

THE WHITE HOUSE OFFICE OF NATIONAL AIDS POLICY



**Joint Meeting of the
PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS (PACHA) &
CDC/HRSA ADVISORY COMMITTEE ON
HIV, VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT (CHAC)**

**May 21, 2015
Atlanta, Georgia**

Record of the Proceedings

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Joint Meeting of the PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS (PACHA) & CDC/HRSA ADVISORY COMMITTEE ON HIV, VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT (CHAC) May 21, 2015 Atlanta, Georgia

Minutes of the Joint Meeting

The White House Office of National AIDS Policy (ONAP) convened the first joint meeting of the Presidential Advisory Council on HIV/AIDS (PACHA) and the Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC). The proceedings were held on May 21, 2015 at the W Atlanta-Downtown Hotel in Atlanta, Georgia.

PACHA is a Federal Advisory Committee (FAC) that is chartered to provide advice, information and recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) regarding programs and policies to improve the U.S. response to the HIV/AIDS epidemic and to advance a progressive HIV/AIDS research agenda. CHAC is a FAC that is chartered to advise the Secretary of HHS, Director of CDC, and Administrator of HRSA on objectives, strategies, policies and priorities for HIV, viral hepatitis, and STD prevention and treatment efforts for the nation.

The overarching purpose of the meeting was for ONAP to gather expert advice, input and recommendations from PACHA and CHAC on the updated National HIV/AIDS Strategy (NHAS) for 2016-2020. The U.S. government and its partners would continue to use the updated NHAS to guide the overall response and efforts to improve domestic HIV/AIDS over the next five years.

Information for the public to attend the joint PACHA/CHAC meeting in person or participate remotely via teleconference was published in the *Federal Register* in accordance with Federal Advisory Committee Act rules. All sessions of the meeting were open to the public (*Attachment 1: Participants' Directory*).

Opening Session

Douglas Brooks, MSW

Director

Office of National AIDS Policy

Mr. Brooks opened the meeting at 9:05 a.m. and welcomed the participants to the first joint PACHA/CHAC meeting. He thanked the PACHA and CHAC members for contributing their valuable time and expertise to provide critical guidance to ONAP on the updated NHAS for 2016-2020.

Mr. Brooks announced that the PACHA and CHAC members would report to their assigned breakout groups to formulate high-level recommendations on the overall NHAS and provide specific input on each of the NHAS goals in terms of gaps and areas of improvement.

Call to Order of the PACHA Membership

Karen DeSalvo, MD, MPH, MSc

Acting Assistant Secretary for Health

U.S. Department of Health and Human Services

Dr. DeSalvo administered the following Oath of Office to five new PACHA members.

I do solemnly swear that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I will take this obligation freely without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

Upon taking their oaths, the new PACHA members were officially sworn in. The participants joined Dr. DeSalvo in applauding the five members on their new appointments.

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- Jeffrey Akman, MD; Vice President for Health Affairs, George Washington University & Dean, George Washington School of Medicine and Health Sciences
- Oliver Clyde Allen III; Presiding Bishop, United Progressive Pentecostal Fellowship of Churches
- Ulysses Burley III, MD, MPH; Program Director, Evangelical Lutheran Church
- Yvette Flunder, DMin; Founder and Senior Pastor, City of Refuge United Church of Christ & Presiding Bishop, Fellowship of Affirming Ministries
- Gabriel Maldonado, MBA; Executive Director and CEO, TruEvolution

Kaye Hayes, MPA

HHS Office of HIV/AIDS and Infectious Disease Policy
 PACHA Executive Director

Ms. Hayes conducted a roll call and confirmed that 22 PACHA members and the liaison representative to CHAC were in attendance.

Call to Order of the CHAC Membership

Jonathan Mermin, MD, MPH

Director, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
 Centers for Disease Control and Prevention
 CHAC Designated Federal Officer, CDC

Dr. Mermin conducted a roll call to determine the CHAC voting members, *ex-officio* members and liaison representatives who were in attendance. He announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. He reminded the CHAC voting members of their responsibility to disclose any potential individual and/or institutional conflicts of interest for the public record and recuse themselves from voting or participating in these matters.

CONFLICT OF INTEREST DISCLOSURES	
CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Sanjeev Arora, MD, FACP (University of New Mexico Health Sciences Center)	Recipient of federal funding from CDC; recipient of pharmaceutical research contracts from AbbVie and Gilead Sciences for new hepatitis C virus (HCV) drug development

CONFLICT OF INTEREST DISCLOSURES

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Virginia Caine, MD (Marion County, Indianapolis Public Health Department)	Recipient of federal funding from HRSA for Ryan White; member of the National Medical Association Board of Trustees
Guillermo Chacon (Latino Commission on AIDS)	Recipient of federal funding from CDC; member of Community Advisory Boards for Merck and ViiV Healthcare
Kathleen Clanon, MD (Alameda County, Oakland Medical Center)	No conflicts disclosed
Carlos del Rio, MD (Rollins School of Public Health Emory University)	Recipient of federal funding from CDC and the National Institutes of Health (NIH)
Dawn Fukuda, ScM (Massachusetts Department of Public Health)	Recipient of federal funding from CDC and HRSA
Camilla Graham, MD, MPH (Beth Israel Deaconess Medical Center)	Member of the Massachusetts Medicaid Program Drug Utilization Review Board
Debra Hauser, MPH (Advocates for Youth)	Recipient of federal funding from CDC; member of the Trojan's Sexual Health Advisory Council
Marjorie Hill, PhD (Consulting Services)	Recipient of federal funding from CDC and HRSA
Steven Johnson, MD (University of Colorado School of Medicine)	Recipient of federal funding from HRSA and NIH; member of the ViiV Healthcare Advisory Board
Michael Kaplan (AIDS United)	Recipient of federal funding from CDC and HRSA; recipient of pharmaceutical funding
Jennifer Kates, PhD (Kaiser Family Foundation)	No conflicts disclosed
Amy Leonard, MPH (Legacy Community Health Services)	Recipient of federal funding from CDC and HRSA

Dr. Mermin confirmed that the 14 voting members and 7 *ex-officio* members in attendance constituted a quorum for CHAC to conduct its business during the joint meeting with PACHA on May 21, 2015.

Mr. Brooks noted a major difference between the two committees. New PACHA members take an Oath of Office and are officially sworn in. CHAC voting members are required to publicly disclose their individual and/or institutional conflicts of interest during each public meeting.

Welcoming Remarks by the PACHA and CHAC Chairs

Kathleen Clanon, MD, CHAC Co-Chair

Medical Director

Alameda County Health Care Services Agency

Dr. Clanon explained that CHAC formulates advice to CDC and HRSA to identify areas of interagency synergy, but also to fill gaps in the prevention and treatment of HIV, viral hepatitis and STDs. She confirmed that CHAC was extremely pleased to attend its first joint meeting with PACHA.

Dawn Fukuda, ScM, CHAC Co-Chair

Director, Office of HIV/AIDS

Massachusetts Department of Public Health

Ms. Fukuda informed PACHA that CHAC convened its biannual meeting on the previous day. She highlighted key outcomes from CHAC's discussions.

- CHAC made a recommendation to convene a new Youth Workgroup to specifically focus on emerging youth-related issues:
 - HIV in youth
 - Sexual health
 - Lesbian/gay/bisexual/transgender/questioning (LGBTQ) youth
 - High HCV rates in youth due to misuse of opiates
 - Low rates of viral suppression among racial/ethnic minority youth
 - Unique challenges of young black men who have sex with men (YBMSM)
- CHAC identified critical gaps that will need to be filled to cure HCV in the United States:
 - Enhanced HCV surveillance capacity in health departments
 - Expanded HCV treatment in multiple settings
 - Improved access to an HCV prevention, care, treatment and cure infrastructure
 - Increased insurance coverage, particularly to address health inequities of low-income persons living with HCV
 - Inclusion of HCV provider training in HIV and other infectious disease care systems
 - Opportunities to leverage the HIV prevention and care infrastructure to better serve persons with HCV

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- CHAC described the infrastructure that will be necessary to ensure the successful implementation of pre-exposure prophylaxis (PrEP) in the field:
 - Extensive training and education to build the capacity of providers to deliver PrEP
 - Additional venues to access, implement and scale-up PrEP
 - Risk profiles to identify and reach populations that can greatly benefit from PrEP (e.g., subgroups of MSM, youth, women and transgenders)

Ms. Fukuda summarized three key issues that CHAC emphasized in all of its discussions: health disparities; implementation of data-to-care approaches; and the use of new technologies (e.g., electronic medical records and enhanced surveillance) to support high-quality care in medical settings.

