

# **Plan to Support Ending the HIV Epidemic in King County**

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Washington State Department of Health  
EHE & Non-EHE Partner Organizations  
HIV Prevention & Care Community Members  
New Voices

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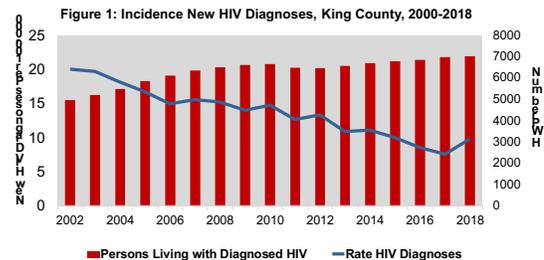
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## SUMMARY

In 2015, King County became the first urban area in the U.S. to achieve the World Health Organization 90-90-90 objective, and in 2018 an estimated 93% of all persons living with HIV (PLWH) were aware of their status, 92% of newly diagnosed persons were linked to HIV care within one month of testing positive and 85% of diagnosed persons were virally suppressed.<sup>1</sup> Our county had made remarkable progress in the fight against HIV. But our success was accompanied by a troubling trend: the social marginalization of HIV. HIV incidence continues to disproportionately affect Black and Latinx men who have sex with men (MSM), and both viral suppression and PrEP use is lower among Black MSM than among White MSM.<sup>2</sup> Also, the time from contraction to diagnosis among MSM -

estimated using the median HIV inter-test interval among newly diagnosed cases – has not changed for more than a decade, suggesting that our progress testing those at greatest risk for HIV has stalled.<sup>2</sup> Finally, and perhaps most importantly, King County faces a new and locally unprecedented HIV epidemic among persons who inject drugs (PWID).

Fueled by growing epidemics of homelessness and injection drug use, the number of non-MSM PWIDs newly diagnosed with HIV increased over four-fold in 2018, resulting in the largest one-year increase in the number of new HIV diagnoses in King County since 2002.<sup>2</sup> However, the number of new diagnoses among persons with other risks, including MSM who do not inject drugs, remained stable.<sup>2</sup>



King County confronts a new HIV epidemic, one that will require a new plan if we are to achieve the End the HIV Epidemic (EHE) goal of reducing new HIV diagnoses by 75% by 2025. The EHE initiative seeks to strengthen the HIV healthcare and public health workforce in areas of the U.S. most affected by HIV, including King County, through four key pillars: 1) diagnosing PLWH as quickly as possible following infection; 2) treating PLWH as soon as they are diagnosed and assuring their sustained viral suppression; 3) protecting persons at high risk for acquiring HIV using scientifically proven interventions, particularly HIV pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs); and 4) rapidly detecting and responding to growing clusters of PLWH to halt further spread of HIV.

In this document we outline our approach to engaging community stakeholders in developing an EHE plan for King County, summarize the epidemiology of HIV in King County and the results of a situational analysis to assess current needs of people at high risk for HIV infection and gaps in strategies to address their needs through existing HIV prevention, HIV care, and social service systems, and close with a plan for how partners working to end the HIV epidemic in King County plan to work together and use EHE and non-EHE funding to implement targeted activities under each pillar to achieve rapid and radical decreases in HIV incidence over time. However, in the context of the coronavirus pandemic and other likely economic and social shifts in our region, we anticipate needing to revise the plan as implementation of EHE activities progresses. As such, we consider this plan to be a living document - one that we will revisit and revise at least annually during the initiative.

## SECTION ONE: COMMUNITY ENGAGEMENT

To develop the King County EHE plan, we engaged a broad set of community stakeholders with long-standing commitment and experience with our HIV prevention and care system as well as identified and engaged "new voices" - individuals from populations and organizations completely new to HIV, and for some, public health. The overarching frame of this engagement was to identify actionable strategies to promote fundamental healthcare system change to improve access and care engagement and tailored interventions for populations currently most impacted by the HIV epidemic, such as PrEP for PWID. Planning members included people from populations at risk for acquiring or living with HIV, community-based organizations (CBOs), medical providers, healthcare organizations (HCOs) and social service providers, and representatives from state and local governmental agencies - especially those outside of public health (e.g., from systems specific to corrections, homelessness, and substance use). Beyond planning, engaging these new stakeholders helped create a foundation and relationships needed to implement and ultimately achieve the goals of our EHE plan.

Our experience in collaborating as a community to develop other HIV plans, such as the current Washington State HIV plan, End AIDS Washington (EAW) 2014-2020, and recommendations from the BREE Collaborative, helped shape how we organized the planning process. Specifically, we developed a planning infrastructure that balanced the need for comprehensive input with the need to efficiently develop a plan by September (and then later, December), 2020. We hired an EHE Planning Coordinator in December 2019 to facilitate the planning process and she, in turn, rapidly convened the first two meetings of the core planning body (the "EHE Planning Committee" (EPC) described below) in January and February of 2020 to define and solidify the formal planning structure, review and identify gaps in the epi synopsis and situational analysis, discuss activities for the CDC EHE application, and start identifying new voices participants through committee members' respective networks and communities.

Unfortunately, soon after the February meeting took place the first cases of Covid-19 in the US were identified in King County and rapidly evolved into a local public health emergency that interrupted the EHE planning process not only for PHSKC but for almost all members of the planning committee. Between February and when the planning was revived in the summer, almost a fourth of people initially engaged in the planning process were either no longer employed at their agencies or were overwhelmed with addressing the pandemic from within their organizations to continue to engage. Further, the recently hired EHE planning coordinator was temporarily and then permanently re-deployed to assist with the pandemic response. As a result, PHSKC engaged a former employee to return and complete the planning process and when the planning body reconvened, they decided to modify the planning structure to include a smaller number of subcommittees and additional mechanisms for input on proposed activities that did not involve attending formal meetings, such as a public input meeting and online feedback mechanism on the EHE website. Ultimately, the EH planning structure included the following:

1. EHE Planning Committee (EPC)

To involve diverse stakeholders in the EHE planning process, we initially convened an ad hoc subcommittee of the WSDOH HIV Planning Steering Group (HPSG) to solidify an approach to EHE planning. This group and additional King County stakeholders

recommended additional members from populations and organizations serving populations at disproportionately high risk for or living with HIV in King County, including members representing Black and Latinx populations in King county, the varied experiences of populations experiencing homelessness, injecting drugs, and/or engaged in sex work in our region, and the diverse experiences of our LGBTQ community.

Ultimately the EPC was comprised of 27 members with representatives from each large stakeholder group (HIV planning bodies, community partners, service providers, and implementation partners), with 15-20 attending each meeting. This body met five times - twice before the pandemic started and three times since - to discuss and revise the planning process, epi report, situational analysis, draft activities proposed in the HRSA and CDC applications, activities they and other stakeholders suggested be added, and input obtained from meetings of the EPC advisory groups described below.

## 2. EPC Advisory Groups

To engage additional stakeholders not part of the core planning body, the EPC planning coordinator convened two EHE-specific advisory groups, and solicited input and recommendations from the two existing formal HIV prevention and care planning bodies guiding prevention and care services in King County: the Seattle Ryan White Part A TGA Planning Council and the Washington State HIV Planning Steering Group. Specifically,

- A. *Prevention and Care Advisory Group (PCAG)*: The PCAG was comprised of people representing populations at high risk for or living with HIV, community-based organizations and social service providers serving these populations, and other vital community stakeholders, including new voices. PCAG met twice during the planning process to review and provide input on the epi profile, situational analysis and activities under consideration by EPC. The discussions and recommendations from PCAG were summarized and sent to the group for revise and refinement, then sent to the EPC and reviewed in detail during the next EPC meeting. Input from PCAG members had an immediate impact on the EHE plan, with all recommendations either incorporated as additions or substantive changes or framing for implementation of EHE activities. PCAG was comprised of 27 participants and between 12-20 participated in each meeting.
- B. *Healthcare Advisory Group (HCG)*: The HCG was comprised of physicians, health systems administrators, and pharmacy managers from all major health care systems, community health centers, large private practices in King County, as well as representatives from our state's Medicaid program. This group met once during the planning process to review and provide input on activities and initiate a formal healthcare learning collaborative to address specific EHE activities described below. Of note, many of these individuals and organizations were new voices and had never engaged in HIV prevention and care planning efforts before and brought new ideas and enthusiasm for achieving the goals of EHE within the various healthcare delivery systems in our county. HCG was comprised of 43 members - 24 were able to participate in the planning meeting and more voiced plans to participate in the collaborative work moving forward.

- C. *Seattle TGA Part A Planning Council*: The Seattle TGA Part A Planning Council is comprised of a diverse group of stakeholders who work together to understand and use Ryan White Part A funds to address the needs and service system gaps for people with HIV in King, Snohomish, and Island Counties. The EPC coordinator incorporated into the situational analysis reviewed by the EPC, shared information and sought input from council members during regular council meetings during the EHE planning process, and encouraged council members to participate in EHE planning as members of the PCAG. The planning council is currently comprised of 22 people.
- D. *Washington State HIV Planning Steering Group (HPSG)*: The HPSG is a formal, standing advisory committee comprised of people living with HIV and HIV prevention and care providers throughout the state of Washington. PHSKC staff engaged in EHE planning engaged with HPSG four times - first when developing the planning structure and then additional times to solicit input and recommendations about draft EHE activities. The HPSG is currently comprised of 21 members.

The discussions and recommendations from each advisory group meeting were summarized by the EHE coordinator, sent to each group for review and refinement, and then provided to the EPC for their review and discussion during EPC meetings. Ultimately, the EPC decided to incorporate almost all of the advisory bodies' suggestions, adopting some verbatim and others as overarching values and/or recommendations for EHE implementation.

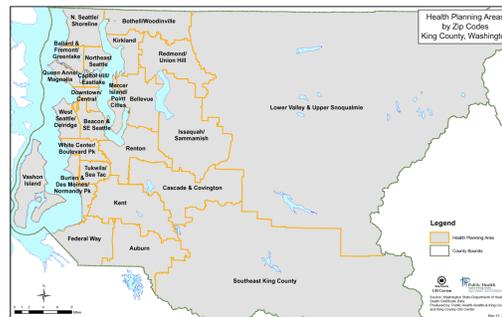
### 3. Public Information and Dialogue Session

To engage people not able or interested in participating in the formal planning and advisory groups listed above, we posted the draft EHE plan to the PHSKC website, provided an email address to which people could submit questions and feedback, scheduled a public information and discussion session via zoom and sent a notification about all of these opportunities to provide input to the Seattle TGA Planning Council, EPC, and a longstanding listserv maintained by PHSKC that communicates information to a wide variety of HIV and non-HIV related stakeholders - and requested that they share the email with their respective personal and professional networks. The feedback and recommendations from public comments and the public meeting were summarized, incorporated into the final draft plan, and either adopted, revised, or deleted during the last meeting of the EPC. Ultimately three people submitted feedback through email and nine participated in the zoom information and dialogue session.

