SEATTLE TGA HIV PLANNING COUNCIL MEETING MINUTES

Date: September 14, 2026 | **Time**: 4:00p – 6:30p | **Location**: Chinook Building / Virtual via Zoom

Council

Planning Council Members Present: Andrew Ashiofu (Co-Chair), Jen Balkus (Public Health Seattle King County), Katie Hara (Bailey Boushay House), Kelly Hill, David Burden, Raaka Kumbhakar (Madison Clinic), Alma Garcia-Santos (Lifelong), Morgan Feder (Lifelong) Victor Velasquez (Seattle Roots)

Staff Present: Karen Chung (Planning Council Coordinator)

Public Present: Dashiell Huebner (Recipient Office), Scott Beck (Recipient Office), Linnae Baird (Public Health Seattle King County), German Galindo, Maria Corcorran (SHE-Clinic), Becca Hutcheson (EHE Initiative, Public Health Seattle King County), Julie Dombrowski (Madison Clinic)

Council Members Absent: Michael Louder, Juliana Odindo, Samantha McDonald, Chris Wukasch

---

Call to Order

- Meeting called to order at 4:06pm by Co-Chair Andrew Ashiofu

Administrative & Staff Updates

- **Staff transition:** This is the first Council meeting without Rose; Karen Chung (Planning Council staff) is managing the transition, including regaining access to the Planning Council cell phone, re-establishing text reminder workflows, and learning the food-

ordering process for in-person meetings — which are expected to be resolved before the October meeting.

- **Telecom reimbursements & stipends:** Karen is working to issue these without disruption to the existing schedule
- **New member:** David Burden was officially confirmed as a Planning Council member by the King County Executive; new member orientation scheduled for upcoming Friday.

Agenda/Minutes

- The agenda was approved by acclamation.
- The minutes were approved by acclamation.

Positive Caucus Report

- The International Day of Friendship event was a collaborative effort involving the full Positive Caucus team and staff.
- **Key takeaways:**
    - Future events will allow more organic cadence.
    - Food variety received positive feedback.
    - Venue was too small for anticipated attendance; outdoor tables were prepared as contingency. Future events will target a larger venue or return to **Judkins Park**.
    - Budget met; target participation projections achieved.
    - Jen commended the effort; echoed the venue concern — the AMP space was too tight for networking and socialization, which are central to the event's purpose.
- **Next year:** Ideas will begin germinating around February, with a target venue/plan locked by March–April.

System of Care Committee Report

- In Laura's absence, Karen gave the committee report.
- **Standard Review/Approval: Housing**
    - Council reviewed the changes accepted and proposed by System of Care Committee.

- **Motion** (Katie)**:** *The Planning Council approves the revisions proposed by the System of Care Committee for Housing standards.*
    - Second (Andrew)
    - No discussion
    - Vote: Passed
        - Yes – 6 – Katie, Andrew, Jen, Raaka, David, Victor
        - Abstention – 2 – Alma, Morgan
        - No – 0

Ending the HIV Epidemic: Low barrier services in South King County and North Seattle

Presenter: Dr. Maria Corcorran (SHE Clinic)

- Dr. Corcorran presented on SHE Clinic's service delivery model. Key highlights were:
    - **Low-barrier care** targets patients with the highest complexity of medical and social needs who are not engaged in conventional care, using walk-in access, integrated high-intensity case management, and (optionally) incentives.
    - **Status-neutral (one-door) model:** HIV testing, treatment, and prevention are offered in the same space regardless of a patient's HIV status — critical for confidentiality in community settings where HIV stigma is high.
    - **Services provided** include STI testing and treatment; HIV testing and treatment; PrEP; treatment for opioid use disorder (Suboxone on-site; methadone referrals); Narcan distribution; Hepatitis C treatment; chronic hepatitis B management; birth control and reproductive counseling; pregnancy diagnosis with expedited referral pathway to UW Family Medicine at Northgate for perinatal care; gender-affirming care; abscess/wound care; basic primary care (chronic disease management for diabetes, hypertension).
    - **Incentives offered:** $15 gift card (typically to a local grocery store) for returning for test results and $30 per HIV primary care visit for patients living with HIV.
    - **Outcomes:** Since July 2018: 1,800+ unique individuals served. 30 persons living with HIV enrolled; 23 had a viral load test in the past year, of whom 78% were virally suppressed
    - **Keys to Success**
        - Partnership with Aurora Commons
        - Trauma-informed physical environment

        - Patient-centered care
        - Walk-in access and high-intensity case management
        - Commitment to rapid modification:
        - Status-neutral design
- **Resource & Sustainability Considerations**
    - Resource-intensive model: requires off-site supply logistics, courier services for labs and refrigerated medications, and a multidisciplinary team.
    - High emotional burden on staff; burnout is a real risk.
    - Patient population is predominantly Medicaid or uninsured — private insurance reimbursement rates are not achievable, and standard primary care metrics are not the focus.
    - EHE funding has been critical for stability; concern expressed about sustainability if EHE is eliminated, given the clinic lacks capacity to chase small grants every six months.