Nancy Mahon, JD, PACHA Chair

Senior Vice President, M·A·C Cosmetics
Global Executive Director, M·A·C AIDS Fund

Ms. Mahon clarified that PACHA's guidance primarily focuses on determining next steps and new directions. PACHA makes strong efforts to use its advisory role in a powerful manner to achieve the greatest impact on HIV/AIDS. For example, the 2010-2015 NHAS was effective overall, but PACHA will now direct its attention to providing advice on maintaining the momentum and scaling up the 2016-2020 NHAS.

Ms. Mahon acknowledged the important need for both committees to listen and provide input to assist ONAP in updating the NHAS at a macro level. To achieve this goal, she asked her PACHA and CHAC colleagues to consider their individual and/or institutional priorities only in the context of translating these issues into broad policy.

Ms. Mahon's position was that this approach would provide PACHA and CHAC with a tremendous opportunity to change national policy. She was extremely pleased that PACHA would be able to undertake this important effort in close collaboration with CHAC.

Keynote Address

Mr. Brooks was honored that Dr. David Satcher agreed to deliver the keynote address to the first joint PACHA/CHAC meeting. He highlighted key milestones in Dr. Satcher's distinguished career in both the public and private sectors.

- Dual appointment: 16th Surgeon General of the United States & 10th Assistant Secretary for Health in HHS
- Four-Star Admiral, U.S. Public Health Service Commissioned Corps
- 13th Director of the Centers for Disease Control and Prevention
- Former President of Meharry Medical College
- Former Interim President of Morehouse School of Medicine

David Satcher, MD, PhD, FAAFP, FACPM, FACP

Director, Satcher Health Leadership Institute
Morehouse School of Medicine

Dr. Satcher began his keynote address by highlighting benchmarks in the HIV/AIDS epidemic in the 1980s that are still relevant while ONAP prepares to update the NHAS for 2016-2020. Dr. Joycelyn Elders, the 15th Surgeon General of the United States, was a pioneer in including sex and sexuality topics (e.g., masturbation, contraceptives and teen sex education) in public health. Dr. Elders's outspoken advocacy for these controversial issues led to her termination as the U.S. Surgeon General in 1994.

Dr. Satcher informed the participants that 21 years later, he was extremely proud to attend the inauguration of the newly endowed Joycelyn Elders Chair in Sexual Health Education at the University of Minnesota on May 14, 2015. A highlight of the inauguration ceremonies was a joint interview given by Drs. Elders and Satcher on National Public Radio.

Dr. Satcher was pleased that Dr. Elders was honored with the prestigious Elders Chair. He confirmed that her pioneering efforts greatly influenced the release of his landmark Surgeon General's Report in 2001, *The Call to Action to Promote Sexual Health and Responsible Sexual Behavior*.

Dr. Satcher described the impact of HIV/AIDS on his professional career. He founded the Department of Community Health and Family Medicine in 1981 that included the first residency and clinical teaching programs at Morehouse School of Medicine. His plans to oversee the new department changed due to the announcement that Meharry Medical College would close.

Dr. Satcher was committed to ensuring that Meharry remained open due to its remarkable achievement of graduating >50% of all African American physicians and dentists in the United States. Moreover, 75% of Meharry graduates practiced in underserved communities, but the institution historically had been excluded from publicly funded facilities.

Dr. Satcher's appointment as the 8th President of Meharry Medical College from 1982 to 1993 significantly changed the trajectory of his career. The stigma of AIDS in the early 1980s was highly prevalent, including its label as the "gay disease." Dr. C. Everett Koop, the 13th Surgeon

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General of the United States, took bold actions to combat public fear, discrimination and inaccurate information regarding AIDS. He commissioned the mailing of an eight-page report, *What Every American Needs to Know About AIDS*, to all 107 million U.S. households in 1988. The report represented the largest mailing in U.S. history and the first time the federal government provided explicit sex information to the public.

Due to the high level of stigma associated with AIDS at that time, Vanderbilt University denied a request from Dr. Otis Bowen, the HHS Secretary from 1985 to 1989, to make a presentation on AIDS at its institution. Dr. Satcher's invitation to Dr. Bowen to give the presentation at Meharry Medical College led to his election as the Chair of the Council of Graduate Medical Education (COGME). Under Dr. Satcher's leadership, COGME released a report on the need for a strong health workforce and more diversity in health professions. The report resulted in Dr. Satcher's appointments under the Clinton Administration: member of the Health Reform Council, U.S. Surgeon General/HHS Assistant Secretary for Health (ASH), and Director of CDC.

Dr. Satcher recalled that one of his first priorities as the newly appointed CDC Director was to create one structure to house eight different HIV/AIDS programs from various centers and offices. He asked Dr. Helene Gayle to chair a committee to explore strategies to achieve this goal. Based on the committee's recommendation, Dr. Satcher received approval and funding to establish CDC's new National Center for HIV/AIDS, STD and TB Prevention and appointed Dr. Gayle as the new director.

As the CDC Director, Dr. Satcher awarded funds to ~36 organizations to evaluate needle-syringe exchange programs (NSEPs) in terms of their safety and efficacy in reducing the spread of HIV. As the U.S. Surgeon General and ASH, Dr. Satcher presented these data and received strong support from President Clinton and the HHS Secretary to provide federal resources for NSEPs. The studies clearly demonstrated that NSEPs reduced HIV transmission and played no role in increasing drug use. However, President Clinton reversed his support immediately before the press conference. He was advised that Congress would never pass legislation to allocate federal resources to support NSEPs.

Dr. Satcher faced a dilemma in his dual appointment. As the ASH, he was required to support the Administration's position on all public health matters. As the U.S. Surgeon General, he was required to use the best available science to make public health decisions that were in the best interest of the American public. As the U.S. Surgeon General, Dr. Satcher visited and strongly urged states to fund and initiate NSEPs at the local level because no federal resources would be allocated to this effort.

The federal government still has not allocated funding to support NSEPs, but creative initiatives have been launched to overcome these barriers. The 1988 Institute of Medicine (IOM) report, *The Future of Public Health*, noted that "the need for leadership is too critical to leave the

emergence of leaders to chance alone.” Dr. Satcher founded the Satcher Health Leadership Institute (SHLI) based on this guiding principle.

The mission of SHLI is to develop a diverse group of leaders who will impact policy and practice to reduce and ultimately eliminate health disparities. SHLI’s mission is closely aligned with the “division of the institution” philosophy that calls for a leadership impact on the creation and advancement of health equity. SHLI is committed to conveying lessons learned, experiences and best practices to build leadership skills in young persons.

Dr. Satcher concluded his keynote address with a challenge for PACHA and CHAC members to also “pass the baton.” Despite the tremendous progress that has been made in the HIV/AIDS epidemic over the past 30 years, each new generation of young leaders will be responsible for undertaking this effort and achieving even greater outcomes. Most notably, the high level of stigma associated with HIV/AIDS and sexuality has persisted over the past 30 years and led to significant health disparities.

Dr. Satcher’s key message to young women in each incoming class at Spelman College is that sexual relationships should begin with a caring relationship rather than sex. Overall, caring leaders with knowledge, courage and perseverance will be needed to eliminate health disparities.

The participants responded to Dr. Satcher’s inspiring keynote address with a lengthy standing ovation.

Ms. Mahon strongly encouraged PACHA and CHAC to take action on Dr. Satcher’s challenge to “pass the baton.” As the U.S. Surgeon General, for example, Dr. Satcher requested federal support and funding of NSEPs beginning in the late 1990s. However, the federal government has taken no action on this issue nearly 20 years later.

Ms. Mahon urged her PACHA and CHAC colleagues to utilize their collective power to rectify this national oversight. She planned to introduce a draft resolution later in the meeting and call for a formal vote by PACHA and CHAC. The resolution would request a Congressional hearing on federal funding for NSEPs. The participants applauded Ms. Mahon’s bold actions in this regard.

Charge to the NHAS Breakout Groups

Jean Flatley McGuire, PhD

Professor of Practice & Interim Chair
Health Sciences Department
Northeastern University

Dr. McGuire served as the facilitator of the meeting and gave the formal charge to PACHA and CHAC. The PACHA and CHAC members would meet in their respective breakout groups for two hours. To utilize the limited time in the most efficient and productive manner, the breakout groups would structure their discussions in two distinct parts: (1) provide input on high-level, overarching themes of the updated NHAS and (2) propose recommendations on specific NHAS goals. If time permitted, the breakout groups would explore strategies to increase interagency coordination.

Dr. McGuire charged each breakout group with formulating its guidance based on three major questions.

- Are important high-level strategic concepts omitted from the updated NHAS that should be included?
- Do any sections or language in the updated NHAS need to be deleted?
- Do any sections or language in the updated NHAS need to be modified, clarified or more strongly emphasized?