## SECTION TWO: EPIDEMIOLOGIC PROFILE

The epidemiologic profile below is a snapshot summary from the [2019 HIV Epidemiology Report for King County](#).<sup>2</sup> The 2020 Epidemiology Report will be published in early 2021.

King County is the most populous county in Washington State and the 12<sup>th</sup> most populous county in the U.S., with over 2.2 million residents in 2018. The area has a rapidly growing population associated with a booming technology sector (about 16% increase between 2010 and 2018), with an associated increase in housing costs and decreasing affordability for lower income persons. The average income of a King County resident is \$40,656 a year, compared to a U.S. average of \$28,555 a year. King County is bordered by Puget Sound to the west, the Cascade Mountains to the East, and Snohomish and Pierce counties to the north and south respectively. King County has seen a steep rise in homelessness over the past decade, as well as increases in methamphetamine and opioid use.

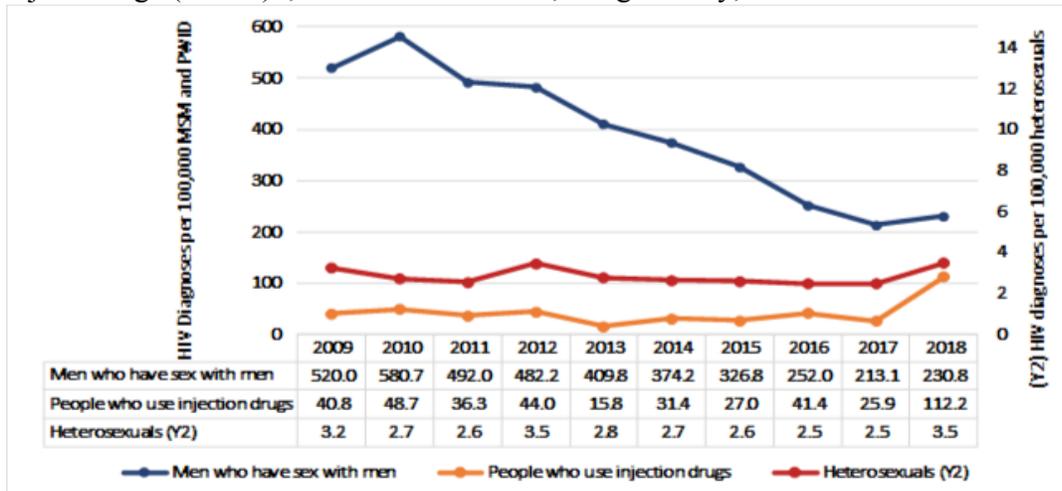


In terms of public health infrastructure, King County has a joint city/county health department, Public Health – Seattle & King County (PHSKC), comprised of 1,400 employees, 40 sites, and an annual budget of \$686 million. Of note, PHSKC has the largest and second oldest syringe services program in the nation and exchanged ~8 million syringes in 2018.

There are an estimated 7,468 people living with HIV in King County, including 7,023 (93%) diagnosed with HIV and 5,855 (84%) of whom are virally suppressed. Over the past decade, the county has met numerous goals related to HIV prevention, treatment, and care. It was the first urban jurisdiction in the U.S. to meet the World Health Organization's 90-90-90 goals, ensuring that  $\geq 90\%$  of all persons with HIV (PLWH) know of their status,  $\geq 90\%$  of diagnosed persons receive medical care, and that  $\geq 90\%$  of those in care are virally suppressed. However, in 2018, the area experienced an outbreak of HIV among persons who inject drugs (PWID), raising the possibility that the county's long-term progress was in jeopardy.

**Increase in New Diagnoses:** In 2018, there were 218 (54%) new HIV diagnoses among King County residents. This was the largest one-year increase in the number of new HIV diagnoses since 2002 (up from 162 diagnoses in 2017). The increase was driven by a 400% increase in the number of new HIV diagnoses among PWID, while the number of new diagnoses in persons with other risks, including men who have sex with men (MSM) who do not inject drugs, remained stable (Figure 2). The increase in HIV among PWID is concentrated among persons who are living homeless, many of whom are women who exchange sex. The occurrence of HIV in this population represents a shift in King County's HIV epidemic - HIV among PWID in King County has traditionally been concentrated in MSM who inject methamphetamine, 40-45% of whom are HIV positive, while 1-4% of non-MSM PWID are HIV positive.

Figure 2: Rate of New HIV Diagnoses for Men Who Have Sex with Men (MSM), People Who Inject Drugs (PWID)<sup>A</sup>, and Heterosexuals<sup>B</sup>, King County, 2009-2018



<sup>A</sup> People who use injection drugs exclude men who have sex with men. <sup>B</sup> Heterosexuals include individuals with unknown HIV risk.

King County uses the National HIV Strategy (NHAS) as a framework for monitoring progress related to HIV-related goals, using annual dashboards and 2014 data as a baseline (Table 2).

Progress towards NHAS Goals include:

- 1) **Reduce New HIV Infections:** In 2014, King County aimed to reduce the rate of new HIV infections by 25% by 2020, which mirrors the NHAS goal. We met this goal in 2017. However, the increase in HIV diagnoses among PWID resulted in the county falling short of the 25% reduction goal in 2018.
- 2) **Improve Health Care Access and HIV-Related Health Outcomes:** NHAS aims to ensure that 90% of people living with HIV are engaged in care and 80% are virally suppressed. King County has higher local goals for both indicators (95% and 90%, respectively). King County has met the national goals with 90% in care and 84% suppressed (see Figure 3, 2018 continuum below), and we are on pace to reach our higher local goals.
- 3) **Reduce HIV-Related Disparities:** King County has an explicit goal of ensuring that there are no differences in viral suppression or the incidence of new HIV diagnoses by gender or race/ethnicity within HIV risk groups. (In monitoring the HIV epidemic in Blacks, we separately consider US and foreign-born populations since a large proportion of new diagnoses among Blacks in King County occur in immigrants who acquire HIV outside of the US, infections that are not avertable by local public health.) The county has made mixed progress toward reducing disparities in HIV outcomes across groups defined by race/ethnicity. On the one hand, HIV diagnosis rates continue to be substantially higher for both U.S.-born Black and U.S.-born Latinx persons relative to Whites. On the other hand, differences in viral suppression between groups have declined over the past decade. Table 3 below presents multiple care characteristics for subsets of PLWH.

In addition to NHAS, King County has been guided by the goals of the End AIDS Washington (EAW) plan to establish new, more ambitious targets in response to program success. EAW seeks to decrease new HIV diagnoses by 50% by 2020, and to ensure that 90% of PLWH are in care and 80% are virally suppressed.

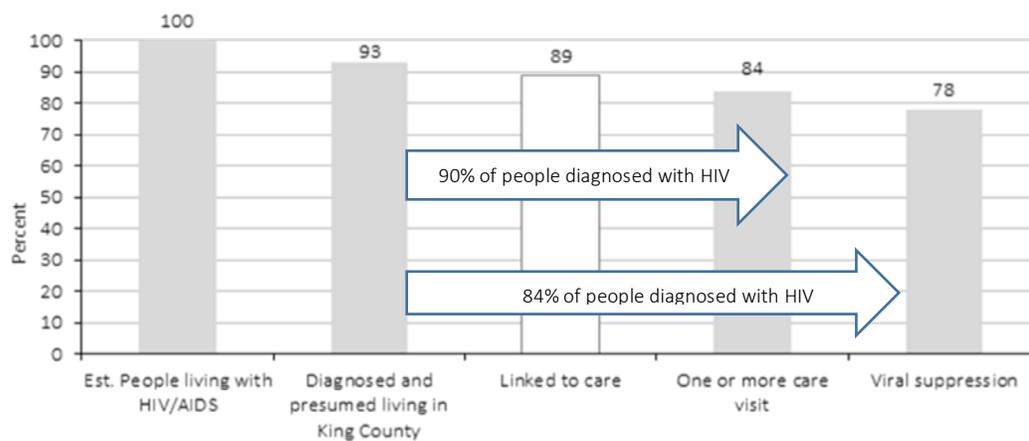
Table 2. King County HIV Goals and Evaluation Metrics: 2019 Dashboard

King Co. 2018 HIV dashboard (partial)	2020 GOALS		DATA, 2014-2018		TREND (KEY BELOW)
	U.S. GOALS	KING CO.	2014	2018	
<b>HIV TESTING, CASE FINDING, PREVENTION</b>					
New HIV diagnoses, rate	↓25%	↓25%	11.0/100,000	10.0/100,000	⊗
Know HIV status	90%	95%	92%	93%	⬆️★
Late HIV diagnosis	--	<20%	24%	25%	⊗
Recent HIV testing, MSM	--	75%	73%	69%	⊗
PrEP use, high-risk MSM	--	50%	9%	49%	⬆️
Syringe coverage	200/PWID	365/PWID	258/PWID	300/PWID	⬆️★
<b>HIV CARE, MORBIDITY, MORTALITY</b>					
Linked to care in 1 month	85%	90%	88%	89%	⬆️
Linked to care in 3 months	--	95%	92%	94%	⬆️
In HIV care	90%	95%	89%	90%	⊗★
Viral suppression	80%	90%	79%	84%	⬆️★
Viral suppression in 4 months	--	75%	58%	75%	✅
Homelessness	<5%	<5%	14%	11%	⊗
HIV/AIDS mortality	↓33%	↓33% (0.8/100)	1.2/100 PLWdH	0.9/100 PLWdH	⬆️

Abbreviations: PrEP, pre-exposure prophylaxis for HIV; PLWdH, people living with diagnosed HIV; MSM, men who have sex with men.

