

Report to the Legislature

STI & HBV Legislative Advisory Group Recommendations

December 1, 2022

ESSB 5092, Sec. 222.22



Prepared by:
Office of Infectious Disease on behalf of
the STI & HBV Legislative Advisory Group



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Contents

- Executive Summary 1**
- Background 3**
 - Public Health Importance for Washington State 3
 - Table 1: Disproportionate Rates of Gonorrhea and Chlamydia Infection, 2021 5
 - Table 2: Disproportionate Rates of Syphilis Infection, 2019-2021 6
 - Syphilis and the Public Health Lab 12
 - Recommendation Development Process 12
- Recommendations 14**
 - 1. High-priority recommendations that require new funding 14
 - 2. High-priority recommendations requiring policy change or new action 22
 - 3. Additional high-priority issues currently being addressed that the advisory group endorses 27
 - Table 3: Recommendations by ESSB 5092 Objective 29
 - 4. Additional recommendations that are important, but lower priority or contingent on other actions happening first 32
- Conclusion 35**
- Appendix A: The STI & HBV Legislative Advisory Group 37**
- Appendix B: The STI & HBV Legislative Advisory Group Committees and Committee Members 39**
- Appendix C: Glossary of Terms 41**

Executive Summary

During the 2021 session, the Washington State Legislature passed [Engrossed Substitute Senate Bill \(ESSB\) 5092](#), the state operating budget bill. ESSB 5092 includes a proviso, section 222.22, that charges the Washington State Department of Health (DOH) with convening a workgroup to make recommendations concerning funding and policy initiatives to address the spread of sexually transmitted infections (STI) in Washington. The proviso stipulates that the workgroup develop recommendations, prioritized based on need and available funding, to achieve the following objectives:

- Eradicate congenital syphilis and hepatitis B by 2030.
- Control the spread of gonorrhea, syphilis, and chlamydia.
- End the need for confirmatory syphilis testing by the Public Health Laboratory.
- Expand access to PrEP and PEP (HIV pre-exposure prophylaxis and HIV post-exposure prophylaxis).

The Department of Health convened the STI & Hepatitis B Virus (HBV) Legislative Advisory Group to develop recommendations responsive to the legislature's request. The advisory group developed 14 high-priority recommendations that require new funding and 7 high-priority recommendations requiring policy change or new action. In addition, the advisory group endorsed 2 high-priority issues currently being addressed by the state, and offered 18 additional recommendations that are important, but lower in priority or contingent on other actions happening first.

1. High-priority recommendations that require new funding

- 1.1 Conduct a statewide landscape analysis of STI, PEP, PrEP, and HBV services, including laboratory and jail services.
- 1.2 Convene a planning group to develop a comprehensive HBV elimination strategy.
- 1.3 Increase the number of sexual health/STI specialty clinics that provide comprehensive, high-quality clinical services and offer connection and referral to other services to support sexual health.
- 1.4 Expand jail-based sexual health services.
- 1.5 Enhance prenatal care and support services for pregnant people at risk for syphilis through low-barrier services.
- 1.6 Expand field-based treatment for syphilis.
- 1.7 Expand sexual health services provided outside of traditional clinical settings.
- 1.8 Develop a learning collaborative of leaders and medical providers in large health care organizations to promote system-level changes in STI, HBV, and HIV care.

- 1.9 Increase access to expedited partner therapy.
- 1.10 Modernize DOH surveillance data systems for STIs, HIV, and HBV.
- 1.11 Expand local epidemiologic, surveillance, assessment, and disease intervention capacity for HBV.
- 1.12 Expand funding and facilities for laboratory support for clinical and nonclinical sexual health services.
- 1.13 Support, train, and assist private labs across the state to ensure use of proper testing algorithms, reporting, and specimen submittal procedures.
- 1.14 Support evidence-based case management services to improve treatment for HBV and syphilis, and linkage and retention for HIV PrEP.

2. High-priority recommendations that require policy change or new action

- 2.1 Mandate syphilis testing on all stillbirths.
- 2.2 Allow medical assistants (MAs) with telehealth access to a supervising clinician to provide intramuscular injections in the field.
- 2.3 Allow disease intervention specialists to give intramuscular injections under the standing order of a local health officer.
- 2.4 Require all health insurance carriers that currently offer sexual and reproductive health coverage to pay for gonorrhea, chlamydia, syphilis, viral hepatitis, and HIV prevention services without cost sharing in all sexual health clinics.
- 2.5 Clarify legal status of expedited partner therapy, including a hold harmless clause for prescribing physicians.
- 2.6 Authorize public health entities to access electronic health records (EHR)/electronic medical records (EMR) for reporting and surveillance purposes.
- 2.7 Revise regulations for syphilis subsample submission and confirmatory testing.

3. Additional high-priority issues currently being addressed that the advisory group endorses

- 3.1 Support efforts to provide re-entry Medicaid coverage for incarcerated persons.
- 3.2 Support efforts to keep infants with their birth parents.

4. Additional recommendations that are important, but lower priority or contingent on other actions happening first

Eighteen additional recommendations are outlined in this section.

Background

During the 2021 session, the Washington State Legislature passed [Engrossed Substitute Senate Bill \(ESSB\) 5092](#), the state operating budget bill. ESSB 5092 includes a proviso, section 222.22, that charges the Washington State Department of Health (DOH) with convening a workgroup to make recommendations concerning funding and policy initiatives to address the spread of sexually transmitted infections (STI) in Washington. The proviso stipulates that the workgroup develop recommendations, prioritized based on need and available funding, to achieve the following objectives:

- Eradicate¹ congenital syphilis and hepatitis B by 2030.
- Control the spread of gonorrhea, syphilis, and chlamydia.
- End the need for confirmatory syphilis testing by the Public Health Laboratory.
- Expand access to PrEP and PEP (HIV pre-exposure prophylaxis and HIV post-exposure prophylaxis).

The Department of Health convened the STI & Hepatitis B Virus (HBV) Legislative Advisory Group (Appendix A) to develop recommendations responsive to the legislature’s request. This report presents the recommendations of that advisory group.

Public Health Importance for Washington State

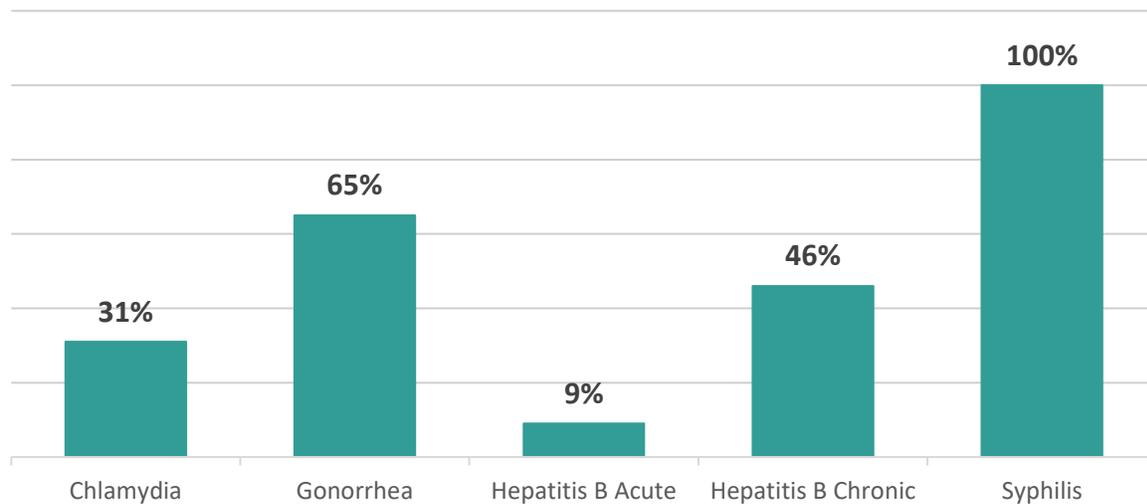
Washingtonians experience a significant and growing burden of STI and a continued burden of HBV.² Rates of gonorrhea and chlamydial infection continue to rise while the state confronts a new and ever-growing epidemic of syphilis in heterosexuals resulting in the highest rates of congenital syphilis observed in decades (Figure 1). New diagnoses of HIV persist despite the availability of treatment that renders people living with HIV unable to transmit the virus to others and medication for HIV pre-exposure prophylaxis (PrEP) that protects people not living with HIV from acquiring the virus. Meanwhile, HBV, a vaccine-preventable infection, continues to spread. In addition to all of this, Washington residents confront a new pandemic of monkeypox virus (MPOX), which is transmitted primarily through skin-to-skin contact, including sexual activity. Federal funding for sexual health clinics from the Centers for Disease Control

¹ Note that the term “eradicate” means the “permanent reduction to zero of the worldwide incidence of infection caused by a specific agent as a result of deliberate efforts; intervention measures are no longer needed. Example: smallpox.” Throughout this document, we use “eliminate” instead of “eradicate” because elimination is what can be achieved for congenital syphilis and hepatitis B in the present generation. “Elimination of infections” means “reduction to zero of the incidence of infection caused by a specific agent in a defined geographical area as a result of deliberate efforts; continued measures to prevent re-establishment of transmission are required. Example: measles, poliomyelitis.” For more information, see [“The Principles of Disease Elimination and Eradication” by Walter R. Dowdle](#).

² At the time of writing this report, DOH did not have 2021 data analyses complete for all conditions. 2021 data is provided in the report where possible.

and Prevention has fallen 41% since 2003.³ This new pandemic has demonstrated once again the inadequacy of our state and national approach to controlling STIs. The recommendations that follow offer steps our state can take to reverse these trends.

Figure 1: Percent Increase of New Reported Cases, 2015-2019



4

Gonorrhea and Chlamydia

Washington’s epidemics of gonorrhea and chlamydia are growing and characterized by health disparities, with elevated rates of infection occurring among gay, bisexual, and other men who have sex with men; people living with HIV; and Black and Indigenous/Native American/Alaska Native people.

³ Kaiser Health News. Can our society learn the lesson that underfunding public health has consequences? <https://khn.org/news/article/babies-die-as-congenital-syphilis-continues-a-decade-long-surge-across-the-us/>.

⁴ Washington State Department of Health surveillance data. Data from 2020-2021 are excluded from this graphic due to the presumed impacts of the COVID-19 pandemic on STI and HBV testing, treatment, and case reporting.

Table 1: Disproportionate Rates of Gonorrhea and Chlamydia Infection, 2021

Demographic Group	Relative Gonorrhea Rates	Relative Chlamydia Rates
People living with HIV	38.9X higher than general population	6.4X higher than general population
Gay, bisexual, and other men who have sex with men	13.4X higher than general population	2.3X higher than general population
Black American or African born	6.7X higher than white, non-Hispanic population	4.1X higher than white, non-Hispanic population
American Indian or Alaska Native	3.3X higher than white, non-Hispanic population	3.0X higher than white, non-Hispanic population
Hispanic or Latina/Latino/Latine/Latinx	1.7X higher than white, non-Hispanic population	2.4X higher than white, non-Hispanic population

Syphilis and Congenital Syphilis

Washington’s syphilis epidemic continued to grow through the COVID-19 pandemic. Between 2019 and 2021, the number of reported syphilis cases increased by 49%, while the number of cases of primary and secondary syphilis — early-stage infection characterized by a high risk of transmission — increased by 79%.