Dr. McGuire advised PACHA and CHAC to consider the existing and future political climates. For example, the original 2010-2015 NHAS was developed for one Administration, but the updated 2016-2020 NHAS will overlap the current Obama Administration and a new, unknown Administration. However, ONAP does not expect PACHA and CHAC to dilute or minimize the urgency of their guidance based on outcomes of the 2016 Presidential election that are unknown at this time.

Dr. McGuire acknowledged that time constraints would not allow the breakout groups to report all of their key findings and recommendations during the meeting. As a result, PACHA and CHAC would be given a deadline of May 27, 2015 to submit additional comments to ONAP in writing, including footnotes, references and action steps. PACHA and CHAC also would be asked to provide ONAP with rigorous, reliable and timely data that should be considered to refine the updated NHAS indicators.

Dr. McGuire concluded her overview of the charge by pointing out an important revision. The published agenda includes a fourth breakout group for PACHA and CHAC to address NHAS Goal 4, "Increase Coordination of HIV Programs Across the Federal Government and Among Federal Agencies and State, Territorial, Tribal and Local Governments." However, PACHA and CHAC would hold three rather than four breakout groups and address interagency coordination as a cross-cutting issue.

Mr. Brooks posed a series of questions to assist the breakout groups in providing high-level, overarching and macro-level guidance to ONAP on the updated NHAS.

- Do the updated NHAS goals and indicators have the capacity to make further progress in the HIV/AIDS epidemic?
- Are the updated NHAS goals and indicators for specific subpopulations sufficient to decrease risks in YMSM of color, particularly YBMSM?
- Does the updated NHAS adequately describe gaps or unintended consequences in HIV/AIDS prevention, treatment and care as a result of the Affordable Care Act (ACA)? Despite its imperfections, ONAP's position is that ACA is one of the most important and influential social justice legislations enacted by the federal government in U.S. history.
- Does the updated NHAS sufficiently convey the fact that despite ACA implementation, the Ryan White HIV/AIDS Program (RWHAP) is still needed to provide wraparound services to HIV/AIDS clients across the country?
- Does the updated NHAS clearly articulate and strongly emphasize the need to focus on HIV disparities, discrimination and stigma?
- Can the updated NHAS goals and indicators be achieved with existing resources? Because new federal funds will not be allocated, ONAP acknowledges that innovative strategies will be needed. Most notably, public-private partnerships should be formed to leverage funding from private foundations and corporations to support implementation of the updated NHAS.

Mr. Brooks recessed the meeting for the PACHA and CHAC members to report to their respective breakout groups. He conveyed that the federal agency representatives and members of the public were welcome to attend the breakout groups as silent observers.

NHAS BREAKOUT GROUP REPORTS

Jean Flatley McGuire, PhD

Professor of Practice & Interim Chair
Health Sciences Department
Northeastern University

Dr. McGuire reiterated that time for the NHAS breakout group reports would be constrained to allow for a one-hour public comment session and the PACHA/CHAC review, discussion and formal vote on a new resolution. As a result, she described the format and structure of the NHAS breakout group reports.

Each breakout group would be given a specific amount of time to report its overarching findings on the updated NHAS and highlight key recommendations on its individual NHAS goal. Time would be allotted for PACHA and CHAC members outside of the breakout group to provide additional input. Dr. McGuire would summarize major outcomes from each breakout group report.

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If needed, Mr. Douglas would ask each breakout group to provide clarification or additional details that ONAP should consider in updating the NHAS. The three NHAS breakout group reports are set forth below.

Breakout Group Report: NHAS Goal 1

Adaora Adimora, MD, MPH, PACHA Member

Professor of Medicine

University of North Carolina at Chapel Hill School of Medicine

Dawn Fukuda, CHAC Co-Chair

Director, Office of HIV/AIDS

Massachusetts Department of Public Health

Dr. Adimora and Ms. Fukuda summarized key findings and recommendations from the breakout group that was charged with addressing NHAS Goal 1, “Reduce New HIV Infections.”

Breakout Group 1: Overarching NHAS Themes

- A bold statement should be added: “Each individual in America should have access to the necessary tools to prevent the acquisition of HIV.”
- Successes in the HIV/AIDS epidemic are repeatedly described in the document, but this language should be minimized to allow readers to more quickly learn about the current HIV epidemic and the updated NHAS. References should be added to acknowledge past successes.
- The Executive Summary should be shortened, but a new, bold statement should be added regarding inequalities that serve as major social determinants of health (SDHs), underpin the HIV epidemic in the United States, and require extensive attention. This statement likely would be well received by both the Democratic and Republican parties due to their stronger focus on income inequality.
- The Executive Summary should explicitly recognize the tremendous accomplishments of ACA, but the ongoing need for RWHAP should be strongly emphasized due to its longstanding role in providing additional social services that are desperately needed by persons living with HIV/AIDS (PLWHA).
- The references on injection drug use (IDU) and substance use should be revised and refined. The current language reflects tremendous success in this area, but does not account for persistent problems over time.
- The ongoing HIV epidemic in the subpopulation of undocumented immigrants should be addressed.

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Breakout Group 1: Specific Guidance on NHAS Goal 1

- Language should be added to clarify that the existence of services is not equivalent to access or competence to provide services. The critical importance of increasing access to and enhancing the competent delivery of HIV prevention services to all persons in need should be emphasized. Training and capacity building should be highlighted as action steps in this regard.
- The strong focus on priority populations should be maintained, but the role of all Americans in responding to and preventing HIV should be clearly articulated. This approach would help to reduce stigma and decrease new HIV infections.
- “Gender fluidity” terminology and other language that will resonate with youth should be used.
- New sexual health language should be included in multiple sections.
- The needs of teens and out-of-school youth should be explicitly addressed.
- Leveraging of public-private partnerships to prevent new HIV infections should be a major recommendation. These collaborations will be particularly important to increase knowledge, implementation and utilization of PrEP. For example, STD clinics and prevention programs should be supported and widely promoted to deliver PrEP as an HIV prevention strategy.
- NHAS action plans to reduce new HIV infections should be developed in consultation with experts to obtain external guidance on monitoring the proposed metrics and other data points.
- The important role of RWHAP in preventing and reducing new HIV infections should be highlighted.
- The need for accurate and timely surveillance data should be emphasized, particularly to facilitate real-time decision-making for affected populations.
- Language on HIV transmission rates should be strengthened by describing national progress in this area.
- HIV surveillance on Native Americans should be improved because the traditional practice of combining Asian Americans and Native Americans into one dataset is problematic. Native Americans are a key population for HIV incidence in many jurisdictions.
- A clear distinction should be made between the use of HIV “diagnosis” and “incidence.” The use of diagnosis as a proxy for incidence could lead to inappropriate public health strategies.
- Concrete recommendations should be made to illustrate synergies between effective HIV prevention activities and specific populations.

Breakout Group Report: NHAS Goal 2

Robert Greenwald, JD, PACHA Member

Director, Center for Health Law and Policy Research
Harvard Law School

Mr. Greenwald summarized key findings and recommendations from the breakout group that was charged with addressing NHAS Goal 2, “Increase Access to Care and Improve Health Outcomes for Persons Living with HIV.”

Breakout Group 2: Overarching NHAS Themes

- The focus on access to care should be strengthened to reduce barriers. A structure should be established to facilitate continuity of coverage; support access to ongoing, high-quality health care; and ensure the availability of systems to link and retain clients in care.
- The introduction should be shortened, but compelling statements should be added upfront on stigma-related endpoints that will be achieved over the next five years.
- Aggressive targets with no clear direction toward achievement should be revised and refined to be more realistic. For example, the updated NHAS proposes to improve viral suppression rates of young persons and IDUs, but no new strategies or innovative approaches are described to accomplish this longstanding goal. Long-term, persistent and ongoing strategies will be needed to ensure linkage to and retention in care over time to achieve the viral suppression goal.
- Constraints on the U.S. healthcare infrastructure should be discussed in much more detail because PLWHA are living much longer than in the past. However, the federal government is not allocating new resources to care for the aging PLWHA population over time.
- The intersection and relationship among the three NHAS goals (e.g., HIV prevention, care and health disparities) should be clearly articulated.
- The need to target funding and resources to areas where HIV prevalence is emerging should be emphasized, particularly in rural communities of the country.
- The mobilization of communities across the country should be prioritized by extensively engaging community-based organizations (CBOs) and identifying new community partners.
- More attention should be given to the important role of alternative care providers in the HIV/AIDS epidemic.

