

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
HEALTH RESOURCES AND SERVICES ADMINISTRATION**



**Meeting of the
CDC/HRSA Advisory Committee on
HIV, Viral Hepatitis, and STD Prevention and Treatment
November 16-17, 2016
Rockville, Maryland**

Record of the Proceedings

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**CDC/HRSA ADVISORY COMMITTEE ON
HIV, VIRAL HEPATITIS, AND STD PREVENTION AND TREATMENT
November 16-17, 2016
Rockville, Maryland**

Minutes of the Meeting

The U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) convened a meeting of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis, and STD Prevention and Treatment (CHAC). The proceedings were held at HRSA Headquarters at 5600 Fishers Lane, Pavilion, Rockville, Maryland.

CHAC is a committee that is chartered under the Federal Advisory Committee Act (FACA) 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.

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

Opening Session: November 16, 2016

Laura Cheever, MD, ScM, CHAC Designated Federal Officer (DFO)

Associate Administrator

HRSA, HAB

Dr. Cheever conducted a roll call to determine the CHAC voting members, *ex-officio* members, and liaison representatives who were in attendance. She announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. She informed 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
Bruce Agins, MD, MPH (New York State Department of Health)	Recipient of federal funding from HRSA for multiple Ryan White HIV/AIDS Program (RWHAP) grants
Richard Aleshire, MSW, ACSW (Washington State Department of Health)	Recipient of federal funding from HRSA for RWHAP Part B
Jean Anderson, MD (Johns Hopkins Medical Institutions)	Recipient of federal funding from HRSA for RWHAP grants
Peter Byrd (Peer Educator and Advocate)	No conflicts disclosed
Virginia Caine, MD (Marion County, Indianapolis Public Health Department)	Recipient of federal funding from HRSA for RWHAP grants; recipient of federal funding from CDC for STD prevention activities
Guillermo Chacon (Latino Commission on AIDS)	Recipient of federal funding from CDC for prevention and capacity building activities; recipient of federal funding from HRSA for RWHAP grants
Carlos del Rio, MD (Rollins School of Public Health Emory University)	Recipient of federal funding from HRSA for a RWHAP Part A Clinic; recipient of federal funding from CDC to perform gonococcal resistance testing

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Dawn Fukuda, ScM (Massachusetts Department of Public Health)	Recipient of federal funding from HRSA for RWHAP Part B and a Special Projects of National Significance (SPNS) grant; recipient of federal funding from CDC for HIV prevention activities
Debra Hauser, MPH (Advocates for Youth)	Recipient of federal funding from CDC for adolescent and school health activities
Peter Havens, MD, MS (Children’s Hospital of Wisconsin)	Recipient of federal funding from HRSA for RWHAP Parts B and D
Amy Leonard, MPH (Legacy Community Health Services)	Recipient of federal funding from CDC; recipient of federal funding from HRSA for RWHAP grants
Jorge Mera, MD (Cherokee Nation Hastings Hospital)	Recipient of federal funding from the Indian Health Service (IHS); recipient of federal funding from HRSA for an AIDS Education and Training Center (AETC); recipient of academic funding from Oklahoma University Foundation; former participant at advisory board meetings for Gilead Sciences and AbbVie
Susan Philip, MD, MPH (San Francisco Department of Public Health)	Recipient of federal funding from HRSA for RWHAP grants; recipient of federal funding from CDC for HIV, STD, and viral hepatitis prevention activities
Linda Scruggs, MHS (Ribbon Consulting Group)	No conflicts disclosed

Dr. Cheever confirmed that the voting members and *ex-officio* members (or their alternates) in attendance constituted a quorum for CHAC to conduct its business on November 16, 2016. She called the proceedings to order at 8:47 a.m. and welcomed the participants to the 27th CHAC meeting. She noted that this in-person, HRSA-hosted CHAC meeting was being held in the Washington, DC metropolitan area for the first time since 2012.

Dr. Cheever explained that the agenda was structured with a series of panel presentations to address emerging topics requiring CHAC’s expertise and input. She noted that the panel presentations included extensive discussion periods for CHAC to begin formulating resolutions to CDC and HRSA on these important issues.

Dr. Cheever made several announcements regarding changes to CHAC’s membership in terms of HRSA appointees.

- Mr. Rick Haverkate, the National HIV/AIDS Program Director at IHS, is the new CHAC *ex-officio* member for the agency.
- The participants were asked to welcome Dr. Jean Anderson to her first meeting as a HRSA-appointed CHAC member. She is a Professor of Gynecology and Obstetrics at Johns Hopkins Medical Institutions.
- The terms of four CHAC members expired on June 30, 2016: Dr. Bruce Agins, Ms. Angelique Croasdale, Dr. Carlos del Rio, and Dr. Jennifer Kates. The terms of the outgoing members were extended until December 30, 2016, to allow HRSA sufficient time to recruit their replacements. The outgoing members were presented with certificates of appreciation at the June 2016 meeting. Because Dr. Agins attended the previous meeting via teleconference, he was given his certificate of appreciation in person during the current meeting. The participants joined Dr. Cheever in applauding the four outgoing members for their outstanding contributions during their tenures on CHAC.

Jonathan Mermin, MD, MPH, CHAC DFO

Director
CDC, NCHHSTP

Dr. Mermin also extended his welcome to the participants. He confirmed that CHAC's time, expertise, and thoughtful guidance have been tremendous assets to both CDC and HRSA. He explained that CHAC meetings have served as a forum for multiple HHS agencies to engage in open and productive discussions on the most critical issues related to HIV, viral hepatitis, and STD prevention and treatment for the nation.

Dr. Mermin emphasized that CHAC's ongoing advice on the future direction of CDC and HRSA programs will be particularly useful during the transition to the new Administration. The agencies will continue to solicit CHAC's guidance to ensure that national targets are reached and goals are achieved for HIV, viral hepatitis, and STD prevention and treatment in the most efficient and effective manner.

Dr. Mermin announced changes to CHAC's CDC appointees.

- The terms of three CHAC members are scheduled to expire on November 30, 2016: Dr. Sanjeev Arora, Dr. Virginia Caine, and Mr. Guillermo Chacon. The outgoing members were presented with certificates of appreciation. Dr. Arora was unable to attend the meeting and would receive his certificate in the mail. The participants joined Dr. Mermin in applauding the three outgoing members for their service on CHAC as well as their leadership in the field in HIV, hepatitis C virus (HCV), and STD prevention and treatment.

Dawn Fukuda, ScM, CHAC Co-Chair

Director

Massachusetts Department of Public Health, Office of HIV/AIDS

Ms. Fukuda joined her colleagues in welcoming the participants to the CHAC meeting. She noted a key change in the agenda. Time would be set aside during the discussion period at 2:55 p.m. on day one to include two additional items: (1) an update by the Viral Hepatitis Workgroup and (2) a discussion of the response by Dr. Richard Wolitski, Director, HHS, Office of the Assistant Secretary for Health (OASH), Office of HIV/AIDS and Infectious Disease Policy (OHAIDP), to CHAC's HCV recommendations.

Ms. Fukuda returned to Dr. Mermin's opening remarks. Over the course of the meeting, she asked the members to reflect on CHAC's important role in the transition to the new Administration. She pointed out that the upcoming change in the federal government could have an impact on CHAC's priorities, areas of focus, and formal guidance to the HHS Secretary, CDC Director, and HRSA Acting Administrator.

Update by the Acting HRSA Administrator

James Macrae, MA, MPP

Acting Administrator

HRSA

Mr. Macrae confirmed that HRSA is preparing for the new Administration and emphasized that the agency will continue to focus on activities with a demonstrated, evidence-based record of effectiveness and impact. In particular, he highlighted the key outcomes of HRSA's discussions to date.

HCV

- HRSA will shift from a "screen and treat" to a "test and cure" approach to generate a remarkable impact on HCV at the national level. HRSA will explore opportunities and develop strategies to ensure that funding and appropriate expertise are available to implement the HCV test and cure model.

HIV

- HRSA is aware that tools currently are available to stop the spread of HIV and prevent new infections. Neither an HIV cure nor a vaccine has been developed at this time, but full implementation of existing treatments (e.g., PrEP and antiretroviral therapy (ART) for HIV viral suppression) could have a tremendous impact at the national level.

STDs

- HRSA recognizes that widespread screening and treatment of STDs in both traditional and non-traditional settings would significantly decrease existing infection rates. HRSA will design effective approaches, particularly for the most at-risk populations, to have more access to care and remain in STD care. HRSA will collect and utilize data from multiple sources to inform the decision-making process on targeting these efforts.

Transparency

- HAB will continue to release the RWHAP Annual Client-Level Data Report to the public. Ryan White HIV/AIDS Program Services Report (RSR) data, trends, and other information in the report clearly demonstrate the national impact of HRSA's evidence-based HIV programs.

Innovations

- HRSA will place much more emphasis on innovations to inform the development and implementation of creative pilot projects. HRSA intends to increase its knowledge of innovative community-based projects and provide support to ensure the national scale-up of these evidence-based interventions and best practices. HRSA will solicit advice from CHAC on creating an environment in a federal agency to promote and rapidly scale up innovations.

Global Reach

- HRSA will launch new strategies over the next few months to expand the global reach of its programs in multiple countries. HRSA will share its lessons learned and experiences in the United States with global initiatives and will apply global best practices to its U.S. activities.

Results and Outcomes

- HRSA will continue to solicit guidance from CHAC on identifying data-driven strategic priorities, goals and targets to improve HIV, HCV, and STD screening, treatment, quality of care, outcomes, and disparities.

Challenges and Opportunities

- HRSA will address challenges that are inherent in any transition to a new Administration, but new opportunities, ideas and perspectives will be explored as well. To support this effort, HRSA will examine its current gaps, future vision, and ultimate goals. HRSA will solicit input and support from CHAC on making a strong case to prioritize activities and devote resources to achieving these goals.

Mr. Macrae commended the CHAC members for their tremendous impact on HIV, viral hepatitis and STD prevention and treatment at national, state, and community levels throughout the country. He thanked CHAC for continuing to provide guidance to HRSA, particularly its advice

to strengthen and enhance the CDC/HRSA interagency partnership over time. He confirmed that CHAC's expertise and guidance over the years have played an instrumental role in HRSA's ability to improve its existing activities and identify its future directions.

Mr. Macrae concluded his update by asking CHAC to respond to the following two key questions to inform HRSA's ongoing discussions on the transition to the new Administration:

1. What are HRSA's most helpful and/or effective activities at this time?
2. What strategic opportunities can HRSA leverage to help propel and accelerate momentum related to HIV, HCV, and STD prevention and treatment?

CHAC DISCUSSION: UPDATE BY THE ACTING HRSA ADMINISTRATOR

CHAC provided input in response to the two questions posed by Mr. Macrae.

Question 1: Helpful/effective HRSA activities

- HRSA's decision to showcase its collaboration with CDC at the 2016 National Ryan White Conference on HIV Care and Treatment was a powerful demonstration of the strong partnership the agencies have established between prevention and treatment. The interagency collaboration also has allowed CDC and HRSA to identify, target efforts, and devote resources to the most at-risk populations. HRSA should continue to enhance its partnership with CDC to bridge the gap among clinical outcomes, quality care, and public/ population health in RWHAP programs and policies.

Question 2: Strategies to accelerate momentum

- HRSA should collect new data to increase its focus on trauma-informed care.
- HRSA should engage CHAC, RWHAP recipients, and community stakeholders to educate Congressional staff. To support this effort, HRSA's rigorous data should be presented to Congressional staff to demonstrate the impact and results of its programs at both national and community levels.
- HRSA should take action at this time to ensure that clinical leadership and providers are available for the next generation of the infectious diseases (ID) workforce. Most notably, technical assistance (TA), training, scholarships, and mentorships should be targeted to youth who are ready to serve as leaders in the ID workforce.
- HRSA should collect and present data that will be relevant and important to the new Administration to ensure its existing priority programs will continue to be funded.

Dr. Mermin also responded to Mr. Macrae's request for input on question number one. He agreed with CHAC that HRSA's longstanding partnership with CDC is one of its most effective activities at this time. The interagency collaboration has allowed CDC and HRSA to release joint guidelines and policies to prevention and treatment grant recipients and develop complementary programs. He described several examples in which HRSA's concerted efforts have tremendously benefited and reduced the burden on dual CDC/HRSA grant recipients,

including health departments, clinics, and community-based organizations (CBOs), including, but not limited to the following:

- Collection and release of relevant client-level RWHAP data,
- Collection and release of complementary data with CDC (e.g., increased HIV viral suppression rates, reduced HIV mortality rates, and decreased rates of the proportion of HIV diagnoses),
- Use of quality indicators, and
- Adoption of HCV and STD prevention activities in Federally Qualified Health Centers (FQHCs).

Amy Lansky, PhD, MPH

Director

The White House, Office of National HIV/AIDS Policy

Dr. Lansky provided additional details on the potential impact that the transition to the new Administration may have on CHAC's advisory role. President Obama announced his strong commitment to ensuring a successful and professional transition to the new Administration. The peaceful transition of power is one of the hallmarks of the U.S. democracy and will be demonstrated to the world over the next few weeks. In terms of CHAC, the National HIV/AIDS Strategy: Updated to 2020 (NHAS 2020) will serve as a roadmap over the next three years because the document is based on evidence. Moreover, an existing Presidential Executive Order protects the implementation of NHAS 2020 through 2020.

Dr. Lansky informed CHAC that both CDC and HRSA serve as leading partners on a federal interagency workgroup to update and oversee NHAS 2020, focus on high-impact activities, and engage in other collaborative efforts. However, all of the federal partners acknowledge the challenge in implementing NHAS 2020 in the field. As a result, CHAC's advisory role will be instrumental in providing guidance to key CDC and HRSA on implementing NHAS 2020. She encouraged CHAC to provide CDC and HRSA with creative and strategic advice on achieving NHAS 2020 goals by 2020.

HRSA/HAB Associate Administrator's Report

Laura Cheever, MD, ScM, CHAC DFO

Associate Administrator

HRSA, HAB

Dr. Cheever covered various topics in the Associate Administrator's report to CHAC. The vision of HAB is "optimal HIV/AIDS care and treatment for all." The mission of HAB is to provide

leadership and resources to assure access to and retention in high-quality care, integrated care, and treatment services for vulnerable people living with HIV/AIDS (PLWH) and their families. The [HAB website](#) was recently redesigned to be much more streamlined, intuitive, and user-friendly for mobile devices.

HAB continues to address challenges to achieving an AIDS-free generation. The key barriers to reaching this goal include stigma and discrimination, health disparities, and issues pertaining to social determinants of health (SDOH) and the public health infrastructure. However, public health will be a key driver of success in all of these areas. Most notably, RWHAP is a public health program that funds care and treatment; service delivery; federal, state and local policies; needs assessments; capacity development; and quality improvement. The RWHAP is designed to identify health disparities, promote evidence-informed interventions, and target interventions based on the optimal outcomes for addressing health disparities.

HAB is conducting several activities to support its 2016 priorities.

Priority 1: NHAS 2020/President's Emergency Plan for AIDS Relief (PEPFAR) 3.0

HAB will maximize its expertise and resources (e.g., TA, evaluation, and policies) to support NHAS 2020 and PEPFAR 3.0.

- HAB funded the Center for Engaging Black Men Who Have Sex with Men (MSM) Across the Care Continuum (CEBACC) to develop and target specific activities to this population, particularly young black MSM (YBMSM). CEBACC launched the *HIS Health* training series and the “Well Versed” website for patients and providers in the fall of 2016.
- HAB awarded Secretary's Minority AIDS Initiative Funding (SMAIF) to support the “Building Care and Prevention Capacity: Addressing the HIV Care Continuum in Southern Metropolitan Areas and States” project. The project is designed to increase capacity in four Southern jurisdictions to improve health outcomes for minority MSM, youth, young women, transgender women, and people who inject drugs (PWID).
- HAB awarded a contract to the HIV Research Network (HIVRN) to conduct an evaluation study focusing on the target populations of youth and older adults living with HIV and people who are HIV/HCV co-infected. The study is designed to identify characteristics that predict people who are engaged in care and are likely to have detectable HIV viral loads.
- HAB funded the “Building Futures: Supporting Youth Living with HIV” evaluation study. The study is designed to identify best practices to support youth living with HIV to access RWHAP-funded services.
- HAB funded an evaluation study to assess the factors of clients in clinical care who have detectable viral loads. The study includes both qualitative and quantitative designs to identify differences between PLWH who are and are not HIV virally suppressed.

- HAB issued a new policy letter in August 2016 to inform RWHAP recipients that RWHAP-funded housing services have been extended to RWHAP Part C recipients.

Priority 2: Leadership

HAB will enhance and lead national and international HIV care and treatment through evidence-informed innovations, policy development, health workforce development, and program implementation.

- HAB convened a PLWH and Public Leadership Technical Expert Panel that included a diverse expert panel that discussed leadership qualities and explored strategies to cultivate leaders in the PLWH population.
- HAB awarded SMAIF funding to provide leadership training to people of color living with HIV. The purpose of the initiative is to support national leadership training and increase the engagement of transgender women of color living with HIV in leadership opportunities.
- HAB awarded SMAIF funding to use community health workers (CHWs) to improve access, linkage to, and retention in HIV care. The purpose of the initiative is to increase the use of CHWs to strengthen the healthcare workforce and improve access to health care and health outcomes for racial/ethnic minority PLWH.
- HAB hosted the 2016 National Ryan White Conference on HIV Care and Treatment. The participants included 2,580 RWHAP recipients and 420 clinicians. The conference was organized with 185 workshops (including 105 that were accredited for continuing education) and 152 poster presentations. The key communications from the conference included the development of four videos, a radio media tour, three AIDS.gov daily blog posts, six Facebook live video interview segments, 22,000 impressions, and over 100 engagements on Twitter, Facebook, LinkedIn, and Flickr. The evaluation is not yet finalized but initial evaluation indicates that most attendees learned new interventions to improve outcomes in their programs.
- HAB published a special issue, “First Look at the HRSA HIV Workforce Study,” in the August 2016 edition of [HIV Specialist](#). The publication includes articles on the HIV clinician workforce that describe the supply of and demand for HIV clinicians and services as well as the characteristics of RWHAP providers.
- HAB funded the “Models of Care” evaluation study to gather information on the need for potential adjustments to RWHAP in the future, ensure that RWHAP continues to focus on models of critical care, and position RWHAP to achieve the best health outcomes for PLWH.
- HAB convened the “Retention Measure Expert Panel” to focus on four key issues: (1) identify goals of retention measures; (2) align with NHAS 2020 and other measures; (3) align with goals at national, state, local, and provider levels; and (4) utilize HIV viral suppression as a measure of retention in HIV care.