The rate of syphilis among gay, bisexual, and other men who have sex with men in Washington and in the rest of the United States has been high and growing for more than a decade. However, trends over 2019-2021 reflect the dramatic growth in rates of syphilis among people with opposite sex partners:

- Primary and secondary syphilis infections increased by 179% among cisgender women, and

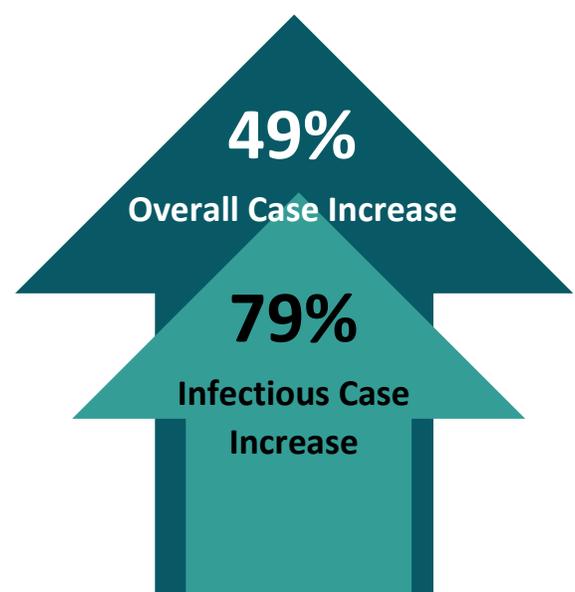
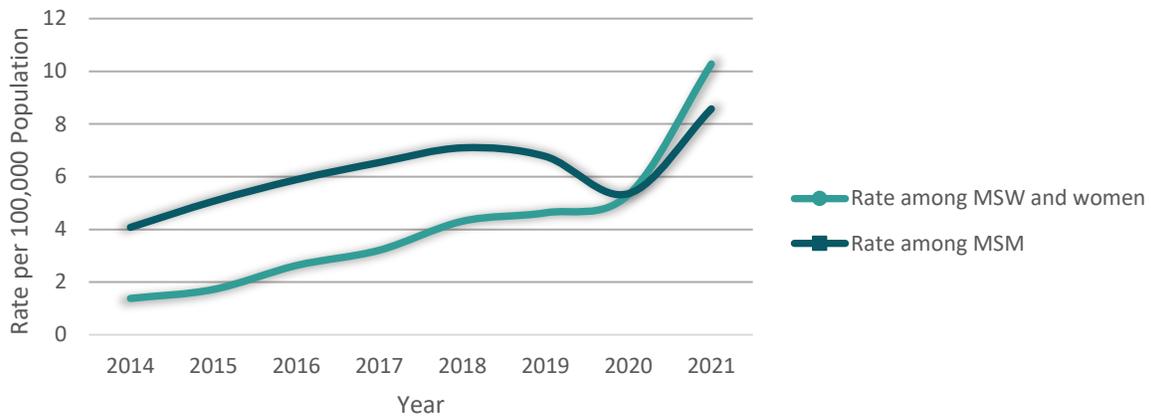


Figure 2: Syphilis 2019-2021

- Primary and secondary syphilis infections increased 105% among cisgender men reported as having cisgender female partners.

Figure 3: Primary and Secondary Syphilis Rates Among Cisgender Men Who Have Sex With Men (MSM), Cisgender Men Who Have Sex With Women (MSW), and Cisgender Women, 2014-2021



Increasing infection rates continue to highlight health disparities for gay, bisexual, and other men who have sex with men; people living with HIV; and people of color.

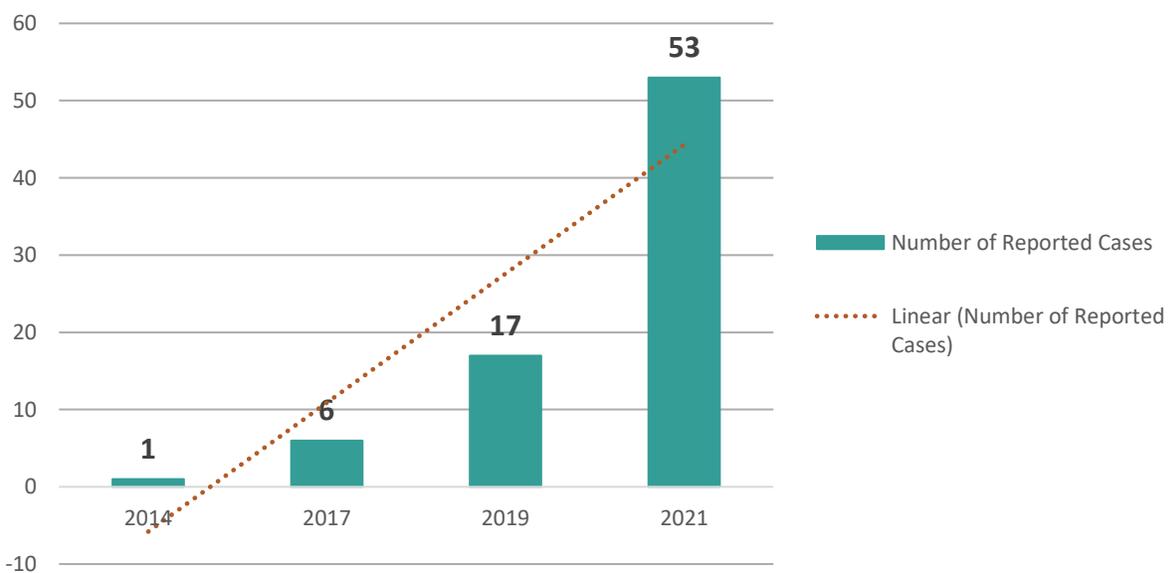
Table 2: Disproportionate Rates of Syphilis Infection, 2019-2021

Demographic Group	Relative Rates
Gay, bisexual, and other men who have sex with men	22.9X higher than general population
People living with HIV	121.4X higher than general population
Black American or African born	3.9X higher than white, non-Hispanic population
American Indian or Alaska Native	2.1X higher than white, non-Hispanic population
Hispanic/Latina/Latino/Latine/Latinx	2.0X higher than white, non-Hispanic population

Between 2000 and 2014, most reported syphilis diagnoses occurred among gay, bisexual, and other men who have sex with men, and cases of congenital syphilis were rare. Throughout this period, no more than two cases were reported in a single year, and many years there were no cases of congenital syphilis reported in the state. That changed in 2014 following an outbreak of

syphilis among heterosexuals in Spokane County. What followed was an explosive increase in congenital syphilis, such that in 2021 medical providers diagnosed 53 cases of congenital syphilis in the state, including 4 cases resulting in stillbirth and 24 instances of prematurity with the potential for long-term and serious health consequences of newborns (Figure 4). Although cases concentrate in the highest population areas of the state, more than a third of local health jurisdictions reported a case of congenital syphilis to DOH. Among these cases, 8% were from mothers experiencing unstable housing or homelessness, 30% were from mothers using any type of substance, 8% were from mothers who had reported exchanging sex for money or drugs, and 44% were from mothers with at least one of these characteristics.

Figure 4: Congenital Syphilis Case Reports, 2014-2021



Many people with syphilis contend with poverty, substance use and mental health disorders, lack of transportation, inadequate insurance, and incarceration. These and other challenges make it difficult for them to access traditionally organized medical care, which typically requires navigating bureaucratic systems and making and keeping appointments. They frequently rely on emergency departments or urgent care clinics, which are not organized to provide primary care or prenatal care. People eligible for Medicaid may have breaks in coverage that disrupt continuity of health care. Some people who use drugs report that health care providers refuse to provide them with prenatal care because of stigma. Compounding all of this, many pregnant people with syphilis live in rural areas of the state with limited access to care and, as noted above, rely on emergency departments for care. All these factors contribute to missed diagnosis, late diagnosis, and incomplete treatment of syphilis that can result in more cases of congenital syphilis. Indeed, in 2021, 75% of congenital syphilis cases in Washington occurred among pregnant persons who had no or inadequate prenatal care.

Human Immunodeficiency Virus (HIV)

In 2020, Washington received 359 reports of new HIV diagnoses, with 157 of those new diagnoses occurring in King County. These are the lowest numbers of diagnoses recorded since 1994. It is not clear whether 2020 data reflects a decline in the incidence of HIV transmission or a decline in HIV testing due to the COVID-19 pandemic. In both Washington and King County, most new HIV cases were among gay, bisexual, and other men who have sex with men (MSM), MSM who inject drugs, and non-MSM persons who inject drugs (Figure 5).

Figure 5: Demographics of New HIV Cases in 2020

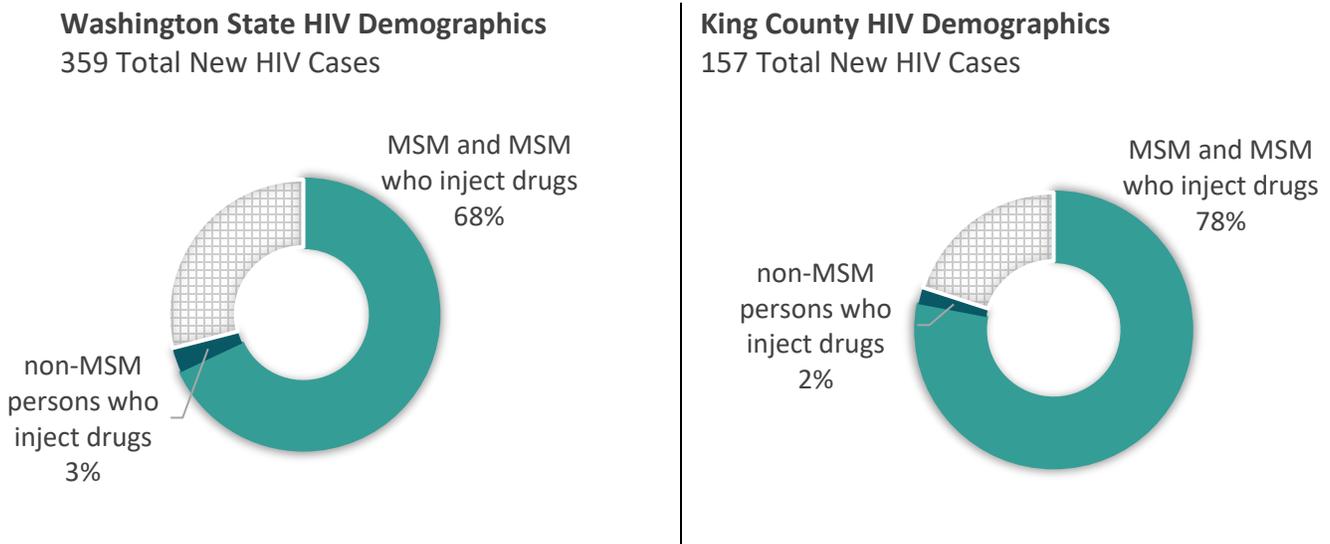
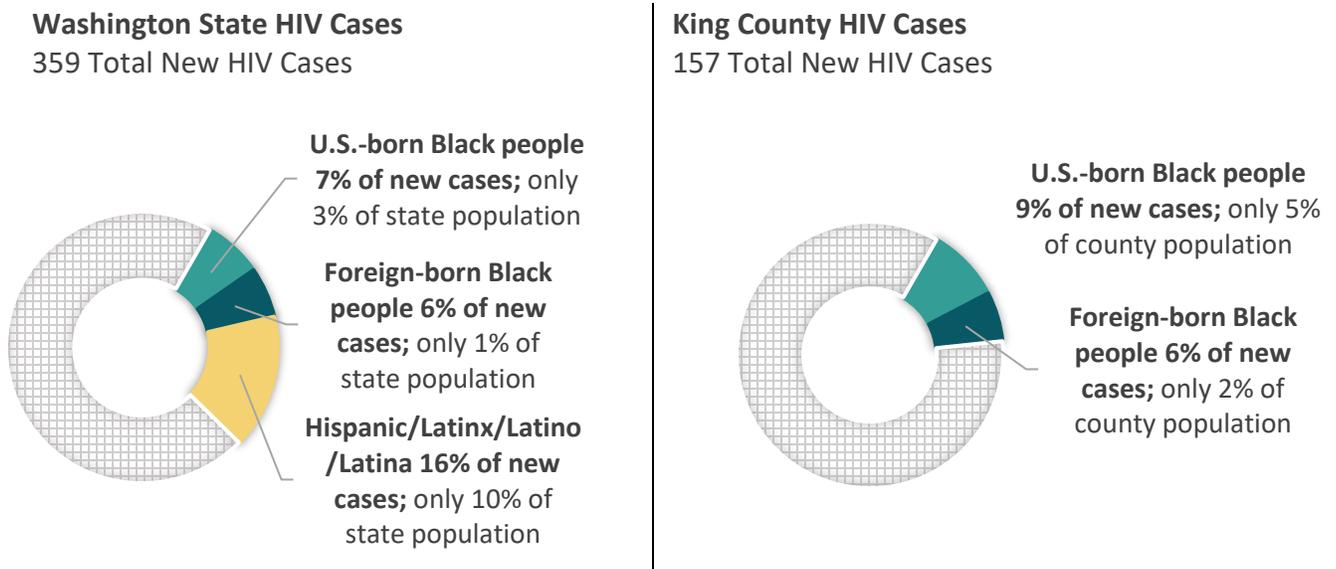