Key: ✅ Goal met   ⬆️ On pace to meet goal   ⊗ Not on pace to meet goal   ★ National goal was met, not local goal

Figure 3: 2018 King County HIV Care Continuum

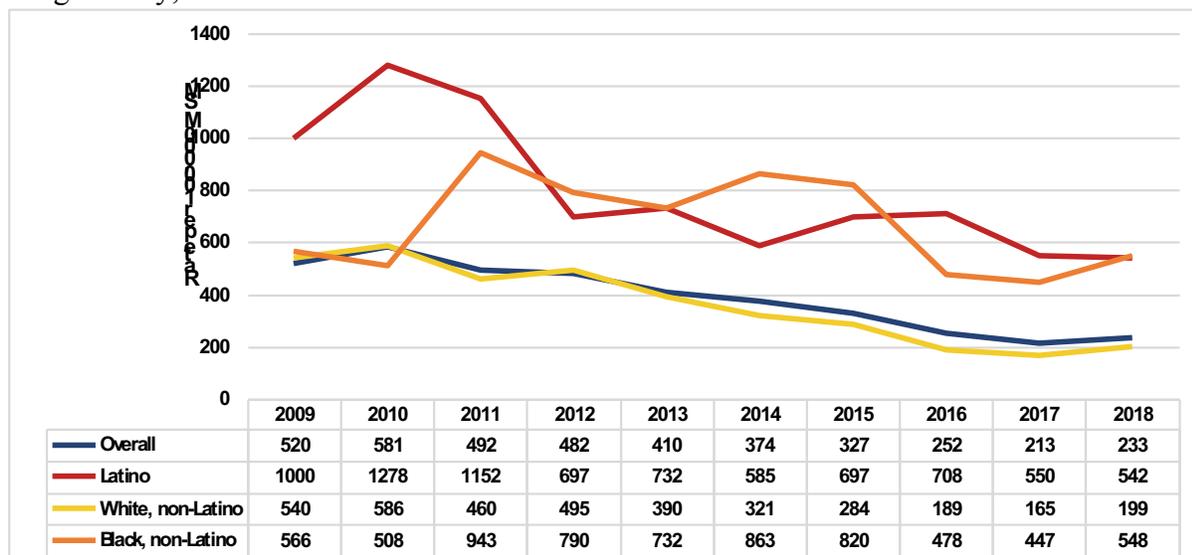


In addition to people living homeless persons, PWID, and others described above, three other populations in King County stand out as having significant HIV care and prevention needs:

**Men who have Sex with Men (MSM):** Although the diagnosis rate in King County among MSM has declined by more than 50% over the last decade, MSM, including MSM who inject drugs, continue to comprise the majority of new HIV diagnoses in King County (70%). We estimate 9% of all MSM living with HIV, but prevalence varies dramatically by race/ethnicity. About 15% of Black MSM, 14% of Latinx MSM, and 12% of American Indian/Alaska Native MSM have diagnosed HIV, compared to 9% of White MSM. PrEP use is lowest among Black and Native American MSM.

**People of Color:** HIV also disproportionately affects the overall Black and Latinx populations (Figure 4). The rate of new HIV diagnosis is higher among U.S.-born Black persons than other racial groups, as is the rate among Latinx persons. And while differences in viral suppression rates between racial/ethnic groups have narrowed in the past few years, viral suppression continues to be lower among US-born Blacks than among other racial/ethnic groups.

Figure 4. Rate of New HIV Diagnosis Among MSM Overall and By Selected Race/Ethnicity, King County, 2009-2018



**Foreign-born Populations:** The disproportionate impact of HIV on Black persons is partly due to a higher prevalence of HIV among foreign-born Black residents. In 2018, 55% of all Black persons diagnosed with HIV were foreign born, and from 2014-2018 64% of non-MSM Black persons diagnosed with HIV were foreign born (primarily born in sub-Saharan Africa). While foreign-born Black persons have the highest rate of new HIV diagnosis, prior work suggests that a majority of persons newly diagnosed with HIV in this population acquired HIV prior to arrival in the U.S. Further, while foreign born Black persons more frequently have late HIV diagnoses, in King County they typically have higher levels of viral suppression than U.S.-born persons with HIV.

Table 3: HIV Care Metrics, including Late Diagnosis, Linkage to Care, Being in Medical Care and Viral Suppression for Selected Groups Living with HIV (PLWdH), King County, 2018

KING COUNTY		NEW HIV DIAGNOSES (2018) <sup>A</sup>			PLWdH IN 2018		
	PWDH (N)	NEW DIAGNOSES IN 2018 <sup>A</sup>	LATE HIV DIAGNOSES (AIDS WITHIN 1 YR OF HIV)	LINKED <sup>B</sup> TO CARE WITHIN 1 MONTH OF DIAGNOSIS	HAD ONE OR MORE CARE VISIT	SUPPRESSED AT MOST RECENT VIRAL LOAD (<200 COPIES)	
<b>TOTAL*</b>	6,976	218	26%	89%	90%	84%	
<b>GENDER</b>							
Men (sex assigned at birth)	6,095	173	24%	90%	91%	84%	
Women (sex assigned at birth)	881	45	31%	89%	90%	82%	
Transgender <sup>A,C</sup>	63	11 <sup>A</sup>	18%	91%	94%	83%	
<b>RACE, ETHNICITY AND NATIVITY</b>							
White	3,819	108	16%	87%	91%	85%	
Black	1,404	49	45%	92%	90%	80%	
	<i>Foreign-born</i>	613	27	59%	93%	91%	
	<i>U.S.-born<sup>D</sup></i>	791	22	27%	91%	81%	
Latinx	974	39	31%	95%	90%	83%	
	<i>Foreign born</i>	486	15	60%	100%	91%	
	<i>U.S.-born<sup>D</sup></i>	488	24	12%	92%	89%	
Asian	295	10	20%	90%	88%	85%	
Pacific Islander <sup>A</sup>	77	14 <sup>A</sup>	36%	93%	90%	75%	
Native American/AK Native <sup>A</sup>	236	33 <sup>A</sup>	21%	82%	92%	81%	
<b>HIV RISK FACTORS</b>							
Men who have sex with men (MSM)	4,644	106	19%	97%	91%	86%	
People who inject drugs (PWID)	274	31	10%	77%	89%	74%	
MSM-PWID	638	21	29%	86%	89%	77%	
Heterosexual	719	24	50%	96%	90%	82%	
	<i>Foreign born</i>	408	16	69%	100%	90%	
	<i>U.S.-born<sup>D</sup></i>	301	52 <sup>A</sup>	54%	87%	90%	
<b>OTHER FACTORS</b>							
Foreign Born	1,538	56	48%	96%	90%	85%	
Meth use (collected since 2009)	381	51	10%	88%	90%	74%	
<b>RACE/ETHNICITY AMONG MSM</b>							
White MSM	3,357	69	14%	93%	91%	87%	
Black MSM	561	18	22%	89%	89%	79%	
Latinx MSM	793	27	30%	100%	90%	84%	
	<i>Foreign born</i>	354	9	56%	100%	89%	
	<i>U.S.-born<sup>D</sup></i>	439	18	17%	100%	88%	

<sup>A</sup> Due to small numbers, fewer than 10 in 2018, newly diagnosed Native Am./AK Natives, Pacific Islanders, U.S.-born heterosexuals, and transgender persons were based on 5 years of diagnoses --from 2014 to 2018. Additionally, note that for Native Americans and Pacific Islanders, multiracial and Latinx persons are included if they are also Native American or Pacific Islander.

<sup>B</sup> "Linked" is based on percent of cases diagnosed in 2018 linking to care based on CD4 or viral load tests within 3 months of diagnosis.

<sup>C</sup> Transgender category, for prevalent cases, includes transgender women (90%) and transgender men (10%); for 5-year incident diagnoses, 9 were transgender women and 2 transgender men.

<sup>D</sup> U.S.-born includes unknown country of birth.

\* Total excludes individuals with unconfirmed relocations as of the time of analysis (e.g., identified by online Internet database searches, but not confirmed by the new jurisdiction or another secondary source) and no laboratory results reported in 18 months (N = 47, resulting in 6,976 PLWH)

## SECTION THREE: SITUATIONAL ANALYSIS

King County confronts a new HIV epidemic, one that will require a new response if we are to achieve the EHE goal of reducing new HIV infections by 75% by 2025. This section provides a snapshot summary of the most recent situational analysis of the HIV epidemic in King County, including the most up to date quantitative and qualitative data describing the needs of people at risk for or living with HIV (especially those who are out of care or have an unsuppressed viral load) and gaps in our HIV prevention and care system's capacity and activities to address those needs. This snapshot is organized by the four pillars of EHE and whenever possible incorporates needs and gaps that have emerged since the start of the coronavirus pandemic.

### Pillar 1: Diagnose

HIV Testing– PHSKC and WA DOH have explicit, validated screening guidelines to promote annual or quarterly HIV/STI screening of MSM and transgender persons based on risk, promote widespread HIV testing through direct provision of tests, and monitor HIV testing frequency in higher risk populations (Table 4). In 2018, the PHSKC Sexual Health Clinic and publicly-funded CBO's, including Center for Multicultural Health, Entre Hermanos, Gay City, Lifelong, Neighborhood House and POCAAN, performed 15,255 HIV tests and 28% of all newly diagnosed cases were diagnosed through publicly-funded HIV testing.<sup>3</sup> HIV testing is also available in King County through all healthcare organizations and private medical providers, public health centers and teen health clinics, community health centers, and Planned Parenthood sites.<sup>4</sup> However, 20% of persons diagnosed with HIV in 2018 had an AIDS diagnosis within a year of HIV diagnosis, with the greatest risk of late diagnosis seen among foreign-born persons who are neither MSM nor PWID.<sup>2</sup> There remains a need for focused efforts to test persons at high risk, while expanding HIV testing as part of routine medical care, particularly among PWID and persons from countries where HIV is highly prevalent.<sup>2</sup>

<b>TABLE 4: PHSKC &amp; WA DOH HIV SCREENING GUIDELINES<sup>2</sup></b>
<b>ALL RESIDENTS</b>
<ul style="list-style-type: none"> <li>· Test at least once between the ages of 18 and 64</li> <li>· Test concurrent with any diagnosis of gonorrhea or syphilis</li> <li>· Pregnant women should test in the 1st trimester and women who use methamphetamine, opioids, or exchange sex should test again in the 3<sup>rd</sup> trimester.</li> </ul>
<b>MEN WHO HAVE SEX WITH MEN (MSM) AND TRANSGENDER PERSONS WHO HAVE SEX WITH MEN*</b>
Indications for testing every 3 months (any of below risks in the prior year)*: <ul style="list-style-type: none"> <li>· Diagnosis of a bacterial sexually transmitted infection (STI) (e.g. early syphilis, gonorrhea, chlamydia)</li> <li>· Use of methamphetamine or poppers (amyl nitrate)</li> <li>· &gt;10 sex partners (anal or oral)</li> <li>· Condomless anal intercourse with an HIV+ partner or partner of unknown status</li> <li>· Ongoing use of HIV pre-exposure prophylaxis (PrEP)</li> </ul> MSM and transgender persons who have sex with men without the above risks should HIV test annually <sup>+</sup>
<b>PERSONS WHO INJECT DRUGS*</b>
<ul style="list-style-type: none"> <li>· Annual HIV testing all PWID</li> <li>· Every 3 months in PWID who exchange sex for money or drugs or who are pregnant</li> </ul>
* Persons should also be tested for syphilis, gonorrhea and chlamydia at all exposed anatomical sites + Persons who have not had sex in the prior year or who are in long-term mutually monogamous relationships do not require annual HIV/STI testing.