Priority 3: Partnerships

HAB will enhance and develop strategic domestic and international partnerships both internally and externally.

- HRSA, CDC, and the Centers for Medicare & Medicaid Services (CMS) established the HIV Health Improvement Affinity Group (HHIAG). The purpose of the HHIAG is to support state collaborations between public health and Medicaid programs to improve sustained HIV viral suppression rates among Medicaid and Children's Health Insurance Program (CHIP) enrollees who are living with HIV. The HHIAG's current membership includes 19 states.

Priority 4: Integration

HAB will integrate HIV prevention, care, and treatment as well as mental/behavioral health in an evolving healthcare environment.

- HAB provided TA to RWHAP Parts A and B recipients to support the implementation of integrated HIV planning. HAB's support covers activities for states that submitted a CDC/ HRSA Integrated HIV Prevention and Care Plan. The major outcome of this funding is to encourage a streamlined approach to HIV grant planning and promote effective local and state decision-making to develop systems of prevention and care.
- HAB funded the Affordable Care Enrollment Technical Assistance Center to assist RWHAP recipients and sub-recipients in enrolling diverse clients in health insurance coverage, particularly people of color.
- The HRSA PrEP Workgroup hosted a "PrEP 101" session for federal staff to complement HRSA's National HIV Testing Day webinar in June 2016. The workgroup also updated the SF-424 application guide to include information on PrEP and the HIV care continuum.
- The HAB PrEP Workgroup released a RWHAP PrEP program letter in June 2016. The workgroup also hosted a webcast that was attended by 500 RWHAP recipients and providers. The webcast described approaches to leverage program systems to support PrEP services within the parameters of the RWHAP legislative authority.

Priority 5: Data Utilization

HAB will use data to target, prioritize and improve policies, programs and service delivery. The data sources will include program reporting systems, surveillance, modeling, and other programs as well as results from evaluation and special project efforts.

- HAB is linking client-level data in the RSR (baseline year of 2010) and AIDS Drug Assistance Program (ADAP) Reports (baseline year of 2014) for easier utilization of both datasets.

- HAB awarded a contract to conduct electronic specification, testing and validation of four existing HIV clinical quality measures that were endorsed by the National Quality Forum: gaps in visits, frequency of medical visits, ART prescriptions, and HIV viral suppression.
- HAB is integrating HIV care and housing data to improve health outcomes along the HIV care continuum. The goals of this initiative are two-fold: (1) use information technology to promote the integration and coordination of HIV and housing services and (2) improve entry, engagement, and retention in care for homeless and unstably housed PLWH with mental illness and substance use disorders.
- HAB will release the 2015 RWHAP Annual Client-Level Data Report in December 2016. A supplement to the 2014 report was released in 2015 to feature data on RWHAP Part A recipients, Eligible Metropolitan Areas, and Transitional Grant Areas.

Dr. Cheever provided CHAC with a preview of key data from the 2015 RSR that HAB will release in 2016. Of 533,036 clients who received services from RWHAP-funded providers in 2015, 97 percent were PLWH. RWHAP served approximately 50 percent of estimated persons with diagnosed HIV infection in the United States in 2015. Racial/ethnic minority populations account for 73 percent of RWHAP clients. Of all RWHAP clients, 65 percent are living at or below the Federal Poverty Level (FPL).

PLWH in the 45-54 age group continue to account for the majority of RWHAP clients, but increases in the number of RWHAP clients were reported in the age groups of 25-34, 55-64, and 65 years and older from 2011-2015. By reported gender, the breakdown of RWHAP clients in 2015 is: males 71.3 percent, females 27.6 percent, and transgender people 1.1 percent. By health outcomes, HIV viral suppression rates among RWHAP clients increased from 72.6 percent in 2011 to 83.4 percent in 2015. PLWH who are unstably housed, youth, YBMSM, and young women have the lowest HIV viral suppression rates.

By geographic location, Southeastern states accounted for the lowest HIV viral suppression rates in 2010, but all states reported significant improvements in 2015. The top ten states with the highest increases in HIV viral suppression rates from 2010-2015 are listed below.

<u>State</u>	<u>Percentage Point Increase</u>
Indiana	28.6%
Louisiana	23.3%
Mississippi	23.2%
Ohio	23.0%
New Jersey	20.6%
Maryland	19.9%
Wisconsin	19.2%
Missouri	18.9%
District of Columbia	18.9%
Wyoming	18.7%

Dr. Cheever highlighted two key changes in HAB's organizational structure. An Office of Program Support was established to address areas that need to be improved based on responses to the RWHAP recipient survey, such as communications, electronic reporting capacity, and RWHAP recipient site visits. A Clinical and Quality Branch was established in the Division of Policy and Data to enhance HAB's existing quality improvement activities. The Clinical and Quality Branch is providing leadership for a number of HAB's clinical activities, such as HCV initiatives and the integration of mental/behavioral health into HIV models of care.

CDC/NCHHSTP Director's Report

Jonathan Mermin, MD, MPH, CHAC DFO

Director
CDC, NCHHSTP

Dr. Mermin covered various topics in his Director's report to CHAC. At the agency level, CDC is continuing to provide leadership for the Zika outbreak response. The complex outbreak has required CDC to deploy over 10 percent of its workforce to the Emergency Operations Center, other parts of the United States, and overseas countries to address scientific and programmatic uncertainties related to the Zika virus.

Transmission of the Zika virus has been reported in Miami, Puerto Rico, and American Samoa, but local transmission in the United States has been limited to date. Travelers have accounted for the vast majority of U.S. cases. CDC is continuing to gather data to answer Zika-related questions for pregnant women and women who are considering pregnancy and also to determine the proportion of Zika infections from sexual transmission. CDC expects that ongoing surveillance efforts will strengthen its knowledge of the Zika virus over the next year.

At the CDC center level, NCHHSTP filled three leadership positions: Dr. Patricia Dietz (Associate Director, Program and Performance Improvement Office); Dr. Kathleen Ethier (Director, Division of Adolescent and School Health); and Mr. Michael Melneck (Deputy Director, Management and Operations). NCHHSTP recently initiated searches to fill two key leadership positions that are vacant at this time: Associate Director for Health Communication Science and Associate Director for Health Equity.

NCHHSTP is continuing to address the impact of HIV and HCV on the national opioid epidemic. CDC's vulnerability assessment model documented poor alignment between U.S. counties that are vulnerable to rapid dissemination of HIV/HCV infection among PWID and jurisdictions with existing syringe services programs (SSPs). CDC's model also emphasized the need for access to sterile injection equipment to prevent HIV/HCV outbreaks among PWID.

The Consolidated Appropriations Act of 2016 modified the historical prohibition on the use of federal funds to support SSPs. The legislation now allows programs to redirect federal funds to purchase specific SSP components, including HIV and viral hepatitis testing kits. However, the purchase of needles, syringes, or other devices to inject illegal drugs with federal funds is still prohibited.

The legislation authorizes CDC to designate and approve jurisdictions that submit a determination of need for an SSP based on specific criteria. CDC has approved determinations of need for SSPs for several jurisdictions to date. With the exception of West Virginia's three identified counties, CDC's approvals cover the entire state.

California	Minnesota
Colorado	New Jersey
Indiana	Utah
Kentucky	Vermont
Maryland	Washington
Massachusetts	West Virginia (Berkeley, Cabell-Huntington and Kanawha Counties)
Michigan	Wisconsin

The [NCHHSTP Annual Report 2015](#) was published to provide information on CDC's HIV/AIDS, viral hepatitis, STD and TB prevention programs.

At the division level, the Division of HIV/AIDS Prevention (DHAP) has observed several national milestones in the HIV epidemic. A nine percent reduction in new HIV diagnoses has been reported over the past five years. Disparities in HIV have significantly decreased, particularly among African American women and PWID. DHAP has identified numerous contributors to these national achievements: an increase in the number of PLWH who know their status; the availability of basic HIV information; wider access to HIV treatment; changes in the *HIV Treatment Guidelines* to include all PLWH regardless of their immune status; and broader availability of PrEP. However, access to HIV prevention, care, and treatment services and SDOH issues have not been adequately addressed to date in jurisdictions with a high prevalence of PLWH.

DHAP recently released a surveillance report, "Diagnoses of HIV Infection Among Adolescents and Young Adults in the United States and Dependent Areas, 2010-2014." Key findings of the report are summarized as follows:

- Young PLWH 13-24 years of age accounted for an estimated 22 percent of all HIV diagnoses and had the second highest rate of HIV diagnoses (34.3/100,000) in 2014.
- Estimated HIV rates for youth 13-19 years of age decreased, while rates for young adults 20-24 years of age remained stable.

- Compared to 23 percent of Hispanics and 17 percent of whites, African American adolescents and young adults accounted for 55 percent of HIV diagnoses.
- Young gay/bisexual men accounted for 66 percent of all HIV diagnoses.

DHAP recently released new [HIV fact sheets](#). The topics covered in the fact sheets include “Living with HIV 101,” “PrEP 101,” “HIV 101,” “Vaginal Sex and HIV Risk,” and “Anal Sex and HIV Risk.”

DHAP contributed to the August 2016 publication in *Clinical Infectious Diseases*, “Guidelines by the American Thoracic Society, CDC and Infectious Diseases Society of America (IDSA) on Treatment of Drug-Susceptible Tuberculosis” (TB). The new guidelines include specific recommendations for coordinated treatment of TB and HIV as well as comprehensive care for all TB patients. However, the guidelines do not address individual TB outbreaks. For example, a TB outbreak that originated in Atlanta (Fulton County), Georgia five years ago has now spread to eight other states. People who are homeless (approximately 100 percent), African American (90 percent), and TB/HIV co-infected persons (50 percent) have been disproportionately affected. The persistent TB outbreak has been difficult to control due to isoniazid resistance.

The Division of Viral Hepatitis (DVH) recently published an article in the *Morbidity and Mortality Weekly Report (MMWR)* that showed a 22 percent increase in the rate of women 15-44 years of age who tested positive for HCV. The current rate reflects an increase from 139/100,000 in 2011 to 169/100,000 in 2014. The proportion of infants born to women living with HCV also increased by 68 percent over the same time period.

The *MMWR* article reported a disproportionate impact in Kentucky and found that the state had the highest acute HCV rate in the nation in 2014. The HCV rate among women of childbearing age in Kentucky tripled from 275/100,000 in 2011 to 862/100,000 in 2014. DVH participated in an HCV Town Hall meeting in Hazard, Kentucky that was convened by the Kentucky Department for Public Health and Shaping Our Appalachian Region. The town hall participants proposed four major recommendations to decrease HCV rates in Kentucky: (1) identify resources to assist local efforts for HCV detection, prevention, and education; (2) identify resources for SSPs; (3) improve data collection; and (4) build partnerships.

The Division of STD Prevention (DSTDP) recently released the *Sexually Transmitted Disease Surveillance Report, 2015*. Key findings of the report are summarized as follows:

- The number of combined chlamydia, gonorrhea and syphilis cases in 2015 represented the highest number of STDs reported in U.S. history.
- MSM accounted for the majority of new primary/secondary syphilis and gonorrhea cases.
- The 27 percent increase in syphilis among women since 2014 included a concomitant increase in congenital syphilis.

DSTDP has been holding discussions with multidisciplinary groups to identify concrete action steps to address the record high rates of STD diagnoses. DSTDP's position is that the major contributors to this problem are a weaker infrastructure of STD clinics across the country and specific aspects of serosorting among HIV-positive men. However, DSTDP believes that scaling up and targeting existing interventions with demonstrated efficacy would have a significant impact on reducing STD rates, particularly syphilis and gonorrhea.

DSTDP data from its new Gonococcal Isolate Surveillance Project showed that a percentage of isolates with decreased susceptibility to azithromycin increased by over 300 percent from 2013-2014. DSTDP's investigation of several cases of azithromycin-resistant gonorrhea in Hawaii found decreased susceptibility to ceftriazone. New drugs in phase II/III trials appear to be promising in terms of their efficacy. However, DSTDP acknowledges the critical need to maintain the focus on prevention because the U.S. Food and Drug Administration (FDA) is not likely to approve new gonorrhea drugs for a few years.

The Division of Adolescent and School Health (DASH) released the first national study of the health of lesbian/gay/bisexual (LGB) high school students, *Sexual Identity, Sex of Sexual Contacts and Health-Related Behaviors Among Students in Grades 9-12—United States and Selected Sites, 2015*. The study was based on Youth Risk Behavior Survey (YRBS) data that showed the following outcomes:

- Levels of bullying were higher among LGB students than their peers.
- Suicide attempts in the past 12 months were reported by 29 percent of LGB students. This rate was four times higher than their peers.
- A majority of LGB students (60 percent) discontinued their usual activities due to overwhelming sadness.
- Injection of illegal drugs was five times higher among LGB students than their peers.
- Safety concerns caused over 1 in 10 LGB students to miss school in the past 30 days.
- Rates of rape and physical dating violence were higher among LGB students than their peers.

DASH described all aspects of the health and well-being of LGB youth in the study to publicize the alarming rates of bullying, physical violence, and suicide attempts in this population. The study findings highlight the responsibility of public health and schools to launch a national call to action to better meet the needs of LGB students, including transgender and questioning (LGBTQ) youth. To support future studies, DASH has validated questions for LGBQ youth and currently is piloting new questions to gather data on transgender youth. The CDC website includes [survey data on LGB high school students](#) from approximately 30 states.

DASH published its [2015 Annual Report](#) to provide a comprehensive description of its activities and accomplishments, key projects, and future directions.

CHAC DISCUSSION: HRSA/HAB ASSOCIATE ADMINISTRATOR AND CDC/NCHHSTP DIRECTOR REPORTS

CHAC discussed the following topics during the question/answer session with Drs. Cheever and Mermin:

- Opportunities to use state Integrated HIV Prevention and Care Plans to enhance the alignment of tools, activities, and services funded by CDC and HRSA: electronic laboratory reporting (ELR), real-time surveillance capacity, innovations, and operational/programmatic research.
- HRSA's approaches and messaging to widely promote RWHAP as a core public health program to communities.
- CDC and HRSA strategies to better define, quantify, and address HIV stigma in the healthcare system and communities: increased use of CHWs, engagement of PLWH in prominent leadership positions, easier access to HIV services, and public health education and communication campaigns to change social norms and acceptance of stigmatized HIV populations.
- CDC and HRSA approaches to address clinical gaps between HIV diagnoses and treatment of youth, particularly since the use of PrEP is not FDA-approved for youth under 18 years of age.
- HRSA's efforts to replicate the same level of HIV care, services and resources in small rural areas, particularly since RWHAP clinics are primarily concentrated in large metropolitan areas and surrounding counties.
- The potential ability of states to combine their HIV and HCV data to improve national monitoring, tracking, and surveillance of co-morbidities.
- The critical need to establish a "RWHAP-like" infrastructure for HCV for national scale-up of the HCV treat and cure model.
- Leadership by CDC and HRSA at the federal level on workforce development activities related to quality assurance of medical case managers and CHWs in prevention, care, and dissemination of information.

CHAC made several comments and suggestions for CDC and HRSA to consider in their ongoing HIV, HCV, and STD prevention and treatment activities. These include the following:

- CHAC thanked HAB for awarding a contract to HIVRN to conduct an evaluation study of youth and older adults living with HIV and HIV/HCV co-infected patients. This initiative directly responds to CHAC's unanimous resolution during the June 2016 meeting for the HHS Secretary to restore funding to HIVRN. However, CHAC reported the need to continue to urge support of HIVRN as a critical and unique national HIV clinical database. The HAB contract is an excellent first step, but ongoing funding was not awarded to HIVRN through a fiscal year (FY) 2017 cooperative agreement (CoAg).
- CHAC commended CDC and HRSA on their leadership at the federal level in addressing the HIV epidemic. Prevention and treatment efforts by the agencies have played an

instrumental role in the tremendous progress that has been made to date, particularly the increase in HIV viral suppression rates and the reduction in new HIV diagnoses. However, resources should be more closely aligned with the HIV epidemic to address disparities that have persisted over time. For example, CDC data show that PrEP predominately is used by insured whites 25 years of age and older, but younger, uninsured racial/ethnic minorities have a much higher risk of infection. More federal resources also should be targeted to address disparities in HCV and STDs.

- CDC presented data that showed marked increases in HCV rates among women of childbearing age and infants born to women living with HCV. The potential for complacency with HIV in this population is extremely high due to the remarkable public health success in the prevention of mother-to-child transmission of HIV. Most notably, HRSA data showed that young women living with HIV are one of the subgroups with the lowest HIV viral suppression rates. CHAC suggested that CDC and HRSA strengthen their screening, surveillance, and outreach activities for young women who are at risk for or living with HCV due to their likelihood of becoming pregnant.
- CHAC reported to be impressed with the CDC and HRSA national reports on their HIV, HCV, and STD prevention and treatment activities. However, CHAC suggested that the agencies expand their reports or publish supplements to inform communities of specific actions that are being taken at the federal level to address these issues. For example, CHAC suggested the development of a HRSA supplemental report to describe interventions that will be implemented to increase low HIV viral suppression rates among PLWH who are unstably housed, youth, YBMSM, and young women. CHAC also suggested the development of a CDC supplemental report to highlight programming that will be launched to address the record high rates of STDs in the United States.
- Several CHAC members issued a call to action to their colleagues to widely disseminate and publicize CDC's national study of the health of LGB high school students. The members reported the need to inform their peers, networks, community leaders, constituents, school districts, and other stakeholders of the incredibly disturbing, devastating, and awful data highlighted in the study. During the Business Session on the following day, Ms. Hauser planned to recommend the establishment of a new CHAC Youth Workgroup to include a broader population of LGBTQ youth. Based on CHAC's formal approval, the new workgroup would propose recommendations to address health issues of LGBTQ youth described in the national study. Most notably, CHAC members determined that actions can be taken at this time to increase the safety of LGBTQ youth in schools and better meet their needs in healthcare settings. The workgroup's ultimate goal would be to identify LGBTQ high school students at baseline, track and monitor the cohort, and determine whether specific interventions had an impact on outcomes reported in CDC's national study.