Figure 6: Disproportionate Disease Burden of New HIV Cases in 2020



New HIV diagnoses data also show disproportionate disease burden by race and ethnicity. Statewide, the percentages of new cases among U.S.-born and foreign-born Black people, and Hispanic or Latina/Latino/Latine/Latinx people are significantly larger than their respective percentages of the state population. In King County, only the percentages of new cases among U.S.-born and foreign-born Black people are significantly larger than their respective percentages of the county population. Among both Black and Hispanic or Latina/Latino/Latine/Latinx populations, new HIV diagnoses disproportionately affect people born outside of the United States.⁵

HIV Pre-exposure Prophylaxis (PrEP)

HIV PrEP involves people at risk for HIV taking antiretroviral medication to prevent them from acquiring HIV. PrEP is highly effective and a core component of the national effort to prevent new cases of HIV. Washington and King County PrEP implementation guidelines state that medical providers should recommend PrEP to gay, bisexual, and other men who have sex with men (MSM), and transgender people who have sex with men at elevated risk for HIV. The guidelines supply specific criteria to determine risk.⁶

In King County, approximately 44% of MSM at elevated risk for HIV use PrEP. This estimate is shy of King County's goal of 50% and has stalled during the COVID-19 pandemic. Data on PrEP use among transgender populations at higher risk for HIV are limited, but we estimate that 20-50% of transgender people at elevated risk for HIV use PrEP. PrEP use among non-MSM people who inject drugs is very low (<1%).⁷

Estimates based on 2021 STI case data reported to DOH point to similar trends statewide: approximately 43% of MSM with documented STI-related HIV risk used PrEP, while 37.5% of transgender people with documented STI-related HIV risk used PrEP. Available data also suggest significant inequities in PrEP use within the identified risk categories, with rates significantly lower in Black and American Indian or Alaska Native populations relative to White, non-Hispanic people.

Hepatitis B Virus (HBV)

Most adults with chronic HBV infection acquired infection through perinatal transmission — from a pregnant person to a baby. New acute infections also occur among adults, most often through sex and sharing of drug injection equipment. Untreated, HBV infection can lead to liver

⁵ [HIV/AIDS Epidemiology Report and Community Profile 2021, Washington State & King County.](#)

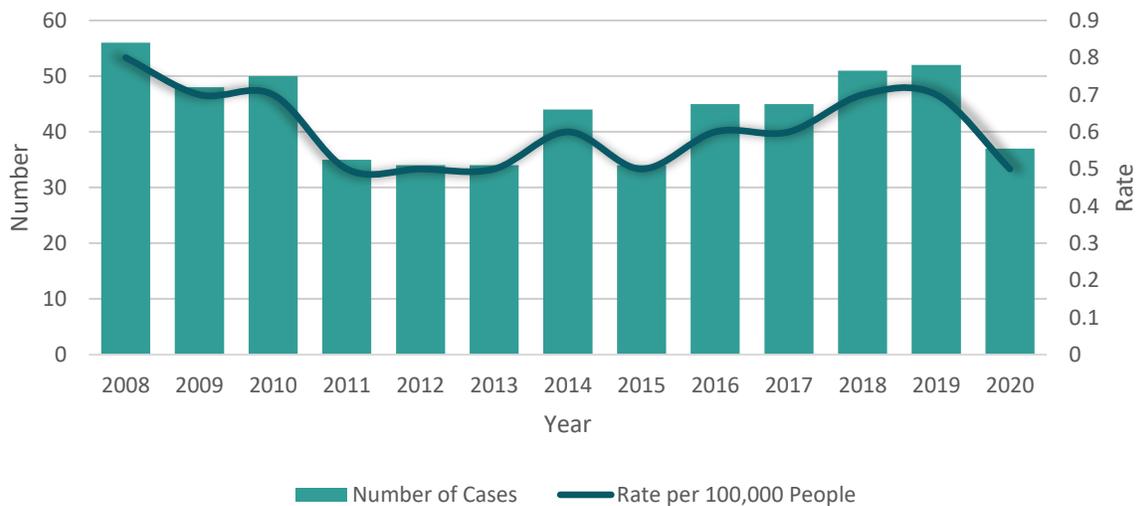
⁶ Public Health – Seattle & King County, Washington State Department of Health. (October 2015) [Pre-Exposure Prophylaxis \(PrEP\) Implementation Guidelines 2015.](#)

⁷ Public Health – Seattle & King County, Washington State Department of Health. (2021) [HIV/AIDS Epidemiology Report and Community Profile, Washington State and King County.](#)

failure, liver cancer, and death. Since 2001, HBV has contributed to the deaths of at least 1,026 Washingtonians.

Annual reports of acute HBV infection have fluctuated between 37 and 52 infections each year since 2016. Risk factors are often unknown, or multiple risk factors are present; however, of the cases for which risk factors are known, injection drug use was most frequently reported for cases in 2016-2020. Rates of acute hepatitis B remain low among children and young adults, likely due to successful infant and childhood vaccination strategies.

Figure 7: Reported Cases of Acute HBV by Year, 2008-2020



8

Over the last decade, reports of chronic HBV infections have increased.⁹ In 2020, 1,375 cases of chronic HBV were reported in Washington. This represents the lowest number of reports since 2015, likely reflective of the COVID-19 pandemic’s impacts on testing and case reporting. Country of birth data are missing for the majority of reported chronic cases. However, anecdotally, we know many and likely most chronic cases occur among immigrants to the United States and in children of persons born outside of the United States, with most cases acquired through perinatal transmission. According to the Centers for Disease Control and Prevention (CDC), people not born in the United States account for 70% of all chronic HBV cases in the United States. Many of these people were born in Asia, the Pacific Islands, and Africa.¹⁰

⁸ Washington State Department of Health Hepatitis Surveillance Records; WA OFM Population Estimates. 2020 data should be interpreted with caution due to the impacts of the COVID-19 pandemic on availability of screening, linkage to care, and investigative resources.

⁹ [Washington State Communicable Disease Report 2019](#)

¹⁰ CDC. [People Born Outside of the United States and Viral Hepatitis](#).

Perinatal infections among Washington residents have remained very low due to use of effective post-exposure prophylaxis.

Figure 8: Reported Cases of Chronic HBV by Year, 2008-2020



11

The Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices recommend universal HBV vaccination for all individuals up to age 59 regardless of risk factors.¹² The Centers for Disease Control and Prevention will likely issue updated HBV screening recommendations in fall 2022 to recommend universal HBV screening of adults 18 years and older, replacing risk-factor based guidelines which had poor uptake.¹³

Monkeypox Virus (MPOX)

Washington is navigating a new epidemic of MPOX concentrated among gay, bisexual, and other MSM. This epidemic has taxed the state’s STI control infrastructure much like the earliest days of the HIV epidemic. For example, the number of patients seen in King County’s Sexual Health Clinic skyrocketed from approximately 75 per day to 350 per day as patients sought monkeypox clinical care and immunizations. Elsewhere in the state, the absence of similar clinics hobbled public health’s initial response to the new epidemic.

¹¹ WA DOH Hepatitis Surveillance Records; WA OFM Population Estimates. 2020 data should be interpreted with caution due to the impacts of the COVID-19 pandemic on availability of screening, linkage to care, and investigative resources.

¹² CDC. (2022) [Universal Hepatitis B Vaccination in Adults Aged 19–59 Years: Updated Recommendations of the Advisory Committee on Immunization Practices — United States, 2022](#). Morbidity and Mortality Weekly Report.

¹³ CDC. (2022) [Peer Review Plan for Recommendations for Hepatitis B Screening and Testing](#).

Syphilis and the Public Health Lab

Syphilis testing and confirmatory testing at the Public Health Laboratory is an important part of the state's response to syphilis. Chapter 246-101 WAC requires a laboratory to send a subsample of each positive syphilis test result to the Washington State Public Health Laboratory in Shoreline for confirmation. The rule applies uniformly to laboratories across the state.

Over the last decade, the Public Health Laboratory has seen a significant increase in the number of samples sent for syphilis testing and confirmatory testing. As of the end of October 2022, the Public Health Laboratory had already tested 16,243 samples for syphilis and was on track to test over 18,000 samples for the year. The year-to-date 2022 figure is already a 73% increase compared to the number of samples tested for syphilis by the Public Health Laboratory in 2015. A combination of increasing syphilis cases and changes made to testing algorithms contribute to the large number of samples.

Opinions about requiring a subsample submission to the Public Health Laboratory vary. Some laboratories find the practice inconvenient. Many rural providers and laboratories rely on the confirmatory testing performed by the Public Health Laboratory. For syphilis surveillance work and clinical decision-making, confirmatory testing performed by the Public Health Laboratory creates a long-term, single lab record available for review.

Recommendation Development Process

The STI & HBV Legislative Advisory Group (Appendix A) met in late 2021 and throughout 2022 to develop recommendations, prioritized based on need and available funding, to:

- Eliminate congenital syphilis and hepatitis B by 2030.
- Control the spread of gonorrhea, syphilis, and chlamydia.
- End the need for confirmatory syphilis testing by the Public Health Laboratory.
- Expand access to PrEP and PEP (HIV pre-exposure prophylaxis and HIV post-exposure prophylaxis).

The advisory group convened five committees to draft recommendations (Appendix B). This committee model was designed to make sure that the recommendations would focus on key components of the clinical and public health system; engage important subject matter experts and community voices; and focus on the specific problems identified by the legislature. Each committee focused on one of the following areas:

- **Strengthening Healthcare Organization Systems:** This committee recommended changes to address STI/HBV prevention, testing, and treatment, and to expand access to HIV pre- and post-exposure prophylaxis (PrEP and PEP). The committee focused on the whole health care system to affect as many Washington residents as possible.
- **Enhancing STI Specialty Infrastructure:** A dedicated STI/HBV clinical infrastructure is needed to provide sexual health and STI services in specialized, clinical, outreach, and

community settings. This infrastructure ensures services reach disproportionately affected populations, including Black; Indigenous/Native American/Alaska Native; Hispanic or Latina/Latino/Latine/Latinx; other people of color; gay and bisexual men and other MSM; and transgender and gender-expansive persons.

- **Eliminating Congenital Syphilis:** The STI & HBV Legislative Advisory Group focused on congenital syphilis recommendations because of the growing national and statewide epidemic.
- **Eliminating Hepatitis B:** Hepatitis B elimination warranted its own committee due to its uniqueness among the conditions addressed by the proviso, both in terms of available prevention interventions (i.e., HBV vaccine) and the primary populations impacted.
- **Improving Surveillance, Epidemiology & Monitoring:** This committee recommended ways to strengthen STI and HBV data collection and analysis to aid the planning, implementation, and evaluation of work under the proviso.

The advisory group also considered national strategic plans when making their recommendations: [National HIV/AIDS Strategy 2022-2025](#); [Sexually Transmitted Infections National Strategic Plan 2021-2025](#); and [Viral Hepatitis National Strategic Plan 2021-2025](#). Goals for each of the strategic plans are similar, essentially:

- Goal 1: Prevent new infections
- Goal 2: Improve the health of people by reducing adverse outcomes
- Goal 3: Accelerate progress in research, technology, and innovation
- Goal 4: Reduce disparities and promote health equity
- Goal 5: Achieve integrated, coordinated efforts

Recommendations

The STI & HBV Legislative Advisory Group developed a series of recommendations to help Washington advance the objectives defined by the proviso. We grouped our priority recommendations into four broad categories that integrate the proviso objectives and national strategic plan goals. All the following recommendations seek to advance at least one of the following four purposes:

1. Better defining the state of STI and HBV prevention and care in Washington, with the goal of refining plans for STI and HBV control.
2. Expanding dedicated clinical and outreach services to test and treat STIs in disproportionately affected populations.
3. Improving how the broad health care system provides STI and HBV care.
4. Strengthening the public health infrastructure related to STI and HBV.

The advisory group broke the high-priority recommendations into three sections: recommendations that require new funding, recommendations that require a policy change, and endorsement of current actions. Sections 1-3 include a detailed description of each recommendation. Section 4 lists important, lower-priority recommendations.

The advisory group numbered the recommendations to help with conversation. Recommendation numbers do not represent a rank order.