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Breakout Group 2: Specific Guidance on NHAS Goal 2

- Page 19 of the updated NHAS should be revised as follows. Step 2A should discuss reducing barriers to care and guaranteeing continuity of coverage. Step 2B should discuss linking persons to care 30 days post-HIV diagnosis. This approach will ensure that a system of wraparound services is available to retain clients in care before linkages are made. Issues related to transparency, coverage, cost and the capacity of provider networks should be addressed during the linkage to care process.
- The focus on HIV/HCV co-infection should be much stronger. HCV is the leading cause of morbidity in PLWH and causes more deaths in the general U.S. population each year than HIV. Because barriers to HCV care are much more restrictive and onerous than in the past, HCV should be integrated into the HIV linkage to care process. This approach would cure HCV in PLWH and eliminate the leading cause of death in this population.
- Mental health and substance abuse issues should not be characterized as separate HIV co-morbidities. Comprehensive behavioral health should be fully integrated into HIV care to successfully link and retain clients in care and improve their viral suppression rates. The mental health expertise and capacity of primary care providers should be enhanced to increase access to care for PLWH with mental health issues. An extensive body of evidence has clearly demonstrated a strong correlation between treatment of mental health problems in PLWH and higher rates of retention in care and viral suppression. Referrals to Substance Abuse and Mental Health Administration (SAMHSA) services have not been sufficient to achieve the linkage to/retention in care and viral suppression targets.
- Differences among states in ACA implementation should be rigorously monitored. Federally Qualified Health Centers should be designated to oversee the integration of HIV care into primary care settings. The federal government also should explore creative opportunities to engage non-Medicaid expansion states in ACA.
- Research should be recommended to determine the effectiveness of patient navigators to engage PLWH and other vulnerable populations in care.
- Gay men should not be combined with women and girls in discussions on trauma and post-traumatic stress. More references should be cited from the extensive body of evidence that has been gathered on the tremendous level of trauma in gay men and transgender persons.
- The important role of RWHAP in providing PLWH with a comprehensive public health-based system of care and continuity of coverage should be emphasized. Extremely low Medicaid reimbursement rates should be resolved to ensure a strong primary care workforce, particularly for low-income PLWH.
- Housing is repeatedly mentioned as an SDH, but other factors also should be highlighted to meet the basic needs of PLWH: transportation, healthy food and nutrition services.
- Interventions that will be needed to effectively provide care to PLWH in jails, state departments of corrections and private correctional institutions should be described in detail. Actions to ensure seamless continuity of care when PLWH are released from correctional settings should be outlined as well.

Breakout Group Report: NHAS Goal 3

Marjorie Hill, PhD, CHAC Member
Consulting Services

Scott Schoettes, JD, PACHA Member
HIV Project Director & Senior Attorney
Lambda Legal

Dr. Hill and Mr. Schoettes summarized key findings and recommendations from the breakout group that was charged with addressing NHAS Goal 3, “Reduce HIV-Related Health Disparities.”

Breakout Group 3: Overarching NHAS Themes

- The updated NHAS should be shortened to be more understandable and user-friendly to lay audiences. Most notably, repetitive language in multiple sections should be deleted and referenced.
- The Executive Summary should have a much stronger focus on disparities and SDHs at the outset to establish a framework for high-risk populations that are discussed later in the document.
- The tone of the updated NHAS recommendations should be bold, assertive, prescriptive and consistent (e.g., the use of “must” rather than “should be considered”).
- Specific HIV issues targeted to youth and young adults, particularly prevention and education, should be prioritized. Most notably, the new LGBT metric is limited to high school students and does not include young persons up to 24 years of age.
- The updated NHAS appears to stigmatize sexual health by promoting abstinence. The tone of the document should be modified to embrace sexuality as normal and healthy.
- The updated NHAS should be revised to compile all informal discussions on technology, including social media, into one thorough and dedicated section.

Breakout Group 3: Specific Guidance on NHAS Goal 3

- Disparities should be framed at a broader macro level because the updated NHAS primarily focuses on disparities in the context of HIV. The expanded language should address health equity and SDHs.
- Recommendations on disparities should use “must” rather than “should” to convey a bold and assertive tone and clearly identify priorities.
- Specific NHAS targets should be driven by the baseline of each population and HIV epidemiology. The common target of reducing disparities by 15% will not decrease

disparities in all populations. Due to their higher HIV rates, for example, a 45% reduction in disparities might be more appropriate for YBMSM.

- The moral obligation of the federal government to target resources to small populations with limited epidemiological data should be emphasized, including transgender women, indigenous persons and transnational immigrants.
- Stigma should be more broadly defined and addressed in terms of societal, institutional and internalized frameworks.
- Deficit and resiliency models should be utilized to determine the efficacy and success of PLWH in the HIV epidemic.
- Sexuality should be framed as a normal, healthy part of the human experience. Any language that appears to stigmatize sexual health should be deleted.
- More emphasis should be placed on including U.S. territories to reduce disparities in these populations.
- HCV should be defined as an additional disparity for PLWH.

PACHA/CHAC Discussion on the Breakout Group Reports

Dr. McGuire moderated a discussion for other PACHA and CHAC members to highlight key issues for ONAP to consider in updating the NHAS.

PACHA/CHAC Input: Overarching NHAS Themes

- The updated NHAS mentions “tribal” once. The document should be revised to acknowledge the unique relationship between the federal government and tribes. For example, this language will be important for organizations to advocate for gay/bisexual Native American men with the Indian Health Service, National Congress of American Indians and tribal leadership.
- The disparities section should have fewer nuances and be less prescriptive in terms of program recommendations. The updated NHAS will need to have a certain level of flexibility to be implemented by local health departments. A glossary of terms should be added to provide guidance to local public health, particularly in the context of SDH issues.
- The life expectancy and relevance of the updated NHAS should be thoroughly considered. For example, the chronology at the beginning of the document that lists the accomplishments of President Obama in addressing the HIV/AIDS epidemic is appropriate. However, other references to the Obama Administration throughout the document should be reconsidered because the 2016-2020 NHAS will still be in effect when a new, unknown Administration takes office in January 2017. The NHAS is a national strategy that should continue to be strongly endorsed and supported by the American public regardless of the Administration in office.

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PACHA/CHAC Input: NHAS Goal 1

- The new indicator to define HIV risk behaviors of high school students should not include oral sex.
- A clear statement should be included to affirm the sexual identities of LGBT youth. A supportive message in the updated NHAS would help to mitigate stigmatizing and shaming of LGBT youth.
- The inability of some communities to conduct HIV prevention activities due to cost should be conveyed.
- Activities by the CHAC/CDC Sexual Health Workgroup should be reviewed as a resource to include appropriate sexual health language. Most notably, the workgroup's "sexual health" definition is positive and does not stigmatize any group.
- Caution should be taken in targeting priority populations on the basis of their high rates of HIV or behavioral risk factors. This approach has led to the unintended consequence of stigmatizing certain subgroups. For example, stigma by risk group was prevalent in the 1980s because gay white men had the highest rates of HIV/AIDS. Stigma by race/ethnicity is now much more prevalent because African American men, women and MSM have the highest burden of HIV.
- Targeting of resources to priority populations is tremendously important and should be retained in prevention efforts to reduce new HIV infections. Most notably, researchers often cited the 2010-2015 NHAS in grant applications to justify conducting HIV studies on specific populations. The updated NHAS should include a bolder, much stronger statement to emphasize this issue: "HIV is a crisis in African Americans, particularly YBMSM. Appropriate resources must be targeted to this population."
- An explicit statement should be added to highlight the continued importance of targeting resources to priority populations with high HIV rates or risks (e.g., African Americans, MSM of all race/ethnicities, and transgender men and women). Risks for transgender women will need particular attention due to their reluctance to present to gay men's clinics for prevention and treatment services. The new language also should recognize the continued existence of the HIV epidemic in non-priority populations.
- The reallocation and re-amplification of resources to priority populations continues to be a significant issue that should be heavily emphasized in the updated NHAS. However, jurisdictions should be advised to consider other factors that also play a critical role in HIV disparities: capacity, scalability, social connectedness, resiliency and the current compendium of interventions. Resources beyond those provided by the federal government should be brought to bear and amplified in the updated NHAS.
- Resources should be allocated to faith-based organizations (FBOs) that conduct HIV education and prevention activities. The broader faith community stigmatizes and marginalizes FBOs that are involved in HIV efforts. Although 70% of African Americans are members of or have a strong connection to FBOs, only 5% of mega-churches with $\geq 5,000$ members are FBOs of color. The updated NHAS should underscore the fact that without resources, FBOs have no incentives or support to conduct HIV activities.

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- The call for all Americans to have a certain level of education and knowledge in HIV is commendable, but this language should be stronger and more explicit for youth. Schools should be encouraged to provide education on sexuality and HIV beyond the biology of the disease. Most notably, schools should educate their students on gender equality in terms of contraceptive use and LGBT inclusiveness.