The NCHSTP Division Directors made several remarks in response to CHAC's suggestions on HIV, HCV, and STD disparities. Dr. Eugene McCray, DHAP Director, confirmed that several activities are underway at CDC to address HIV disparities, such as an upcoming HIV technical expert panel with Southern states, a rigorous review of existing data to better understand HIV in

special populations, and new HIV initiatives specifically targeted to Hispanic people in selected states.

Dr. John Ward, DVH Director, explained that CDC is making efforts to expand the traditional definition of “disparities” to include factors other than racial/ethnic disparities. For example, DVH is placing much more emphasis on geographic disparities (e.g., HCV in rural versus urban areas), the scarcity of HCV prevention and treatment services, and socioeconomic factors that drive injection drug use (IDU) and result in large HCV epidemics.

Dr. Gail Bolan, DSTDP Director, reported that beginning with the FY2014 Funding Opportunity Announcement (FOA), STD grant recipients have been required to comply with two key mandates. First, grant recipients must use local data to allocate their federal awards to the most heavily impacted areas. Second, grant recipients must match their STD and HIV data through geocoding to identify “hot spots” and scale up interventions.

DSTDP is attempting to modernize its surveillance system with enhanced capacity to identify STD disparities. Standards were developed to improve clinical training in STD clinics and scale up effective services for clients, including complex HIV/syphilis cases and culturally sensitive interventions for LGBT and adolescent clients. The DSTDP Office of Health Equity is using its “Community Approaches to Reducing STDs” CoAg to promote a community engagement model for STD prevention. DSTDP now holds separate meetings with grant recipient groups of special significance in addition to convening its traditional all-grant recipient meetings. DSTDP and the special grant recipient groups focus on STD disparities in their individual jurisdictions, such as Southeastern states; state/city pairs; and large, medium and small states.

Dr. Lansky returned to CHAC’s discussion on stigma. She announced that the federal government hosted numerous technical expert panels and summits on stigma in 2016, including topics focusing on stigma research, interventions, and metrics. Information obtained through these events found stigma to be a complex issue that requires broad and innovative social changes. Laws have been passed to protect PLWH from discrimination in housing, employment, and other sectors, but these laws do not address stigma.

Dr. Lansky pointed out that another federal consultation on stigma is not needed at this time. She noted that efforts are underway to compile and widely disseminate recommendations on stigma from the 2016 events. She encouraged CHAC to use these findings, innovations, and available SMAIF and SPNS resources to take concrete action steps on addressing stigma.

Ms. Kaye Hayes, the CHAC *ex-officio* member for OHAIDP, added that the Presidential Advisory Council on HIV/AIDS (PACHA) convened a stigma summit in 2016. The summit was well represented by a diverse group of federal partners, community representatives, and youth. PACHA plans to release thoughtful guidance on stigma in early 2017 based on the outcomes of the summit.

People Living with HIV Leadership

Antigone Dempsey, Med

Director

HRSA, HAB, Division of Policy and Data

Advice Requested from CHAC by HAB:

1. What are the most important actions that should be taken to promote public leadership of PLWH?
2. What different strategies should the federal government implement to promote public leadership of PLWH?
3. What are the best approaches to engage non-federal stakeholders to promote public leadership of PLWH?
4. What are the priorities for action to promote public leadership of PLWH?

Ms. Dempsey presented background information on the PLWH and Public Leadership technical expert panel that HAB convened on May 18, 2016. The engagement of PLWH in public leadership will help achieve the primary NHAS 2020 goals and maximize health outcomes of PLWH through their progression along the HIV care continuum toward HIV viral suppression. HAB established national and international PLWH leadership as one of its priorities for 2016.

Substantial progress in ending the HIV epidemic has been made over time, particularly the increase in the national HIV viral suppression rate from 69.5-81.4 percent. However, outcome data for RWHAP clients highlight areas requiring additional attention, such as HIV viral suppression rates that are five to 17 percent below average among PLWH who are unstably housed, youth/young adults 15-34 years of age, and transgender people. PLWH public leadership can help to improve HIV outcomes.

HAB awarded SMAIF funds to a project that supports leadership, planning and training for people of color who are living with HIV, including transgender women of color. The project is designed to develop tools to enable PLWH to participate on planning bodies, care teams, organizations, and boards of directors. HAB launched the project in September 2016.

Jesse Milan, Jr., JD

Interim President and CEO

AIDS United

Mr. Milan co-facilitated and highlighted key outcomes of the PLWH and Public Leadership Technical expert panel. The 15 panelists were public health leaders with diverse backgrounds, expertise, and experiences. The breakdown of the panelists included 11 PLWH and two transgender people. The panelists represented the provider community, health departments,

HIV programs, and CBOs. Mr. Milan presented a series of slides with the names and affiliations of the panelists.

The overarching purpose of the technical expert panel was to better understand and identify existing strategies and models to promote PLWH public leadership and more fully engage PLWH in public leadership opportunities. The goals of the technical expert panel were three-fold. First, gaps and barriers to PLWH public leadership would be identified and better understood. Second, promising strategies and models of PLWH public leadership would be discussed. Third, key strategies and innovative tactics would be highlighted to better involve PLWH in public leadership and serve the needs of PLWH, including those who receive RWHAP-funded services.

The technical expert panel panelists agreed on the following definition: “A leader is someone who leverages their power, agency and responsibility on behalf of himself/herself to champion the cause of X.” The panelists then brainstormed and responded to two questions: (1) What living or deceased person with HIV whose leadership you admire? (2) What is the quality of this individual’s leadership that you most admire?

The brainstorming exercise was transformative and demonstrated that leadership qualities were more important to the panelists than leadership qualifications. The panelists noted that a focus on qualities might identify leaders in non-traditional settings who are ready to serve in this capacity at this time. Mr. Milan and Ms. Dempsey reviewed the following list of qualities that the panelists found to be most important for PLWH leadership:

- A mentor and teacher
- A visionary, passionate and energetic person
- A person who “goes the extra mile”
- A person who is “thirsty for knowledge”
- An activist
- A strong person
- A convener who bridges divided issues
- An unapologetic person
- Dedication to a lifetime of service
- Commitment to social justice
- Willingness to “put in late nights”
- A person who makes unpopular statements and states “what must be said”
- An optimistic person
- Persistence in the fight to survive
- A hopeful person
- A “beautiful soul”
- A sense of humor
- A person who is encouraging
- A person who is open about their HIV status
- A master at their craft
- A tireless person
- A transformative thinker

- Willingness to “grind it out”
- Willingness to ask, “If not me, then who?” as the mantra for action
- Dedication to working with youth and marginalized populations
- A groundbreaking person
- Willingness to partner
- A bright and balanced person
- A role model
- Fearlessness in “speaking up”

The panelists were asked to address four key questions to inform the development of strategies to best enhance PLWH public leadership, which included:

- What promising approaches are available to promote PLWH public leadership?
- What are the existing barriers and gaps in the development of PLWH public leadership and what actions can be taken to close these gaps?
- What is the impact of public leadership of PLWH on their clinical outcomes, health status, and quality of services?
- How can HAB support the development of PLWH public leadership?

In addition to agreeing on a common definition of “leadership” and describing the major qualities of PLWH public leaders, the panelists also focused on three other issues. Mr. Milan summarized the following key themes from the discussions:

Gaps and Barriers

- PLWH have wide-ranging expertise through education and/or life experiences that often is not acknowledged, tapped, or leveraged.
- Ongoing obstacles of discrimination, stigmatization, bias, power, and privilege differentials are not given adequate attention in terms of social justice and human rights.
- Leadership of young PLWH under 30 years of age is hindered by limited opportunities in top positions and strong protocols for safe and productive memberships.
- Services for transgender people are still inadequate at this time.

Promising Strategies

- Mentoring and peer programs could be specifically developed for PLWH.
- New opportunities can be created for continuing education and training of PLWH, such as assistance to ensure that PLWH obtain general education, college, and/or advanced degrees.
- PLWH input can support the development of quality programs.
- Developing the leadership skills of PLWH, could improve opportunities for senior and mid-level management positions.
- PLWH experience and knowledge can be leveraged to help with prioritizing, conducting and publishing research. For example, 309,000 peer-reviewed articles on HIV have

been published over the past 35 years, but the number of PLWH who served as co-principal investigators or co-authors of these efforts has been minimal.

- Increasing and expanding public policy activities for PLWH.

Priorities for Consideration

- Expand the definition of “consumer” to include PLWH who might need RWHAP services, but have important experiences and expertise to contribute.
- Integrate peer training, “train-the-trainer” courses, and mentoring into existing programs and events.
- Hold in-person conferences with skill-building tracks. Support travel costs for attendees to these meetings due to lack of financial resources to attend on their own.
- Develop public-private partnerships to assist in financial longitudinal programming.
- Allocate funding to support evidence-based, successful programs.
- Improve recruitment strategies and leadership development to support and prioritize vulnerable populations: women of color, transgender people, youth, American Indian/Alaska Native populations, Asian/Pacific Islanders, and PLWH.
- Provide TA to engage RWHAP clients to serve as advisors to improve RWHAP services, develop FOAs, etc.
- Use ideas from the consultation to develop and distribute a public leadership survey to a larger cross-section of PLWH to gather additional feedback and validate the discussions from the meeting.
- Develop more partnerships to integrate HIV and transgender-related care services.

HAB’s next steps will be to apply the information from the technical expert panel to help inform its activities in two key areas. First, TA topic areas will be identified to support PLWH leadership development and potential partnerships among HAB, its federal partners, and stakeholders. Second, ideas will be shared on HAB’s future focus areas, including special studies, TA CoAgs, and SPNS initiatives.

In response to Mr. Milan’s request for feedback, other technical expert panel panelists provided their perspectives. Mr. Aleshire emphasized that the diversity of the participants was extremely beneficial. He noted that the broad range of PLWH by age, race, and gender would be particularly useful in developing recommendations to reflect the PLWH population. He hoped that HAB would host follow-up technical expert panels with other groups of PLWH to continue to gather additional input in the future.

Ms. Scruggs noted that the ideas developed during the 2016 technical expert panel were the same as or similar to those proposed to HRSA during a meeting that was held in 1994 where, she reported, stakeholders emphasized the need to engage and integrate PLWH into the HIV workforce, partnerships, family-centered care, all levels of programs/program development, and service delivery. Ms. Scruggs discussed the need for changes to occur at this time. She pointed out that mentorships, meaningful partnerships with the federal government, and other

opportunities have now placed PLWH in a much stronger position to serve in leadership roles than in the past.

Mr. Byrd reported that people who have lived with HIV since birth would benefit from being more extensively engaged in technical expert panels and other events in the future. He conveyed that their valuable experiences would help this PLWH subpopulation to serve as public leaders.

CHAC DISCUSSION: PEOPLE LIVING WITH HIV LEADERSHIP

CHAC commended HRSA and its partners for focusing on public leadership of PLWH. The members who have devoted their careers to HIV were particularly pleased that the federal government is taking leadership of this innovative and powerful approach. CHAC provided the following input in response to HAB's request for advice on the next steps in this initiative:

Question 1: Promotion of public leadership of PLWH

- Options should be provided to PLWH in terms of serving as “public” leaders. For example, PLWH can serve as public leaders without disclosing their status through traditional media or social media. PLWH can serve as public leaders by educating their Congressional representatives and local policymakers or by supporting and empowering other PLWH to disclose their status to reduce stigma.
- PLWH leadership should be fully integrated into quality of care. The representation of PLWH on quality management committees, quality teams, and quality improvement initiatives should be a standard of HIV care. Most notably, HRSA funds the National Quality Center (NQC) at the New York State Department of Health AIDS Institute. A portion of the grant is used to support NQC's rigorous [Training of Consumers on Quality \(TCQ\) Program](#). NQC proudly reported that the first group of TCQ graduates, including PLWH, has successfully taken leadership roles in local and regional quality activities throughout the country. Moreover, recipients that were recently awarded funds by the Washington State Department of Health (WSDOH) to provide services to PLWH will be required to select one to three consumers from their local communities to complete NQC's TQC Program.
- Internships and training programs should be offered to develop the skills of PLWH who are “natural” leaders in capacity building, peer counseling, and other aspects of HIV.

Question 2: Different strategies by the federal government

- HRSA should convene the PLWH Public Leadership technical expert panel as a permanent event on a regular basis. Historically marginalized and underserved subpopulations, such as PLWH with substance use problems and homeless PLWH, should be well represented at future meetings.
- CDC and HRSA should allocate funding to support baseline education that would allow local programs to successfully compete for federal HIV prevention and treatment FOAs.
- Federal agencies traditionally have engaged PLWH up to 30 years of age to serve on advisory bodies and provide a “youth” perspective on their activities. However, this age

range is far too old to represent input from actual youth. Federal agencies should invest resources in developing public leadership skills of teens living with HIV. To support this effort, federal agencies should consult with youth-serving organizations, such as Advocates for Youth, to identify and recruit HIV-positive teens to attend future technical expert panels, complete training courses, and serve as public leaders in their communities. Opportunities for teens living with HIV to describe their experiences, such as stigma and poor access to services, would allow federal agencies to design evidence-informed programming to meet the actual needs of youth.

Question 4: Priorities for action

- Young PLWH, particularly those from disenfranchised communities, should be promoted as public leaders to build their resilience and improve their overall health and well-being.
- The Denver principles that were developed in 1983 to empower PLWH should be reviewed to determine their relevance in the current environment.

PANEL PRESENTATION: ELIMINATING HCV

April Stubbs-Smith, MPH

Director

HRSA, HAB, Office of Training and Capacity Development, Division of Domestic HIV Programs

Ms. Stubbs-Smith facilitated the panel presentation and explained that this item was placed on the agenda to inform CHAC of multi-agency and local efforts to eliminate HCV. CHAC would be asked to provide guidance in the following areas at the conclusion of the panel presentation:

- The future direction of federal HCV expansion and elimination initiatives,
- Specific issues that should be considered in HCV elimination activities,
- Next steps in the planning process for the National Viral Hepatitis Action Plan (VHAP),
- Key policy considerations, and
- Strategies to incorporate additional capacity building into HCV elimination efforts.

Ms. Stubbs-Smith introduced the panel of speakers and opened the floor for their presentations.

Update on the 2017-2020 National Viral Hepatitis Action Plan

Corinna Dan, RN, MPH

Viral Hepatitis Policy Advisor

HHS, OASH, OHAIDP

Ms. Dan presented an update on the 2017-2020 VHAP. VHAP serves as a roadmap for the nation's response to viral hepatitis by promoting action, transparency, and accountability; establishing goals, priorities, and measurable targets; and specifying actions to be taken by both federal and non-federal partners. This multi-agency effort includes 23 federal partners that have updated the 2014-2016 VHAP through 2020. The 2017-2020 VHAP will be released in early 2017.

The status of viral hepatitis in the United States from the release of the first VHAP in 2011 to 2014 is summarized as follows:

- Goal 1 was to increase the proportion of people who are aware of their chronic hepatitis B virus (HBV) infection from 33-66 percent. The baseline rate of 33 percent in 2009 did not change in 2014.
- Goal 2 was to increase the proportion of people who are aware of their chronic HCV infection from 45-66 percent. The baseline rate of 45 percent in 2010 increased to 54 percent in 2014.
- Goal 3 was to reduce the number of new cases of HCV infection by 25 percent. The baseline estimate of 1,229 cases in 2011 increased to 2,195 cases in 2014. The increase in new HCV infections of over 200 percent is a major concern to the federal partners.
- Goal 4 was to eliminate mother-to-child transmission of HBV. The baseline estimate of 747 infants with perinatal HBV infection in 2009 increased to 952 cases in 2014. However, the increase was reported as "no change" due to the unstable baseline estimate. The baseline rate of 64.1 percent of infants with the HBV vaccine birth dose in 2010 increased to 72.4 percent in 2014.

Ms. Dan highlighted key changes in the 2017-2020 VHAP. An updated vision statement was drafted: "The United States will be a place where new viral hepatitis infections have been eliminated, where all people with chronic hepatitis B and C know their status, and everyone with chronic hepatitis B and C has access to high quality health care and curative treatments, free from stigma and discrimination."

National goals were established: (1) prevent new viral hepatitis infections; (2) reduce deaths and improve the health of people living with viral hepatitis; (3) reduce viral hepatitis health disparities; and (4) coordinate, monitor, and report on the implementation of viral hepatitis actions. However, the four national goals cannot realistically address elimination in 2020 due to the 200 percent increase in the number of new HCV infections from 2011-2014. The federal partners anticipate that HCV elimination goals can be considered for 2030.

Viral hepatitis indicators were clearly defined and are aligned with Healthy People 2020 and the CDC/DVH Strategic Plan 2020 goals: four indicators to measure progress in preventing new viral hepatitis infections; four indicators to measure progress in reducing deaths and improving

the lives of people with chronic hepatitis; and nine indicators to measure progress in reducing viral hepatitis health disparities.

The federal partners are aware of critical gaps in the national viral hepatitis response that increase the difficulty in reaching elimination. Viral hepatitis infections are increasing rather than advancing toward elimination due to the national opioid epidemic. Existing resources do not support active surveillance in all states. Prevention messages and programs do not have sufficient reach. Screening recommendations are not being fully implemented. People with viral hepatitis have reported their inability to access timely treatment to prevent disease progression and onward transmission.

Ms. Dan concluded her presentation with slides of viral hepatitis materials CDC has created for education and awareness campaigns that are available for dissemination.

CMS's Role in the National Viral Hepatitis Response

LT Emeka Egwim, PharmD
Senior Assistant Pharmacist
CMS, Division of Pharmacy

Dr. Egwim described CMS's role in the national viral hepatitis response. The CMS Division of Pharmacy oversees the Medicaid Drug Rebate Program (MDRP) in all 50 states, the District of Columbia, U.S. territories and over 600 drug manufacturers. Manufacturers have established a *quid pro quo* relationship with state Medicaid programs by offering discounted rates for prescription medications. In return, state Medicaid programs will offer these prescriptions to their patients.