1. High-priority recommendations that require new funding

Recommendations in this section require new funding to develop new programs or sources of medical care or enhance existing infrastructure. Table 3 shows which proviso objective(s) the recommendation addresses.

1.1 Conduct a statewide landscape analysis of STI, PEP, PrEP, and HBV services, including laboratory and jail services.

The advisory group recommends that the state dedicate resources to undertake a comprehensive analysis of existing services related to STI, PEP, PrEP, and HBV services, including laboratory and care provided in jails. The advisory group's initial work revealed that Washington lacks a comprehensive, contemporary inventory of what services are available in which parts of the state and where gaps in essential services exist.

In 2021, the Tacoma-Pierce County Health Department and the University of Washington Center for AIDS and STD collaborated on a local landscape analysis designed to inform a plan to improve STI clinical and prevention services in Pierce County. Center for AIDS and STD faculty and Spokane Regional Health District staff are currently working on a similar analysis in Spokane County. State funding made both landscape analyses possible.

The advisory group proposes that the legislature support an expanded landscape analysis that builds on the Center for AIDS and STD analytic model. The analysis should supply a clear picture of STI and HBV prevention and care services statewide and will inform future efforts to improve and monitor STI and HBV clinical and public health activities.

1.2 Convene a planning group to develop a comprehensive HBV elimination strategy.

The advisory group recommends that the state develop and implement a statewide HBV elimination strategy. So far, Washington has not developed a strategic elimination plan for HBV. In 2020, the United States Department of Health & Human Services published *The Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025)*. The national strategic plan supplies a framework to eliminate HBV in the United States.

The advisory group proposes that the state convene a planning body to develop a state HBV elimination strategy aligned with the national framework. Support for the planning body could be DOH-led or a collaborative effort between state agencies. We recommend that the planning body include diverse representatives from interested and affected parties, including people living with chronic HBV. With resources, the planning body could develop a strategic plan for HBV surveillance, prevention, testing, and treatment, which they will submit to the legislature for review.

1.3 Increase the number of sexual health/STI specialty clinics that provide comprehensive, high-quality clinical services and offer connection and referral to other services to support sexual health.

The advisory group recommends that the state develop a new network of walk-in sexual health clinics that provide comprehensive sexual health services to all patients regardless of insurance status or ability to pay. Washington’s health care system successfully provides sexual health services for many patients, and access to care has improved substantially for many patients since passage of the Affordable Care Act. Data presented earlier in the report, however, demonstrate that expanding access to conventionally organized health care is not enough to control the STI epidemic or to ensure access to care for all patients.

A successful STI control system requires dedicated sexual health clinics capable of providing comprehensive sexual health services. Public health clinics and disease control programs traditionally serve as centers of excellence and keepers of best practice and knowledge, from which primary care professionals often learn. Currently, the Public Health – Seattle & King County Sexual Health Clinic at Harborview Medical Center is the only comprehensive, dedicated sexual health clinic in the state. Although other areas of the state have clinics, particularly

“sexual and reproductive health clinics,”¹⁴ that provide critical sexual health services along with other reproductive health services, this network cannot serve the volume of patients needed to meaningfully change the trajectory of the STI and HIV epidemics. In addition, in most instances, these clinics do not provide walk-in services.

Only the full array of services available in a sexual health clinic with walk-in capability equips the public health system to meet the challenges of the existing STI and HIV epidemics. Sexual health clinics offer:

- Clinical evaluations, testing, and treatment for common STIs
- Testing for HIV and viral hepatitis
- HIV pre- and post-exposure prophylaxis
- Selected vaccinations
- Contraception
- Referral for ongoing medical care
- Connection to public health case investigation, contact tracing, and outreach services

Unlike many other clinical settings, public sexual health clinics have access to outreach services performed by disease intervention specialists and other staff. Outreach services are critical to reach patients and people at risk for whom transportation to clinical centers is difficult or not possible.

The advisory group proposes an expanded network of sexual health clinics to include new clinics and new walk-in services provided by existing health care providers, allowing for the efficient provision of care statewide. This network has the potential to act as regional hubs for clinical consultation, telemedicine services, outreach services, and mobile clinics for patients and providers in outlying areas.

1.4 Expand jail-based sexual health services.

The advisory group recommends improving staffing and programming to make sexual health services a routine offering in jails across the state. Jail environments present the easiest opportunity to provide information, education, testing, treatment, and prevention services to people at high risk of STIs and HIV. People at risk of STIs and HIV struggle to connect to the health care system, are often difficult to locate, and engage with criminal-legal systems. Sometimes their only access to health care occurs while in jail.

¹⁴ [“Sexual and reproductive health clinics”](#) (historically called “family planning clinics”) offer direct clinical services and education to help people choose if and when to have children and to plan healthy and well-timed pregnancies. In addition to contraception and preconception health, many clinics offer testing and treatment for STIs and HIV, screening for some cancers, and gender-affirming care.

For example, in many cases of congenital syphilis, the only time the birthing parent accessed medical care and STI testing was during a brief stay in jail. Frequently, disease intervention specialists identify new cases of STIs and HIV after an exposed partner becomes incarcerated and tests positive. Even with the relatively meager testing available in jails, 194 cases of chlamydia, 196 cases of gonorrhea, and 152 cases of syphilis were identified in jail settings in 2021.

Inadequate resources and systems prevent jails from reaching their full public health potential. Jails lack resources to implement and sustain routine STI, HIV, and viral hepatitis testing and treatment. A patchwork structure of health care staffing, with some staff outsourced and other staff locally employed, stretches staff thin and creates inconsistent standards of care.

1.5 Enhance prenatal care and support services for pregnant people at risk for syphilis through low-barrier services.

The advisory group recommends low-barrier prenatal care and expanded support services for pregnant women with syphilis and at risk for syphilis, with the goal of preventing congenital syphilis. In 2021, 44% of the pregnant persons who gave birth to a baby diagnosed with congenital syphilis in Washington were living homeless, using illicit substances (most often methamphetamine), or exchanging sex for money or drugs. Pregnant persons at risk for syphilis often struggle to attend appointments for prenatal care, leading to missed opportunities to diagnose and treat syphilis and avert cases of congenital syphilis.

Low-barrier clinics with walk-in care emphasize harm reduction and include wraparound services. Wraparound services bring together substance use disorder treatment, behavioral health support, case managers, and housing support, and can be effective in improving access to care for people who are part of communities not well served by traditionally organized health care systems.¹⁵ Clinicians with expertise in addressing congenital syphilis shared a model low-barrier clinic with the advisory group; [Team Lily](#) at the Zuckerberg San Francisco General Hospital is a promising example of how such a clinic may improve care for pregnant people.¹⁶

The advisory group proposes adding the low-barrier clinic model to Washington’s continuum of health care services. Services should include the following:

- Low-barrier clinical services in areas with high rates or numbers of cases of syphilis in women, or high rates or numbers of cases of congenital syphilis.

¹⁵ Rutman D, Hubberstey C, Poole N, Schmidt RA, Van Bibber M. (2020) [Multi-service prevention programs for pregnant and parenting women with substance use and multiple vulnerabilities: Program structure and clients’ perspectives on wraparound programming](#). BMC Pregnancy Childbirth.

¹⁶ University of Washington (2021). National STD Curriculum Podcast [Season 1, Episode 7: Congenital syphilis and syphilis in women](#).

- Resources to address barriers and help pregnant patients with syphilis complete recommended treatment: short-term housing, incentives, and transportation.
- Expansion of existing pregnancy support services, including First Steps Maternity Support Services and Parent Child Assistance Programs, to ensure access to low-barrier services for people with syphilis.

1.6 Expand field-based treatment for syphilis.

The advisory group recommends that the state invest new resources into staffing an expanded team of outreach workers. Outreach workers treat patients with syphilis outside of clinical settings, providing treatment where patients live, work, or wherever they are located.

The growing syphilis epidemic among heterosexuals is concentrated in communities that struggle to access traditionally organized health care, which typically requires people to make and keep appointments. Most cases of congenital syphilis occur among people who navigate some combination of unstable housing, substance use, poverty, and mental illness. Pregnant people with syphilis often require intramuscular injections of penicillin given once a week for three weeks. For some people, receiving this treatment is virtually impossible in a conventionally organized health care system, placing their unborn babies at risk for a devastating infection. Expanding field-based treatment can help patients receive the care they need and protects their unborn children.

1.7 Expand sexual health services provided outside of traditional clinical settings.

The advisory group recommends that the state allocate new funding to expand sexual health outreach services, ideally in coordination with the development of new sexual health clinics (see recommendation 1.3). Such outreach helps people in populations which bear a disproportionate burden of STIs and those who cannot easily access clinical centers, particularly people in rural and suburban areas with limited access to medical care and stigmatized and historically excluded populations who may not otherwise receive medical services. New resources will help outreach workers, field medical assistants, and nursing staff provide STI testing for populations not served by the current system of care and ensure that people who test positive receive treatment and needed support services. Expanded sexual health outreach services could be offered by mobile clinics, pharmacies, community-based organizations, and clinical or non-clinical outreach teams in field settings.

1.8 Develop a learning collaborative of leaders and medical providers in large health care organizations to promote system-level changes in STI, HBV, and HIV care.

The advisory group recommends creation and implementation of a statewide learning collaborative. Learning collaboratives promote system-level changes to medical care by bringing together representatives from different organizations. Collaborative participants implement common changes across their health care organizations and share lessons learned with their peers to promote widespread adoption of successful systems and policy changes.

The University of Washington and Public Health – Seattle & King County have organized three learning collaboratives, all located in King County. The first collaborative worked to improve hepatitis C care, and no longer meets. Two subsequent collaboratives, one including large health care systems’ primary care work, and a second focused on emergency departments, are ongoing and seek to implement recommendations related to lesbian, gay, bisexual, transgender, questioning, and queer care developed through the Bree Collaborative,¹⁷ with a focus on increasing HIV testing and PrEP use. These collaboratives have also sought to increase syphilis testing and improve care related to Monkeypox Virus (MPOX). At present, Washington lacks a statewide learning collaborative related to STIs or HBV.

The advisory group proposes a statewide learning collaborative for medical providers and leaders from large health care organizations to develop and implement policies and processes that improve STI and HBV services and increase the use of HIV PEP and PrEP. We expect the collaborative may also want to take on improvements in care related to other infectious diseases, like MPOX and hepatitis C virus.

1.9 Increase access to expedited partner therapy.

The advisory group recommends expanded support for a statewide program to make expedited partner therapy more widely available for people with a gonorrhea or chlamydia infection and their sex partners. Expedited partner therapy is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea without requiring partners’ prior evaluation by a medical provider. Typically, a medical provider gives the diagnosed patient medications or a prescription for each of their exposed partners. Randomized control trials show that this approach significantly decreases the risk of recurrent gonorrhea or chlamydia infections.^{18 19}

Between 2007 and 2019, the state provided medical providers with expedited partner therapy packets at no cost, leading to the highest level of expedited partner therapy use in the United States.²⁰ Due to funding problems, that program was discontinued. The Department of Health needs staffing, programming, medication purchasing, monitoring, and dissemination support for a sustainable program.

¹⁷ Bree Collaborative. (2018) [LGBTQ Health Care Report and Recommendations](#).

¹⁸ Centers for Disease Control and Prevention. [Expedited partner therapy in the management of sexually transmitted diseases](#). Atlanta, GA: US Department of Health and Human Services, 2006.

¹⁹ Golden M et al. (2005). [Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydial infection](#). N Engl J Med.

²⁰ Strenger MR et al. (2015) [Patient-Reported Expedited Partner Therapy for Gonorrhea in the United States: Findings of the STD Surveillance Network 2010-2012](#). Sex Transm Dis.

1.10 Modernize DOH surveillance data systems for STIs, HIV, and HBV.

The advisory group recommends supporting the development and implementation of modernized surveillance databases for STIs, HIV, and HBV. While different issues exist in the data systems for each condition, current surveillance databases are outdated and susceptible to malfunction. Modernization is critical to ensure timely and accurate disease reporting, case investigation, disease intervention, follow up, case management, and linkage to care and services. Modernization is also critical to support data system interoperability and for inclusion in DOH-wide data systems efforts, supporting a unified approach to collecting, analyzing, and sharing data across programs and with partners, to identify common problems and jointly design solutions.