Partner Services– In King County, partner services are provided by PHSKC, and PHSKC has conducted population-based HIV partner services for over a decade. Partner services are voluntary and confidential services available to individuals who test positive for HIV, as well as their sex and needle-sharing partners. PHSKC seeks to provide partner services to all persons with newly diagnosed with HIV to: 1) to ensure that the partners of persons diagnosed with HIV

learn of their potential exposure, are tested for HIV, and learn their HIV status; 2) to ensure that persons diagnosed with HIV are linked to sustained medical care and to other social and support services (*Pillar 2*); and 3) to link persons at risk for acquiring HIV to prevention services, particularly PrEP (*Pillar 3*). (*Partner services cluster investigation activities are described under Pillar 4.*) At present, disease intervention specialists (DIS) work with a surveillance epidemiologist to investigate newly reported HIV cases and provide partner services to persons newly diagnosed with HIV. **However, the increase in cases observed in 2018 coupled with the increasing social marginalization of persons newly diagnosed with HIV and the emergence of a new HIV epidemic among PWID has taxed existing staff beyond their capacity; new cases are now harder to locate and require more time for investigation.**

Geographic distribution of new cases – King County encompasses 2,307 square miles and includes 35 cities, the largest of which is Seattle. Throughout this document north and central King County will be referred to as north and central Seattle, respectively. Among persons newly diagnosed in 2018, 21% lived in central Seattle, 46% in south King County, 17% in north Seattle, and 10% in east and 6% in west King County.<sup>2</sup> In 2019, the proportion of residents in south King County cities with suppressed viral loads ranged from 76-86%, with 79% viral suppression among Kent, 83% among Renton, and 76% among Federal Way residents - the three cities in which over half of PLWH in south King county live.<sup>2</sup> Yet the current system of HIV care is highly geographically concentrated, with 80% of all PLWH receiving care through a medical provider in central Seattle and **relatively few HIV providers exist outside of the city center**. Of particular concern, the availability of HIV care in south King County is very limited, with a one month wait for new patients to be seen in Madison Clinic’s satellite clinic in south King County, and the only significant source of HIV care in north Seattle is Northwest Hospital, a facility that as of 2020 is part of UW Medicine and thus a potential resource for expanded capacity in the future, but at present is a far distance from populations most at risk for HIV or who are out of care or virally unsuppressed (OOC/unsuppressed) in north Seattle and primarily serves older residents insured through Medicare and people in need of inpatient psychiatric care.

Populations at high risk for HIV Infection<sup>2</sup> - As described in the epidemiologic synopsis above, HIV diagnosis rates declined in the past decade among groups defined by major HIV transmission risk categories, followed by increases between 2017 and 2018 among PWID, particularly those living homeless and women who exchange sex.<sup>2</sup> HIV diagnoses among MSM who do not inject drugs remained stable. Among specific subgroups:

*MSM* – In 2018, MSM accounted for 59% of all new HIV diagnoses in King County. Since 2009, the number of HIV tests performed among MSM increased by 63% and in 2018, the median time since last HIV negative test among newly diagnosed MSM was 9.5 months. Among MSM diagnosed with HIV in 2018, over two-thirds, 69%, had tested HIV negative in the prior 2 years and only 5% reported never having tested for HIV previously. Of MSM with a negative HIV test prior to HIV diagnosis in 2018, 48% had tested negative within 2 months of diagnosis. HIV among MSM in King County is characterized by profound racial and ethnic disparities. HIV incidence continues to disproportionately affect Black and Latino MSM compared to White MSM. Latino MSM and Black MSM account for 21% and 14% of all new HIV diagnoses, respectively, but are only 10% and 6% of the estimated King County MSM population, respectively. In 2018, Black MSM diagnosed with HIV were more likely than White MSM to

have never HIV tested (12% versus 5%).

*U.S. Born People of Color*— Among U.S. born Black and Latinx persons, MSM is the predominant risk group (see paragraph above about HIV incidence disparities among Black and Latino MSM). Over the decade, heterosexual HIV diagnosis rates declined for U.S. born Blacks and Latinx person (32% and 28%, respectively). Several CBOs provide HIV testing services specifically aimed at preventing and otherwise mitigating the impact of HIV on communities of color in Seattle and greater King County but to date have limited case finding.

*PWID* – King County faces a new and locally unprecedented HIV epidemic among PWID, both MSM and non-MSM, fueled by growing epidemics of homelessness and injection drug use. PHSKC has increased HIV screening efforts for PWID by training syringe services program staff and outreach staff to perform rapid, point of care HIV screening tests, yet we need to do more. In 2018, PHSKC conducted a rapid needs assessment among PWID living homeless in north Seattle (n= 15) and learned that PWID in north Seattle need education about HIV and the importance of HIV testing and care, financial incentives and local access to testing and medical care are most likely to promote testing and care engagement, and street-based exchange sex in north Seattle increased after an anti-trafficking law passed in early 2018 which resulted in the shutdown of backpage, Craigslist personals, and other online forums sex workers used to use to advertise.

## **Pillar 2: Treat**

After an HIV diagnosis, most people in King County seek care and achieve viral suppression within a few months. But to reduce the incidence of HIV in King County we need to better understand and focus Pillar 2 activities on engaging in care PLWH who are OOC/unsuppressed. Based on HIV surveillance data, data collected through the Medical Monitoring Project (MMP) and D2C activities, and information gathered to inform HIV care and prevention efforts, we have a significant amount of information about OOC/unsuppressed persons, their comorbidities, service needs, and health outcomes (Table 5).<sup>4-7</sup> We define OOC/unsuppressed as having no CD4 count or viral load reported to surveillance for  $\geq 12$  months (“out of care”) or a VL  $>500$  copies/mL at the time of last report (“virally unsuppressed”). Compared to the overall population of diagnosed PLWH, OOC/virally unsuppressed persons are younger, more likely to be US-Born Black,<sup>7</sup> and have lower levels of income and education.<sup>7</sup>

Surveillance data suggest that approximately 1000 people with diagnosed HIV in King County are currently OOC/unsuppressed. However, case investigations consistently find that approximately 15% of PLWH who appear to be OOC have moved out of the county, and an additional 10% reside in the county and are in-care, but without recent laboratory test results reported to our health department. **Thus, we estimate that approximately 750 PLWH in King County are OOC/unsuppressed requiring care.**<sup>2</sup>

Syndemics Homelessness, substance use, and mental illness are syndemics that compound the difficulty of achieving and maintaining viral suppression. Among persons newly diagnosed with HIV, methamphetamine-using MSM are more likely to be unstably housed (24% vs. 6%), and in the Max Clinic, 45% of patients have substance use disorders, homelessness and untreated mental illness at the time of enrollment in the clinic.<sup>2</sup>

Table 5. Characteristics of PLWH by HIV care status, 2018, King County, WA.

Characteristic	Estimated Number (%) of Out of Care or Unsuppressed Persons <sup>D</sup> (n=757)	Virally suppressed <sup>D</sup> (n=6,220)	Total PLWH (n=7,023)
Cisgender Men	640 (85%)	5,399 (87%)	6,079 (87%)
Cisgender Women	108 (14%)	767 (12%)	880 (13%)
Transgender persons	9 (1%)	54 (1%)	64 (1%)
Age in 2018			
< 25 years	13 (2%)	121 (2%)	135 (2%)
25-44 years	380 (50%)	2,035 (33%)	2,431 (25%)
45+ years	364 (48%)	4,064 (65%)	4,457 (63%)
Race/Ethnicity:			
White	367 (48%)	3,452 (56%)	3,843 (55%)
Black or African American	186 (25%)	1,219 (20%)	1,414 (20%)
Latinx	122 (16%)	852 (14%)	983 (14%)
Other/Multiracial	82 (11%)	697 (11%)	783 (11%)
Living homeless	167-280 (22-37%)	NA	NA
Region of King County <sup>A</sup>			
Central	260 (34%)	2,098 (34%)	2,383 (34%)
South	262 (35%)	2,295 (37%)	2,570 (37%)
North	124 (16%)	1,010 (16%)	1,138 (16%)
East	51 (7%)	329 (5%)	382 (5%)
West	47 (6%)	414 (7%)	463 (7%)
Substance use <sup>B</sup>			
Methamphetamine	26%	18%	19%
Heroin	5%	4%	4%
Hazardous alcohol use	15%	NA	NA
Cocaine or crack	10%	9%	9%
HIV Risk Factor			
MSM	441 (58%)	4,205 (68%)	4,679 (67%)
PWID	42 (6%)	232 (4%)	277 (4%)
MSM/PWID	89 (12%)	549 (9%)	641 (9%)
Heterosexual	93 (12%)	615 (10%)	713 (10%)
Other or Unknown	92 (12%)	545 (9%)	713 (10%)
Incarcerated in jail, prior year <sup>C</sup>	7%	NA	NA

NA=Not available, <sup>A</sup> 87 (1%) of 7025 PLWH had unknown location (13 unsuppressed & 74 suppressed)

<sup>B</sup> Based on 145 unsuppressed/not in care, 1,116 suppressed PLWH and 1,261 overall PLWH with a partner services interview near the time of diagnosis. <sup>C</sup> Includes two of three King County jails. <sup>D</sup> Numbers with suppression and the estimated numbers out of care/unsuppressed will not add up to the total due to exclusion of persons presumed to be out of the jurisdiction

**Homelessness** – Homelessness is a large and growing care barrier to HIV care in King County.<sup>2,8,9</sup> We estimate that 11% of King County residents diagnosed with HIV were living homeless in the past year. Homelessness among PLWH is a critical problem in King County and an important barrier to ensuring that all PLWH successfully receive life-saving HIV treatment. In 2018, 21% of Ryan White Part A funds were spent to support housing for PLWH. We estimate that 22-37% of OOC/ unsuppressed PLWH are living homeless, based on 2015-17 MMP data (22%) and Ryan White service data (37%). Homelessness is more common among transgender persons (41%), PWID (34%), 18-29 year-olds (30%), cisgender women (28%), non-Latino Blacks (18%), and Latinos (16%). **Unstable housing is the strongest predictor of failure to achieve viral suppression 12 months after a new HIV diagnosis.**

**Substance use** - We estimate that more than half of OOC/virally unsuppressed PLWH engage in hazardous substance use. Among participants in the D2C program from 2012-16, methamphetamine was the most commonly reported substance used in the past year (26%), followed by hazardous alcohol use (15%), heroin (6%), and crack (6%). **Among MSM**

**diagnosed with HIV in King County, those who use methamphetamine are much less likely to be virally suppressed 6 months following an HIV diagnosis (31 vs 54%).<sup>8</sup>**

*Mental health* - Untreated mental illness is likewise common among persons who are OOC/unsuppressed and is a barrier to care engagement and viral suppression. Few population-based data are available about mental illness among PLWH in King County. Among Max Clinic patients, 27% have diagnosed psychotic, bipolar or personality disorders and 44% have diagnosed depressive or anxiety disorders. **The Max Clinic experience demonstrates that severe mental illness is common among high-need PLWH, and that a low-barrier HIV clinic can engage PLWH with mental illness.**

### Unmet Needs

Data on unmet needs among PLWH who are OOC or unsuppressed come from epidemiologic data, focus groups and key informant interviews with PWIDs in north Seattle (n=15), service providers working with PWIDs (n=18), Max Clinic patients (N=25), PLWH who participated in the 2019 Part A Planning Council Needs Assessment focused on people recently OOC and providers who work with them. These assessments highlighted the following gaps:

- *Geographically accessible care* – The HIV care system in King County is highly concentrated in central Seattle, yet persons OOC/unsuppressed, PWID in north Seattle, and PLWH in south King County found most were not willing to come into the center of the city for care, reflecting a combination of difficulty with transportation, belief that central Seattle is unsafe, and a preference to stay in their community.
- *Walk-in care* – The availability of walk-in care and support services is essential.<sup>6</sup> OOC/unsuppressed PLWH emphasized that they needed walk-in visits to accommodate the unpredictability of their lives and provide immediate attention to acute concerns. Such care also removes the perceived stigma associated with failure to keep appointments. The paucity of clinics providing such care is big deficiency in the existing clinical infrastructure of King County, and strongly argues for the differentiated model of care.
- *Integrated mental health, substance use, and social services*– The need for mental health services and medication assisted treatment in King County far exceeds the availability of services.<sup>10</sup> OOC/unsuppressed PLWH interviewed preferred to receive substance use and mental health services at their HIV care sites, and indicated a need for services such as laundry, showers and lockers for medication storage. At present, no HIV-focused clinical services in King Co. are co-located with these sorts of services and the one agency providing day shelter services to PLWH is located in central Seattle.
- *Care that is culturally competent* – While Max Clinic patients identified their relationships with staff, as well as walk-in care and incentives, as the three key factors associated with success in receiving care in the clinic, PWID interviewed in north Seattle reported having been poorly treated when receiving medical care in north Seattle, both by medical and ancillary staff - experiences that deterred them from engaging in medical care unless urgent.
- *Housing* – A quarter to one-third of all OOC/unsuppressed persons are unhoused, with additional persons having unstable housing. Homelessness is a crisis in King County, especially for people of color,<sup>11</sup> and the need for housing is perhaps the single greatest unmet need among OOC/virally unsuppressed PLWH in King County.

- *Transportation* – Transportation is a major barrier to care. Among PWID interviewed in north Seattle, none had a car and the complexity and time involved in navigating public transit was a key barrier to engaging in HIV care downtown.
- *Food and money* –Poverty is a formidable barrier to care as meeting basic needs takes precedence over HIV care. While the Seattle Ryan White Part A system includes food services, much like medical services, many PLWH experiencing homelessness in north Seattle and south King County struggle to access the centralized location of these services.

In July, 2020 the Seattle TGA Part A Planning Council conducted a survey of HIV case managers to identify needs that had emerged for PLWH in King County since the start of the coronavirus pandemic.<sup>15</sup> At that time, 120 (3%) of the case managers' clients had tested positive for Covid-19 and 68% reported having ten or more clients experiencing increased needs since the pandemic started, especially in relation to food, housing or shelter to isolate, short term rental assistance to avoid eviction, personal hygiene supplies, masks, support in following Covid-19 safety protocols, access to the internet to engage in medical care through telehealth, financial resources, and substance use, mental health and social support services. Additional funding through the Cares Act helped address these gaps over the course of the year.

#### Current strategies for engaging OOC/unsuppressed PLWH

For PLWH who have difficulty in engaging in HIV care, King County offers differentiated care in central Seattle, partner services, and data-to-care activities to promote linkage to treatment. We propose to expand upon these strategies to address the unmet needs articulated above.

*Differentiated Care* – As a result of Ryan White funding and Medicaid expansion, no King County resident needs to go without HIV care due to a lack of money or health insurance. For most PLWH, the existing HIV care system is accessible and effective. However, some people with HIV have difficulty receiving HIV care, often as a result of homelessness, mental illness and substance use disorders. In 2015, PHSKC and its collaborators began developing a system of differentiated care designed to alter the health care system and provision of health services to better meet patients' needs.<sup>2,7</sup> This system includes the Mod (Moderate Intensity) and the Max (Maximum Intensity) Clinics at Harborview Medical Center. Both clinics provide walk-in HIV care and social services, with the Max Clinic also offering high-intensity case management, food, transportation support, and financial incentives to encourage engagement and viral suppression, as well as integration of substance use treatment – particularly medications for opioid use disorder (MOUD) – into clinical services. Among 170 MAX Clinic patients, 64% were virally suppressed at their most recent visit, a significant indicator given the majority were sporadically engaged in care and virally unsuppressed on intake.<sup>7</sup> However, Mod and Max clinics are both located in central Seattle, while 35% of virally unsuppressed persons live in south King County and 16% in north Seattle.<sup>2</sup> Thus, **there is a profound need to create low-barrier clinical and support services in north Seattle and south King County.**

*Partner services and linkage to care*<sup>12</sup> – PHSKC seeks to provide partner services to all persons with newly diagnosed with HIV. DIS work with a surveillance epidemiologist to investigate newly reported HIV cases, define which cases are truly new, provide newly diagnosed persons with partner services, and ensure that patients link to care. DIS do not close new cases until patients have linked to care, and all newly diagnosed cases are discussed at a monthly case conference comprised of DIS, surveillance staff, and the HIV/STD program director. This

process improved linkage to HIV care in King County<sup>1</sup> and resulted in 89% of all newly diagnosed persons linking to care within 1 month of diagnosis in 2018. However, the increase in cases observed in 2018 coupled with the increasing social marginalization of persons newly diagnosed with HIV **taxed existing staff beyond their capacity; new cases are now harder to locate and require more time for investigation and to promote linkage to care.**

*Data to Care (D2C) & Real Time Data to Care (RT D2C)* – For individuals who do not or cannot seek care, PHSKC has a multi-tiered “data-to-care” (D2C) system.<sup>13</sup> Our current D2C activities include surveillance-based outreach; venue-based D2C with identification of out of care/unsuppressed (OOC/unsuppressed) persons via information exchange with selected emergency departments (EDs), inpatient hospitals, and jails; and referrals from HIV providers and case managers. Our D2C team - which includes surveillance staff, medical leadership and DIS - is integrated with the Max Clinic, linking this work to our broader effort to improve care engagement. Another CDC funded project, PIPER, is underway to work with pharmacies to more rapidly identify persons who stop ART, provide them with outreach services and promote their resumption of treatment.

Our experience, like that of other jurisdictions, is that surveillance-based D2C – identifying persons presumed to be OOC/unsuppressed based on surveillance data and using outreach to promote their relinkage – is inefficient.<sup>2</sup> Using surveillance data to identify persons who are OOC/unsuppressed is a sound idea but D2C is less effective without a concurrent effort to alter the medical care system to diminish barriers to successful treatment. Real-time D2C (RT D2C) is an alternative to surveillance-based D2C in which health departments and collaborators identify and re-link to care OOC/unsuppressed persons real time - when they are in EDs, inpatient hospitals, jails, STD clinics or receiving STD partner services. Our team has established real-time D2C systems in the UW Medicine system, two King County jails<sup>3</sup>, and through STD partner services.<sup>14</sup> **However, in order to have a comprehensive RT D2C system we need to expand RT D2C to include all hospitals in King County and a third jail.** To achieve this, we plan to implement additional staffing and a commercial data information exchange - Collective Medical Technologies - which will send DIS a notification when OOC/unsuppressed persons register in participating hospitals and clinics. (The Collective Medical system collects data from all hospitals and EDs in King County, as well as the South Correctional Entity).

### **Pillar 3: Prevent**

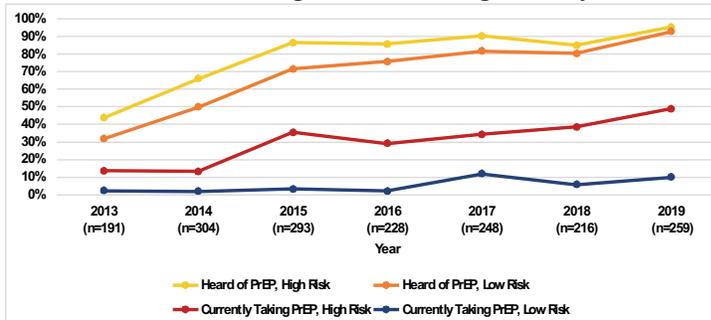
In King County, the main activities for preventing sexual transmission of HIV are pre-exposure prophylaxis (PrEP) and condom promotion and provision. For PWID, prevention activities are largely provided through our syringe services programs (SSPs).

PrEP – King County has made substantial progress using PrEP to prevent HIV infection, with nearly one-half (49%) of King County MSM at high risk for HIV, and 28% of all MSM, on PrEP.<sup>2</sup> The WSDOH supports a PrEP drug assistance program (PrEP DAP) that supports laboratory testing and medications for those who are uninsured or underinsured, as well as PrEP navigation services provided through CBOs. The largest single provider of PrEP in WA State is the PHSKC STD Clinic, which links PrEP provision to population-based partner services, has PrEP navigation services available on-site, and provides same-day start PrEP with a de-medicalized model of PrEP care that only requires patients to see a medical provider annually.

(Non-medical staff assist patients in receiving quarterly HIV/STI testing and renal function testing.) At present, the clinic manages approximately 650 patients on PrEP. In addition to the PHSKC STD Clinic, PrEP is available through most community health centers, public health clinic sites, the Seattle Indian Health Board clinic, all major Healthcare Organizations, the Veterans Administration clinics, Planned Parenthood, Gay City Health Project and Wellness Center, the Kelly-Ross Pharmacy One-Step PrEP program, the Evergreen School Based Health Center, immediate care centers, and several private medical providers in King County, most of which are contracted providers through the WSDOH PrEP DAP program to make PrEP available to King County residents who need assistance in covering the costs of medical visits, lab testing, and medications. Several organizations in King County, including the Center for Multicultural Health, Entre Hermanos, Gay City Health Project, Harborview Madison Clinic, Lifelong, and Seattle Counseling Services provide PrEP navigation services to support people at risk for HIV in accessing PrEP, health insurance enrollment, HIV/STI testing, condoms, and other HIV prevention and support services.

PrEP awareness has grown rapidly over time and is almost universal among both high and low risk MSM (Figure 5).<sup>16</sup> However, respondents to the Black MSM PrEP survey reported lower awareness of PrEP, and black MSM report the lowest level of PrEP use (18%), while Latinx MSM report the highest levels (34%).<sup>2</sup> Black STD Clinic PrEP patients also have lower rates of PrEP retention with over half of those initiating PrEP at the clinic discontinuing use within 12 months. Understanding reasons for PrEP discontinuation is necessary to address low PrEP retention rates. Further, in the Black MSM PrEP survey, knowledge of PrEP and its efficacy and HIV risk perception were the two main barriers to PrEP initiation (and also the main motivators).