NAPSRA Report

- The committee has reviewed data for the **Assessment of the Efficiency of the Administrative Mechanism** and will review and hopefully finalize a report with recommendations for the next Council meeting.

Ending the HIV Epidemic: MAX Clinic, MOD Clinic, and Mobile Outreach Team

- Dr. Dombrowski presented on the low-barrier care models at MAX Clinic, MOD Clinic, and the Mobile Outreach Team.
- **MAX Clinic**
    - Walk-in access; integrated high-intensity case management (medical social workers + public health DRIS officers); financial incentives: $25 per lab draw every 2 months, $50 for viral suppression; harm reduction-oriented care; cross-sector coordination (jail, housing agencies); commitment to rapid modification.
    - Outcomes
        - First 50 patients: 20% had ever achieved viral suppression in the year before enrollment → 82% in the year after.

        - More recent analysis: MAX Clinic patients consistently show ~80% higher likelihood of viral suppression after enrollment vs. before.
    - Annual cost (2023 analysis): ~$1.6 million/year; ~$6,400 per patient enrolled.
    - Most MAX Clinic visits do **not** involve a physician — slightly over half involve the medical and non-medical case management team, which is described as the heart of the clinic.
    - **Key external partnerships:** Bailey-Boushay House (10 set-aside HOPWA vouchers; frequent nursing coordination); supportive housing facilities; jail (weekly coordination with release planners).
- **MOD Clinic**
    - Created in response to referrals of patients who were virally suppressed but not attending clinic — a different need than MAX was designed for.
    - Walk-in, co-located with Madison Clinic, 5 days/week. Over time, has enrolled patients with complexity comparable to MAX; patient preference often determines placement.
    - Led by Raka Kumbakar; includes a patient navigator focused on coordination and relinkage; case managers/social workers are the same team as Madison Clinic.
    - **Outcomes** (initial analysis, n=164): Viral suppression did not increase initially, but engagement in care and sustained viral suppression both improved significantly.
    - More recent analysis (presented at CROI): Viral suppression improved; primary care metrics (vaccine completion, cancer screening, blood pressure control, diabetes management) post-enrollment approached Madison Clinic levels.
    - **Annual cost**: ~$800K/year; ~$2,900 per patient enrolled (half the time and staff of MAX).
- **Mobile Outreach Team** (Launched 2023)
    - **Partnership:** Public Health Seattle–King County, Peer Seattle, and Harborview. Team includes a DRIS, a Peer Services Specialist (supervised by Peer Seattle), and a UW medical team.
    - **Outcomes** (2023–2026, ~3.5 years): ~440 patients enrolled; ~75% candidates after screening; ~75% of candidates successfully contacted; ~80% of those contacted accepted services. Of those who accepted services: 154 patients (78%) had at least one care visit; 120 (61%) restarted ART; 116 (59%) achieved viral suppression.
- **Long-Acting Injectable ART is a key priority**

    - **LATITUDE study** demonstrated that people not virally suppressed on oral medications do better on long-acting injectables (cabotegravir-rilpivirine/CABONUVA).
    - **Biggest operational bottleneck:** High medication cost requires pre-authorization from both insurer and hospital before dispensing; initially insufficient staffing to manage this — resolved by hiring a dedicated patient coordinator and nurse.
    - Victor raised the question of whether removing financial incentives post-LATITUDE caused outcome dips — Julie noted no published data exists on this, as patients returned to routine care after the study and were not followed further.
- **Outcomes**: Across all patients enrolled in low-barrier care: 88% have ever been virally suppressed; 72% were virally suppressed at last check. Viral suppression is ~80% more likely after low-barrier care enrollment vs. before, consistently across analyses. Patients with more complex barriers (homelessness, opioid/stimulant use, severe mental illness, combinations thereof) show greater improvement with low-barrier care than those with fewer barriers.
- A **community data report** is produced every few months summarizing enrolled patient characteristics, priority populations, and system-level reach — Staff will distribute it with presentation slides to Planning Council mailing list.
- Becca Hutcheson spoke to the funding elements of the low-barrier clinics.
    - EHE (CDC + HRSA braided funding) supported status-neutral models by funding OAHS and medical case management for people with HIV, and EIS/outreach for those at risk — HRSA was supportive of creative service category use.
    - Currently, SHE Clinic is funded only through CDC (not Part A), as the number of people with HIV served there is relatively low and North Seattle has fewer PLWH than central Seattle.
    - Part A funding of status-neutral models is possible but requires creative structuring; without CDC funding, status-neutral models are harder to sustain through Part A alone.
    - For MAX Clinic: EHE primarily funded expanded hours and, increasingly, the long-acting injectable team (almost all LAI staff currently EHE-funded).
    - For MOD Clinic: EHE funds a patient navigator and coordination support.

Adjournment

- Meeting adjourned approximately 6:15pm.