Modern functions, data structure, and data elements would transform surveillance activities and data management, particularly for chronic infectious diseases. For example, the bulk of HBV surveillance data consists of acute and chronic HBV case data. The ability to implement data system changes in a timely manner will allow public health to better collect data surrounding HBV treatment, to monitor and promote treatment of HBV, and implement targeted interventions among populations and geographic regions in our state who need it most. Case management functions are necessary for disease intervention, linkage to care, and follow up on retention in care and treatment.

For HIV and other STIs, the ability to consume or import electronic files like laboratory reports would increase efficiency and timeliness of reporting and case investigation. Having one system to collect across conditions, or systems that are interoperable, would allow for timely identification of individuals diagnosed or tested for multiple conditions and support getting those individuals linked to the care and services they need in a timely manner. Enhanced tools to support DOH and local health jurisdictions' workflows to ensure completeness of reporting and follow up would also be an outcome. These enhancements allow for comprehensive surveillance and follow-up. With the tools to adopt a more comprehensive approach to disease intervention, public health outreach staff can, for example, contact people for STI partner notification and link them to services like HIV PrEP.

1.11 Expand local epidemiologic, surveillance, assessment, and disease intervention capacity for HBV.

The advisory group recommends hiring and retention of epidemiology and disease investigation staff to undertake HBV surveillance monitoring, promote perinatal case management, and increase patient linkage to medical care and treatment. Public health agencies lack dedicated state funding for HBV surveillance and assessment. As a result, the DOH and local health jurisdictions cannot accurately characterize the burden of HBV and trends in infection, nor can they monitor the number of cases linked to treatment and the proportion of people who continue required ongoing and lifesaving therapy.

1.12 Expand funding and facilities for laboratory support for clinical and nonclinical sexual health services.

The advisory group recommends expanding funding and laboratory facilities for two reasons:

1. More laboratory capacity will be necessary to support the recommended specialty clinics and outreach testing; and
2. More laboratory resources and locations can improve equity for residents in rural, central, and eastern jurisdictions.

The turnaround time between specimen collection and test results affects the speed at which a provider can treat, and a local health jurisdiction can intervene in, the spread of disease. Rural jurisdictions in central and eastern parts of the state are keenly aware of this; the Public Health Laboratory is on the western side of the state, in Shoreline. Adding public laboratories in eastern and western Washington will shorten turnaround time for lab results and reduce the cost of specimen shipment. This is especially important for public health intervention for disproportionately affected rural Black, Indigenous/Native American/Alaska Native, and Hispanic or Latina/Latino/Latine/Latinx, and other communities of color.

The advisory group proposes one or more of the following actions to expand funding and facilities for laboratory support:

- Increase the number of commercial and public health laboratories available for service.
- Expand support for state-funded specimen shipment or courier service to ensure equitable access regardless of the patient or clinic's distance to the laboratory.
- Resource sufficient staffing to conduct laboratory services and modernize technological resources.

1.13 Support, train, and assist private labs across the state to ensure use of proper testing algorithms, reporting, and specimen submittal procedures.

The advisory group recommends staffing a unit at the Public Health Laboratory to build capacity for STI specimen processes performed by local, commercial, and academic laboratories.

Funding will build statewide laboratory capacity to move away from the subsample submission requirement for syphilis testing. It will also allow the Public Health Laboratory to provide more support in a timely, proactive manner when staff or offerings change at commercial labs and the resulting changes to ordering, diagnosis, and reporting could result in obstacles to disease surveillance and public health intervention. Using the Public Health Laboratory in this manner would represent an effective leveraging of existing lab resources.

1.14 Support evidence-based case management services to improve treatment for HBV and syphilis, and linkage and retention for HIV PrEP.

The advisory group recommends a new program to support public health-administered case management services for HIV PrEP and PEP, treatment for syphilis among pregnant people, and

treatment for chronic HBV. Obtaining and effectively using medical, social, and educational services can be a significant challenge for communities with the greatest risk factors for STIs, HIV, and hepatitis B. Case management is an evidence-based intervention that helps clients access public services. Housing, food, transportation, mental health services, substance use treatment and prevention services make it possible to successfully receive medical and preventive care. Case management is effective in a variety of health care and social service settings including outreach to people in jails, shelters, mobile clinics, and other non-traditional settings.

2. High-priority recommendations requiring policy change or new action

Recommendations in this section require a policy change to create something new or enhance existing infrastructure. Table 3 shows which proviso objective(s) the recommendation addresses.

2.1 Mandate syphilis testing on all stillbirths.

The advisory group recommends mandated syphilis testing for all stillbirths, if the birthing parent is unavailable for testing. Positive results must be reported to the local health jurisdiction using the birthing parent's name. Congenital syphilis can result in stillbirth. Because hospitals do not consistently perform autopsy and testing after a stillbirth, some cases of syphilis-induced stillbirth go undetected. This results in an underestimate of harms caused by congenital syphilis and may lead to missed opportunities to test and treat infected parents. Many stillbirths are determined to be related to syphilis because the birthing parent is tested at the time of the stillbirth, but this kind of measure would only be employed when the birthing parent is unable or unwilling to be tested. In the case of a positive result from mandated testing via this process, disease intervention specialists would initiate an investigation to locate, test, and treat the parent(s). This would not only lead to improved health outcomes for them, but it would also result in less likelihood of delivery of future babies with congenital syphilis, as some parents of identified cases who were not located and treated have delivered additional babies with congenital syphilis in subsequent years. Thorough stakeholder engagement would be necessary to inform sensitive and meaningful implementation.

2.2 Allow medical assistants (MAs) with telehealth access to a supervising clinician to provide intramuscular injections in the field.

The advisory group recommends amending [chapter 18.360 RCW](#) to grant explicit authority to administer medications and vaccines prescribed by a licensed provider, specifically intramuscular injections, as part of telemedicine visits. Medical assistants routinely administer these injections, including vaccines and commonly used therapies for STIs, in clinical settings when a supervising clinician is available onsite. Washington currently allows MAs to give

intramuscular injections as part of telemedicine visits.²¹ Rules proposed by DOH's MA licensing program would prohibit medication administration while under telemedicine supervision only. Under current law, a health care practitioner must either be on premises or have direct visual supervision of a MA administering medication, depending on the type of drug. A statutory change would protect the MAs ability to treat patients, per medical provider orders, in nonclinical settings such as field outreach settings, community-based organizations, and syringe services programs.

Effective syphilis treatment requires administration of intramuscular injections of long-acting benzathine penicillin. Allowing MAs to give intramuscular injections during telehealth visits fills a gap in care, particularly for pregnant patients with syphilis. Outreach services are critical for STI, HIV, and HBV infection control, and MAs already play a role in improving outcomes. Protecting the current MA scope of practice will help Washingtonians access necessary medical care.

2.3 Allow disease intervention specialists to give intramuscular injections under the standing order of a local health officer.

The advisory group recommends amending [RCW 70.24.120](#) to allow STI disease intervention specialists to administer intramuscular injections outside of clinical settings, with the goal of expanding local health jurisdictions' ability to treat patients outside of clinical settings. Currently, disease intervention specialists may obtain specimens through venipuncture or fingerstick puncture to test for STIs, blood-borne pathogens, and other infections as defined by board rule. This recommendation expands the current scope of practice.

A handful of jurisdictions in other states have implemented benzathine penicillin in the field, most commonly for maternal syphilis, with success. Three out of five programs employ registered nurses (RNs) to supervise disease intervention specialists on field visits: Louisiana; Los Angeles County; and Bexar County, Texas. Louisiana also offers integrated treatment as part of a perinatal case management for high-risk pregnancies.

Washington could implement a similar benzathine penicillin treatment program through a standing order from a local health officer.²² The barrier is staffing. Relatively few local health departments have RNs available to do this work or funding needed to support staffing, programming, and administration of these services. Hiring RNs is often difficult for public health jurisdictions due to staffing shortages and competition with hospitals and clinics.

²¹ [RCW 18.360.010\(11\)\(c\)](#).

²² According to an [Advisory Opinion from the Nursing Care Quality Assurance Commission](#), a nurse may follow standing orders within the nurse's scope of practice. [RCW 70.24.120](#) permits disease intervention specialists to obtain specimens under a standing order.

Expanding the disease intervention specialist scope of practice is a potential solution. We know from experience with delegation that people with lower levels of health care training can learn to safely administer intramuscular injections. The advisory group proposes that disease intervention specialists undergo specific training and certification before administering injections and only administer medications prescribed by a licensed medical provider with prescribing authority. A health officer may be the prescriber in most cases.

The advisory group believes that decreasing congenital syphilis requires expanding treatment options outside of clinical settings and expanding the workforce available for outreach-based treatment. Disease intervention specialists are well-poised to do this work.

2.4 Require all health insurance carriers that currently offer sexual and reproductive health coverage to pay for gonorrhea, chlamydia, syphilis, viral hepatitis, and HIV prevention services without cost sharing in all sexual health clinics.

The advisory group recommends that the state enact rules or laws requiring state-regulated health insurers to pay for comprehensive sexual health services — including gonorrhea, chlamydia, syphilis, viral hepatitis, and HIV prevention services — in sexual health clinics without cost sharing.

As discussed above, the advisory group’s strategy for improving STI care involves both development of a statewide network of dedicated sexual health clinics and improvements in the wider health care system. The new network of sexual health clinics needs to be accessible to all Washington residents with a financing plan that is sustainable. Accomplishing these goals will require legislative action.

The United States Preventive Services Task Force issued A and B grade recommendations related to syphilis²³, gonorrhea and chlamydia²⁴, viral hepatitis²⁵, and PrEP.²⁶ Under the Patient Protection & Affordable Care Act, health plans must provide preventive services with an A or B

²³ The USPSTF recommends early screening for syphilis infection in all pregnant women. 1/1/2019 implementation; <https://uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-in-pregnancy-screening>

²³ Specifically, Hepatitis C, Hepatitis C Virus Infection in Adolescents and Adults: Hep C screening for all. 1/1/2021 implementation.

²⁴ The USPSTF recommends chlamydia and gonorrhea screening is specific to sexually active women under 24 and sexually active women 25 and up at risk. 1/1/23 implementation.

<https://www.cdc.gov/nchhstp/highqualitycare/preventiveservices/std.html>

²⁵ The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening> 1/1/21 implementation.

²⁶ The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

<https://uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis> 1/1/20 implementation.

grade with no cost-sharing.^{27 28} However, challenges remain: interpretation and implementation of these policies varies; guidelines do not mandate that care be provided without cost-sharing for patients with an STI who are asymptomatic; and many patients are still billed for STI care, HIV PrEP, and viral hepatitis testing. Many of these patients do not expect the bill, and the absence of no-cost care is a barrier to successful STI control.

Legislation mandating that insurers pay for care in sexual health clinics will expand access to comprehensive low-barrier sexual health services. The advisory group believes that requiring insurers to pay for care in STI clinics may necessitate new rules and laws requiring that they contract directly with the clinics and define them as statewide in-network providers. This will expand access to comprehensive care for patients with state-regulated health insurance and ensure that providers receive fair reimbursement for care.

2.5 Clarify legal status of expedited partner therapy, including a hold harmless clause for prescribing physicians.

The advisory group recommends adoption of statutory language that clarifies the legal status of expedited partner therapy and holds providers harmless for liability flowing from the practice. Medical providers that use expedited partner therapy presumptively treat gonorrhea and chlamydia in the sexual partners of people diagnosed with these infections. Expedited partner therapy is a necessary tool in chlamydia and gonorrhea prevention and treatment. Some providers express concern about adverse reactions to medications among partners treated through expedited partner therapy, though no significant reactions of this type have been documented among the many tens of thousands of partners treated through this intervention. Despite this experience, this concern may be a barrier to expedited partner therapy use.

[According to the Centers for Disease Control and Prevention, the legal landscape in 46 states, including Washington, permits the practice of expedited partner therapy.](#)²⁹ The Centers for Disease Control and Prevention's research also indicates that some Washington laws may negatively impact the practice. Even though no liability issues have arisen to our knowledge, some health care providers report fear of liability as a reason they do not practice expedited

²⁷ United States Preventive Services Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine. Their recommendations are based on a rigorous review of existing peer-reviewed evidence and are intended to help primary care clinicians and patients decide together whether a preventive service is right for a patient's needs. The Task Force assigns each recommendation a letter grade (an A, B, C, or D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service. The Task Force does not consider the costs of a service when determining a recommendation grade. The recommendations address only services offered in the primary care setting or services referred by a primary care clinician. Recommendation [topics can be found here](#).