Figure 5: PrEP awareness and use among MSM in King County- Seattle PRIDE Survey, 2013-19

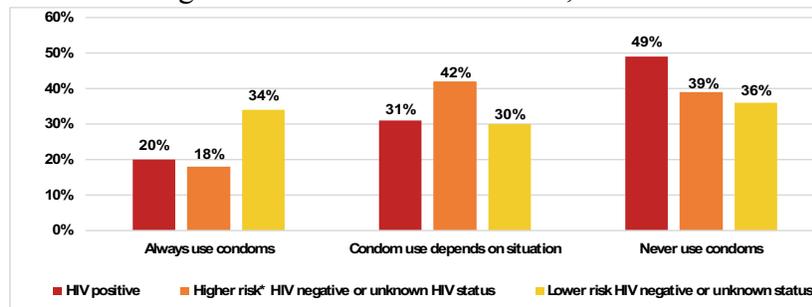


PrEP use is also low among transgender or non-binary/genderqueer persons in King County.<sup>17</sup> Among 2019 Pride Survey participants who identified as transgender or non-binary/genderqueer and reported cisgender male or transgender women sex partners (n=116), 8% reported currently being on PrEP and 7% reported formerly being on PrEP.

Finally, PrEP use is under 1% among PWID.<sup>19</sup> In 2019, PHSKC conducted focus groups with PWIDs (n=27) and interviews with service providers working with PWIDs (n=18) to explore PrEP delivery models for PWID. In addition, data were obtained from a needs assessment of women engaged in transactional sex and obtaining care at the SHE clinic in north Seattle, from which transportation, distrust and poor prior interactions with healthcare providers, and drug use were identified as the primary barriers to engaging in HIV prevention services.<sup>20</sup> **Providers, focus group, and interview participants recommended three models for delivering PrEP to PWID: a drug user health center, a mobile health unit, or an “add-on” program within an existing service point.**

Condoms – PHKSC, the WSDOH and community collaborators distributed over 450,000 male condoms in King County in 2018.<sup>2</sup> In addition, in the past two years, PHSKC sought to increase condom use by making free condoms more readily available in economically disadvantaged communities in south King County and through distribution of condom fit kits at the STD Clinic.

Figure 6: Condom use among men who have sex with men, 2019 Seattle PRIDE Survey



Among sexually active MSM respondents to the 2019 PRIDE Survey, 28% reported always using condoms, 34% sometimes used condoms, and 38% never used condoms (Figure 6).<sup>17</sup> Among higher risk HIV negative/unknown status MSM (e.g. men who reported in the past year: serodiscordant condomless anal sex, 10 or more anal sex partners, methamphetamine or popper use, or an STI diagnosis), most (60%) used condoms at least some of the time, though only 18% reported using them all of the time. Although some evidence suggests that condom use among MSM is declining – a trend that is likely partially, but not completely attributable to PrEP - most sexually active MSM (68-70%) continue to use condoms at least some of the time, and many MSM indicate they are willing to use condoms more.

Among sexually active King County residents who completed 2019 Behavioral Risk Factor Surveillance System interviews, 53% of adult and 43% of young (18-24 year old) MSM reported using a condom the last time they had sex. Among heterosexual youth, a population at high risk for bacterial STIs, condom use remains suboptimal. In 2018, 7% of 8th graders, 19% of 10th graders, and 32% of 12th graders in King County who responded to the Healthy Youth Survey reported ever having had sex and among sexually experienced respondents, 46% of 8th graders, 54% of 10th graders, and 53% of 12th graders used a condom the last time they had intercourse. **While we are seeing improved access due to recent initiatives, access to free condoms continues to be a barrier to condom use among MSM and heterosexual youth.**

Syringe Services Program (SSP) – King County has a robust network of SSP programs, with PHSKC providing services in central Seattle and south King County, the Hepatitis Education Project providing services in the southern part of central Seattle, and the People's Harm Reduction Alliance providing services in the University District, north Seattle, and East King County. In 2018, the PHSKC SSP exchanged approximately 8 million syringes, an increase of 1 million syringes since 2017.<sup>2</sup> These SSPs also offer HIV and hepatitis testing, Hepatitis A and B vaccinations, TB screening, substance use disorder treatment referrals, naloxone training and distribution, social work services, and wound care.

In 2018, in response to a cluster of HIV infections among PWID in north Seattle, King County conducted a needs assessment of PWID living homeless in north Seattle (n=15).<sup>2</sup> Participants described having very limited access to clean injection equipment in north Seattle, despite high demand. Indeed, an increase in HIV cases among PWIDs, **namely a cluster of cases in north**

**Seattle, were in an area with fewer local services, including no regular SSP.** Thus, despite overall high levels of viral suppression among people living with HIV in King County (including PWID) as well as the highest level of syringe coverage in the U.S., to reduce HIV incidence we must expand SSP access to geographic areas (especially north Seattle) where residents at risk for acquiring HIV currently have insufficient access to syringe services.

#### **Pillar 4: Respond**

Molecular Surveillance and Cluster Investigation - PHSKC has had a molecular surveillance program for over 20 years and has identified various clusters through partner services, time-space proximities, and analyses of drug resistance test (molecular) methods. In addition, Washington State participates in CDC-funded molecular surveillance to detect clusters of HIV infection and PHSKC conducts cluster investigations and outreach for cluster members who are virally unsuppressed or out of care. Specifically, PHSKC has an experienced team of DIS's who provide partner notification services, link newly diagnosed PLWH to care, implement D2C activities (*overlap with Pillar 2*) and undertake cluster investigations.<sup>12</sup> Further, collaborating investigators at UW (Drs. Josh Herbeck and Roxanne Kerani) conduct NIH-funded research on phylogenetic analysis and HIV cluster response and PHSKC developed a program to monitor the potential for transmission of “PrEP-resistant” HIV strains and conduct outreach to engage viremic individuals to prevent transmission.

While PHSKC has a robust cluster investigation and molecular surveillance program, after identifying a recent cluster of HIV diagnoses among PWID largely based in north Seattle it became clear that the **current team does not have the resources to do field outreach or the sort of intensive investigation that we would ideally conduct as part of cluster investigations** (*overlap with Pillar 2*). Additional support is needed to help more rapidly identify clusters, increase how often we process and analyze molecular cluster and partner services data, and more robustly conduct outreach activities for cluster members.

Collaboration Needs to Achieve EHE Goals – Collaboration across partners is essential to identifying, linking, engaging, retaining, achieving, and sustaining viral suppression. King County’s HIV control effort includes hospitals, homeless shelters, jails, case management organizations (including LGBTQ community and minority CBOs), supportive housing, and food programs. But service gaps persist, as detailed by pillar above. Our collaboration with two King County Jails is working, but we have no connection to the jail in south King County or those in cities bordering north Seattle. Although we have been successful working with EDs in the UW system, we lack collaborations with other EDs. Finally, while our network of clinical, social service and community collaborators has expanded in response to recent outbreaks among PLWH living homeless, we need to expand our network of collaborators, particularly those who work with and provide care and services to persons who are living homeless. **The changing epidemiology of HIV in our area requires that we find new partners in south King County and north Seattle, and that we cultivate new collaborations with organizations who have the trust of the often marginalized communities – racial and ethnic minority communities, women who exchange sex, substance users - that are increasingly affected by HIV.** We also need to develop new interagency collaborations that integrate clinical care with social services, ideally under a single roof. Addressing these needs will require building new capacities, infrastructure, and collaborations.

## SECTION FOUR: KING COUNTY EHE PLAN

The following plan articulates King County's goals, outcome measures and activities by EHE Pillar and aims to achieve the following overarching goals of the National EHE Initiative:

- Reduce new HIV infections in King County by 75% in 5 years
- Reduce new HIV infections in King County by 90% in 10 years
- Reduce HIV-related health disparities among people living with HIV

In an effort to decrease disparities and increase equity in HIV prevention and care engagement and ultimately individual and population-level health outcomes, the King County EHE planning committee articulated the following values to guide EHE implementation:

1. EHE activities need to address structural racism.
2. EHE activities need to address stigma in all of the forms experienced by persons at high risk for acquiring and living with HIV infection. These forms include but are not limited to stigma related to PrEP use (and by extension, sexual activity), HIV infection, drug use, homelessness, and current or history of incarceration. Further, EHE activities need to be implemented in ways that do not inadvertently reinforce or exacerbate stigma.
3. Whenever possible, activities should be provided by organizations comprised of or serving PLWH and/or persons at high risk for acquiring HIV infection. If such an organization is not available or able to provide these services, or through doing so PLWH may experience increased barriers to care related to stigma, we plan to explore options for new services.
4. EHE activities should encourage partnerships between health care organizations and community-based organizations, and if the partnership is part of a contractual relationship, the government entity should incorporate efforts to ensure that community-based organizations are in an empowered role in the partnership.

The King County EHE plan incorporates and builds upon the priorities and strategies articulated in the National HIV/AIDS Strategy 2020, Washington State Integrated HIV Prevention and Care Plan, End AIDS Washington 2020, the Bree Collaborative, and the 2020 HIV planning and resource allocation process of the Ryan White Part A HIV Planning Council. Further, we will update the plan to align with the new HIV National Strategic Plan and national and state initiatives that emerge over the EHE initiative period.

The EHE plan captures activities planned through all sources of EHE funding in King County, pillar-specific HIV prevention and care activities not funded through EHE, and activities participants in the EHE planning process suggested and the EPC decided to incorporate as priorities for future HIV prevention and care resources received in King County during the EHE initiative. Finally, the EHE plan is a living document and will be reviewed and updated at least annually and if/when we experience increases or decreases in HIV prevention or care funding in the jurisdiction over time.

For each pillar we present a table articulating goals, outcome measures, and most recent data, if available, for each measure, followed by descriptions of planned pillar activities, key partners for accomplishing the activities, potential data sources for measuring outcomes, and anticipated EHE funding allocations for each.

## **Pillar One: Diagnose**

*EHE Goal: Diagnose all people with HIV as early as possible after infection.*

### **Key Activities and Strategies:**

1. *Increase routine HIV testing in clinical settings*— We plan to work with HCO's and community health centers throughout King County to identify and implement strategies to increase routine HIV testing, and re-screening of people at increased risk of HIV, in clinical settings such as emergency departments, hospitals, FQHCs, and other primary care settings - with an emphasis on organizations serving people outside of the central Seattle core.
  - As many people at high risk for HIV in King County, including persons experiencing homelessness and/or engaged in drug use and sex work, receive health care through EDs, we plan to facilitate a learning collaborative across EDs across King County to support their identification and implementation of innovative strategies and sustainable structural changes that increase routine HIV testing within their respective settings.
  - Consistent with a syndemic approach, we plan to encourage clinical settings to also offer testing for viral hepatitis, STI's, and other conditions comorbid with HIV.
  - We plan to encourage and if possible incentivize innovative health care and community-based partnerships to increase HIV testing among persons at high risk for HIV
2. *Increase HIV testing in non-clinical settings*— We plan to expand HIV testing to additional non-clinical sites, including shelters, jails, and other settings serving populations at high risk for HIV (especially MSM, people of color, and people experiencing homelessness, using drugs, and/or engaged in sex work), especially in north Seattle and south King County. As part of this activity, MWAETC plans to focus specific efforts on expanding on-site HIV testing in drug treatment/recovery, mental health, and permanent supportive housing settings.
  - In response to COVID-19, we plan to increase and support the use of home-based and other low barrier HIV testing strategies.
  - If possible, during WA COVID-19 Safe Start Phase 2 and beyond, we will explore ways to leverage public health COVID-19 testing and vaccination infrastructures to reach and test more persons at risk for HIV.
  - Consistent with a syndemic approach, we plan to encourage non-clinical settings to help clients access testing for viral hepatitis, STI's, and other conditions comorbid with HIV.
3. *Increase partner notification services* —We plan to intensify partner notification services in order to provide partner services to all persons with newly diagnosed HIV infection and increase the number of exposed partners identified, tested, and linked to PrEP, HIV care, and other HIV, STI, and viral hepatitis prevention and treatment services.
4. *Develop and implement health education-related strategies to increase HIV testing among people of color* —We plan to work with CBO's and people from diverse communities, especially in north Seattle and south King County, to develop and implement culturally appropriate health education related activities, such as public awareness and testing mobilization campaigns, to increase awareness of HIV and HIV testing and reduce HIV-related stigma among Black and Latinx communities and among persons for whom English is not their primary language.
  - Consistent with a syndemic approach, we plan to promote education and testing for viral hepatitis, STI's, and other conditions comorbid with HIV.