PACHA/CHAC Input: NHAS Goal 2

- The importance of biomedical research should be more strongly emphasized to improve health outcomes of PLWH. Ongoing research investments will be needed to advance to the next generation of HIV treatment regimens, develop HIV vaccines, and ultimately discover a cure. The flat NIH budget has decreased the level of resources for HIV research.
- Breakout Group 2 advised ONAP not to characterize mental health and substance abuse issues as separate HIV co-morbidities. However, clinicians need to use the term “co-morbidities” to incorporate mental health issues into primary medical care and provide HIV patients with a comprehensive package of care.
- This indicator should be expanded with the following action step: “Increase the percentage of newly diagnosed patients linked to HIV care with a CD4 count >200 copies/ml.” The action step will be helpful in providing guidance on treating late HIV diagnoses.

PACHA/CHAC Input: NHAS Goal 3

- References to “faith-based communities” should be expanded to include faith-based leadership and FBOs.
- The impact of laws and policies on disparities, stigma, criminalization and discrimination should be emphasized. For example, transgenders face enormous disparities due to difficulties in obtaining legal documentation for their new gender identities. Transgender women without new legal documents are housed in correctional facilities for men, refused admittance to women’s shelters, and denied other services for women. Moreover, sex workers are reluctant to accept condoms from outreach workers or community groups due to their fears of arrest.
- The tremendous allocation of federal funds by the NIH Office of AIDS Research to train diverse health professionals should be highlighted as an opportunity to build provider capacity in HIV-related health disparities.
- The adolescent developmental framework should be utilized to decrease youth-related disparities. The framework should be prominently displayed in the updated NHAS rather than in action plans to specifically focus on the unique developmental needs of youth.
- Support should be provided to pipeline programs for health professionals.
- Poverty should be directly addressed and characterized as an HIV health disparity.
- The Gardner, *et al.* study on the spectrum and cascade of HIV care should be referenced. HRSA-funded AIDS Education and Training Centers (AETCs), clinicians in the field and prescribers extensively use the study as a resource.

- Goals and targets should be framed in a manner that will enable grassroots CBOs with no federal funding to also implement the updated NHAS. Most notably, non-funded CBOs are the only providers of HIV prevention and health education services in many jurisdictions.

Summary of the NHAS Breakout Group Reports and Follow-Up Discussion

Dr. McGuire summarized the major outcomes from the breakout group reports; moderated the PACHA/CHAC discussion on interagency coordination; and opened the floor for Mr. Brooks to provide clarifying remarks.

Summary of the NHAS Breakout Group Reports

OVERARCHING THEMES OF THE UPDATED NHAS

Bolder language should be included, particularly to emphasize issues related to income inequality, racial disparities and disparities across the lifespan.

Issues related to stigma and technology should be emphasized at the outset.

The updated NHAS should be shortened and have more specificity to be understandable to lay audiences. Successes in the HIV/AIDS epidemic are repeated throughout the document, but this language should be minimized with references.

The intersection and relationship among the NHAS goals should be clearly articulated at the beginning of the document.

A flexible strategy should be proposed to appropriately balance the tension between targeting resources to priority populations (e.g., youth and undocumented immigrants) and responding to other areas with a high HIV prevalence.

Out-of-school youth up to 24 years of age should be better characterized with more rigorous data. Language to promote action steps should be consistent and assertive (e.g., “must” versus “should be considered”).

Community mobilization should be enhanced to ensure that communities view themselves as key partners in implementing the updated NHAS.

The continued importance of and need for RWHAP should be more strongly emphasized due to gaps in the ability of ACA to achieve NHAS prevention and treatment goals. For example, ACA does not cover RWHAP wraparound services that are desperately needed by PLWH.

NHAS GOAL 1, “REDUCE NEW HIV INFECTIONS”

The updated NHAS should have a much stronger focus on reducing HIV in youth.

Summary of the NHAS Breakout Group Reports

- Language on sexual health and interventions targeted to youth should be more prominent throughout the document.
- The NHAS indicator to decrease “sexual risk behaviors” of youth should be clarified and reframed with a more positive tone to shift the risk of youth without diminishing their sexual behaviors and gender identities.
- Gender fluidity terminology and other language that will resonate with youth should be added. Synergies between effective HIV prevention activities and specific populations should be identified.

Resources from other sectors should be reallocated and re-amplified for HIV prevention efforts. Increased access to and more competent delivery of HIV prevention services should be available to all persons in need.

The role of STD clinics in offering HIV prevention services (e.g., conducting surveillance, delivering PrEP and linking clients to care) should be highlighted.

NHAS GOAL 2, “INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PLWH”

Barriers to accessing HIV care should be decreased, including gaps in ACA; issues related to transparency, coverage and cost; and the capacity of provider networks. These barriers should be addressed to successfully link and retain clients in care.

Language should be added to address challenges in treating cases of late HIV diagnoses and improving health outcomes of these persons.

Full integration of the HCV cure framework into the HIV linkage to care strategy should be promoted to reduce HCV-related morbidity in PLWH.

The need to build the capacity of both HIV specialists and primary care providers should be emphasized.

Monitoring the impact of ACA implementation in states on access to HIV care and health outcomes of PLWH should be recommended.

The critical role of RWHAP in building provider capacity should be highlighted.

Ancillary services beyond housing that are necessary to meet the basic needs of PLWH should be recognized.

Methods to effectively deliver care to PLWH in correctional settings should be described.

Mental health and substance abuse issues should be extensively incorporated into HIV care rather than being addressed as co-morbidities.

The need for ongoing federal investments to support HIV biomedical research should be underscored.

NHAS GOAL 3, “REDUCE HIV-RELATED HEALTH DISPARITIES”

“HIV-related health disparities” should be expanded to include SDHs, health equity and poverty. Disparities recommendations should be conveyed with a bold and assertive tone.

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Summary of the NHAS Breakout Group Reports

The common indicator to reduce disparities by 15% should be modified for certain populations based on their baselines and HIV epidemiology.

HCV should be characterized as an additional disparity for PLWH.

“Sexuality” should be defined as a normal and healthy part of the human experience. Language that stigmatizes sexual health should be deleted.

Resources should be targeted to small populations with limited epidemiological data: transgender women, indigenous persons and transnational immigrants.

At the conclusion of her summary of the breakout group reports, Ms. McGuire moderated the PACHA/CHAC discussion on interagency coordination.

- An assessment should be conducted to identify synergies between PACHA and CHAC in terms of their agendas, messaging and platforms to provide advice and guidance to HHS agencies.
- All agencies that fund or support testing should play a role in routine HIV testing in order to achieve the NHAS target of 90% of persons knowing their HIV status.
- Consistent training materials should be developed for various entities that will be involved in implementing the updated NHAS: federal agencies, public health instructors, seminary professors and other high-level leaders in communities.
- Federal partners should coordinate efforts to collect and release HIV incidence data in a timelier manner to ensure that policy and funding decisions are based on the most up-to-date information.
- Roles and responsibilities of agencies that should be engaged as federal partners in implementing the updated NHAS should be clearly articulated.
 - The U.S. Department of Labor can address the training, education and employment needs of PLWH.
 - SAMHSA can leverage its tremendous budget to increase the provision of trauma-informed care, substance abuse and mental health services to PLWH. SAMHSA currently is funding two initiatives for Minority Serving Institutions to partner with CBOs to integrate HIV and HCV prevention, education and training for young persons.
 - The Equal Employment Opportunity Commission can decrease workplace stigma and disparities by enforcing employment protections for PLWH.
 - The U.S. Department of Education can approve more comprehensive sexual health education to youth in middle and high school and also can offer incentives to school districts to implement behavioral interventions.

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Mr. Brooks highlighted several key points from the breakout group reports and the PACHA/ CHAC follow-up discussions that ONAP would consider in its ongoing efforts to update the NHAS for 2016-2020.

- References to the Obama Administration will be reconsidered to ensure that the updated NHAS serves as a transition document between the outgoing and new Administrations.
- The outstanding efforts by the CHAC/CDC Sexual Health Workgroup will be used as a resource in crafting sexual health language.
- Language to more strongly emphasize the need for additional HIV biomedical research would be welcome.
- Suggestions to revise language (e.g., “HIV/mental health co-morbidities”) will be carefully considered in the context of specific target audiences for the updated NHAS.

Mr. Brooks’s position was that any national HIV strategy or plan should focus on four areas: (1) provide HIV testing to all Americans; (2) deliver treatment to all persons with a positive HIV test result; (3) administer PrEP to HIV-negative persons at highest risk; and (4) ensure access to support services to retain HIV-negative persons in prevention services and HIV-positive persons in treatment.

In response to the PACHA/CHAC discussion on interagency coordination, Mr. Brooks announced that the Executive Order to establish the updated NHAS is being circulated to various agencies at this time. The Executive Order specifically identifies all departments and agencies that President Obama has required to be involved in the updated NHAS.