²⁸ CDC. [Preventive Services Coverage](#).

²⁹ CDC, [cdc.gov](https://www.cdc.gov/std/ept/legal/default.htm), Legal Status of Expedited Partner Therapy (EPT), <https://www.cdc.gov/std/ept/legal/default.htm> (last updated April 2021).

partner therapy. Health care providers and patients would benefit from legal clarity and liability shielding.

Legal clarity and liability shielding may lead to the following benefits:

- Increasing use of expedited partner therapy.
- Establishing expedited partner therapy as standard practice.
- Affirming public health’s role as a safety net.

2.6 Authorize public health entities to access electronic health records (EHR)/electronic medical records (EMR) for reporting and surveillance purposes.

The advisory group recommends mandating that all health care organizations grant public health agency access to EHR/EMR for the purposes of case investigation and surveillance. Designated public health agency staff will complete appropriate training in privacy and confidentiality and, when appropriate, sign confidentiality agreements with health care organizations. Disease intervention specialists or other designated public health staff will exercise this mandate if either of the following conditions applies:

- Health care organizations do not comply with the state’s notifiable disease reporting requirements; or
- Case investigations require more information to locate diagnosed or exposed persons or determine the outcome of the investigation.

State law authorizes public health to investigate cases of reportable communicable disease, including HIV, syphilis, gonorrhea, and chlamydia.³⁰ Investigations are designed to confirm diagnoses, understand transmission, determine disease-related risk factors, and evaluate whether additional intervention is needed to ensure that patients and partners are adequately treated. At present, these investigations often rely on disease intervention specialists going to a health care facility to access medical records, a process that is laborious and inefficient.

Public health surveillance conducted by DOH and local health jurisdictions has improved in completeness and timeliness because of electronic laboratory reporting. Collecting detailed clinical information about reported cases is still heavily dependent on manual processes. Detailed clinical information is necessary to confirm the diagnosis, understand transmission, determine disease-related risk factors, and evaluate whether additional intervention is needed to ensure that patients and partners are adequately treated.

The increasing commonness and functionality of EHR/EMR systems in Washington present important opportunities to advance public health surveillance and improve efficiency. If made accessible to public health staff for the purposes of disease surveillance, EHR/EMR data have

³⁰ [RCW 70.24.022](#); [WAC 246-100-202](#).

the potential to further increase the breadth, detail, timeliness, and completeness of public health surveillance. This can make better data available to guide public health interventions. EHR/EMR also provide a unique opportunity to integrate efforts to improve patient care into public health surveillance, bridging the gap between public health practice and clinical medicine.

2.7 Revise regulations for syphilis subsample submission and confirmatory testing.

The advisory group recommends revising the requirement for subsample submission and confirmatory testing by adding an opt-out clause. After weighing the pros and cons of the proviso objective from the perspective of different local health jurisdictions, the advisory group decided that an exemption for certain sample types, test types, or lab categories would be better than removing the requirement entirely. Without capacity building, removing confirmatory testing may disrupt syphilis surveillance and investigation work in smaller local health jurisdictions.

The advisory group proposes that the State Board of Health work with regulated entities, local health jurisdictions, and other interested parties to consider revising rules related to subsample submission requirements and confirmatory testing for syphilis in Washington Administrative Code, chapter [246-101 WAC](#), Notifiable Conditions. We encourage the Board to explore allowing laboratories to opt out of specimen submission to the Public Health Laboratory with certification.³¹

3. Additional high-priority issues currently being addressed that the advisory group endorses

Recommendations in this section do not require action. The advisory group acknowledges and endorses parallel work. Table 3 shows which proviso objective(s) the recommendation addresses.

3.1 Support efforts to provide re-entry Medicaid coverage for incarcerated persons.

The advisory group endorses efforts to provide pre-release coverage immediately before release or discharge, as this would help support efforts to finance STI testing and treatment. The Washington State Health Care Authority submitted an 1115 waiver renewal to the Centers for Medicare & Medicaid Services (CMS) requesting permission to reinstate Medicaid eligibility during the last month of incarceration to establish continuity of health care upon reentry. The

³¹ The Board has statutory authority under the Revised Code of Washington to adopt rules for the prevention and control of infectious diseases ([RCW 43.20.050](#)). Note that changes made to chapter 246-101 WAC went through the rulemaking process in March 2021 and take effect in January 2023. The Board cannot amend the chapter again until those go into effect.

STI & HBV Legislative Advisory Group endorses such efforts because preparing incarcerated individuals for successful re-entry helps support health care access, STI testing, and treatment upon release.

3.2 Support efforts to keep infants with their birth parents.

The advisory group endorses efforts that help keep infants with their birth parents. An important part of addressing congenital syphilis is assuaging the fear and stigma pregnant people who use drugs may face when using prenatal and other health care services. The Washington State Department of Children Youth & Families and other entities are developing policies that aim to keep infants and children with their birth parent and support parents who use drugs. The advisory group endorses such efforts.

Table 3: Recommendations by ESSB 5092 Objective

Recommendation	Eliminate congenital syphilis and hepatitis B by 2030	Control the spread of gonorrhea, syphilis, and chlamydia	End the need for confirmatory syphilis testing by the Public Health Laboratory	Expand access to PrEP and PEP
1.1 Conduct a statewide landscape analysis of STI, PEP, PrEP, and HBV services, including laboratory and jail services.	✓	✓	✓	✓
1.2 Convene a planning group to develop a comprehensive HBV elimination strategy.	✓			
1.3 Increase the number of sexual health/STI specialty clinics that provide comprehensive, high-quality clinical services and offer connection and referral to other services to support sexual health.		✓		✓
1.4 Expand jail-based sexual health services.	✓	✓		
1.5 Enhance prenatal care and support services for pregnant people at risk for syphilis through low-barrier services.	✓			
1.6 Expand field-based treatment for syphilis.	✓	✓		
1.7 Expand sexual health services provided outside of traditional clinical settings.		✓		✓

Recommendation	Eliminate congenital syphilis and hepatitis B by 2030	Control the spread of gonorrhea, syphilis, and chlamydia	End the need for confirmatory syphilis testing by the Public Health Laboratory	Expand access to PrEP and PEP
1.8 Develop a learning collaborative of leaders and medical providers in large health care organizations to promote system-level changes in STI, HBV, and HIV care.	✓	✓		✓
1.9 Increase access to expedited partner therapy.		✓		
1.10 Modernize DOH surveillance data systems for STIs, HIV, and HBV.	✓	✓		✓
1.11 Expand local epidemiologic, surveillance, assessment, and disease intervention capacity for HBV.	✓			
1.12 Expand funding and facilities for laboratory support for clinical and nonclinical sexual health services.		✓		
1.13 Support, train, and assist private labs across the state to ensure use of proper testing algorithms, reporting, and specimen submittal procedures.		✓	✓	
1.14 Support evidence-based case management services to improve treatment for HBV and syphilis, and linkage and retention for HIV PrEP.	✓	✓		✓
2.1 Mandate syphilis testing on all stillbirths.	✓	✓		
2.2 Allow medical assistants (MAs) with telehealth access to a supervising clinician to provide intramuscular injections in the field.	✓	✓		

Recommendation	Eliminate congenital syphilis and hepatitis B by 2030	Control the spread of gonorrhea, syphilis, and chlamydia	End the need for confirmatory syphilis testing by the Public Health Laboratory	Expand access to PrEP and PEP
2.3 Allow disease intervention specialists to give intramuscular injections under the standing order of a local health officer.	✓	✓		
2.4 Require all health insurance carriers that currently offer sexual and reproductive health coverage to pay for gonorrhea, chlamydia, syphilis, viral hepatitis, and HIV prevention services without cost sharing in all sexual health clinics.	✓	✓		✓
2.5 Clarify legal status of expedited partner therapy, including hold harmless clause for prescribing physicians.		✓		
2.6 Authorize public health entities to access electronic health records (EHR)/electronic medical records (EMR) for reporting and surveillance purposes.	✓	✓		
2.7 Revise regulations for syphilis subsample submission and confirmatory testing.			✓	
3.1 Support efforts to provide re-entry Medicaid coverage for incarcerated persons.	✓	✓		
3.2 Support efforts to keep infants with their birth parents.	✓			

4. Additional recommendations that are important, but lower priority or contingent on other actions happening first

More information about these recommendations can be provided upon request.

4.1 Resource effective communication and marketing materials to reach the public and medical providers to increase understanding of sexual health and sexual health services. Increasing STI infrastructure will require increased awareness in communities where services exist, along with increased awareness of sexual health issues, conditions, and symptoms. Materials should be in multiple languages and prioritize disproportionately affected communities.

4.2 Resource expanded provider education to increase STI clinical expertise, including a partnership with medical residency programs. Medical providers continue to miss STI symptoms and opportunities to test and treat people.

4.3 Resource routine opt-out testing for people who enter incarceration. Testing in jails is key to STI detection, treatment, and control in populations most affected by the current STI burden. Jail health service providers could do this work in partnership with programs for trainees with diagnosis and prescriptive ability, such as physicians, nurse practitioners, and physician assistants.

4.4 Dedicate funding to build and sustain regional epidemiological capacity for surveillance, monitoring, and evaluation work to support HIV, STI, and viral hepatitis prevention efforts. Funding should include staffing, training, consultative structures, and data analysis applications. See regional models implemented in [Michigan](#), [West Virginia](#), [New York](#), and [New Jersey](#).

4.5 Resource DOH to hire an outbreak response coordinator to identify clusters and outbreaks of disease; coordinate with disease intervention specialists; and coordinate other responses, such as vaccination mobilization.

4.6 Resource monetary incentives for STI testing of individuals named as partners of confirmed cases, including short-term funds to build out policies and procedures for procurement and reporting. A program in [Oregon](#) offers non-cash incentives to support engagement in HIV and syphilis medical care.

4.7 Resource a licensed medical provider as permanent staff in DOH's Office of Infectious Disease to provide medical oversight for community-based non-clinical testing partners; sign off on Medical Assistant - Phlebotomy licensure for contractors and partners; and conduct provider

detailing and education. The lack of medical oversight has been a barrier for some community-based organizations to offer STI, HIV, and viral hepatitis testing in community settings where populations of focus live, work, and play. Community settings include, but are not limited to, street outreach, fairs, festivals, bath houses, bars, and clubs.

4.8 Add mandated reporting of pregnancy status when known or if probable to required laboratory reporting of positive chlamydia, gonorrhea, and syphilis laboratory results. [Mandated reporting of pregnancy status is already required for HBV.](#)

4.9 Develop accessible, culturally and linguistically appropriate HBV awareness campaigns utilizing multiple platforms and trusted messengers including, but not limited to, printed materials, social marketing, and media platforms.

4.10 Resource viral hepatitis vaccination services at a broad range of clinical and non-traditional community-based settings including, but not limited to, corrections, treatment centers, churches, syringe service programs, and other sites identified by affinity groups or social service or advocacy organizations. Provide hepatitis B vaccine to non-traditional clinical sites in high burden counties serving priority populations at risk for HBV. Sites to include, but not limited to, syringe service programs, substance use disorder treatment programs, and other community-based organizations.

4.11 Increase low-barrier HBV screening opportunities for groups with poor access to traditional health care services, with emphasis on outreach-based screening and in-language services to reach the communities most impacted by HBV, including foreign-born Asian, Pacific Island, and African immigrants and refugees and their families.

4.12 Develop community- and clinic-based infrastructure to improve culturally and linguistically appropriate patient navigation for individuals living with HBV. Include resources for HBV clinical case managers and peer navigation in clinical settings to link and retain people in HBV care and prevent disease progression.

4.13 Include HBV screening and treatment quality indicators in the [Washington Statewide Common Measure Set](#).

4.14 Mandate the offer of HBV testing and vaccination to all adults 18 years and older receiving primary care services in a facility, clinic, center, office, or other setting where primary care services are provided.

4.15 Resource initiatives for health care systems and institutions to develop innovative strategies to increase HBV vaccination and testing, such as the use of prompts in electronic medical record/electronic health record systems.