**Key Partners:** EHE-funded entities (including the Mountain West AETC (MWAETC)), PLWH, CBO's, faith-based organizations, community media outlets, social service providers, FQHCs, healthcare systems, private clinicians, hospitals and emergency department leadership, jails, and social marketing firms.

**Potential Funding Resources:** CDC Prevention and Surveillance Funds, State funding, County funding, EHE Initiative funding, Medicaid, private insurance, and additional in-kind resources that support the non-EHE funded work of key partners above.

**Estimated Funding Allocation\*:** Annual: \$428,452 (CDC)

*\*This estimate refers to the allocation of CDC and HRSA funds received by PHSKC for implementing EHE activities. Additional EHE and non-EHE funding will support the implementation of Pillar 1 activities above as well.*

**Outcomes:** Increases in the proportion of persons at high risk for HIV diagnosed with HIV because of routine testing, partner notification, or symptoms of acute HIV infection; increase in the number of healthcare and non-healthcare settings offering HIV testing; increase in the percentage of persons tested through routine testing efforts in healthcare facilities participating in the healthcare collaborative (described below); decrease in the rate of new HIV diagnoses; decrease in the percentage of persons diagnosed with stage 3 (AIDS) within 3 months after initial HIV diagnosis, increase in the proportion of persons with newly diagnosed HIV who complete a partner services interview; and elimination of racial and ethnic disparities in new HIV diagnoses.

**Monitoring Data Sources:** WA State HIV/AIDS Reporting System (eHARS), lab slip database and partner services database.

## **Pillar Two: Treat**

*EHE Goal: Treat people with HIV rapidly and effectively to achieve sustained viral suppression.*

### **Key Activities and Strategies:**

1. *Expand low barrier HIV care* – Most King County PLWH are virally suppressed, but achieving viral suppression among the remaining unsuppressed PLWH requires new, more intensive efforts to diminish structural barriers to care and integrate support services into care delivery. We plan to expand our system of differentiated care in the following ways:
  - *Expand number of PLWH receiving low-barrier care at the Max Clinic (central)*
  - *Expand number of PLWH receiving lower-barrier care at the Mod Clinic (central)*
  - *Open a new low-barrier clinic in north Seattle*
  - *Open a new low-barrier clinic and/or initiate a variety of low-barrier HIV care services addressing the needs of different populations in south King County* - As part of this activity we plan to engage in rapid formative work in south King County to inform the location(s) and types of low-barrier services to initiate - this may involve a brick and mortar clinic, investing in existing clinical settings, mobile services, or a combination of these, depending on the needs of the communities in south King county. We also plan to provide incentives (bus passes, grocery and food vouchers, etc.) to PLWH to help them engage and sustain HIV care through low barrier care sites/services.
2. *Provide co-located services in care sites* –We plan to expand the availability of adherence support (including medication storage) and social, mental health, and substance use (including harm reduction) services to improve HIV care engagement by co-locating or linking these services at low-barrier care sites. We plan to solicit services from organizations located in each geographic area served.
  - We plan to encourage HIV care sites to provide information to PLWH about the availability of peer support services and help those interested access peer services.
3. *Increase the availability of lower-barrier care within traditional HIV care delivery settings* - We plan to work with King County HIV care sites to increase the availability of evening and weekend hours and walk-in care for PLWH who can navigate traditional care systems but due to inflexible work hours, lack of sick leave, or other factors, delay or forego HIV care. And for HIV providers who treat few persons funded through Ryan White, we plan to engage in efforts to help educate them on options for insurance and sustained access to HIV medications for patients who suddenly lose health insurance due to the COVID-19 pandemic to prevent their dis-engagement from care.
4. *Support use of telemedicine for HIV care* - In light of COVID-19, we plan to support the expanded use of telemedicine for delivery of HIV care.
5. *Expand HIV clinical capacity* - We plan to engage members of the EHE Healthcare Advisory Group, HIV clinical training programs, and the MWAETC to implement strategies to increase the capacity of existing clinical providers in north Seattle and south King county to provide HIV care to PLWH. And as part of their EHE activities, MWAETC plans to increase HIV clinical capacity among novice/new HIV care providers and jail health clinicians. And consistent with a syndemic approach, we plan to encourage new HIV providers to offer testing and linkage to services for hepatitis, STI's, and other conditions comorbid with HIV.
6. *Improve delivery of care to LGBTQ populations and persons who inject drugs or engage in sex work* – We plan to work with HIV care providers and other members of the health care

system to implement recommendations from the Bree Collaborative (LGBTQ health care) and recommendations for improving health care to persons using drugs or engaged in sex work to improve the safety of care delivery sites and promote care engagement among populations most at risk of being virally unsuppressed. As part of this work we plan to convene a formal learning collaborative focused on implementing recommendations from the Bree collaborative and the MWAETC has plans for providing trainings on SOGI and TA opportunities around providing inclusive care to transgender and non-binary individuals, social determinants of health, implicit bias and trauma-informed culture/environments, and identifying and managing substance use and mental health disorders in primary care settings.

7. *Enhanced linkage to care for persons with newly diagnosed with HIV*– We plan to enhance monitoring of all newly diagnosed PLWH until they achieve viral suppression, intervening to promote engagement for those with a lapse in care and those who do not have evidence of declining viral loads leading to suppression (indicators of "early disengagement"). We plan to engage providers and organizations serving transgender and populations at high risk for HIV to support their efforts to link and retain patients and clients in care. And as part of their EHE activities, MWAETC plans to focus specific efforts training oral health and jail release planners in effective models of linkage to care.
8. *Expand early start of antiretroviral therapy* - we plan to continue efforts to facilitate immediate access to antiretroviral therapy for persons newly diagnosed with HIV.
9. *Expand real-time data-to-care (RT D2C)*– We plan to expand our RT-D2C system to enable health departments and collaborators identify OOC/unsuppressed persons when they present to EDs, inpatient hospitals, jails, STD clinics, pharmacies, or receive STD partner services.

These activities build upon a comprehensive system of care for people living with HIV who have low incomes supported through Ryan White funding, including:

- *Early intervention Services* to identify and provide HIV education and testing for high-risk persons who do not know their HIV status and link to care those who test positive.
- *Medical Case Management services* (funded through the WSDOH Ryan White Part B program) and *Non-Medical Case Management* help PLWH access medical and non-medical services (such as housing, oral health, food/meal, and adherence support).
- *Housing Services* provide short-term assistance to PLWH in need of emergency shelter, motel/hotels, and transitional housing placements.
- *Food bank/Home delivered meals* services provide prepared meals and grocery bags, essential household items (toiletries), and nutritional counseling to PLWH.
- *Medical transportation* services provide reimbursement for one-way rides for Ryan White clients to get and/or from core medical or support service appointments.
- *Oral health* services ensure PLWH receive diagnostic, preventative & therapeutic oral care.
- *Outpatient Ambulatory Health Services - Treatment Adherence* services support PLWH around treatment readiness and medication adherence.
- *Psychosocial support* services include individual and group support sessions.

Washington is a Medicaid expansion state - as such the Seattle TGA has a core medical services waiver and does not use Ryan White Part A funding to support medical or mental health services.

**Key Partners:** EHE-funded entities, PLWH, healthcare systems, FQHCs, private clinicians, CBO's, faith based organizations, social service providers, hospitals and emergency department leadership, jails, MWAETC, and the HIV prevention training centers.

**Potential Funding Sources:** CDC Prevention and Surveillance Funds, HRSA Ryan White funding, WA DOH funding, King County funding, City of Seattle funding, EHE Initiative funding, Medicaid, private insurance, and additional in-kind resources that support the non-EHE funded work of key partners above.

**Estimated EHE Funding Allocation\*:** Annual: \$1,362,856 (\$759,404 HRSA, \$603,452 CDC)  
*\*This estimate refers to the allocation of CDC and HRSA funds received by PHSKC for implementing EHE activities.*

**Outcomes:** Increases in the percentage of newly diagnosed PLWH linked to HIV medical care within 14 and 30 days of diagnosis; increase in the proportion of PLWH retained in HIV medical care; increase the percentage of PLWH who are virally suppressed at last medical visit; increase the proportion of newly diagnosed PLWH achieving viral suppression within 4 months of diagnosis; increase in the percentage of PLWH relinked to care across all data to care activities; and elimination of disparities in linkage to care, retention in care, and viral suppression by race, ethnicity, gender, and drug use (PWID).

**Monitoring Data Sources:** eHARs, CAREWare/Provide (Ryan White), partner services database, Comprehensive HIV/AIDS Relinkage database (CHARD) and a commercial data information exchange - Collective Medical System - which collects data from all hospitals and EDs in King County, as well as the South Correctional Entity.