The legal agreement with the HHS Secretary stipulates that all medications by manufacturers enrolled in the MDRP must be covered. However, exceptions to the law include a few medications that do not require coverage, such as those used for promotion, fertility, and erectile dysfunction. The law also permits utilization management techniques that allow states to safeguard against fraud, waste, and abuse of drugs. These techniques include prior authorization of formularies, preferred drug lists, and clinical criteria. The law clearly states that none of the utilization management techniques should result in the denial of clinically appropriate or medically necessary treatment and care for Medicaid beneficiaries.

Dr. Egwim reported that sofosbuvir was available on the market in 2013 at a list price of approximately \$1,000 per pill. The controversial price of the drug received a great deal of media coverage. State Medicaid programs informed CMS that the extremely high cost of sofosbuvir would far exceed their budgets. However, CMS found that numerous payers implemented

programs with limited access to HCV medications. CMS further determined that many of the programmatic restrictions were unreasonable and resulted in denials of necessary care for patients with HCV.

Sofosbuvir requires interferon, but multiple patients with HCV are unable to complete an interferon-based regimen due to its profile of severe adverse side effects. Data show that only 30-40 percent of patients who complete an interferon-based HCV regimen are cured based on a sustained virologic response (SVR). Because patients with HCV were not adequately treated with older regimens, new medications were developed without interferon.

CMS took several actions to prepare state Medicaid programs to modify their budgets to accommodate a new category of beneficiaries. Strong partnerships were established with state Medicaid programs. Extensive input was obtained from advocates and stakeholders throughout the country, including the National Alliance of State and Territorial AIDS Directors (NASTAD), AIDS Institute, and National Viral Hepatitis Roundtable. A great deal of feedback was gathered from providers, patients, and drug manufacturers.

CMS compiled this input to inform the development and publication of a guidance document to states on November 5, 2015. CMS also issued a letter to four of the five major drug manufacturers that produce directly-acting antiviral HCV medications. The CMS letter restated and emphasized the existing law, policies, and requirements for the coverage of HCV medications, including prior authorization of formularies and permissible restrictions. States were informed of their discretion to establish limitations on the coverage of drugs, but were reminded that the requirements must be consistent with the law and should not result in the denial of necessary care.

States were encouraged to exercise sound clinical judgment and conduct comparative analyses in terms of treatment costs of new HCV regimens on the market. References and links were provided on available resources, such as pharmacy and therapeutic committees, Drug Utilization Review Boards, and current treatment guidelines on the management of HCV. States were notified that the amount, duration, and scope of care covered by Medicaid managed care organizations (MCOs) should not be less than billable, fee-for-service care. Approved medications that are billable for fee-for-service care also should be billable under managed care.

CMS noticed a significant change after the release of its guidance document to states and its letter to drug manufacturers in November 2015. Several states that previously had limited access to pharmaceutical treatment for HCV lifted their restrictions. This change primarily was driven by litigation filed against Washington State that resulted in a ruling in favor of the provider and patient. As a result, Delaware, Florida, Massachusetts, and Washington lifted all of their restrictions, particularly those related to the effect of liver damage as measured by fibrosis scores. Multiple states previously required patients to have advanced fibrosis with a score of F3

or F4 to receive HCV treatment, but these four states have lowered this restriction to a score of F2. The states made this change with the expectation that manufacturers would reduce their HCV drug prices.

The list price of HCV drugs remains high, but the actual cost to states is much lower due to federal rebates of at least 23 percent and additional supplemental rebates that states can acquire through negotiations with manufacturers. Supplemental rebates are not publicly disclosed and can greatly vary across states. However, CMS has learned through its ongoing dialogue with states and manufacturers that the cost of HCV medications over the course of a full 8- to 12-week regimen could range from \$20,000-\$25,000 or less. Although the current cost of an HCV treatment regimen is significantly less than the previous cost of \$80,000-\$90,000, several states are still concerned about the price.

The aforementioned states expressed concerns about a potential surge of patients with HCV. However, other systematic barriers to access to care were observed that are beyond the control of state payers. CMS is closely collaborating with states to address these issues, particularly those related to HCV screening and testing. CMS also is partnering with manufacturers to develop new payment models to reduce the cost of HCV drugs and increase access to care.

Overview of the San Francisco HCV Elimination Initiative

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Ms. Burk and Dr. Luetkemeyer presented an overview of the San Francisco HCV Elimination Initiative (End Hep C SF). San Francisco has the highest rate of liver cancer in the United States and currently is collecting data to estimate its prevalence of HCV. The San Francisco registry currently includes over 16,000 unduplicated HCV cases since data collection was initiated in 2009. Of 22,500 PWID who are estimated to be active injectors in San Francisco, approximately 60 percent have HCV. San Francisco reported 16,000 PLWH persons as of year-end 2015. The HCV prevalence in the HIV population historically has been approximately 25 percent.

San Francisco identified several factors to increase the possibility of reaching HCV elimination. The compact size of the city of only seven by seven miles enables easy access to clinics to

support testing and linkage efforts. A strong HIV program infrastructure was established, such as the [“Getting to Zero” initiative](#). An infrastructure of effective drug user health services was launched, including opiate replacement therapy and syringe access services.

Medical providers are committed and willing to treat and manage HCV patients in primary care clinics and outside of clinical settings. The Medi-Cal HCV policy in California allows treatment to be provided to the vast majority of Medi-Cal beneficiaries. San Francisco has a history of bold and innovative prevention programs and is a leader on research in PWID. San Francisco oversees a CDC-funded hepatitis surveillance program.

San Francisco plans to advance toward HCV elimination with appropriate scale-up, alignment with other activities, and sound coordination of End Hep C SF. The guiding principles of the initiative are to identify undiagnosed HCV, prevent infection and re-infection, and ensure access to treatment and service delivery. Several components and tools are incorporated into the initiative to support an HCV continuum of care and include the following:

- Access to HCV medications
- HCV rapid testing
- Opiate replacement therapy
- Syringe access
- Re-infection prevention counseling
- Safer injection counseling
- Outreach and education
- Access to specialty care
- Linkage to HCV care
- Methadone-based directly observed therapy (DOT)
- Primary care-based treatment

San Francisco designed End Hep C SF with a steering committee and four workgroups. The research and surveillance workgroup is focusing on a triangulation process for HCV data, modeling to estimate and reduce the prevalence of HCV, and the development of treatment goals. The prevention and education workgroup is focusing on an anti-HCV stigma campaign and provider/patient education. The treatment access workgroup is focusing on the expansion of primary care-based treatment and innovative treatment models for hard-to-reach populations with HCV. This workgroup is also focusing on a data-driven, community-based testing assessment for HCV and the expansion of established linkage programs.

San Francisco developed recommendations in four key areas to support and inform national HCV elimination efforts. The first category of recommendations address improved HCV data. Rigorous and accurate HIV data have been critical to successful treatment and prevention initiatives. Based in the HIV model, improved epidemiology and surveillance data also will be important components to guide and evaluate HCV interventions. Investments should be made

in federal, state, and local surveillance systems to track progress in the HCV epidemic and ongoing elimination efforts.

The second category of recommendations address HCV testing and linkage. Primary care-based HCV testing is crucial, but overlooks several populations that are highly impacted by HCV. Support should be provided to screening and linkage programs outside of traditional primary care settings, including the following:

- Syringe access programs
- Homeless shelters and drop-in programs
- County jails
- Single-room occupancy hotels
- Public housing projects
- Methadone programs
- Residential drug treatment programs
- Food pantries and free meal programs
- Mobile testing and treatment

The third category of recommendations address access to HCV treatment. Barriers to accessing HCV medications should be reduced by decreasing the administrative burden on prescribers, particularly prior authorizations, and aligning insurance coverage with evidence-based guidelines published by the American Association for the Study of Liver Diseases/IDSA. Most notably, recent data show that multiple states still use fibrosis- or sobriety-based requirements to restrict access to HCV treatment for Medicare patients. However, this practice is illegal and not based on science.

Primary care-based treatment and the pool of HCV providers should be expanded. Innovative models should be designed to treat hard-to-reach populations with HCV. San Francisco has proposed a number of creative models that should be considered for national scale-up.

Hard-to-Reach Population	Site of HCV Treatment
People who are active substance users	Syringe exchange programs
People newly in recovery	Residential drug treatment programs
Methadone and Buprenorphine clients	Opiate substitution treatment sites
People who are Homeless	Shelter-based care and drop-in centers
Incarcerated populations	Jail- and prison-based treatment settings
PLWH	Incorporation into primary HIV-based care (due to complex interactions between HIV and HCV drugs)
People who are poorly engaged in care	Navigators to ensure linkage to appropriate patient-centered care

The fourth category of recommendations address prevention of HCV re-infection. Robust studies recently were published that demonstrate the need to target interventions to two key populations. The 2015 Volk study reported the incidence of sexually acquired HCV in PrEP programs among both HIV-positive and HIV-negative MSM. The 2016 Inglitz study reported increases of up to 25 percent in the HCV re-infection rate over the past 12 years among HIV-positive MSM in Europe who successfully completed therapy.

HCV re-infection rates in the United States are not as high as those in Europe, but better surveillance, improved data reporting, and thoughtful messaging for HIV-positive MSM are needed domestically. Most notably, many HIV concordant partners are electing not to use condoms due to their suppressed HIV viral loads and wider availability of PrEP. As a result, messages should be carefully crafted to effectively reduce HCV re-infection rates among HIV-positive MSM.

The 2016 Dore study showed that active IDUs can be successfully treated with high SVRs. An SVR rate of over 95 percent was observed in the study population, but other outcomes were distressing. Of eight re-infections reported in the study, five occurred within the first 12 weeks of treatment. Of all IDU clients in the study who had achieved an SVR and had not been re-infected, 20 percent were still not using clean needles and 40 percent used drug equipment that had previously been used.

Strong support should be provided for HCV prevention efforts. Media and education campaigns about HCV re-infection should be targeted to providers and tailored for specific patient populations, such as HIV-positive MSM and active IDUs. Investments should be made to support and sustain opiate substitution treatment, syringe access programs, and effective prevention strategies for MSM.

Overview of the New Mexico HCV Elimination Collaborative

Kimberly Page, PhD, MPH

Professor and Chief of Epidemiology, Biostatistics, and Preventive Medicine
University of New Mexico Health Sciences Center

Dr. Page presented an overview of the New Mexico HCV Elimination Collaborative. New Mexico formed the Collaborative to address its extremely high burden of HCV. Of the entire state population of 2 million, 45,000 people are estimated to be living with HCV. Recent data from the National Health and Nutrition Examination Survey show that New Mexico has the highest HCV rate in the nation.

The overarching objective of the Collaborative is to develop and implement a statewide strategy and action plan to eliminate HCV in 20 years in partnership with state and national leadership

and key stakeholders. The multidisciplinary Collaborative represents the fields of academic medicine, social and public health research, and public policy. The members include CDC, IHS, the New Mexico Department of Health (NMDOH), University of New Mexico (UNM), New Mexico Corrections Department (NMCD), New Mexico Medicaid Program, and New Mexico Secretary of Health.

The Collaborative is structured with a “collective impact” framework that is based on a common agenda, communication strategy, progress measures toward shared outcomes, and mutually reinforcing activities. Project ECHO (Extension for Community Healthcare Outcomes) serves as the model infrastructure for the time frame of the Collaborative’s management and leadership. Short-term goals will be completed in five years and long-term goals will be completed in 20 years. The Collaborative expects to finalize its strategic plan in early 2017.

The Collaborative includes a Steering Committee and four workgroups: Strategic Information, Ending Hepatitis C Transmission, Chronic Infection, and Public Information. All four workgroups have created planning sheets to identify and track their individual goals, needs, timelines, barriers, feasibility, interventions, and current status. The workgroups will tailor activities for specific populations, but efforts to address social and racial/ethnic disparities that can impact the HCV elimination objectives will be a common theme across the Collaborative. The target populations include the following:

- PWID
- People who are homeless/marginally housed
- People who are Incarcerated
- American Indians
- “Baby boomers” (i.e., people in the 1945-1965 birth cohort that account for 75 percent of HCV cases)
- People who receive medication-assisted treatment (MAT)
- Families
- Youth/pediatric populations
- PLWH

The Collaborative identified several local data sources to inform its decision-making on strategic approaches. HCV surveillance data will be collected from NMDOH, but these data lack support, rigor, and a systematic approach. Data on key risk groups will be collected by the UNM Viral Hepatitis Research Team. Medical record data on the HCV burden, testing, genotypes, and fibrosis will be collected from UNM, clinics and providers, laboratories, the state pediatric registry, and state Medicaid program.

The Collaborative is creating its infrastructure by leveraging expertise and resources from existing programs and initiatives. Project ECHO will serve as the model program to build capacity in providing HCV treatment and launch a communications network. RWHAP clinics

and ADAPs will be used as the infrastructure for HCV/HIV co-infected patients. Community Health Centers (CHCs) will be used to establish research partnerships. NMDOH's CDC-funded programs for viral hepatitis will be utilized, but these initiatives lack resources for testing. Substance use treatment facilities will be engaged as new collaborative partners. Correctional facilities will be involved due to their active peer education and HCV treatment programs.

Research efforts will include studies funded by CDC and the Patient-Centered Outcomes Research Institute as well as data collected by the UNM Viral Hepatitis Research Team. The research will focus on key population estimates, disease and intervention modeling, prevention and treatment research, clinical trials, and implementation science.

The Collaborative is aligned with other activities in New Mexico to support increased HCV treatment. The overarching goal of Project ECHO is to increase provider capacity to treat all PLWH in New Mexico. The state Medicaid program established the following goal: "By 2020, reduce morbidity and mortality by providing evidence-based treatment for all identifiable members with chronic hepatitis C infection, while being responsible fiscal stewards."

The collection of data on the size of the HCV population in New Mexico helped to inform the development of new statewide Medicaid guidelines. Changes to the treatment criteria in July 2016 now cover all HCV patients regardless of their fibrosis score or substance use history. The Collaborative will consider other modifications in New Mexico as well, such as a revised checklist, education to provider networks, an expanded role of care coordination, new data collection and staging requirements, expanded screening, and finances. The Collaborative will extensively engage other health support services, such as primary care, case management, and MAT services.

The Collaborative reviewed Medicaid data that showed a 4.7-fold increase in approvals for HCV treatment among all MCOs in New Mexico. The dramatic increase is based on the difference between 475 HCV patients who were approved for treatment from January 2014-October 2015 versus 814 HCV patients who were approved for treatment from November 2016-June 2016. The tremendous increase in approvals for HCV care and treatment for Medicaid beneficiaries has particularly benefited the 1945-1965 birth cohort in New Mexico. The Collaborative's next steps will be increase approvals for HCV treatment for non-Medicaid beneficiaries.

The Collaborative will target interventions to four key areas. The first set of interventions will focus on collecting strategic information. New research will be conducted to characterize the burden of HCV infection, morbidity and mortality. Predictive modeling will be performed as well. Social science researchers will be recruited to identify social disparities that impact knowledge, behaviors, and access to HCV testing, treatment, and care.

Surveillance will be enhanced for people under 30 years of age to identify best practices for access to HCV screening, testing, and treatment in this population. Similar to other states throughout the country, New Mexico also has observed a marked increase in HCV among

young IDUs. Enhanced surveillance efforts are expected to capture approximately 40 percent of young IDUs who present to emergency departments (EDs) and over 50 percent of young IDUs who present to syringe/needle exchange programs. Enhanced surveillance also will be targeted to prenatal clinics and other settings where young people seek healthcare services.

The second set of interventions will focus on ending HCV transmission. Treatment will be expanded to all target populations. NMCD will expand its peer education program to identify strategies to enhance prison-to-community transitions that promote the continuity of health care. At this time, correctional facilities in New Mexico only approve HCV treatment for incarcerated people with extremely high fibrosis levels.

Research will be conducted to assess evidence-based strategies to prevent and treat HCV, particularly in PWID and other high-risk populations. Approaches will be identified to expand and enhance MAT within community, correctional, and other settings. Strong emphasis will be placed on prevention due to ample and robust evidence that shows MAT, including methadone and Buprenorphine, has the ability to reduce the incidence of HCV by over 50 percent.

The third set of interventions will focus on decreasing chronic HCV infections. Project ECHO will be used as a model to increase provider training and capacity in the management and treatment of HCV patients. Information will be gathered on access to HCV programs, research, and insurance coverage to facilitate increased access to and reduce delays for treatment in all populations. Case management, patient navigation, and DOT will be implemented as key strategies to increase patient adherence and reduce co-morbidities.

The fourth set of interventions will focus on disseminating information to the public. Didactics will be offered through Project ECHO and provider training sessions. An HCV public information campaign will be launched to provide client education and raise awareness. Existing collaborations with professional associations will be enhanced (e.g., the New Mexico HIV and HCV Summit and the Southwest Tribal Summit) to increase public knowledge of HCV.

The Collaborative has achieved several notable milestones to date. The Steering Committee and workgroups are convening monthly meetings. The workgroups drafted their individual planning sheets. Strategic information was collected to estimate the size of the HCV population for the entire state of New Mexico and several subpopulations. A report on HCV in people under 30 years of age in New Mexico was drafted and is expected to be published in the *MMWR*.

HCV training for both established and new providers is underway in correctional settings and rural areas of the state. NMCD expanded its peer education program and will soon disseminate findings on HCV among incarcerated people in New Mexico. Policy changes by the state Medicaid program have resulted in a 4.7-fold increase in approvals for HCV treatment for Medicaid beneficiaries. Research was initiated in the areas of HCV epidemiology, prevention,

and treatment in high-risk groups. Planning efforts are underway to conduct new studies in additional focus areas.

An editorial was published in a local newspaper regarding access to HCV treatment for PWID and incarcerated people. The New Mexico Collaborative is well represented on the National HCV Elimination Collaborative. This group provides a platform for agencies, organizations, and advocates across the country to convene monthly meetings to share best practices, discuss ongoing planning efforts, and review progress to date in achieving the national goal of HCV elimination.