4.16 Promote HBV provider training and education resources like the University of Washington's [Viral Hepatitis Project ECHO](#) and the University's [Hepatitis B Online](#) curriculum and resource provider detailing (interactive educational outreach to physicians to provide unbiased, non-commercial, evidence-based information about medications and other therapeutic decisions, with the goal of improving patient care).

4.17 Examine innovative purchasing strategies to procure HBV medications for state-purchased health care insurance and programs, including Apple Health (Medicaid), the Public Employees Benefits Board Program, The School Employees Benefits Board Program, The Department of Corrections, The Department of Labor & Industries, and the Department of Social & Health Services (state hospitals).

4.18 Work with United States Citizenship and Immigration Services to ensure arriving immigrants are provided with culturally and linguistically appropriate information about the Centers for Disease Control and Prevention recommended universal HBV screening and vaccinations for children and adults.

Conclusion

Underlying public health concerns highlighted in this report is the reality of workforce shortages due to burnout, exhaustion, and retirement of knowledgeable public health staff. The advisory group has seen from new investments in Foundational Public Health Services that resources for public health are critical. However, difficulties in hiring and retaining public health staff provide an obstacle to implementation of new and current resources.

Given the current challenges we face in addressing STIs, viral hepatitis, and other conditions of public health importance, the advisory group is certain that traditional health care delivery systems alone will not solve these public health crises. We need public investment to build public health infrastructure and innovative systems of care that will meet the needs of communities experiencing the greatest disparities.

Appendix A: The STI & HBV Legislative Advisory Group

The governor appointed all advisory group members. Members represented the organizations and communities prioritized in ESSB 5092. The Washington State Department of Health is grateful to the advisory group for their time and expertise in developing and approving the recommendations contained in this report.

Name	Title	Organization
Zandt Bryan	Sexual Health & Prevention Program Manager	Washington State Department of Health
Beau Butler	Prevention Program Manager	Lifelong-Health for All
David Corrado	Development & Communications Manager	People of Color Against AIDS Network
Kirsten Duncan	Lead Disease Intervention Specialist	Spokane Regional Health District
Matthew Golden, Advisory Group Chair	Professor of Medicine, University of Washington Director, PHSKC HIV/STD Program Director, UW Center for AIDS and STD	Public Health - Seattle & King County & University of Washington
Ashley Hoover	Epidemiologist	Northwest Portland Area Indian Health Board
Jennifer Jones-Vanderleest	Physician, Jail Health Services	Public Health - Seattle & King County
Micah Matthews	Deputy Executive Director	Washington Medical Commission
Katrina May	Program Manager	Seattle Indian Health Board
Emily Mulanax	School-Based Health Center Coordinator	Peninsula Community Health Services
Sarah Murray	Nurse Manager	Blue Mountain Heart to Heart

Name	Title	Organization
Lili Navarrete	Commissioner; Director of Public Affairs	Commission on Hispanic Affairs; Raíz Project with Planned Parenthood of Greater Washington and North Idaho
Brenda O'Brien	Project Coordinator	Commission on Asian Pacific American Affairs
Taifa (Nomi) Peaks	Pharmacist Consultant	Pharmacy Quality Assurance Commission
Amy Person	Health Officer <i>(during the creation of the recommendations)</i>	Benton-Franklin Health District <i>(former affiliation)</i>
	Regional Medical Officer <i>(current position)</i>	Washington State Department of Health <i>(current affiliation)</i>
Kimberly Riano	ARNP	Planned Parenthood (Olympia) & Olympia Free Clinic
Hannah Stanfield	Care Improvement & Innovations Manager	Washington Association for Community Health
Stephanie Sola	Clinician Manager	Planned Parenthood of the Great Northwest, Hawai'i, Alaska, Indiana, Kentucky
Martha Zuniga	Deputy Director	Entre Hermanos

Appendix B: The STI & HBV Legislative Advisory Group Committees and Committee Members

In addition to advisory group members appointed by the governor, additional experts were engaged in five topic-specific work groups to help draft recommendations. The Washington State Department of Health is grateful to the committee members for sharing their time and expertise with the advisory group. Committee members are listed below.

Strengthening Healthcare Organization Systems

- David Corrado, People of Color Against AIDS Network
- Matthew Golden, MD, MPH, Public Health – Seattle & King County, University of Washington
- Jennifer Jones-Vanderleest, MD, MSPH, Public Health – Seattle & King County
- Melissa Kundur, RN, BSN, MCG, Washington State Health Care Authority
- Everett Maroon, Blue Mountain Heart to Heart
- Katrina May, Urban Indian Health Institute
- Emily Mulanax, Peninsula Community Health Services
- Taifa “Nomi Peaks, PharmD, Pharmacy Quality Assurance Commission
- Christine Quinata, Washington State Health Care Authority
- Hannah Stanfield, Washington Association for Community Health
- Tenaya Sunbury, PhD, MS, Washington State Department of Social & Health Services
- Megan Toothaker, Lifelong
- *Mike Barnes, Washington State Department of Health – staff support*
- *Genee Grimmett, Washington State Department of Health – staff support*

Enhancing STI Specialty Infrastructure

- Zandt Bryan, Washington State Department of Health
- Kirsten Duncan, Spokane Regional Health District
- Ella B. Guilford, Washington State Department of Health
- Heather Hill, RN, BSN, Benton-Franklin Health Department
- Taylor Johnsonbaugh, Public Health – Seattle & King County
- Roxanne Kerani, University of Washington
- Sarah Murray, RN, Blue Mountain Heart to Heart
- Meena Ramchandani, University of Washington, Public Health – Seattle & King County
- Kelsey Stedman, RN, MSN, Kitsap Public Health District
- Kim Steele-Peter, Tacoma-Pierce County Health Department
- Luis Viquez, Gay City
- Martha Zuniga, Entre Hermanos
- *Katrina Miller, Washington State Department of Health – staff support*

Eliminating Congenital Syphilis

- Lindley Barbee, MD, MPH, University of Washington
- Tiffani Buck, MPH, MS, ARNP, Washington State Department of Health
- Rizza Cea, DNP, MA, CNM, Washington State Department of Health
- Kirsten Duncan, MPH, Spokane Regional Health District
- Ashley Hoover, MPH, Northwest Portland Area Indian Health Board
- Teresia Otieno, Center for Multicultural Health
- Amy Person, MD, Washington State Department of Health
- Tenaya Sunbury, PhD, MS, Washington State Department of Social & Health Services
- *Michelle Jorgensen, BSW, Washington State Department of Health – staff support*
- *Leyna Yarosz, Washington State Department of Health – staff support*

Eliminating Hepatitis B

- Mohammed Abdul-Kadir, MS, MPH, International Community Health Services
- Michael Byun, MPA, Asian Counseling and Referral Service
- Chas DeBolt, RN, MPH, Washington State Department of Health
- Mackenzie Driscoll, Spokane Regional Health District
- Ashley Hoover, MPH, Northwest Portland Area Indian Health Board
- DoQuyen Huynh, DNP, FNP, ARNP, FAAN, Washington State Health Care Authority
- Nina Kim, MD, MSc, University of Washington
- Nadine Shiroma, Asian Pacific Islander Coalition of Washington and Hepatitis B Foundation
- Anthony Si-Nam Le, Washington State University
- Haley Smith, Washington State Department of Health
- Mark Springer, Spokane Regional Health District
- Denise Stinson, MN, RN, Tacoma-Pierce County Health Department
- Amber Tejada, Hepatitis Education Project
- *Anna Halloran, Washington State Department of Health – staff support*
- *Jon Stockton, Washington State Department of Health – staff support*

Improving Surveillance, Epidemiology, and Monitoring

- Rachel Amiya, PhD, Washington State Department of Health
- Anna Berzkalns, Public Health – Seattle & King County
- Kari Haecker, Washington State Department of Health
- Ashley Hoover, MPH, Northwest Portland Area Indian Health Board
- Wendy Inouye, Kitsap Public Health Department
- Christine Khosropour, PhD, MPH, University of Washington
- Sarah Murray, RN, Blue Mountain Heart to Heart
- Stephanie Sola, Planned Parenthood of the Great Northwest, Hawai'i, Alaska, Indiana, Kentucky

Appendix C: Glossary of Terms

Access is the potential for actual entry of a population into the health system. Entry is dependent upon the wants, resources, and needs that individuals bring into the care-seeking process. The ability to obtain wanted or needed services may be influenced by many factors, including travel, distance, wait times, available financial resources, and availability of a regular source of care. Access also refers to the extent to which a public health service is readily available to individuals in need within a community. Accessibility also refers to the capacity of the agency to provide service in such a way as to reflect and honor the social and cultural characteristics of the community and focuses on agency efforts to reduce barriers to service.

Assessment is a core function of public health, involving the systematic collection and analysis of data in order to provide a basis for decision making. This may include collecting statistics on community health status, health needs, community assets, and/or other public health issues. Assessment includes the process of regularly and systematically collecting, assembling, analyzing, and making available information on the health needs of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems.

Best practice(s) refers to the current best clinical or administrative practice or approach, given the situation, the consumer's or community's needs and desires, the evidence about what works for this situation/need/desire, and the resources available.

Case, in epidemiology, is a countable instance in the population or study group of a particular disease, health disorder, or condition under investigation. Sometimes, "case" is a word used in shorthand to refer to an individual diagnosed and reported with a particular disease or health condition. In surveillance, this refers specifically to a person with a reportable condition (e.g., HIV, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C) who has been diagnosed and reported to the health department while living in Washington. This would not include results of anonymous testing.

Case investigation and contact tracing, a core disease control measure employed by local and state health department personnel for decades, is a key strategy for preventing further spread of infections, like STIs and hepatitis B. The basic form of this method involves identifying cases of infection through surveillance and reporting; interviewing the diagnosed person to identify people who are exposed or at risk of acquiring the infection; and following up with identified persons to ensure they are made aware of the risk of acquisition, learn about the infection, and access health care services to receive appropriate treatment. Enhanced forms of this method may include identification of second or third level contacts in the social and/or sexual network of diagnosed and exposed persons; as well as identification of venues where people meet and exposure may result in order to conduct structural interventions or to place additional outreach, education, and service offerings.

Chlamydia is the most common reportable sexually transmitted infection. It can cause permanent damage to a person’s reproductive system. This can make it difficult or impossible to get pregnant later. Chlamydia can also cause a potentially fatal ectopic pregnancy (pregnancy that occurs outside the womb). Chlamydia can be spread by having vaginal, anal, or oral sex with someone who has chlamydia. A pregnant person with chlamydia can give the infection to their baby during childbirth.

Cisgender defines an individual whose gender identity aligns with the one typically associated with the sex assigned to them at birth. This is a term that is preferable to “non-trans,” “biological,” or “natal” man or woman.

Cluster is an aggregation of cases of a disease or other health-related condition which are closely grouped in time and place. The number of cases may or may not exceed the expected number; frequently the expected number is not known.

Congenital syphilis is a disease that occurs when a pregnant person with syphilis passes the infection on to their baby during pregnancy or at delivery. Congenital syphilis can cause miscarriage, stillbirth, prematurity, low birth weight, or death shortly after birth. At birth, a baby with a syphilis infection may not have signs or symptoms of the disease. However, if the baby does not receive treatment right away, the baby may develop serious problems within a few weeks. Health problems can include deformed bones, severe anemia, enlarged liver and spleen, jaundice (yellowing of the skin or eyes), brain and nerve problems (like blindness or deafness), meningitis (swelling of the protective membranes covering the brain and spinal cord), and skin rashes.

Demographic information are characteristics about people — such as age, sex, gender, race, and occupation — used to characterize populations.

Disease intervention specialists or **DIS** are highly trained staff at the forefront of disease intervention work. Disease intervention is key to sexually transmitted infection prevention and control. Disease intervention consists of two main parts. First, it rapidly identifies people who don’t know they may be infected or at risk of acquiring diseases. Second, it helps people receive testing and treatment or other prevention measures quickly. This helps to stop diseases from spreading and prevents serious health problems caused by undetected or untreated infection. While disease intervention specialists primarily work with sexually transmitted infections, more recently they have been hired to address viral hepatitis, tuberculosis, and other conditions. They also lend their expertise during urgent outbreak situations. DIS have been used in several public health responses from Ebola to COVID-19 to Monkeypox (MPOX).