## **Pillar Three: Prevent**

*EHE Goal: Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).*

### **Key Activities and Strategies:**

1. *PrEP access and delivery* – We plan to expand access to PrEP by increasing the number of providers offering PrEP (especially in north Seattle and south King County, and among providers serving PWID), EHE funded PrEP expansion activities at Country Doctor Community Health Center and NAVOS (through the Healthcare for the Homeless Network), linking high risk persons who test negative for HIV to PrEP (including PWID), and implementing pharmacy models of PrEP delivery. The MWAETC also plans to increase availability of PrEP through training and TA with drug treatment, community mental health, permanent supportive housing, needle exchange, community health centers, family planning clinics, and dental sites, as well as new groups of medical providers, such as plastic surgeons. If new funds become available we plan to increase PrEP availability through telehealth and mobile models, especially for PWID.
  - To support adherence to PrEP among persons experiencing homelessness and PWID, we plan to develop options for medication storage and pursue policy changes to allow for more frequent dispensing of PrEP to persons who frequently lose medications due to environmental factors or drug use (i.e. belongings repeatedly stolen or lost).
  - Through EHE funding, the MWAETC plans to develop trainings and TA resources to support pharmacies in engaging in pharmacy-based PrEP.
  - To encourage engagement of people at risk for HIV with comprehensive care, we plan to encourage pharmacists engaged in PrEP delivery models to offer information about health insurance and primary care to persons not already engaged in comprehensive care.
  - We plan to support current efforts underway to work with pharmacists participating in PrEP delivery to help identify and provide training and support to primary providers reticent to prescribe PrEP.
2. *PrEP care navigation and retention* – We plan to work with health care providers and community partners to diminish barriers to PrEP initiation and retention, such as integration of PrEP navigation into clinical settings, syringe services programs, developing capacity for PrEP referrals and navigation within CBO's (especially those serving PWID), PrEP at release from correctional facilities, identification of locations for high volume prescribing, and linkage to insurance and/or the state PrEP Drug Assistance Program.
3. *Conduct PrEP education with communities of color and PWID* – To improve acceptability and uptake of PrEP in communities of color and PWID, we plan to work with community partners to develop and implement educational activities for persons at high risk for HIV and providers to address stigma related to HIV and PrEP. MWAETC also plans to develop culturally appropriate PrEP materials for PWID and people of color in need of PrEP.
4. *Expand condom access project* – We plan to expand geographical condom distribution in King County through FQHCs, CBOs, jails, local businesses and schools. In alignment with the WA Integrated HIV Prevention and Care plan, we plan to make condoms more available and acceptable for persons at high risk of HIV infection.

5. *Increase syringe services programs (SSP)* – King County already has robust SPPs, however we plan to expand the geographical sites for distribution of clean syringes, especially in north Seattle, to increase the number of clean syringes distributed per PWID.
6. *Expand availability and accessibility of medication for opioid use disorder* – As recommended by the End AIDS Washington Plan, we plan to add waived suboxone providers at clinics and in field settings and the MWAETC plans to provide training, TA, and other resources to increase provider's knowledge and skills in treating opiate use disorder.
7. *Improve delivery of PrEP to LGBTQ populations and persons who inject drugs or engage in sex work* – We plan to work with PrEP delivery providers and other members of the health care system to implement recommendations from the Bree Collaborative (LGBTQ health care) and recommendations for improving health care to persons using drugs or engaged in sex work to improve the safety of PrEP delivery sites and promote PrEP engagement among populations most at risk of HIV infection. As part of this work we plan to convene a formal learning collaborative focused on implementing recommendations from the Bree collaborative and the MWAETC has plans for providing trainings on SOGI and TA opportunities around providing inclusive care to transgender and non-binary individuals, social determinants of health, implicit bias and trauma-informed culture/environments, and identifying and managing substance use and mental health disorders in primary care settings.

**Key Partners:** EHE-funded entities, PLWH, CBO's, Black PrEP Expansion Group ([Link Up Project](#)), social service providers, FQHCs, healthcare systems, private clinicians, jails, local businesses, schools, and WA Bree Collaborative partners.

**Potential Funding Sources:** CDC Prevention Funds, State funding, County funding, EHE Initiative funding, Medicaid, private insurance, and in-kind resources that support the non-EHE funded work of key partners above.

**Estimated EHE Funding Allocation:** Annual: \$888,452 (CDC)

*\*This estimate refers to the allocation of CDC and HRSA funds received by PHSKC for implementing EHE activities. Additional EHE and non-EHE funding will support the implementation of Pillar 1 activities above as well.*

**Outcomes:** Increase in the number of sites providing PrEP in King County; increase the number of high risk persons in King County who are using PrEP (MSM, PWID, women who are living homeless or exchange sex, trans persons who have sex with men); elimination of racial and ethnic disparities in PrEP use; increase in the number of syringes exchanged per PWID; decrease in the percentage of PWID reporting needle sharing; and increase in the number of condom distribution sites in King County.

**Monitoring Data Source:** To monitor Pillar 3, we plan to use the National HIV Behavioral Surveillance (NHBS) survey, the Behavioral Risk Factor Surveillance Survey (BRFSS), PRIDE Survey and Syringe Services Program (SSP) data.

## **Pillar Four: Respond**

*EHE Goal: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.*

### **Key Activities and Strategies:**

1. *Community engagement for increased transparency and acceptance of cluster investigation and molecular surveillance* – We plan to engage community members and medical providers through EHE-funded formative work, presentations and web-based information to improve transparency and acceptability of cluster investigation and molecular surveillance activities.
2. *Conduct molecular surveillance and cluster investigations* –We plan to conduct cluster analysis no less than monthly to identify new clusters and new cluster members, increasing how often we process and analyze molecular cluster and partner services data.
3. *Using a syndemic approach, provide outreach services to known cluster members* – We plan to provide outreach services to cluster members with an unsuppressed viral load to help them achieve viral suppression, offer them partner services, test and link their partners to HIV care or PrEP, and facilitate their and their partners' access to STI and hepatitis treatment, primary care, and mental health, substance use (including harm reduction), and social services.
4. *Collaborate with partners to address gaps in clinical or support services identified during cluster responses* - Partner with MWAETC and other training/TA providers dedicated to developing the capacity of medical, social, mental health, and substance use service systems' capacities in King County to provide TA, training, and other support as needed during and after cluster responses.

**Key Partners:** EHE-funded entities, PLWH and other community members, healthcare providers, and University of Washington epidemiologists and researchers with expertise in cluster network analysis and molecular surveillance.

**Potential Funding Sources:** Core HIV Surveillance funding from CDC, EHE funding from HRSA and/or CDC and NIH CFAR funds.

**Estimated EHE Funding Allocation:** Annual: \$264,796 (\$90,596 HRSA, \$174,200 CDC)

*\*This estimate refers to the allocation of CDC and HRSA funds received by PHSKC for implementing EHE activities. Additional EHE and non-EHE funding will support the implementation of Pillar 1 activities above as well.*

**Outcomes:** Increases in knowledge and acceptability of cluster investigation and molecular surveillance interventions among medical providers and community members; increase in the percentage of all PLWH in clusters who were not virally suppressed at the time of cluster identification who achieved viral suppression within 6 months of identification as part of the risk network; increases in the percentage of all partners of cluster members who were not known to be HIV positive at the time of cluster identification who were tested or re-tested w/in 6 months of identification as part of the risk network; and increases in the percentage of partners of cluster members who tested negative for HIV and were not on PrEP who were referred for PrEP within 6 months of identification as part of the risk network.

**Monitoring Data Source:** CDC's Secure HIV Trace, CDC's Microbe Trace, & Divein (UW system). Additional data will be collected using partner services and CHARD databases.

## **Pillar Five: Sustain**

*Develop capacity within the King County HIV prevention and care systems to sustain activities identified as effective in reducing HIV incidence after the EHE initiative ends.*

### **Key Activities & Strategies:**

- 1) *Develop and implement an ongoing infrastructure for community engagement* - We plan to develop a structure for ongoing engagement with community stakeholders, convening the group(s) at least annually to review progress on EHE goals, identify revisions or modifications as needed, and discuss approaches to sustaining activities over time.
- 2) *Conduct a mid-initiative evaluation and implement a sustainability plan by the end of EHE initiative* - In the middle of year 3 or beginning of year 4 - depending on the mid-point for each EHE activity - we plan to initiate a mid-initiative evaluation to identify specific activities that appear to be successful in reducing HIV incidence in King county and then develop and implement a plan for sustaining them after the EHE initiative funding ends.
- 3) *Increase cross-systems collaboration* - We plan to identify and participate in groups serving people with HIV outside of the traditional HIV care system (for example, systems serving people experiencing homelessness or unstable housing, substance use disorders, mental health conditions, and food insecurity) to assure they are aware of and can address the needs of people at risk for or living with HIV in their systems, and conversely, so the HIV prevention and care systems in King County are aware of initiatives and resources available through those systems for addressing the needs of people living with or at risk for HIV.
- 4) *Workforce capacity development* - Increasing the availability of service providers specifically from communities at risk for or living with HIV supports the reach and uptake of HIV prevention and care interventions in our community. We plan to build equity and the diversity of the HIV prevention and care workforce by:
  - Collaborating with the MW AETC around a workforce analysis.
  - Participating in and supporting existing efforts to address inequities in training opportunities and compensation between CBO's and government sectors so persons from diverse communities are hired and retained within the community-based workforce.
  - Exploring government and foundation options for supporting the education (perhaps through loan forgiveness) of people and communities at risk for or living with HIV so they are better prepared to work in the HIV prevention and care field.
  - Increasing the availability of phlebotomy training available for new staff at CBO's.

**Key Partners:** EHE-funded entities; PLWH; healthcare systems, FQHCs, private clinicians, CBO's, and social service providers involved in implementing EHE activities; government and planning/advisory bodies for systems specifically focused on PWID, people experiencing homelessness, substance use disorders, and mental health conditions; state and local governments, and capacity building providers.

**Potential Funding Sources & Estimated Funding Allocation:** n/a, not a funded EHE pillar

**Outcomes:** Process measures - infrastructure in place, mid-year evaluation complete, plan for sustaining successful activities developed and implemented by the end of EHE year 5, documentation of cross-systems participation and collaboration, and participation in efforts to improve equity and increase diversity among the HIV prevention and care workforce.

**Monitoring Data Source:** program records will serve as the primary data source.

## **SECTION FIVE: CONCURRENCE PROCESS**

As noted in Section One, King County does not currently have a local planning body that addresses both HIV care and prevention. The state has the WSDOH HIV Planning Steering Group, which includes several King County representatives, and the Seattle TGA Ryan White Planning Council which focuses on HIV care planning for a three-county area. In considering the needs of the King County EHE plan, our group, including both PHSKC and the WSDOH staff, believed that the best body from which to seek concurrence is the EPC, which was designed to include a more diverse cross section of representatives of King County communities and providers than either the full HPSG or the Ryan White Planning Council. However, as noted above, the EHE plan incorporates data and needs assessment information from each of these planning bodies and PHSKC shared updates and sought feedback from each group over the course of the planning year.

Ultimately, concurrence was the culmination of an 18-month process of engaging a wide variety of stakeholders through 14 in-person then online meetings (EPC (5), PCAG (2), HAG (1), Planning Council (3), and HPSG (2)) and two public input mechanisms. The EPC discussed all input provided by advisory groups and the public, selecting those changes they felt held the greatest potential for achieving the goals of radically decreasing incidence of HIV and disparities in diagnosis and care outcomes among specific populations over the next decade. After reviewing the final input from advisory bodies and the public in early December, the EPC made final revisions to the EHE plan and provided formal concurrence verbally and via emails after reviewing the final version of the plan in mid-December. The EHE plan will be posted on the PHSKC website and continue to be updated during and in response to lessons learned during the plan's implementation.

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