing new HIV infections and by keeping people with HIV healthy. People living with HIV are encouraged to participate in all three parts of this planning system, which includes the HIV Planning Steering Group, HIV Stakeholder Village, and HIV Special Emphasis Workgroups. The Stakeholder Village component was designed specifically to maximize opportunities for participation of PLWH and PAHR in HIV planning.

HIV Planning Steering Group (HPSG)

The HPSG is a 21-member, formal, standing, advisory committee. It works with the DOH to develop a statewide HIV plan.

The Stakeholder Village

The Stakeholder Village is open to everyone. It does not have formal members. Its purpose is to both give and receive information.

HIV Special Emphasis Workgroups

Ad-hoc groups of subject matter experts focused on a specific HIV topic or issue.

- d. The Integrated HIV Prevention and Care Plan is a living document. These strategies will be refined as we move through implementation. They are dynamic. They will be informed by community conversations and collaboration that take place throughout their implementation. It is the intent of the HPSG that these recommendations provide a solid foundation for this intensely collaborative work. Using this plan as a road map we hope to create transformational change and through that change End AIDS in Washington State!

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