Overview of NASTAD's Technical Assistance for HIV/HCV Co-Infection

Britten Pund

Director

NASTAD, Health Care Access

Ms. Pund presented an overview of NASTAD's TA services to address HIV/HCV co-infection. NASTAD is a national non-profit organization that was founded in 1992 to represent public health officials with responsibility for administering HIV and hepatitis programs funded by state and federal governments. NASTAD's membership covers all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the U.S. Pacific Islands, Africa, the Central American region, and the Caribbean region. NASTAD's primary activities are to interpret and influence policies, conduct training, offer TA, and provide advocacy mobilization for U.S. health departments and Ministries of Health globally.

NASTAD's mission is to end the intersecting epidemics of HIV, viral hepatitis, and related conditions by strengthening domestic and global governmental public health through advocacy, capacity building, and social justice. NASTAD's vision is "a world free of HIV and hepatitis." NASTAD currently is encouraging states to respond to a two-part challenge that recently was issued by its new chair:

- Make HIV and hepatitis epidemiologically rare diseases.
- Ensure that care for PLWH who are co-infected with hepatitis, including those who are tethered to stigma and discrimination, will be seamless with no barriers.

NASTAD's organizational structure is similar to a state health department and includes programs focusing on HIV and hepatitis prevention, care, and treatment for both mono-infected and co-infected clients, health equity, policy, and legislative affairs. NASTAD provides three types of TA services to states. Informal TA services include listservs, workgroups, requests for information through surveys and other mechanisms, presentations, advocacy efforts, policy

statements, blogs, and a website. Formal TA services include webinars, teleconferences, in-person meetings, and topic-specific workshops. Intensive TA services include SWOT (strengths, weaknesses, opportunities and threats) analyses, peer-to-peer TA, and mentorship.

NASTAD takes several actions to support its policy and advocacy efforts. NASTAD ensures that legislative and policy priorities related to HIV and hepatitis prevention, care, and treatment issues are incorporated into federal appropriations and legislation. For example, NASTAD disseminates up-to-date information on HIV/HCV drug pricing and analyzes the impact of cost on prevention and treatment modalities. Advocates throughout the United States assist NASTAD in this capacity by articulating the important role of health departments to the Administration and Congress.

NASTAD co-chairs the Federal AIDS Policy Partnership, Ryan White Workgroup, HIV Prevention Advocacy Coalition, HIV Health Care Access Workgroup, and AIDS Budget and Appropriations Coalition. NASTAD is a member of a hepatitis appropriations partnership that represents a coalition of pharmaceutical companies and CBOs with a strong commitment to increasing federal funding for viral hepatitis. NASTAD also serves on an ADAP coalition of pharmaceutical companies and CBOs that is dedicated to increasing federal funding for ADAPs. NASTAD is a member of the Coalition for Health Funding, Prevention Justice Project, Sexuality Education Coalition, Family Planning, CDC Coalition, and Friends of HRSA.

NASTAD previously focused on HIV only, but its hepatitis program was launched in 2000 in response to TA requests by the membership to address HCV. The program has grown over time to address both HIV and HCV mono-infections as well as HIV/HCV co-infection. NASTAD provides TA and capacity building assistance to Viral Hepatitis Prevention Coordinators (VHPCs) through program management, policy development, planning, and evaluation. NASTAD facilitates peer-to-peer mentoring to VHPCs through various modalities, including workgroup meetings, teleconferences, webinars, on-site TA, in-person meetings, and training.

NASTAD assists states in their efforts to implement VHAP, health reform, and U.S. Preventive Services Task Force (USPSTF) recommendations on HBV/HCV testing. Most of NASTAD's TA services and support are targeted to CDC-funded health departments and HIV/hepatitis programs. NASTAD implements a drug user health framework to conduct its hepatitis prevention and care activities because IDUs account for the majority of new HCV infections and experience the most significant challenges in terms of accessing HCV treatment.

NASTAD recently was awarded a new three-year HRSA CoAg, "Curing HIV/HCV Among People of Color." NASTAD will design the SMAIF-funded demonstration project to ensure that RWHAP Part B recipients develop capacity to scale up effective jurisdiction-wide HCV screening, care, and treatment programs with a focus on curing HCV among HIV/HCV co-infected people of color. NASTAD will serve as the coordinating center for two state health departments that will be selected for the demonstration project.

Selection criteria will include states in the South and Southwest; states with a high incidence of HCV among HIV/HCV co-infected people of color in their jurisdictions based on the submission of local data; states with insufficient funding and inadequate access to HCV screening, care and treatment services; and states with a large population of people of color and health equity issues. The demonstration project with RWHAP Part B recipients will be parallel to the jurisdictional approach that is being developed by RWHAP Part A recipients in Hartford, Connecticut; Philadelphia, Pennsylvania; and New York, New York.

CHAC DISCUSSION: ELIMINATING HCV PANEL PRESENTATION

CHAC thanked the guest speakers for attending the meeting to describe their exciting and innovative projects to help the nation advance toward HCV elimination. CHAC and the panel of presenters engaged in an extensive discussion and made several suggestions to make further progress in this area.

- The federal agencies and their partners should extensively engage community leaders, clinicians, advocates, and other stakeholders in a national effort to lift provider-based restrictions that are not logical, rational, or evidence-based. State payment systems that continue to enforce provider-based restrictions are taking this action solely to restrict access to HCV treatment and care from a cost perspective. For example, primary care physicians/providers (PCPs) in Indiana are not permitted to treat HCV patients, but several rural counties in the state do not have ID specialists or gastroenterologists. Local MCOs in California previously had a similar restriction for Medi-Cal beneficiaries, but the ban was eliminated when the MCOs were confronted with rigorous data and strong advocacy. Robust data show that providers without these specialties have the ability to effectively treat HCV patients. Most notably, older interferon-based HCV treatment regimens were associated with profiles of severe adverse events (e.g., suicide and elevated liver enzymes), but the newer regimens without interferon do not require the same level of care or provider expertise. Moreover, Project ECHO serves as an excellent model in which PCPs are successfully providing HCV and/or HIV treatment to expand access to care. Several states have partnered with their Medicaid programs to overcome provider-based restrictions by developing creative strategies to redefine a “specialist” or “trained provider.” For example, New York State providers who complete a specific type of training and treat “X” number of patients are qualified to write prescriptions for HCV medications.
- The federal agencies and their partners should compile key points from the HCV panel presentation and widely disseminate the information for use at the grassroots level. Communities should package and present the materials to the new Administration and Congressional staff to advocate for additional prevention and treatment resources to achieve HCV elimination. To support this effort, communities should demonstrate a clear linkage between the national opioid epidemic and the dramatic increase in HCV cases. Communities also should engage the medical, public health, social work, and

nursing sectors in their grassroots HCV elimination efforts to accomplish one of the most notable public health successes in U.S. history. The HCV-positive population in the United States is estimated to be three times larger than the HIV-positive population at this time.

- Providers typically do not view ADAPs as a source for HCV treatment. As a result, ADAPs should take specific actions to expand HCV treatment to more HIV/HCV co-infected clients. For example, ADAPs in some states have engaged and educated providers by sending letters to describe their HCV services for this population. ADAPs in other states have launched direct communication and marketing efforts to inform providers of their addition of HCV drugs to the formulary and their successful treatment of HIV/HCV co-infected clients.
- Caution should be taken in solely investing resources to build an infrastructure to treat HIV/HCV co-infection because most people with HCV are HIV-negative. IDUs, particularly those at younger ages, have low HIV rates, but account for a significant proportion of the HCV epidemic. Strategies should be developed to reach the HCV-positive population with funding that is independent of HIV resources. Multiple programs throughout the United States are constrained by responding to their HCV mono-infected clients because HIV still accounts for the greatest share of ID resources. Moreover, discrimination and stigma associated with HCV primarily are due to the inaccurate presumption that all people with HCV are also PLWH.
- The New Mexico HCV Elimination Collaborative should engage commercial insurers as additional members.
- The personal stories of HCV patients and experiences of HCV providers should be compiled and broadly publicized. The key message in this effort should be to remind the public that unlike other chronic diseases, HCV is curable.
- The ongoing HCV elimination efforts should include new interventions that specifically target the management and treatment of undocumented immigrants with HCV.

CDC New Surveillance Report – Changes in Analyzing the HIV Care Continuum

Eugene McCray, MD

Director

CDC, NCHHSTP, DHAP

Irene Hall, PhD, FACE

Deputy Director for Surveillance

CDC, NCHHSTP, DHAP, Epidemiology and Laboratory Science

Advice Requested from CHAC by DHAP:

1. What are CHAC's recommendations on funding based on residence at diagnosis versus the most recent known address and impact assessment of the HRSA algorithm?

Drs. McCray and Hall presented an overview of CDC's revised HIV surveillance reports that reflect changes in data presentations and the HIV care continuum. The changes are intended to ensure that CDC's HIV surveillance reports are consistent with the NHAS 2020 indicators and reflect improvements in the quality of surveillance data, such as current capacity to report unadjusted data and HIV care continuum data.

Adjustments made on national HIV case surveillance data include reporting delays, missing risk factor information, unduplicated data, and age-adjusted death rates. Previous surveillance reports included a table with both raw and adjusted data to illustrate HIV diagnoses by year and selected characteristics, such as transmission category. However, CDC stopped adjusting for reporting delays in November 2016 because data are now reported in a timelier fashion. Data for the most recent years might be affected by both underreporting of cases and duplicate reports. Adjustments for reporting delays, but not for duplicate reporting might result in a bias or an overestimate of the number of HIV cases for the most recent year.

Several changes will be reflected in CDC's HIV surveillance reports, beginning with the 2015 report. Preliminary data for the most recent year will be reported; these data were reported to CDC through June of the following year (or a total of six months reporting delay). Assessments of trends in HIV diagnoses will be based on data with at least a 12-month reporting delay. For example, HIV diagnoses trends from 2010-2014 will be based on data reported by the end of 2015 or later. Deaths and prevalence will be based on data with at least an 18-month reporting delay because death ascertainment require 12-18 months to complete. Data will be adjusted for missing risk factors.

Data will be presented in various formats. Data on case counts will include annual HIV diagnoses, people living with diagnosed HIV, deaths, and the estimated total number of PLWH. Data on care outcomes will include linkage to care among people diagnosed with HIV in a particular year as well as retention in care and HIV viral suppression among people living with diagnosed HIV.

With the exception of HIV diagnoses and linkage to care, "residence at diagnosis" will no longer be used to assign HIV cases to specific jurisdictions. "Most recent known address" will be used for the number of people living with diagnosed HIV, retention in care and HIV viral suppression, and estimated total number of PLWH. "Residence at death" will be used for deaths.

Dr. Hall presented a series of tables to illustrate changes to the HIV surveillance data by jurisdiction, such as residence at diagnosis for linkage to care indicators; most recent known address for care and HIV viral suppression indicators; residence at death for deaths; and most recent known address for the prevalence of diagnosed and undiagnosed HIV. She also

announced that CDC published a supplemental HIV Surveillance Report, *Monitoring HIV Prevention and Care Objectives by Using HIV Surveillance Data: United States and 6 Dependent Areas, 2014*.

The prevalence-based HIV care continuum will be reported at some point in the future using all diagnosed and undiagnosed PLWH as the denominator. CDC has not yet released these data because the best methodology to determine the denominator still needs to be identified. The diagnosis-based HIV care continuum will be reported using all diagnosed PLWH as the denominator. These data are well aligned with the NHAS 2020 indicators.

CDC is aware of several limitations in HIV surveillance data for certain jurisdictions. The estimated total number of PLWH is not reliable for all jurisdictions, particularly those with small case counts. To overcome this barrier, CDC advised jurisdictions to collect HIV care continuum data based on the number of diagnosed PLWH. At this time, six states do not have laws that require laboratories to report CD4 and viral load test results to CDC.

Historic Medical Monitoring Project (MMP) data have underestimated care, ART prescriptions and HIV viral suppression of diagnosed PLWH. Because MMP now samples directly from HIV case surveillance data, CDC expects to develop an indicator for ART prescriptions in the future. In the interim, jurisdictions can use historic MMP data for the ART prescription indicator among people in care. Jurisdictions also can compare their current MMP data and National HIV Surveillance System data to estimate the percentage of ART prescriptions.

CDC's funding algorithms historically have been based on diagnosed PLWH at the residence of diagnosis. However, these data were not adjusted for varying reporting delays among federal agencies. CDC currently is assessing its funding algorithms to determine the potential impact of using the most recent known address. CDC's position is that this data element includes more accurate case counts, but is subject to data reporting issues. For example, the 33 jurisdictions that reported complete laboratory data to CDC in 2014 accounted for 70 percent of diagnosed PLWH. States typically clean and improve their data as a part of their data-to-care follow-up activities. CDC established a standard for jurisdictions to submit HIV death data within 12 months of the death year to complete the death ascertainment.

CDC conducted a preliminary analysis of using the most recent known address for its funding algorithms. The analysis showed that HIV case counts might increase or decrease. Moreover, jurisdictions that made tremendous efforts to clean their data both gained and lost HIV cases. CDC's next steps will be to ensure that all jurisdictions submit their HIV death data within 12 months of the death year to meet the death ascertainment standard. Laboratory reporting and un-duplication activities will be improved. Support will be provided to states to enhance their data-to-care activities.

**CHAC DISCUSSION: CDC NEW SURVEILLANCE REPORT —
CHANGES IN ANALYZING THE HIV CARE CONTINUUM**

- CHAC commended CDC on its ongoing efforts to produce new prevalence-based HIV care continuum data. This dataset will be extremely beneficial for state and local programs that provide services to PLWH.
- CHAC emphasized the critical need for CDC and HRSA to produce HIV care continuum data to compare differences in care outcomes, particularly HIV viral suppression, between RWHAP and non-RWHAP clients. ELR should be expanded to all jurisdictions to achieve this goal.
- CDC should identify resources that will need to be invested to expand complete ELR capacity beyond the 33 current jurisdictions. A robust response to the HIV epidemic will require a highly functioning surveillance system, particularly to determine PLWH who are HIV virally suppressed.

CDC and HRSA leadership made several comments in follow up to CHAC's discussion. Dr. Cheever announced that HAB has no plans at this time to make any changes to the RWHAP datasets or funding algorithms in response to CDC's revised HIV surveillance reports. However, HAB will continue its ongoing discussions with DHAP to determine whether any changes are warranted in the future.

Dr. Cheever appreciated and understood CHAC's strong suggestion for CDC and HRSA to produce HIV care continuum data to compare differences in care outcomes between RWHAP and non-RWHAP clients. CDC and HRSA jointly published two papers in 2014 with MMP and RWHAP data to determine these differences. However, she reminded CHAC that CDC produces national HIV data, while HRSA generates RWHAP client-level data at the program level.

Dr. McCray confirmed that CDC currently is making efforts to expand laboratory reporting to 100 percent of jurisdictions. CDC is closely collaborating with health officers in the six states that do not have laws at this time for laboratories to report CD4 and viral load test results. CDC's ongoing TA, targeted activities, and other support might have an impact on these states in the future.

PANEL PRESENTATION: CMS, CDC, HRSA HIV HEALTH IMPROVEMENT AFFINITY GROUP

Heather Hauck, MSW, LICSW
Deputy Associate Administrator
HRSA, HAB

Advice Requested from CHAC by the HHIAG:

1. What are CHAC's recommendations to the HHIAG regarding its initiatives and future directions?

Ms. Hauck facilitated the panel presentation. She conveyed that the HHIAG serves as model of collaboration across the federal government. She introduced the panel of speakers and opened the floor for their presentations.

Deirdra Stockmann, PhD

Health Insurance Specialist

CMS, Center for Medicaid and CHIP Services, Division of Quality and Health Outcomes

Dr. Stockmann reported that the purpose of the HHIAG is to support state efforts to improve care for and HIV viral suppression among PLWH through TA and state-to-state peer exchange. The HHIAG is specifically identified in the NHAS 2020 Federal Action Plan as a model to encourage new or additional collaboration among HIV/AIDS programs, state Medicaid agencies, and their partners. CMS is proud to be a member of the HHAIG and partner with HHS, CDC, and HRSA in this new initiative. CMS hopes that the strong partnership among the HHS agencies at the federal level will encourage a similar level of collaboration at state and local levels.

Ms. Hauck described HHS's role on the HHIAG on behalf of Dr. Richard Wolitski, Director of OHAIDP, who was unable to attend the meeting. The four NHAS 2020 goals are to (1) reduce new HIV infections; (2) improve access to care and health outcomes; (3) reduce HIV-related health disparities; and (4) achieve a more coordinated national response. The NHAS Federal Action Plan describes the HHIAG as a specific activity and partnership among CDC, CMS and HRSA to make further progress on NHAS 2020 indicator six, "increase the percentage of people with diagnosed HIV infection who are HIV virally suppressed to at least 80 percent."

HIV viral suppression is essential for increasing survival, reducing deaths and disparities, and preventing new infections. Data from HIV Prevention Trials Network 052 showed that HIV viral suppression accounted for a 93 percent reduction in HIV transmission after four years. Moreover, no known cases of HIV sexual transmission have occurred from HIV virally suppressed people. Estimates show that 160,000 new HIV infections will be prevented by 2020 if NHAS 2020 indicator six is reached. The HHIAG partners already have achieved several programmatic successes to increase the possibility of reaching this goal: CMS's ongoing efforts to strengthen collaboration between Medicaid/Medicare and other payer sources; HRSA's strong RWHAP infrastructure; and CDC's improved HIV surveillance, data integration, and prevention activities.

The NHAS 2020, 2016 Progress Report showed that the proportion of diagnosed PLWH who are HIV virally suppressed increased from 46 percent in 2010 to 54.7 percent in 2013. Significant disparities will need to be addressed in key populations, including Southern states,

adolescents/ young adults, transgender women, and unstably housed/homeless people in order to reach the HIV viral suppression indicator of 80 percent by 2020.

LDCR Cathleen Davies

Senior Public Health Analyst
HRSA, HAB, Division of State HIV/AIDS Programs

Abigail Viall, MA

Senior Health Policy Analyst
CDC, NCHHSTP, Program and Performance Improvement Office

LDCR Davies and Ms. Viall described key milestones and activities of the HHIAG to date. An invitation was extended in June 2016 to state health officials and state Medicaid programs to join the HHIAG. Participating states were asked to draft work plans to identify their state-level team members; propose specific goals and projects; and leverage support from state AIDS directors and state Medicaid leadership.