PACHA and CHAC clarified their recommendations to ONAP in response to Mr. Brooks’s observations on the breakout group reports.

- The guidance reflects efforts by PACHA and CHAC to provide bold and assertive input on the updated NHAS as requested by ONAP. The NHAS is a national rather than a federal HIV strategy that must include support from foundations and other parts of the private sector. The PACHA/CHAC advice might appear to be broad and unfocused to the federal government, but improvements cannot be made in the HIV epidemic without addressing the root of the problem (e.g., sexual health equity, poverty, distressed communities and disenfranchisement). Overall, the NHAS should be framed as an aspirational document.
- The PACHA/CHAC input to focus on HCV mono-infection was not intended to compete for HIV resources. The updated NHAS should emphasize HCV in the context of its high morbidity rate in PLWH. Because public health and the healthcare community must take a patient-centric rather than a virus-centric approach, the updated NHAS should be developed in a comprehensive disparities and SDH framework.

- PACHA and CHAC, their constituents, organizations and other stakeholders should educate state, local and territorial elected officials on the need to allocate funding to ensure broad implementation of the updated NHAS in communities.

Call for a Formal Vote of the PACHA and CHAC Memberships

Ms. Mahon presented a draft resolution for a review, discussion and formal vote by PACHA and CHAC.

As PACHA and CHAC, we jointly and respectfully request the elimination of current U.S. law which prohibits federal funding for the support of access to sterile syringes as a necessary component of a comprehensive program to prevent HIV, Hepatitis C and other bloodborne illnesses in people who inject drugs. As an immediate step toward that change in the law, we further request that Congress convene a bipartisan hearing on this critical public health issue which has so gravely affected our cities, and more recently, our suburban and rural communities throughout the nation.

PACHA and CHAC proposed several revisions to refine the draft resolution.

- The language should be changed to "...for the support of controlled access...". Ms. Mahon was not in favor of this revision because the word "controlled" could lead to tremendous barriers to changing the existing law on access to sterile syringes.
- The language should be changed to "...support of access to sterile injection equipment" to include both syringes and needles. **[Amendment accepted]**
- The language should be changed to "people who inject prescription and non-prescription drugs" to include the injection of non-prescribed insulin, vitamins and other substances. Dr. Ronald Valdiserri, Deputy Assistant Secretary for Health in HHS, was not in favor of this revision because no distinction is needed between the use of legal and illegal drugs.
- The language should be changed to "...in people who engage in injection." Dr. Amy Lansky, Senior Policy Advisor in the CDC Division of HIV/AIDS Prevention, is currently detailed to ONAP. She advised PACHA and CHAC not to revise "people who inject drugs" because the federal government commonly uses and clearly understands this language.
- The language should be changed to "As a step toward..." and "...that Congress immediately convene...". **[Amendment accepted]**
- New language should be added to explain that the resolution is intended to reduce sharing of injection equipment. Dr. Valdiserri was not in favor of including a new qualifying statement. For example, HCV transmission during IDU can occur due to contamination rather than sharing of equipment.

- The call for Congress to convene a bipartisan hearing should not result in the unintended consequence of delaying ongoing efforts by advocates in the field. Ms. Mahon emphasized that PACHA has a responsibility to go on the record with its advice to President Obama and the HHS Secretary.

CHAC Co-Chair's call for a vote	Dr. Clanton properly placed a motion on the floor for CHAC to formally approve the draft resolution with the accepted amendments noted for the record.
Outcome of vote	Motion unanimously passed by 14 CHAC voting members with no objections, abstentions or further discussion.
PACHA Chair's call for a vote	Ms. Mahon properly placed a motion on the floor for PACHA to formally approve the draft resolution with the accepted amendments noted for the record.
Outcome of vote	Motion unanimously passed by 22 PACHA members with no objections, abstentions or further discussion.
Next steps	The amended resolution will be finalized in a joint letter that the PACHA and CHAC Chairs will sign and submit to President Obama for consideration and action.

Public Comment Session

Ms. Hayes moderated a session for members of the public to provide testimonies or comments for PACHA and CHAC to consider.

Melanie Medalle, JD
 Reproductive Justice-HIV Law and Policy Fellow
 SisterLove, Inc.

Ms. Medalle provided the following comments. The U.S. Women and PrEP Working Group was established in March 2012 to develop a collective response to the approval of Truvada® as PrEP by the U.S. Food and Drug Administration. The workgroup serves as a national network of HIV and women's health advocates, researchers, academics, government employees, and pharmaceutical industry representatives.

The workgroup has three major functions: (1) educate communities and healthcare providers on PrEP; (2) mobilize advocacy to ensure that women's voices as policy advisors, consumers and healthcare providers influence public policy and funding regarding PrEP; and (3) explore

opportunities to advocate for access to microbicides, treatment as prevention and other new biomedical HIV prevention options for women.

Women account for ~25% of PLWH in the United States, but prevention strategies are urgently needed to protect the HIV-negative population of cisgender and transgender women when male or female condom use is not preferred. PrEP is the first HIV prevention strategy that is fully controlled by the receptive sex partner and not linked to the timing of sex. PrEP also serves as a new protection method for women who cannot or elect not to insist on condom use. The workgroup urges PACHA and CHAC to consider the important need for consumers whose lives are at stake to have a voice in the nation's uptake of PrEP as a lifesaving technology.

The workgroup met with various federal officials from the White House and HHS during a meeting in 2013 chaired by ONAP. The workgroup used this opportunity to discuss its new position statement and obtain information on federal plans to launch PrEP. The workgroup proposed to establish a coordinating group with its members and other civil society partners. The new group would collaborate with federal officials to facilitate the successful, expeditious launch of PrEP to women and men in the United States.

Data were presented during the meeting to demonstrate the vital importance of actively engaging community-based partners in the HIV care and treatment cascade. Barriers to meaningful communication regarding the launch of PrEP also were discussed, particularly unique challenges faced by women. The workgroup acknowledges that the Federal Advisory Committee Act restricts civil society participation in federal forums, but approaches can be applied to overcome these barriers. The formation of the HIV/AIDS Indicators Implementation Group by the HHS Secretary serves as a model in this regard.

Matthew Pieper
Executive Director
Open Hand Atlanta

Mr. Pieper provided the following comments. During their joint efforts to advise ONAP on updating the NHAS for 2016-2020, the National Food is Medicine Coalition urges PACHA and CHAC to consider two key recommendations to improve access to care and health outcomes: (1) increase funding for food and nutrition services provided through RWHAP and (2) incorporate food and nutrition services through ACA.

Proper nutrition is required for PLWHA to increase their absorption of medications, reduce side effects, maintain a healthy body weight, and ultimately achieve viral suppression. PLWHA who are food insecure routinely forego critical medical care, including making and maintaining primary care appointments, filling prescriptions and adhering to treatment. HRSA has allowed the RWHAP Food and Nutrition Services Category to serve as a clinically effective core medical

service since 2006. HRSA has publicly announced that the management of HIV disease necessitates substantial expertise in nutrition and is an integral part of ongoing health care from diagnosis through the disease process.

Access to food and nutrition services meets the NHAS goals. NHAS Goal 1 is to “reduce new HIV infections.” PLWHA who are food insecure are less likely to have undetectable viral loads in a statistically significant manner. The efficacy rate of undetectable viral loads in preventing HIV transmission is 96%. Food nutrition services are a key component of HIV prevention.

NHAS Goal 2 is to “increase access to care and improve health outcomes.” PLWHA who receive effective food and nutrition services are at lower risk for in-patient hospitalizations and also are more likely to maintain scheduled primary care visits, score higher on health functioning tests and adhere to medications.

NHAS Goal 3 is to “reduce HIV-related health disparities.” PLWHA in poverty who receive food and nutrition services have improved health outcomes and fewer disparities. Medically appropriate food and nutrition services must be integrated into all healthcare reform efforts, including RWHAP and ACA, to achieve a more coordinated national response to HIV, reduce healthcare costs and improve health outcomes.

Carl Schmid

Deputy Executive Director
The AIDS Institute

Mr. Schmid provided the following comments. In terms of HIV prevention, CDC funding follows the epidemic at the federal level (e.g., MSM, BMSM, YBMSM and African American women). However, accountability for allocating HIV prevention dollars also must be assured at state, local and CBO levels. In terms of HIV testing, other payers should provide support in the current healthcare reform environment. HIV testing dollars should be used for HCV testing and hepatitis B virus (HBV) vaccination.

In terms of the updated NHAS, emphasis should be placed on the need for ongoing leadership in sexual health and comprehensive sex education. The U.S. Department of Education should be engaged as a key federal partner to ensure that homosexuality and gender identity are included in these efforts.