Disproportionate refers to the overrepresentation of a particular group of people in a particular program, system, or affected population as compared to their representation in the general population. Throughout this report, data about STIs are provided to illustrate the outsized burden of STIs in certain communities in comparison to broader populations.

Electronic health records (EHR) and electronic medical records (EMR) are both electronic systems for maintaining patients' medical histories. They may also include billing and health insurance information. The main difference between EHR and EMR is that EHR are maintained by multiple providers, while EMRs are only maintained by a single provider.

Epidemic is an outbreak over a larger geographic area, affecting a large number of people within a community, population, or region. An epidemic can become a pandemic when it is out of control and international, or spread over multiple countries or continents.

Epidemiology is the study of the distribution and determinants or factors of health-related states or events in specified populations, and the application of this study to the control of health problems.

Expedited partner therapy is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to their partner without the health care provider first examining the partner. Effective clinical management of patients with treatable sexually transmitted infections requires treatment of the patients' current sex partners to prevent reinfection and curtail further transmission. The standard approach to partner treatment has included clinical evaluation in a health care setting, with the original patient notifying their partner or the notification occurring by the provider or a public health professional (e.g., a public health nurse or disease Intervention specialist). Provider-assisted referral is considered the optimal strategy for partner treatment but is not available to most patients with gonorrhea or chlamydial infection because of resource limitations. The usual alternative is to advise patients to refer their partners for treatment.

Field-based treatment, for the purposes of this report, means treatment administered outside the typical medical or clinical environment in settings where the patient resides, stays, or receives other services, such as a home, motel, or street/encampment environment.

Foundational Public Health Services are a limited statewide set of core public health services. These are unique services provided only or primarily by government everywhere, are population-based rather than for the individual, and are services that must be everywhere for them to work anywhere. In many cases they are mandated in federal or state law, but they may remain largely unfunded. They are services that communities, businesses, and individuals depend on. A foundational level of public health services must exist everywhere for services to work anywhere, just like public safety (fire, police); public utilities (power, water); and other public infrastructure (roads, sewers). The governmental public health system, with the governor and legislature, are using a long-term, multi-biennium, phased, building-block approach to fully fund and implement foundational public health services across Washington.

Gonorrhea is a sexually transmitted infection that can cause infection in the genitals, rectum, and throat. It is very common, especially among young people aged 15-24 years. Gonorrhea can be spread by having vaginal, anal, or oral sex with someone who has gonorrhea. A pregnant

person with gonorrhea can give the infection to their baby during childbirth. Gonorrhea may cause pelvic inflammatory disease in persons with uteruses, which may lead to damage to the reproductive system leading to infertility or ectopic pregnancy. Gonorrhea may also cause epididymitis, an infection of the sperm storage organ, leading to organ damage and infertility. Gonorrhea may also spread in the body, causing infection and potential damage to internal organs, joints, and the linings of the brain and heart.

Hepatitis B is a vaccine-preventable liver infection caused by the **hepatitis B virus (HBV)**. Hepatitis B is spread when blood, semen, or other body fluids from a person infected with the virus enters the body of someone who is not infected. This can happen through sexual contact; sharing needles, syringes, or other drug-injection equipment; or from mother to baby at birth. Not all people newly infected with HBV have symptoms, but for those that do, symptoms can include fatigue, poor appetite, stomach pain, nausea, and jaundice (yellowing of the skin or eyes). For many people, hepatitis B is a short-term illness. For others, it can become a long-term, chronic infection that can lead to serious, even life-threatening health issues like cirrhosis (the last stage of chronic liver disease in which the liver is scarred and permanently damaged) or liver cancer. Risk for chronic infection is related to age at infection: about 90% of infants with hepatitis B go on to develop chronic infection, whereas only 2%–6% of people who get hepatitis B as adults become chronically infected. The best way to prevent hepatitis B is to get vaccinated.

Hepatitis C is a liver infection caused by the hepatitis C virus (HCV). Hepatitis C is spread through contact with blood from an infected person. Today, most people become infected with the HCV by sharing needles or other equipment used to prepare and inject drugs. For some people, hepatitis C is a short-term illness, but for more than half of people who become infected with HCV, it becomes a long-term, chronic infection. Chronic hepatitis C can result in serious, even life-threatening health problems like cirrhosis (the last stage of chronic liver disease in which the liver is scarred and permanently damaged) and liver cancer. People with chronic hepatitis C often have no symptoms and don't feel sick. When symptoms appear, they often are a sign of advanced liver disease. There is no vaccine for hepatitis C. Medication treatments can cure most people with hepatitis C in 8 to 12 weeks.

HIV or Human Immunodeficiency Virus is a virus that weakens the body's immune system by destroying T cells that fight disease and prevent infection. If HIV is not treated, it can progress to AIDS (acquired immunodeficiency syndrome). There is currently no effective cure. Once people get HIV, they have it for life. But with proper medical care, HIV can be controlled. People with HIV who get effective HIV treatment can live long, healthy lives and protect their partners. Most people get HIV through anal or vaginal sex, or sharing needles, syringes, or other drug injection equipment.

Incidence refers to the occurrence of new cases of disease or injury in a population over a specified period. Although some epidemiologists use incidence to mean the number of new cases in a community, others use incidence to mean the number of new cases per unit of

population. In Washington State, incident cases of HIV are defined as persons whose first HIV-indicated laboratory result or first diagnosis by a health care provider occurred while living in Washington. Cases with a self-reported positive test more than 6 months prior to the diagnosis date recorded by DOH are not considered incident cases.

Injection drug use, or IDU, is the behavior of using needles, syringes, and other drug injection equipment to take drugs, usually without a prescription. The sharing of drug injection equipment is a common mode of exposure to blood-borne infections including viral hepatitis and HIV.

Local health jurisdictions are local governmental public health agencies. Washington has 30 county health departments, three multi-county health districts, and two city-county health departments. Local health jurisdictions carry out a wide variety of programs to promote health, help prevent disease, and build healthy communities.

Medical assistant or MA is an allied health professional who supports the work of physicians, nurse practitioners, physician assistants, and other health professionals, usually in a clinic setting. Medical assistants are specially trained for the role at the certificate or associate degree level and provide both clinical and administrative support anywhere medical and health care services are provided.

Men who have sex with men or MSM comprise a diverse group in terms of behaviors, identities, and health care needs. The term “MSM” often is used clinically to refer to sexual behavior alone, regardless of sexual orientation (e.g., a person might identify as heterosexual but still be classified as MSM). Sexual orientation is independent of gender identity. In this document, MSM includes transgender men who have sex with men.

Monkeypox or MPOX is a rare disease caused by infection with the monkeypox virus (MPOX). Monkeypox is part of the same family of viruses as variola virus, the virus that causes smallpox, and is vaccine preventable. Monkeypox symptoms are like smallpox symptoms, but milder, and MPOX is rarely fatal. There is a current outbreak in the United States. Data suggest that gay, bisexual, and other men who have sex with men make up most cases in the current outbreak. However, anyone, regardless of sexual orientation or gender identity, who has been in close, personal contact with someone who has MPOX is at risk. Monkeypox can spread from person-to-person through direct contact with the infectious rash, scabs, fluid from sores, or saliva. It also can be spread by respiratory secretions during prolonged, face-to-face contact, or during intimate physical contact, such as kissing, cuddling, or sex. Many have asked if MPOX is a sexually transmitted infection; it can more accurately be described as “sexually transmissible.” Any sustained skin-to-skin contact with someone who has MPOX can spread the virus; the contact does not have to be intimate or sexual.

Office of Infectious Disease, within the Division of Disease Control and Health Statistics at DOH, was charged by the legislature to convene the STI & HBV Legislative Advisory Group and prepare this report based on the advisory group’s recommendations. The Office of Infectious

Disease provides services to prevent and control sexually transmitted infections, HIV, and hepatitis C. The office is also responsible for the HIV Client Services Early Intervention Program which pays for medications, insurance premiums, and limited medical, mental health and dental care for low-income, eligible individuals living with HIV, as well as the PrEP Drug Assistance Program, a drug assistance program for people not living with HIV who meet certain eligibility requirements. The Office of Infectious Disease tracks and assesses disease and health conditions by collecting, analyzing, and evaluating data. It maintains databases that aid in prioritizing resources toward current data trends.

Outbreak is as an occurrence of cases of disease that is more than expected in a given area or among a specific group of people over a particular period of time; or cases clustered by time, space, or common behaviors. Alternatively, a localized as opposed to generalized epidemic. If not quickly controlled, an outbreak can become a generalized epidemic.

Pandemic is an epidemic occurring over a very wide area (several countries or continents) and usually affecting a large proportion of the population.

Post-exposure prophylaxis, or PEP, is the use of antiretroviral drugs after a single high-risk potential HIV exposure event to stop HIV seroconversion (the transition from infection with HIV to the detectable presence of HIV antibodies in the blood). PEP must be started as soon as possible to be effective — and always within 72 hours of a possible exposure.

Pre-exposure prophylaxis, or PrEP, is medicine that reduces the chance of getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.

Public health is a scientific and technical, as well as a social and political, endeavor that aims to protect and improve the health and wellbeing of people and their communities. This work is achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and responding to infectious diseases.

Public Health Laboratory is the Washington State Department of Public Health facility, based in Shoreline, that provides diagnostic and analytical services for the assessment and surveillance of infectious, communicable, genetic, and chronic diseases and environmental health concerns.

Rate is a measure of the relative frequency with which an event occurs in a defined population over a specified time period. Because rates put disease frequency in the perspective of population size, rates are useful for comparing disease frequency in different locations, at different times, or among different groups of persons with potentially different sized populations; that is, a rate is a measure of risk, or of the intensity of the occurrence of an event. Rates are typically expressed using a standard denominator, such as 1,000 or 100,000 people.

Risk factor is an aspect of personal behavior or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased occurrence of disease or other health-related event or condition.

Sexually transmitted infections, or STIs (also known as sexually transmitted diseases or STDs), are bacteria, viruses, and parasites known to be transmitted through sexual contact, including vaginal, anal, and oral sex. Some STIs can be transmitted from parent to child during pregnancy, childbirth, and breastfeeding/chest-feeding. Globally, eight pathogens are linked to the greatest incidence of STIs. Of these, four are currently curable: syphilis, gonorrhea, chlamydia, and trichomoniasis. The other four are incurable viral infections: hepatitis B, herpes simplex virus, HIV, and human papillomavirus.

Surveillance, or public health surveillance, is the systematic collection, analysis, interpretation, and dissemination of population-based health data on an ongoing basis. The purpose is to gain knowledge of the pattern of disease occurrence and potential in a community, in order to control and prevent disease in the community. This activity also involves timely dissemination and use of the data for public health programs.

Syphilis is a sexually transmitted infection that can cause serious health problems without treatment. Infection develops in stages (primary, secondary, latent, and tertiary). Each stage can have different signs and symptoms. Syphilis can be spread by direct contact with a syphilis sore during vaginal, anal, or oral sex. Syphilis can also be spread from a pregnant person with syphilis to their unborn baby — this is known as **congenital syphilis**.

Table is a set of data arranged in rows and columns. In epidemiology, the data are usually summaries of the frequency of occurrence of an event or characteristic occurring among different groups.

Transgender is a term that may be used to describe people whose gender identity is different from the sex assigned at birth. Transgender, or trans, is both a gender identity and an umbrella term that includes identities like woman, man, gender nonconforming, non-binary, genderqueer, and gender expansive.

Transmission of infection is any mode or mechanism by which an infectious agent is spread through the environment or to another person.

Trend is a long-term movement or change in frequency, usually upwards or downwards. In terms of epidemiologic data, it is defined as an unusually long series of consecutive increases or decreases in the data.

United States Preventive Services Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The task force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. All recommendations are published on the task force's website and/or in a peer-reviewed journal. Task force members come from the fields of preventive medicine and primary care, including internal medicine, family medicine, pediatrics, behavioral health, obstetrics and gynecology, and nursing. Their recommendations are based on a rigorous review of existing peer-reviewed evidence and are intended to help primary care clinicians and patients decide together whether

a preventive service is right for a patient's needs. The task force assigns each recommendation a letter grade (an A, B, C, or D grade, or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service. The task force does not consider the costs of a service when determining a recommendation grade. The recommendations apply only to people who have no signs or symptoms of the specific disease or condition under evaluation, and the recommendations address only services offered in the primary care setting or services referred by a primary care clinician.