The response far exceeded the expectation of receiving work plans from no more than six states. The HHIAG was extremely pleased that health departments and CHIP/Medicaid programs in 19 states submitted work plans. The HHIAG determined that the 19 participating states accounted for approximately 50 percent of new HIV diagnoses in 2014 and approximately 55 percent of the current PLWH population in the United States. The 19 HHIAG states are listed below.

Alaska	Mississippi
California	Nevada
Connecticut	New Hampshire
Georgia	New York
Illinois	North Carolina
Iowa	Rhode Island
Louisiana	Virginia
Maryland	Washington
Massachusetts	Wisconsin
Michigan	

The federal partners and states held introductory teleconferences in August-September 2016 to explore additional opportunities with the HHIAG. The first in-person meeting will be convened in December 2016 for states to network with their peers, learn about experiences and best practices, and revise or refine their quality improvement (QI) work plans for implementation in 2017.

The opportunity to establish stronger relationships between HIV programs and state Medicaid programs was a common theme among all 19 states in their work plans, teleconferences, and

follow-up discussions with the HHIAG. The states emphasized the need for these relationships to be structural rather than person-specific in nature, durable rather than ad hoc, and proactive rather than reactive.

The states also expressed an interest in focusing on the exchange and use of public health and Medicaid data to realize health outcome improvements among PLWH. The states plan to share data at aggregate, claims, and individual levels. The states will use the data to guide outreach, engagement, accountability, and continuous QI efforts. The draft work plans of four selected states are highlighted below.

MASSACHUSETTS

Intended Project Focus

- Understand Mass Health members who are living with HIV and their associated services, costs, and clinical outcomes
- Explore opportunities for improved services among high acuity clients (including HIV care coordination in alternative payment models) and evaluate associated costs

Intended Project Outcomes

- Improved ability to use data to identify MassHealth members who are living with HIV, lost to follow-up, and/or high acuity
- Increased engagement of MassHealth members and improved clinical outcomes

Anticipated Critical Milestones and Activities

- Refine the current algorithm to detect and identify Medicaid members who are living with HIV by using diagnosis, testing, and medication codes
- Deploy data-to-care methods currently in use by the health department to detect and identify MassHealth members who are living with HIV and appear to be out of care based on the electronic submission of laboratory data
- Explore the application of the health department's draft acuity scale and possible enhanced service mix for high acuity Medicaid members with a focus on cost inputs associated with these services
- Characterize Medicaid members who are living with HIV longitudinally by HIV viral suppression rates and evaluate relative services and costs associated with various clinical outcomes
- Conduct a QI project with MassHealth providers that will be informed by these analyses and identify opportunities for service enhancements

Collaboration Strategy and Key Stakeholders

- Form an interagency workgroup: Massachusetts Department of Public Health, Office of Medicaid, and MassHealth Office of Providers and Plans
- Periodically engage MassHealth providers and local professional organizations

MICHIGAN

Intended Project Focus

- Assess HIV viral suppression and gaps in medical care by triangulating RWHAP, Medicaid, and surveillance data
- Assess routine screening for HCV, PAP, and PCP prophylaxis as well as lipids

Intended Project Outcomes

- Assessment of gaps in care outcomes by qualified health plans and fee-for-service Medicaid programs stratified by demographics and geography
- Identification of key gaps for a future plan/do/study/act or quality management project

Anticipated Critical Milestones and Activities

- Attend the HHIAG webinar in October 2016 and the HHIAG in-person meeting in December 2016
- Finalize the draft data use agreement in November 2016
- Attend a meeting in November 2016 to assess variables of interest and query writing with data warehouse and Medicaid staff

Collaboration Strategy and Key Stakeholders

- Form a Stage 1 group before January 1, 2017: Medicaid quality staff, RWHAP quality management staff, and epidemiology experts
- Form a Stage 2 collaboration group after January 1, 2017: Michigan Primary Care Association, case management organizations, and expanded RWHAP staff

MISSISSIPPI

Intended Project Focus

- Primary: Focus on coverage of pediatric HIV surveillance (i.e., exposed infants)
- Secondary: Focus on coverage of HIV care coordination services

Intended Project Outcomes

- Primary: Monitoring of mother-infant pairs until the HIV status of the child is determined by four months and up to 18 months after birth
- Secondary: Extended coordination of the mother's HIV care beyond the first 60 days of maternal coverage to assure HIV medication adherence

Anticipated Critical Milestones and Activities

- Implement system changes to monitor infants for seroconversion and extend coordination of services for HIV-infected women of child-bearing age

Collaboration Strategy and Key Stakeholders

- Form an interagency workgroup: Mississippi Division of Medicaid, Mississippi State Department of Health, and University Medical Center

WASHINGTON STATE

Intended Project Focus

- Collect Health Care Authority (HCA) data for the WSDOH to identify Medicaid clients with HIV infection who are not HIV virally suppressed

Intended Project Outcomes

- Short-term: Development of collaborative data analysis to identify opportunities to improve the care of Medicaid clients with HIV infection
- Long-term: Larger number of Medicaid clients with HIV infection who are HIV virally suppressed

Anticipated Critical Milestones and Activities

- Obtain the dataset from HCA (WSDOH)
- Develop and describe the HCA Medicaid HIV care continuum (WSDOH)
- Identify Medicaid clients who are not HIV virally suppressed (WSDOH and HCA)
- Collaborate with clients to remove barriers to accessing HIV care (WSDOH case managers)

Collaboration Strategy and Key Stakeholders

- Develop a data share agreement (WSDOH and HCA)
- Refer clients for WSDOH case management to provide assistance in achieving HIV viral suppression (HCA, Title XIX Targeted HIV Medical Case Management, and Medicaid clients)

Ms. Hauck made several remarks to clarify the role of a non-governmental organization on the HHIAG. Neither the HHS agencies nor the 19 participating states will receive additional funding to conduct the HHIAG activities in 2017. However, HRSA awarded resources to the National Academy for State Health Policy (NASHP) to help the HHIAG to develop an organizational structure and coordinate cross-agency activities. NASHP has a great deal of experience in providing TA to learning collaboratives and affinity groups.

Rachel Yalowich, MPH

Policy Associate
NASHP

Ms. Yalowich described the TA services that NASHP will provide to the HHIAG and the 19 participating states over the next 12 months. The state work plans include several common themes, such as sharing public health and Medicaid data; using data to evaluate outcomes and

performance; and improving the quality of and access to care for Medicaid/CHIP enrollees who are living with HIV. However, individual work plans vary across states.

NASHP will provide group-level TA services to foster and promote state-to-state learning and sharing. States have been assigned to one of three Learning Communities to obtain TA in three major categories: data linkage and outcome evaluation (six states), data analysis and use for delivery system improvement (six states), and provider engagement and QI (seven states). Learning Community-specific webinars will be held every two to three months, while two HHIAG-wide webinars will be convened every six months to focus on mutual areas of interest or TA.

NASHP also will provide one-on-one TA services. States will be offered up to eight hours of ad hoc TA based on their individual needs and requests. The federal agencies and/or other experts will participate on these teleconferences as needed. States can request individualized TA by completing and submitting a form to HIVtechnicalassistance@nashp.org.

NASHP has established the following timeline to provide group-level TA services to the states.

- November 2016: All-state webinar to develop aim/problem statements and performance improvement plans
- December 2016: HHIAG in-person meeting
- February 2017: Learning Community-specific webinar
- April 2017: Learning Community-specific webinar
- June 2017: All-state webinar (topic to be determined)
- August 2017: Learning Community-specific webinar

Dr. Stockmann made several remarks to conclude the panel presentation. The goal of the HHIAG will be to support states in advancing along a continuum that begins with ideas for improvement in HIV care and delivery; shifts to the development of work plans; and ends with the implementation of concrete actions. The next steps during the November 2016 webinar and the December 2016 in-person meeting will be to provide states with a project-planning template and other tools to guide process improvement. States will revise and refine their draft work plans during learning community-specific and all-state deliberations. States will use these networking opportunities to prepare for implementation of their work plans in 2017.

**CHAC DISCUSSION: CMS, CDC, HRSA HIV HEALTH IMPROVEMENT AFFINITY GROUP
PANEL PRESENTATION**

CHAC made several suggestions in response to the HHIAG's request for advice on its initiatives and future directions, which include the following:

- The HHIAG will focus on disparities in the proportion of diagnosed PLWH who are HIV virally suppressed for four key populations, but racial/ethnic groups also should be included in this effort.
- The HHIAG should engage evaluation experts to identify and assess resources, systems support and existing infrastructures that have allowed some states to achieve more positive outcomes with HIV viral suppression than others have.
- The HHIAG should initiate proof-of-concept discussions to explore the possibility of engaging the Substance Abuse and Mental Health Services Administration (SAMHSA) as a new partner. SAMHSA's Block Grant Programs would greatly benefit the HHIAG since substance use and mental health issues have a significant impact on HIV viral suppression.
- Michigan proposes to focus on assessing routine HCV screening, but the possibility of offering incentives for more states to address HCV should be explored. States could design their HHIAG projects to determine the percentage of diagnosed PLWH who are co-infected with HCV and are being treated.

Dr. Stockmann made a follow-up comment in response to one of CHAC's suggestions. Because the HHIAG is an unprecedented initiative, the federal partners agreed at the outset to maintain a sole focus on HIV viral suppression at this time. In addition to Michigan, several other states expressed a strong interest during the introductory teleconferences to expand their HIV platforms, systems, and infrastructures to address HCV and STDs in the future.

Public Comment Period

David Harvey, MSW, ACC

Director

National Coalition of STD Directors

Mr. Harvey reported that similar to CHAC and the federal agencies, National Coalition of STD Directors (NCSD) also is interested in additional deliberations on the intersection between the alarming increase in STD rates and HIV. NCSD will use the vast changes in the affordable healthcare landscape as an opportunity to raise the visibility of these issues in Congress at both the programmatic level and the CDC/HRSA interagency level.

Mr. Harvey reported that NCSD's activities in the field would particularly focus on the increase in syphilis rates among young gay men. NCSD acknowledges that at a minimum, HIV prevention activities warrant updated condom messaging in the current era of PrEP. NCSD will continue to support efforts by CHAC and the federal agencies.

Mr. Harvey also reported that NCSD is extremely pleased that HRSA has taken leadership at the federal level to support the new PLWH Public Leadership initiative. This new effort reflects tremendous progress since AIDS Alliance was awarded a Congressional earmark early in the epidemic to develop and implement its comprehensive Consumer Core Leadership Training Program.

Jeff Taylor

The Reunion Project-Palm Springs

Mr. Taylor inquired about plans by the federal agencies to more aggressively address, collect data on, and report sexual transmission of HCV as an STD. Due to the wide availability of PrEP, the current low rates of condom use are not likely to increase. Creative prevention strategies that do not focus on condoms are needed to identify and enroll people in care to stop the transmission of infections in communities.

CDC leadership responded to Mr. Taylor's question. Dr. Ward explained that recent studies have reported an extremely low incidence of sexual transmission of HCV (approximately one percent) among HIV-infected MSM in the United States. As a result, federal agencies have been prioritizing and targeting their efforts to the dramatic increase in HCV transmission among PWID. However, CDC is aware of the need for updated and accurate messaging. Most notably, a large segment of the target population believes that PrEP provides protection against HCV and STDs other than HIV.

Dr. Bolan announced that CDC hosted the 2016 Syphilis Summit and currently is collaborating with partners to implement key recommendations from this event. CDC is holding community engagement sessions throughout the country to obtain input on new, effective, and innovative strategies to reach gay, bisexual, and other MSM. To address the dramatic decrease in condom use, for example, CDC is consulting with manufacturers regarding the use of new technologies to make condoms a more viable and preferred choice during sexual activity.

CDC staff expressed concerns regarding the recent increase in ocular syphilis, neurosyphilis and congenital syphilis in the U.S. heterosexual population. Syphilis is a curable disease, but blindness has been reported in some ocular syphilis patients and stillborn infants have been reported as a severe adverse outcome of congenital syphilis cases.

CDC staff reported awareness that virtually no progress has been made in biomedical advancements in syphilis since the 1940s. Current serologic tests still do not have the capacity to identify people who are actively infected with syphilis. CDC staff reported that its ongoing discussions have resulted in the National Institutes of Health agreeing to invest more resources in syphilis vaccine development, diagnostics and tools. CDC also is continuing to explore options to replace current drugs that are unable to cure "untreatable, drug-resistant" gonorrhea.

Update by the CHAC Viral Hepatitis Workgroup

Dawn Fukuda, ScM, CHAC Co-Chair

Director

Massachusetts Department of Public Health, Office of HIV/AIDS

Ms. Fukuda presented the Viral Hepatitis Workgroup report on behalf of Dr. Sanjeev Arora, the workgroup chair, who was unable to attend the meeting. During the June 2016 meeting, the workgroup proposed a draft resolution to CHAC on expanding HCV prevention, testing, and treatment capacity in the United States. CHAC voted and unanimously approved the submission of the draft HCV resolution to Dr. Wolitski to be reflected in the 2017-2020 VHAP.

Ms. Fukuda received a thoughtful and comprehensive response from Dr. Wolitski on November 10, 2016, that was distributed to CHAC members for review. She asked CHAC to respond to two major questions posed by Dr. Wolitski: (1) In light of limited resources and different priorities of the incoming Administration, what are CHAC's key areas of focus in HCV prevention, testing and treatment? (2) What is the most appropriate post-election target audience for CHAC's HCV resolution?

During its deliberations on the draft HCV resolution, Ms. Fukuda advised CHAC to consider other ongoing activities to support the national viral hepatitis response, such as the upcoming release of the 2017-2020 VHAP and a new viral hepatitis report by the National Academy of Sciences. She noted that several options are available for CHAC's next steps (e.g., submitting the original version or a revised version of the draft HCV resolution or tabling the resolution until the May 2017 meeting after the release of other national HCV guidance documents).

Ms. Fukuda reminded CHAC that the lack of uptake in HCV treatment has led to a sense of urgency in submitting guidance on HCV prevention, testing, and treatment. Because the workgroup proposed the draft HCV resolution before the Presidential election, she was aware that CHAC might need to reconsider the content, target audiences, and overall framework at this time.

CHAC DISCUSSION: DRAFT HCV RESOLUTION

CHAC engaged in an extensive discussion and proposed numerous revisions to the draft HCV resolution.

- The draft HCV resolution should be revised to ensure alignment with the priorities and realities of the incoming Administration. The aspirational goal of HCV elimination should be retained in the draft resolution, but the language and rationale might need to be

amended. To inform CHAC's revision of the draft resolution, Drs. Mermin and Ward were asked to provide their perspectives on an aspirational goal for HCV elimination.

- The draft HCV resolution should be revised to describe successful models of ongoing HCV elimination efforts. For example, the Cherokee Nation launched its HCV elimination program in 2015. The program has led to remarkable progress in a short period: an increase in HCV treatment from 20 patients in 2013 to over 250 patients in 2014 and an increase in HCV screening from 500 patients per year in 2013 to 16,000 patients per year in 2015. The Cherokee Nation recognizes that the success of its HCV elimination program to date has been possible due to several critical factors, including the following:
 - The introduction of new drugs on the market,
 - Strong political will and support from tribal leadership,
 - Epidemiological expertise from CDC, the Oklahoma State Department of Health, and the University of Oklahoma, and
 - Additional IHS funding for case managers to provide medications to patients; CHWs to reach hard-to-reach populations in the community; and the establishment of a new opiate substitution clinic. (The current waiting list of 300-400 patients far exceeds the clinic's capacity of 60 patients.)

Based on the Cherokee Nation's experiences and lessons learned to date, the draft resolution should emphasize that the elimination of HCV in the United States is a realistic possibility. However, this aspirational goal cannot be achieved without sufficient funding, a strong vision, solid political will, and leadership support at federal, state, and local levels.

- The draft HCV resolution should be revised to include more effective, creative, and thoughtful messaging. CHAC is recommending additional HCV screening and treatment resources, but other Federal Advisory Committees are submitting the same type of guidance for their specific areas of focus (e.g., cancer, diabetes, and heart disease). CHAC should include economic modeling language in the draft resolution to focus more on cost-savings and the return on investment of a national HCV elimination campaign. An example of this language is outlined as follows: "If the federal government invests \$X in HCV prevention and treatment over the next 10 years, the cost-savings from the number of liver transplants and hospitalizations averted would be \$Y." The economic modeling language also should include projections of the tremendous increase in healthcare costs from HCV morbidity and mortality over the next 10 years if no additional federal resources are invested at this time. CHAC's previous advice has reflected its extensive expertise in the public health, clinical, and programmatic aspects of HCV. However, appropriators, policymakers, and other decision-makers at federal, state, and local levels are much more likely to take action on recommendations that address the financial aspects of HCV.

- The draft HCV resolution should be revised to clearly articulate two simple messages: “All persons in the United States who are at risk for HCV should be identified and tested. All persons who are found to be HCV-positive should be treated.”
- The draft HCV resolution should be revised to highlight the important role of existing healthcare systems in achieving HCV elimination, including the following:
 - HRSA Bureau of Primary Health Care (BPHC),
 - FQHCs,
 - Cherokee Nation and other IHS-funded tribal healthcare systems,
 - Innovative community-based models outside of primary care settings (e.g., San Francisco HCV Elimination Initiative and New Mexico HCV Elimination Collaborative), and
 - Health maintenance organizations.

A recommendation to develop and fund a new HCV elimination demonstration project with these innovative programs and models should be included in the revised draft HCV resolution.

- The draft resolution should be revised to describe clinical factors that increase the possibility of achieving HCV elimination. Non-interferon-based regimens have made HCV treatment much more straightforward and able to be delivered in primary care settings with minimal specialist consultation. Pan-genotypic drugs do not require providers to have knowledge of the specific HCV genotype. Similar to TB, DOT can be administered to high-risk HCV patients who are not likely to regularly present for treatment.