In terms of RWHAP, non-Medicaid expansion states have contributed to an unequal delivery of services. RWHAP funding is allocated based on case count or need depending on the specific program part, but resources should be targeted to areas and populations with the greatest needs. HRSA should take steps at this time to consult with and obtain input from communities to ensure

that RWHAP is aligned with the 2016-2020 NHAS. RWHAP should be responsible for providing its patient population with HBV vaccination or HCV testing, care, treatment and cure.

Leisha McKinley-Beach

HIV Prevention Administrator

Fulton County (Georgia) Department of Health and Wellness

Ms. McKinley-Beach provided the following comments. Fulton County became a directly-funded jurisdiction in 2012 and has made significant progress since that time. An HIV/AIDS Task Force was established to improve the county-wide response to this disease. The health department will launch “Test Atlanta” in June 2015 in its first community-government partnership to mobilize HIV testing for Fulton and DeKalb Counties.

The health department made a commitment to scale-up its jurisdictional response to biomedical interventions, such as PrEP, and prevention of mother-to-child transmission of HIV. The health department will continue to collaborate with national, state and local HIV partners to improve prevention, care and treatment services for Fulton and DeKalb Counties.

Rosemary Donnelly, MSN, APRN-BC, ACRN

Program Director, Southeast AIDS Training and Education Center

Emory University School of Medicine

Ms. Donnelly provided the following comments. The Association of Nurses in AIDS Care (ANAC) recognizes that a skilled and effective workforce will be critical in achieving the NHAS goals. Nurses and nurse practitioners (NPs) play a key role in addressing workforce shortages, particularly in HIV and primary care. ANAC encourages NPs and registered nurses to practice to the full extent of their licenses and training in HIV and primary care settings.

To date, 19 states have removed scope of practice barriers in accordance with the 2010 IOM report, *The Future of Nursing: Leading Change, Advancing Health*. This cost-effective approach is in the best interest of patients. ANAC acknowledges the value of AETCs in providing targeted and flexible training to the HIV workforce. ANAC members provide leadership to AETC-funded programs at four schools of nursing that produce highly-skilled and committed NPs with expertise in HIV. However, more AETC training programs should be established.

AETCs have the capacity to respond to emerging HIV areas. For example, AETCs trained healthcare workers to respond to the HIV outbreak in Scott County, Indiana. The use of AETC-trained nurses and NPs in medically served areas will continue to be an integral and effective component of the HIV workforce.

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ANAC calls for improved integration between prevention and care/treatment programs and funding streams, particularly to support the delivery of PrEP. The infrastructure and expertise developed under RWHAP should be better coordinated with CDC's prevention programs. Funding of PrEP services for uninsured and underinsured persons at risk for HIV should be more widely available. Because some PrEP candidates have received positive HIV test results, a seamless transition to care will be essential. Incentives for co-funded positions and co-located programs would be an ideal strategy in this regard.

Murray Penner, BSW

Executive Director

National Alliance of State and Territorial AIDS Directors (NASTAD)

Mr. Penner provided the following comments. NASTAD recently held its annual meeting and reached consensus on reenergizing the critical role of public health and its intersection with the NHAS. NASTAD acknowledges that public health plays a functional role in coordinating preparedness and response and should be fully integrated into all parts of the NHAS. PrEP, needle exchange and other proven interventions will need related activities (e.g., assessment, surveillance and data usage) for effective implementation.

Public health plays an important role in coordinating issues that affect lives (e.g., housing, substance abuse, mental health problems, STDs and HCV) to improve health outcomes and reduce disparities. The investigation of the HIV outbreak in Scott County, Indiana demonstrated the effective integration of public health and science. Needle exchange and comprehensive drug user health programs prevent HIV and HCV transmission.

NASTAD will soon call for an end to the Congressional ban on the use of federal funds for needle exchange. The critical role of public health in achieving the NHAS goals should be emphasized. The NHAS should continue to recommend targeting resources to populations and areas most affected by the HIV epidemic, but not to the exclusion of other groups. Because epidemiological data clearly demonstrate a disproportionate impact of HIV on YMSM of color, particularly YBMSM, efforts should be strengthened to dramatically reduce new infections in these populations.

Dee Dee Chamblee

Founder and Executive Director

LaGender, Inc.

Ms. Chamblee provided the following comments. She founded LaGender in Atlanta in 2001 and received the White House "Champion of Change" Award from President Obama in 2011. Prior to these notable accomplishments, however, she survived as a young sex worker and was arrested multiple times. She was able to access health care and receive housing, food and clothing assistance only after she was diagnosed with HIV in 1987. She was able to focus on her health as an HIV-positive transgender woman only after obtaining support to meet her basic needs.

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Ms. Chamblee emphasized that transgender women of color in Atlanta have an alarmingly high HIV infection rate of 85%. Transgender women are not “men who have sex with men,” but typically are referred to MSM organizations to obtain HIV services. Funding is allocated to MSM organizations to provide services to transgender women, but these groups have no knowledge of the needs of this population.

The Black AIDS Institute previously released a study that showed a tremendous disparity between transgender-specific services “reported” by AIDS service organizations and services actually provided to communities. If the disproportionately high rate of HIV among transgender women continues, an entire population potentially could be destroyed. Stigma is highly prevalent in transgender women with some sectors of the public vocalizing their support for this population to “disappear and die.” However, Ms. Chamblee was proud to announce that transgender women remain present and strong.

Masonia Traylor

Member of the Public

Ms. Traylor provided the following comments. Her diagnosis of HIV and confirmation of her pregnancy occurred two weeks apart in 2011 when she was 23 years of age. She is extensively involved in the national goal to achieve “an AIDS-free generation.” Despite her positive status, her child is now four years of age and continues to be HIV-negative.

Ms. Traylor has been giving public testimony to middle schools, high schools and colleges over the past two years. She has obtained parental permission to share her story with children as young as 10 years of age. She noted that school textbooks continue to provide students with inaccurate information regarding HIV. Despite the availability of an extensive body of research, students are still taught that the disease paradigm begins with an STD, progresses to treatment for HIV and AIDS, and ends in death. Students are not educated on the fact that persons with an HIV or AIDS diagnosis can still have long, healthy and prosperous lives.

Ms. Traylor also was disappointed by language in comprehensive sex education policies in multiple states. To achieve an AIDS-free generation, young persons must be given accurate information based on rigorous studies that have been conducted over the past 34 years of the epidemic. Because school textbooks and policies still are not based on sound evidence, Ms. Traylor, other parents and educators face difficulties in efforts to create an AIDS-free generation for their children, peers and students.

Ms. Traylor promotes an abstinence-based approach in her testimony to middle school, high school and college students, but she realizes that prevention alone is not sufficient. She was tested for HIV annually until her diagnosis in 2011. She urged PACHA and CHAC to solicit advice

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from and extensively engage young persons in their deliberations. Young persons need more knowledge, a stronger presence and ongoing participation in the federal decision-making process.

Tammy Kinney

SisterLove, Inc., AIDS Athens & Positive Women's Network

Ms. Kinney provided the following comments. The 2016-2020 NHAS should emphasize factors that are critical to the health, vitality, dignity and quality of life of all women living with HIV. A new national standard of care with clinical and non-clinical indicators should be developed for all PLWH.

All public and private payers should be held accountable to three key components in the new standard of care: (1) sexual and reproductive justice; (2) high-quality clinical care, including necessary and affordable medications for HIV and mental health conditions; and (3) health care for all PLWH. "All PLWH" should be inclusive of all genders, identities and stages of infection.

Ms. Kinney was diagnosed with HIV over 28 years ago. She was required to address multiple co-morbidities, including mental health problems, substance abuse issues and HCV. All of these conditions should be treated simultaneously when newly diagnosed persons are linked to care. The updated NHAS should promote a holistic approach to provide PLWH with a better quality of life. Most notably, PLWH who receive treatment for mental health problems are more likely to decrease risk behaviors, adhere to their medications and achieve viral suppression.

Closing Session

The closing session of the joint PACHA/CHAC meeting was devoted to acknowledgements.

- Dr. Mermin thanked CHAC for continuing to provide CDC and HRSA with sound advice to guide the direction of their HIV, viral hepatitis and STD prevention and treatment programs. He also thanked Mr. Brooks for convening the joint PACHA/CHAC meeting.
- Ms. Mahon thanked Ms. Kaye Hayes, Executive Director of PACHA, and Ms. Caroline Talev, the PACHA Committee Manager, for their continued support and outstanding efforts to organize PACHA meetings. She also thanked Mr. Brooks for serving as a new important partner to PACHA.
- Mr. Brooks made a series of acknowledgements.
 - The PACHA and CHAC members were thanked for contributing their expertise and providing thoughtful input.