CDC leadership responded to CHAC’s request for input on an aspirational goal for HCV elimination. Dr. Mermin fully supported an aspirational vision and goal for HCV elimination as well as challenging, realistic targets that public health can achieve. On the one hand, a cure is available at this time to reach the goal of eliminating HCV infections in the United States. On the other hand, specific targets that are impossible to meet will not be treated seriously. For example, the elimination of HIV is not a feasible goal at this time because a cure or vaccine has not been developed to combat infections in the current population of 1.2 million PLWH, but greatly reducing incidence, morbidity, and mortality is achievable.

Dr. Ward added that similar to the success of the Cherokee Nation, the U.S. Department of Veterans Affairs (VA) also is close to eliminating HCV in its patient population. The VA prioritized the national goal of eliminating HCV by 2020 with a dedicated program, adequate funding, and rigorous evaluation. Most notably, VA administrators receive either monetary bonuses/incentives or penalties based on their performance in providing HCV-positive veterans with screening and linkage to care services.

Dr. Ward was confident that the VA’s success could be replicated in the larger civilian population. Although more funding would be needed, public health already has multiple

resources to achieve HCV elimination: a national infrastructure of strong HCV capacity and expertise; evidence-based interventions and tools; important lessons learned from HIV; and shorter, less expensive treatment regimens with minimal adverse side effects. The solid public health infrastructure has led to tremendous increases in the proportion of HCV patients cured (from five to 18 percent) and the proportion of people who know their HCV status (from 49-60 percent).

Dr. Ward emphasized that although no federal dollars for HCV elimination efforts have been diverted to address the 150 percent increase in HCV from the national opioid epidemic, the aspirational goal of HCV elimination in the United States is still feasible. In the interim of CDC and HRSA receiving additional funding for HCV elimination efforts, the federal agencies should improve their data sharing activities to target care to the most marginalized populations. For example, CDC recently awarded funding to the National Association of Community Health Centers and Oregon Community Health Information Network to aggregate HCV data from multiple states. CDC hopes that HRSA will become a more active, dynamic partner in this effort.

Dr. Ward informed CHAC of CDC's new initiative that is similar to one of the suggestions proposed during the discussion. CDC awarded an additional \$90,000 to its viral hepatitis prevention grant recipients to partner with FQHCs on developing clinical decision tools, provider education materials, and other resources.

Dr. Cheever clarified that the DFOs need to review the CHAC charter before the members vote on drafting a letter.

Preparation for the CHAC Business Session

Dawn Fukuda, ScM, CHAC Co-Chair

Director

Massachusetts Department of Public Health, Office of HIV/AIDS

Ms. Fukuda pointed out that the Business Session on the following day primarily would be devoted to CHAC's discussion and formal vote on the revised draft HCV resolution. She described the next steps on this topic.

- Champions Mr. Byrd, Dr. Caine, Ms. Fukuda, Dr. Havens
- Content The champions will revise the draft resolution to highlight the sense of urgency related to HCV and articulate CHAC's vision of HCV elimination in the United States as a top priority. The champions will consider the input CHAC provided over the course

of the meeting.

- Add new economic modeling data and language to emphasize the cost-savings and return on investment of a national HCV elimination campaign.
 - Highlight the VA's success in nearly eliminating HCV in its patient population.
 - Recommend the development and funding of a new HCV elimination demonstration project with existing innovative models and programs.
 - Include vignettes/personal stories of HCV patients and describe experiences of HCV providers to emphasize that HCV is curable.
- **Target Audiences** CHAC will receive clarification on its charter from the DFOs to determine the best target audiences for the HCV resolution.

On behalf of CHAC, Ms. Fukuda thanked CDC, HRSA, and the guest speakers for their outstanding and informative presentations. In her summary of day one of the meeting, she identified the following two key issues that might warrant CHAC's formal action during the Business Session on the following day or at a future meeting:

- Guidance to the federal agencies on closing the gap between clinical services and public health/population health and potentially offering incentives for achieving public health/population health objectives, and
- Establishment of a new CHAC Youth Workgroup. (CDC's recent surveillance report showed that young people 13-24 years of age accounted for an estimated 22 percent of all HIV diagnoses and had the second highest rate of HIV diagnoses in 2014. Young gay/ bisexual men accounted for 66 percent of all HIV diagnoses.)

With no further discussion or business brought before CHAC, Dr. Cheever recessed the meeting at 4:47 p.m. on November 16, 2016.

Opening Session: November 17, 2016

Laura Cheever, MD, ScM, CHAC DFO
Associate Administrator
HRSA, HAB

Dr. Cheever conducted a roll call to determine the CHAC voting members, *ex-officio* members, and liaison representatives who were in attendance. She announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record.

Dr. Cheever 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. None of the CHAC voting members publicly disclosed any individual or institutional conflicts of interest for the record that were new or different than those declared on day one of the meeting.

Dr. Cheever confirmed that the voting members and *ex-officio* members (or their alternates) in attendance constituted a quorum for CHAC to conduct its business on November 17, 2016. She reconvened the proceedings at 8:38 a.m. and welcomed the participants to day two of the meeting.

Dawn Fukuda, ScM, CHAC Co-Chair

Director

Massachusetts Department of Public Health, Office of HIV/AIDS

Ms. Fukuda joined Dr. Cheever in welcoming the participants to day two of the CHAC meeting. During the “Preparation for the CHAC Business Session” agenda item on the previous day, she noted that the revised draft HCV resolution and the establishment of a Youth Workgroup would warrant formal action by CHAC.

Ms. Fukuda announced that after the meeting, she and Dr. Agins discussed his interest in CHAC addressing HIV stigma and discrimination. She confirmed that time would be set aside during the Business Session for CHAC’s deliberations on this topic.

**Leveraging Partnerships to Support Increased
Employment/Educational Opportunities for PLWH**

Mark Pepler

Supervisory Public Health Analyst & HAB Employment Workgroup Chair

HRSA, HAB, Division of Metropolitan HIV/AIDS Programs

Amy Griffin

Public Health Analyst & HAB Homeless and Housing Workgroup Chair

HRSA, HAB, Division of State HIV/AIDS Programs

Advice Requested from CHAC by HAB:

1. What innovative or emerging models are available at this time to coordinate housing, HIV

- health care, and employment and successfully address the impact of SDOH on PLWH?
2. What are the key barriers for CBOs with an interest in coordinating HIV health, employment, and housing services for PLWH? What strategies can HAB, the U.S. Department of Labor (DOL), and the U.S. Department of Housing and Urban Development (HUD) implement to minimize these barriers?
 3. What are the top three policy and/or resource issues for PLWH related to the coordination of housing, employment and HIV health services?
 4. What are CHAC's recommendations to HAB, DOL, and HUD to consider in addressing the coordination of these services?

Mr. Pepler and Ms. Griffin presented an overview of HAB's efforts to leverage partnerships to support increased housing and employment opportunities for PLWH. HAB is developing best practice models to coordinate HIV health, housing, and employment services. HAB is partnering with DOL and HUD in this effort.

In terms of housing opportunities for PLWH, studies published in 2013 and 2016 documented that the lack of stable housing and job insecurity are known barriers to achieving positive HIV clinical care outcomes. A substantial body of research has been generated that directly links housing status to health outcomes/health inequities.

The 2014 RWHAP Annual Client-Level Data Report showed that 16.5 percent of clients had temporary or unstable housing. NHAS 2020 and multiple studies have reported temporary or unstable housing as a key risk factor for PLWH. Housing status has been identified as a major contributor to HIV viral suppression rates of RWHAP clients. HAB data showed that HIV viral suppression rates among RWHAP clients in 2014 were 82.8 percent (those with stable housing), 77 percent (those with temporary housing), and 67.1 percent (those with unstable housing).

HUD published a report in 2013, *The Connection Between Housing and Improved Outcomes Along the HIV Care Continuum*, that highlighted two key points: (1) the direct, independent and powerful impact of stable housing on HIV incidence, health outcomes and health disparities; and (2) the role of housing status as a more significant predictor of healthcare access and HIV outcomes than individual characteristics, behavioral health issues, or access to other services.

In terms of employment opportunities for PLWH, studies published in 2004 and 2011 estimated that 45 percent-70 percent of PLWH were unemployed. Of the unemployed PLWH population, however, 40 percent reported their readiness and ability to work. The 2014 Conyers study reported that employment services, such as vocational rehabilitation, improve access to health care, reduce health risk behaviors, and decrease HIV-related stigma.

The 2015 Conyers and Hergenrather study reported that medication adherence was more likely in employed PLWH than in unemployed PLWH. HUD data showed that stable employment has a positive effect on the economic stability of PLWH; improves their mental and physical health;

and reduces their dependence on the RWHAP and other publicly funded healthcare and supportive service programs.

HAB has a strong interest in leveraging housing and employment services that promote long-term stability in HIV viral suppression of PLWH. HAB intends to enhance the existing knowledge base in four areas.

Dr. Cheever provided additional details on HAB's rationale for partnering with DOL and HUD to increase housing and employment opportunities for PLWH. HAB data show that over 50 percent of RWHAP clients are living below the FPL. Good overall health and well-being are much less likely for PLWH who live in poverty than those with better economic conditions. RWHAP is not designed as a housing or employment program for PLWH, but HAB is partnering with DOL and HUD to develop interagency, innovative housing and employment programs to improve the lives of RWHAP clients who are living in poverty.

CHAC DISCUSSION: LEVERAGING PARTNERSHIPS TO SUPPORT INCREASED EMPLOYMENT/ EDUCATIONAL OPPORTUNITIES FOR PLWH

CHAC provided feedback in response to HAB's request for advice.

Question 1: Innovative/emerging models

- Ongoing efforts by HAB and its federal partners to increase housing and employment opportunities for PLWH also should focus on educational opportunities for this population. Community colleges throughout the country now offer innovative training programs for community members to earn a degree as a CHW.
- HAB and its federal partners should review the seven housing recommendations in the New York State blueprint. The blueprint directly links housing issues to vocational training of PLWH and addresses stigma and homophobia experienced by PLWH who are attempting to secure housing. Washington State released similar guidance for PLWH and assigned a workgroup to address each specific issue, including housing, stigma, and health disparities.
- Housing Works has been a leader in advocacy efforts since 1990 to ensure that low-income and homeless PLWH in New York City are provided with housing and related supportive services. Housing Works has expanded its activities over time to measure and integrate HIV viral suppression rates into a powerful housing model that includes employment training, recruitment of homeless people in the workforce, and critical mental health and substance use services. HAB should invite Housing Works staff to make a presentation at a future CHAC meeting.
- AIDS Foundation Houston included a housing component in its longstanding housing program for PLWH to specifically target HIV-positive youth. The youth HIV housing component is comprehensive and includes multiple features: clinical appointment reminders via text messaging, notices of local events that are important and relevant to

young PLWH, opportunities for employment and stable housing, substance use counseling, and medication adherence.

- The Damien Center in Indianapolis is a “one-stop” organization that provides HIV clients with a comprehensive and innovative menu of resources: short-, medium- and long-term housing; career services and employment opportunities; pre-employment internships and training; and referrals to legal services for PLWH who experience discrimination in housing.
- The mayor’s declaration of Seattle’s housing emergency has led to numerous workgroup recommendations to provide services to address the housing problem in the city. PLWH are likely to benefit from these efforts.

Question 2: Barriers

- HAB and its federal partners are to be commended for their plans to address age-based disparities. Most notably, HAB cited RWHAP data that showed young PLWH are much more likely than older PLWH to be unemployed or have unstable/temporary housing. Moreover, LGBT youth account for 40 percent of homelessness among youth. However, HAB also should focus on gender-based disparities. Female PLWH, particularly those with young children, have far more significant barriers to securing housing and obtaining employment than male PLWH. For example, employment stability is much more difficult for female PLWH who need to remain in care and secure reliable childcare.
- HUD’s extremely strict housing restrictions exclude a significant proportion of the PLWH population. Most notably, any individual with substance use is ineligible for HUD housing.

Question 3: Policy and/or resource issues

- HAB’s definition of “unstable housing” does not fully capture the unstable housing rate in the PLWH population. Unlike HUD, for example, the RWHAP data reporting system excludes PLWH who live in their vehicles, “couch surf,” or are temporarily housed in small properties with large groups of individuals. As a result, HAB’s calculation of the unstable housing rate in the PLWH population is grossly underestimated, particularly for HIV-positive youth and women with children. The federal agencies should make efforts to harmonize their data and utilize consistent definitions.
- HAB should collect data from Medicaid and other payer sources to demonstrate the incremental cost of PLWH who are unstably housed. These types of data would allow the federal partners to make a more compelling and stronger case to support the housing and employment initiative for PLWH.
- HRSA awarded FQHCs a significant amount of funding to focus on medical homes for unstably housed people, including PLWH. The federal partners should utilize this rich dataset in the housing and employment initiative for PLWH.

Question 4: Guidance to the federal agencies

- Federal agencies have a long history of engaging non-traditional partners in their initiatives, but more emphasis should be placed on the education, evaluation and accountability of these organizations. Credible, accredited, and vetted non-traditional partners will play a critical role in efforts by HAB and its federal partners to increase housing and employment opportunities for PLWH.
- The federal agencies should explore the possibility of expanding the housing and employment initiative beyond PLWH to include other key populations, such as HIV-negative people who are at high risk, HIV/HCV co-infected people, and seasonal migrant workers/undocumented immigrants with HIV.

In response to one of CHAC's comments, Ms. Griffin acknowledged differences between the HAB and HUD definitions of "unstable housing" in the PLWH population. To address this issue, HAB launched a three-year SPNS initiative to focus on the integration of housing and healthcare data across agencies. HAB plans to apply the findings from the SPNS initiative to update its current definition of "unstable housing."

PANEL PRESENTATION: HIV AND AGING — IMPLICATIONS FOR HEALTH CARE, MENTAL HEALTH, AND SUPPORT NEEDS

Antigone Dempsey, Med

Director

HRSA, HAB, Division of Policy and Data

Advice Requested from CHAC by HAB:

1. What lessons learned by grassroots organizations supporting PLWH 50 years of age and older or long-term HIV survivors could be shared more broadly? How can CDC, HRSA, and/or HHS help disseminate these lessons?
2. How can CHAC encourage CDC, HRSA, and/or HHS to address challenges faced by PLWH 50 years of age and older or long-term HIV survivors?
3. What are the top three policy and/or resource issues for PLWH 50 years of age and older or long-term HIV survivors at this time? How might these issues evolve in the future?
4. What are CHAC's recommendations to CDC, HRSA, and/or HHS to consider in addressing these issues for PLWH 50 years of age and older or long-term HIV survivors?

Ms. Dempsey presented RWHAP data for the United States and three territories to provide a framework for the panel presentation and describe HAB's rationale for focusing on the aging PLWH population. By total aging population, the proportion of RWHAP clients in the age groups of 45-54, 55-64, and 65 years and older increased from 50.5 percent in 2010 to approximately

56 percent in 2014. The number of RWHAP clients 50 years of age and older increased from 176,035 (or 31.7 percent) in 2010 to 206,757 (or 40.4 percent) in 2014.

By service category, utilization of core medical services and support services were relatively similar between RWHAP clients 50 years of age and older and the overall RWHAP population. However, a larger proportion of RWHAP clients 50 years of age and older utilized outpatient ambulatory medical care and food bank/home-delivered meals.

CORE MEDICAL SERVICES

Service	RWHAP Clients \geq 50	Total RWHAP Population
Outpatient ambulatory medical care	56.5%	60.0%
Medical case management	54.3%	55.7%
Mental health	13.3%	13.5%
Nutrition	9.7%	8.4%
AIDS pharmaceutical assistance	5.4%	6.2%

SUPPORT SERVICES

Service	RWHAP Clients \geq 50	Total RWHAP Population
Non-medical case management	28.8%	29.4%
Medical transportation	15.0%	14.6%
Treatment adherence counseling	13.8%	13.5%
Food bank/home-delivered meals	13.5%	10.6%
Health education	12.6%	13.3%

By race/ethnicity, RWHAP clients 50 years of age and older in all racial/ethnic groups had high HIV viral suppression rates of over 80 percent. By gender, male, female, and transgender RWHAP clients 50 years of age and older had high HIV viral suppression rates of over 80 percent.

Ms. Dempsey asked the panelists to introduce themselves to CHAC, identify their affiliations, and describe their personal experiences as long-term survivors of HIV/AIDS.

- Mr. Jeff Taylor is a Steering Committee member of The Reunion Project-Palm Springs (TRP) and Director of the Coachella Valley Community Research Initiative. He is a 35-year survivor of both HIV and cancer.
- Mr. Tez Anderson is the founder of Let's Kick ASS-AIDS Survivor Syndrome (LKA). He is 57 years of age and has survived the traumatic effects of AIDS since his diagnosis of HIV in 1983.
- Ms. Carolyn Massey is the Executive Director of Older Women Embracing Life, Inc. (OWEL). She is a 23-year survivor of HIV.

Ms. Dempsey facilitated a discussion with the panelists to obtain their insights and perspectives on HAB's key questions.

Challenges of long-term HIV survivors

- Mr. Taylor noted that PLWH 50 years of age and older who were not expected to outlive their friends or family members struggle on a daily basis to overcome “survivor’s syndrome,” post-traumatic stress disorder (PTSD), and “funeral fatigue.” Moreover, long-term HIV survivors who feel isolated are challenged by reengaging with the community for their individual physical and mental health.
- Ms. Massey explained that geriatricians who primarily serve HIV-negative patients are extremely uncomfortable with discussing the sex lives and practices of HIV-positive patients. In accordance with the NHAS 2020 goal of designing multidisciplinary approaches to deliver health care, a new medical model should be developed that combines geriatrics and ID care. The RWHAP care continuum serves as an excellent template or blueprint for providing integrated care and support services. PLWH 50 years of age and older also are challenged by maintaining a basic quality of life. The purchase of expensive medications for HIV and other chronic conditions over a long period has led to a significant proportion of this population to live in poverty and rely on publicly funded programs. Moreover, PLWH 50 years of age and older typically are identified as “the disease” rather than as people with hopes and dreams to live an active life, rejoin the workforce, and provide assistance and services to others.
- Mr. Anderson emphasized that PLWH 50 years of age and older are an overlooked population. HIV/AIDS conferences and other events primarily focus on programming, scholarships, internships/mentorships, leadership skill building, and other resources for HIV-positive youth. PLWH 50 years of age and older account for 40 percent of RWHAP clients, but this population is not mentioned in NHAS 2020. Moreover, recent data estimate a 20 percent increase in the proportion of PLWH 50 years of age and older in only five years (from 50 percent in 2015 to 70 percent in 2020). The aging HIV population is not a monolith. PLWH with long-term survivorship of 20 years and longer have vastly different medical and psychosocial needs than PLWH who seroconverted over the past 10 years. People who were diagnosed with HIV in the 1980s-1990s spent the majority of that time on planning to die and bearing witness to the traumatic deaths of entire communities. Long-term HIV survivors who are now 50 years of age and older are ready to advance from simply surviving to fully thriving and flourishing in the world. However, PLWH 50 years of age and older in rural areas are particularly challenged by the lack of opportunities to join HIV survivorship groups and other types of peer or support networks.