- HHS, CDC and HRSA leadership, other staff and outside vendors were thanked for their extensive assistance in convening the meeting.
- The subcommittee that developed the NHAS indicators over the past six months was thanked.
- The federal partners were thanked for their strong support and participation in updating the NHAS.
- Mr. George Fistonich and Dr. Amy Lansky of ONAP were thanked for their ongoing dedication and commitment to update the NHAS each day.
- The members of the public were thanked for taking time from their busy schedules to provide valuable feedback on the updated NHAS from the perspectives of impacted populations, affected communities and stakeholder organizations.
- The participants joined Mr. Brooks in applauding Dr. McGuire for her excellent facilitation of the meeting.

Mr. Brooks clarified that although the printed copies of the updated NHAS were collected, PACHA and CHAC were still welcome to submit comments to aidspolicy@who.eop.gov by May 27, 2015.

With no further discussion or business brought before PACHA or CHAC, Mr. Brooks adjourned the meeting at 4:05 p.m. on May 21, 2015.

I hereby certify that to the best of my knowledge, the foregoing Minutes of the proceedings are accurate and complete.

Date

Kathleen Clanon, MD, Co-Chair
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and
Treatment

Date

Dawn Fukuda, ScM, Co-Chair
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and
Treatment

Date

Nancy Mahon, JD, Chair
Presidential Advisory Council on HIV/AIDS



ATTACHMENT 1

Participants' Directory

PACHA Members Present

Nancy Mahon, Esq., Chair
Dr. David Holtgrave, Vice Chair
Dr. Adaora Adimora
Dr. Jeffrey Akman
Ms. Dawn Averitt
Bishop Oliver Allen III
Dr. Lucy Bradley-Springer
Ms. Gina Brown
Dr. Ulysses Burley
Ms. Cecilia Chung
Dr. Michelle Collins-Ogle
Dr. Yvette Flunder
Ms. Grissel Granados
Robert Greenwald, Esq.
Mr. Gabriel Maldonado
Mr. Douglas Michels
Dr. Ligia Peralta
Mr. Mario Perez
Mr. Harlan Pruden
Scott Schoettes, Esq.
Rev. Vanessa Sharp
Dr. Mildred Williamson

PACHA Members Absent

Dr. Vignetta Charles
Mr. William Collier
Mr. Humberto Cruz
Dr. Patricia Garcia

Mr. Lawrence Stallworth II
Ms. Elizabeth Styffe

PACHA Liaison Representative

Dr. Jennifer Kates
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and
Treatment

PACHA Executive Director

Ms. Kaye Hayes
HHS Office of HIV/AIDS and Infectious
Disease Policy

CHAC Members Present

Dr. Kathleen Clanon, Co-Chair
Ms. Dawn Fukuda, Co-Chair
Dr. Sanjeev Arora
Dr. Virginia Caine
Mr. Guillermo Chacon
Dr. Carlos del Rio
Dr. Camilla Graham
Ms. Debra Hauser
Dr. Marjorie Hill
Dr. Steven Johnson
Mr. Michael Kaplan
Dr. Jennifer Kates
Ms. Amy Leonard
Dr. Britt Rios-Ellis

CHAC Members Absent

Dr. Bruce Agins
Ms. Angelique Croasdale

CHAC Ex-Officio Members Present

Dr. Pradip Akolkar
U.S. Food and Drug Administration

Dr. Paul Gaist
Office of AIDS Research
National Institutes of Health

Ms. Kaye Hayes
Office of HIV/AIDS and Infectious Disease
Policy, U.S. Department of Health and
Human Services

Dr. Iris Mabry-Hernandez
Agency for Healthcare Research and
Quality

Ms. Lisa Neel
Indian Health Service

Dr. Chana Rabiner
(Alternate for Dr. Elinore McCance-Katz)
Substance Abuse and Mental Health
Services Administration

Dr. Richard Wild
(Alternate for Dr. Stephen Cha)
Centers for Medicare and Medicaid
Services

CHAC Ex-Officio Members Absent

Dr. Stephen Cha
Centers for Medicare and Medicaid
Services

Dr. Elinore McCance-Katz
Substance Abuse and Mental Health
Services Administration

CHAC Liaison Representative

Dr. Mildred Williamson
Presidential Advisory Council on HIV/AIDS

CHAC Designated Federal Officers

Dr. Laura Cheever
HRSA/HAB Associate Administrator

Dr. Jonathan Mermin
CDC/NCHHSTP Director

Convener

Mr. Douglas Brooks
Office of National AIDS Policy

Keynote Speaker

Dr. David Satcher
Satcher Health Leadership Institute

Facilitator

Dr. Jean Flatley McGuire
Northeastern University

Federal Agency Representatives

Dr. Gail Bolan (CDC)
Ms. Michelle Bonds (CDC)
Mr. Nick Burton (OMB)
Ms. Terry Butler (CDC)
Ms. Chynna Cole (HHS)
Ms. Chiquita Covington (HHS)
Ms. Antigone Dempsey (HRSA)
Dr. Karen DeSalvo (HHS)
Dr. Patricia Dietz (CDC)
Ms. Kristin Dixon (HHS)
Ms. Teresa Durden (CDC)
Ms. Laura Eastham (CDC)

Minutes of the Joint Meeting:

Presidential Advisory Council on HIV/AIDS (PACHA) &

CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC)

May 21, 2015 ♦ Page 35

Mr. George Fistonich (ONAP)
Ms. Shelley Gordon (HRSA)
Dr. Amy Lansky (ONAP)
Ms. Eva Margolies (CDC)
Dr. Eugene McCray (CDC)
Ms. Susan Robinson (CDC)
Ms. Margie Scott-Cseh (CDC)
Ms. Caroline Talev (HHS)
Dr. Ronald Valdiserri (HHS)
Dr. John Ward (CDC)
Dr. Richard Wolitski (CDC)
Ms. Abigail Viall (CDC)
Dr. Stephanie Zaza (CDC)

Members of the Public

Mr. Chris Aldridge
National Association of County and City
Health Officials

Dr. Chanza Baytop
Abt Associates

Mr. Christopher Broussard
Vision Community Foundation

Ms. Dee Dee Chamblee
LaGender, Inc.

Dr. Stephanie Cohen
San Francisco Department of Public Health

Ms. Rosemary Donnelly
Southeast AIDS Training and Education
Center
Emory University School of Medicine

Mr. Kenyon Farrow
Treatment Action Group

Ms. Debra Fraser-Howze
OraSure Technologies, Inc.

Ms. Bambi Gaddist
South Carolina HIV/AIDS Council

Ms. Ruby Hardy
Fulton County Department of Health and
Wellness

Ms. Patrice Harris
Fulton County Department of Health and
Wellness

Ms. Damaris Henderson
SisterLove, Inc.

Ms. Tam Ho
M·A·C AIDS Fund

Ms. Tammy Kinney
SisterLove, Inc., AIDS Athens &
Positive Women's Network

Ms. Leisha McKinley-Beach
Fulton County Department of Health and
Wellness

Melanie Medalle, Esq.
SisterLove, Inc.

Mr. Murray Penner
National Alliance of State and Territorial
AIDS Directors

Mr. Carl Schmid
The AIDS Institute

Dr. Liza Solomon
Abt Associates

Ms. Masonia Traylor
Member of the Public

Mr. Robert Ware
Salvation Army

Ms. Avian Watson
Vision Community Foundation

Ms. Gretchen Weiss
National Association of County and City
Health Officials

Ms. Lisa Diane White
SisterLove, Inc.



ATTACHMENT 2

Glossary of Acronyms

ACA	Affordable Care Act
AETCs	AIDS Education and Training Centers
ANAC	Association of Nurses in AIDS Care
ASH	Assistant Secretary for Health
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CHAC	CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
COGME	Council of Graduate Medical Education
FAC	Federal Advisory Committee
FBOs	Faith-Based Organizations
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
IDU	Injection Drug Use
IOM	Institute of Medicine
LGBTQ	Lesbian/Gay/Bisexual/Transgender/Questioning
MSM	Men Who Have Sex With Men
NASTAD	National Alliance of State and Territorial AIDS Directors
NHAS	National HIV/AIDS Strategy
NIH	National Institutes of Health
NPs	Nurse Practitioners
NSEPs	Needle-Syringe Exchange Programs
OMB	Office of Management and Budget
ONAP	Office of National AIDS Policy
PACHA	Presidential Advisory Council on HIV/AIDS

PLWH; PLWHA	Persons Living with HIV; Persons Living with HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Administration
SDHs	Social Determinants of Health
SHLI	Satcher Health Leadership Institute
YBMSM	Young Black Men Who Have Sex With Men
YMSM	Young Men Who Have Sex With Men