Ongoing grassroots efforts

- Mr. Taylor reported that TRP is a diverse group of long-term HIV survivors, including older PLWH, providers, community members, and youth/young adults who were born with HIV. TRP convenes one-day summits across the country to address survivorship, trauma, and psychosocial issues related to HIV. The major features of the summits are described as follows: (1) “Healing Circles” and “Honoring Our Experience” sessions for participants to share their personal stories; (2) overviews by healthcare providers to discuss the clinical aspects of HIV and aging; and (3) presentations by service organizations to describe available resources for older PLWH, such as financial/housing services and back-to-work programs. A “Call to Action” is developed at the end of each summit for participants to commit to implementing specific action steps in their individual communities. The calls to action have led to the formation of multiple LKA chapters and the establishment of support groups, buddy programs, and ASO social programs.
- Ms. Massey reported that OWEL provides community outreach that is particularly targeted to address the shame, fear, and confusion experienced by older women who are diagnosed with HIV. OWEL designs its programming and support services based on direct feedback from its target population of HIV-positive older women. OWEL has shared its experiences and lessons learned at federal, state, and community levels. These discussions played a key role in changes in RWHAP funding allocations; new HIV testing by a state health department for pregnant women in the third trimester; and new HIV and/or health ministries by older women and their faith-based organizations (FBOs).
- Mr. Anderson reported that LKA is a group of long-term HIV/AIDS survivors. Input gathered directly from 250 participants who attended the first town hall meeting in 2013 served as a roadmap to develop programming for future town hall meetings and other activities, such as a weekly exercise class for older PLWH. LKA has served as a catalyst for older PLWH to shift from isolation and depression to hopefulness.

Current gaps

- Mr. Taylor noted that from a clinical perspective, limited research has been conducted on HIV and aging, including cognitive problems of older PLWH. However, ongoing efforts by the AIDS Community Research Initiative of America’s Center on HIV and Aging are expected to fill some of the existing gaps in both qualitative and quantitative data. From a social services perspective, employment opportunities, representation on ASOs, and back-to-work programs are lacking for older PLWH. The “From Isolation to Socialization” support group created a back-to-work program for older PLWH, but other innovative strategies include job sharing and building skills and capacity through volunteer positions and internships. Anecdotal feedback has shown that older PLWH who are engaged in the workforce and their communities are happier and healthier individuals and are less likely to be enrolled in behavioral health services or use prescribed psychotropic medication.

- Ms. Massey emphasized the need for public health to invest resources for national scale-up of programs to reach a broader group of PLWH 50 years of age and older. For example, TA should be provided to FBOs to expand their effective church-based programs for this population. Training should be provided to CBOs to offer the “Women Involved in Life Learning from Other Women” (WILLOW) intervention. The WILLOW intervention is designed to provide social skills training and education to adult women living with HIV. OWEL was awarded funding from CDC and has been extremely successful in its implementation of the WILLOW intervention to date. Investments to scale up grassroots outreach and education for older PLWH are a critical need at this time. PLWH 50 years of age and older are projected to account for seven out of every 10 PLWH in the United States by 2020. Moreover, many older adults who are tested are diagnosed with AIDS at the outset because routine HIV screening is not recommended for this population.
- Mr. Anderson conveyed that older PLWH need inclusion and respect in current initiatives. Long-term survivors of the early, traumatic HIV/AIDS epidemic were frontline leaders in the fight for new drug development, research, compassionate care, and anti-discrimination laws to protect PLWHA. However, this population and their achievements have been virtually forgotten.

CHAC DISCUSSION: HIV AND AGING —IMPLICATIONS FOR HEALTH CARE, MENTAL HEALTH AND SUPPORT NEEDS

CHAC thanked the panelists for attending the meeting to share their powerful personal stories of aging with HIV, lifetime experiences in the fight against HIV/AIDS, and overall wisdom. CHAC and the panelists engaged in an extensive discussion and proposed numerous suggestions for HRSA to consider in its ongoing efforts to further develop the HIV and aging initiative.

- Lessons learned and experiences from the RWHAP in providing care to PLWH to age well and live healthy lives should be compiled and disseminated for replication in other chronic diseases (e.g., diabetes, hypertension, congenital heart disease, and cystic fibrosis). RWHAP and other innovative models will play an instrumental role in helping programs to prepare for the care of aging populations with chronic diseases or conditions.
- Older PLWH should provide training and serve as mentors or resources to youth with HIV in becoming advocates and public leaders. To initiate this effort, CDC and HRSA should jointly fund a series of intergenerational technical expert panels with a panel of HIV-positive people 50 years of age and older and youth to discuss their experiences in multiple areas, including their interactions with HIV prevention, care, and treatment providers.

- The development of a new medical model that combines geriatrics and ID care was suggested during the panel discussion. However, older HIV-positive patients would be better served if ID specialists were retrained to provide geriatrics care rather than retraining geriatricians to care for older HIV patients. The newly combined specialty of HIV/geriatrics should be included in medical school curricula.
- Caution should be taken in recommending a newly combined HIV/geriatrics specialty. Geriatrics care is complex and requires an integrated approach from a team of geriatricians and geriatric nurses, social workers, and treatment supporters. In addition to addressing medical needs, multidisciplinary geriatric teams also provide education, health literacy, and safety interventions to prevent and protect elderly patients against falls, abuse, and violence.
- The dwindling HIV workforce is a serious concern in both the public health and clinical communities. Retirements, deaths, and new careers outside of the HIV field have caused a major deficiency in the pool of HIV providers. Future goals, indicators, and other targets that have been established for HIV will not be achieved unless immediate attention is given to resolving workforce issues. CHAC should engage in an extensive discussion during the Business Session on submitting a formal resolution to the HHS Secretary to address the major problems in the HIV workforce.
- HRSA should consider the three following key action steps in its further development of the HIV and aging initiative.
 - New interventions should be designed to specifically help PLWH to age well. Unlike older HIV-negative people who develop chronic conditions (e.g., arthritis, diabetes, or hypertension), HIV in older PLWH can exacerbate these medical issues and the overall aging process.
 - CDC should update its HIV screening recommendations, particularly to account for older people who are viewed as “low risk” by the provider community.
 - Mental health providers and counselors, particularly those with expertise and training in PTSD, should be available for long-term HIV survivors. Older PLWH are continuing to experience trauma and PTSD because of routinely receiving their personal “death sentences” from providers and witnessing an extraordinarily high number of HIV/AIDS-related deaths in their communities at the height of the epidemic in the 1980s-1990s. However, mental health services also should focus on the tremendous resiliency of long-term HIV survivors.
- The lack of HIV prevention programs targeted to aging PLWH was noted during the panel discussion due to the discomfort of providers discussing the sexual lives and practices of their older patients. Much more emphasis should be placed on prevention in both older PLWH and HIV-negative populations. Most notably, a sharp increase in STD

rates has been observed in older women. Moreover, some providers have reported diagnosing HIV in older patients over 70 years of age.

- New studies on the health of older PLWH should be designed and evaluated to collect more qualitative data, such as the impact of SDOH and personal experiences as PLWH have aged over time. Federal agencies typically cite high HIV viral suppression rates as a measure of success in PLWH 50 years of age and older, but limited attention is given to other health outcomes in this population. For example, physical health from a medical perspective can be relatively similar between an HIV-negative individual 75 years of age and a long-term HIV survivor 60 years of age. Moreover, long-term HIV survivors have lifelong medical problems from the severe side effects and toxicity of early treatment regimens. New research also should be designed to identify and clearly define the overall population of “long-term HIV survivors” (i.e., the number of PLWH who seroconverted before the introduction of highly active ART in 1996). Data on racial/ethnic differences in PLWH who are aging should be gathered as well. Most notably, issues related to housing, employment, transportation, food insufficiency, health literacy, healthcare access, and overall poverty in older PLWH have been found to be more prevalent in African Americans and Hispanics than in whites.

Dr. Cheever provided clarifying remarks in two key areas in follow-up to the rich discussion by CHAC and the panelists. First, limited research on HIV and aging was noted as a key gap. However, Johns Hopkins and the New England AETC have served as leaders in providing education and training on HIV and aging. The New England AETC convenes an annual meeting to specifically address this issue.

Second, a suggestion was made to develop a newly combined HIV/geriatrics specialty. Geriatricians are practitioners who specialize in addressing the unique needs of frail, elderly patients, often 80 years of age and older, such as the prevention of falls and other safety measures. With the exception of this small, specialized population, internists, family practitioners, and PCPs provide care and treatment for the majority of patients in the United States. Thought should be given of the best way to leverage existing staff rather than waiting for a new cadre to be developed.

Mr. Byrd concluded the discussion and confirmed that CHAC would revisit the topic of HIV and aging. In preparation for the Business Session, he asked the members to consider whether this issue warrants an additional panel presentation and further discussion at future meeting or if CHAC should form an HIV and Aging Workgroup.

Update by the CHAC PrEP Workgroup

Dawn Fukuda, ScM, CHAC Co-Chair

Director

Massachusetts Department of Public Health, Office of HIV/AIDS

Ms. Fukuda reported that CHAC charged the PrEP Workgroup with drafting recommendations to CDC and HRSA on supporting wider use and availability of PrEP. During the November 2015 meeting, CHAC voted and unanimously approved the workgroup's draft letter to CDC and HRSA leadership. In their joint response to the CHAC Co-Chairs dated September 7, 2016, Drs. Cheever and Mermin expressed strong support of the four recommendations and agreed with CHAC's priorities to increase uptake and utilization of PrEP.

Ms. Fukuda thanked Drs. Cheever and Mermin for their thoughtful and comprehensive response to CHAC. She identified several areas in the letter that require clarification and/or additional discussion.

1. Would CDC or AETCs be responsible for capacity building and training for PCPs and other providers to deliver PrEP?
2. What actions will CDC take to align the *STD Treatment Guidelines* and *PrEP Guidelines* to ensure harmonized and consistent recommendations between the two sets of guidelines, such as frequency of testing?
3. What messaging will CDC and HRSA develop to address condom-less sex in the context of PrEP and sexual health in the context of HIV viral suppression?
4. What models have been successful in leveraging the existing infrastructure, particularly RWHAP and ADAPs, to deliver PrEP services?

Dr. Cheever provided HRSA's perspective on some of the questions posed by Ms. Fukuda.

Question 1: Capacity building and training for PrEP delivery

- HAB values the tremendous expertise of and views RWHAP providers as important partners in the delivery of PrEP in communities. BPHC and other HRSA bureaus outside of HAB have established a workgroup to explore the role of CHCs and non-RWHAP providers in expanding PrEP delivery in their clinics.

Question 3: Messaging for condom-less sex

- National data show that syphilis rates among gay men are extraordinarily high. HRSA recognizes that community confidence in PrEP's protective abilities in HIV prevention may contribute to the decrease in condom use and the increase in STD rates. HRSA

also is aware of the critical need for effective messaging from clinicians to patients to address the complex topic of the potential role of PrEP in the resurgence in STDs.

Dr. Mermin provided CDC's perspective on some of the questions posed by Ms. Fukuda.

Question 1: Capacity building and training for PrEP delivery

- CDC has prioritized PrEP through multiple mechanisms: release of guidelines, strategic inclusion of PrEP language in new FOAs, development of a comprehensive plan to expand access, and implementation of PrEP programs and special pilot projects in multiple jurisdictions. These efforts have increased PrEP uptake, but utilization across the country is still not ideal. As a result, CDC is conducting research to identify barriers to coverage of PrEP and other gaps.

Question 2: Harmonized guidelines

- CDC funded a newly published study that reported an extremely high incidence of STDs among people who take PrEP. The study also indicated the occurrence of more frequent STDs while people are on a PrEP regimen. The study concluded that implementation of CDC's PrEP guidelines of frequent screening every three months (or every six months at a minimum) would decrease STDs in gay men and the broader community. Both the PrEP and STD guidelines recommend frequent STD testing every three to six months and the provision of regular treatment. CDC has observed strong adherence to the PrEP guidelines in programs throughout the country. However, CDC acknowledges the need to address disparities in access to PrEP, particularly in African American and Hispanic gay/bisexual men.

Question 3: Messaging for condom-less sex

- Similar to HRSA, CDC also noted the resurgence in STD rates in the United States. CDC data showed that over two million STDs were diagnosed in 2015 and represented the highest number of infections ever reported in U.S. history. The emerging threat of untreatable, drug-resistant gonorrhea is a significant concern as well. PrEP programs should take an active role in responding to the national STD epidemic, particularly among gay/bisexual men. For ideal prevention of HIV acquisition or a dramatic reduction in the risk of transmission, CDC's current guidelines recommend condom use with a PrEP regimen and adherence to ART for HIV viral suppression. CDC's available tools include an online risk reduction tool; an application to locate PrEP providers by zip code; and published data on protective factors (e.g., ART and PrEP) and absolute risks of different sex acts. Extensive efforts are underway at CDC to distribute communications materials to enhance knowledge of PrEP among both providers and consumers, particularly in African American and Hispanic communities. However, CDC is still challenged by developing effective messaging to empower clinicians and consumers to make informed decisions regarding condom use in the current era of PrEP.

CHAC DISCUSSION: UPDATE BY THE PREP WORKGROUP

- CDC should explore strategies to encourage USPSTF to reclassify PrEP as prevention rather than treatment. Multiple programs across the country are unable to or challenged by offering PrEP because the current USPSTF recommendations do cover PrEP as a preventive service. For example, several programs in non-Medicaid expansion states in the South are burdened by additional provider and laboratory costs related to PrEP.
- PrEP traditionally has been targeted to gay/bisexual men and young people at high risk for HIV acquisition. Women, however, particularly HIV-negative, uninsured/underinsured women in serodiscordant relationships, should be an additional target population for PrEP. PrEP messaging and communications for high-risk young women of childbearing age who become pregnant will play an important role in further prevention of mother-to-child transmission of HIV.
- Major resources should be invested to rebuild the infrastructure of STD clinics because these sites are ideally suited for the delivery of PrEP. High-risk populations that are primary candidates for PrEP (e.g., young gay/bisexual African Americans and Hispanics) are much more likely to present to STD clinics in their communities rather than EDs for HIV/STD prevention and treatment as well as primary care.

Dr. Mermin made several clarifying remarks in response to CHAC's discussion. A new study will soon be published on existing gaps in PrEP coverage. The study estimates that lack of financial coverage accounts for only a small proportion of eligible candidates who cannot access PrEP. The study describes significant barriers to access PrEP, such as the burden of paperwork and limited knowledge of PrEP among providers. CDC's projections show that PrEP is only reaching 10 percent of the total population of candidates (or approximately 100,000 people) at this time.

Dr. Mermin informed CHAC that CDC already has submitted a request to USPSTF to reclassify PrEP as a preventive service. However, CDC is aware of the complexities associated with its request. Most medications are intended to cure, treat, or stabilize a disease or condition, but PrEP is a medication with a sole purpose of preventing HIV acquisition.

CDC described an existing precedent to support its request to USPSTF. Aspirin is a medication for treatment that currently is recommended by USPSTF for primary prevention. The USPSTF reclassification of PrEP as a preventive service would eliminate the requirement for a co-pay for people who are covered by health insurance marketplace programs. CDC hopes that USPSTF will respond to its request for evaluating PrEP as a preventive service in the near future.

Dr. Mermin explained that women account for 50 percent of CDC's estimated population of 1.2 million people in the United States who are candidates for PrEP. Efforts are underway to collect data on cohorts of at-risk women who participated in CDC-funded PrEP demonstration projects and clinical trials.

Dr. Mermin agreed with CHAC that community-based STD clinics are much better suited than EDs to deliver PrEP. He announced that multiple jurisdictions are leveraging synergies between their STD and HIV treatment and prevention programs. For example, New York City plans to expand the delivery of PrEP in its STD clinics. CDC data show that the most accurate indicators of HIV risk are rectal gonorrhea and chlamydia or syphilis at any site.

Ms. Fukuda concluded the discussion, but she confirmed that issues related to PrEP would be placed on the next meeting agenda.

CHAC Business Session

Dawn Fukuda, ScM, CHAC Co-Chair

Director

Massachusetts Department of Public Health, Office of HIV/AIDS

Ms. Fukuda opened the Business Session and called for CHAC's review, discussion, and/or formal action on several topics.

TOPIC 1: DRAFT CHAC MEETING MINUTES

A motion was properly placed on the floor by Mr. Guillermo Chacon and seconded by Dr. Peter Havens for CHAC to approve the June 14-15, 2016, meeting minutes.

CHAC unanimously adopted the Draft June 14-15, 2016, Meeting Minutes with no changes or further discussion.

TOPIC 2: ESTABLISHMENT OF A NEW CHAC YOUTH WORKGROUP

The following recommendation was proposed for CHAC's consideration and formal action.

CHAC recommends the establishment of a Youth Workgroup. The workgroup's preliminary charge will be to examine effective healthcare strategies and school-based interventions to address health-related behaviors and outcomes among youth based on recent YRBS data: HIV/STDs, bullying, interpersonal violence, sexual assault, suicide, and depression. The workgroup's target populations will include LGBTQ youth, allied/straight youth, and in-school youth.

Action	Description
Co-Chair's call for a vote	Ms. Debra Hauser properly placed a motion on the floor for CHAC to formally approve the recommendation. Ms. Amy Leonard seconded the motion.
Outcome of vote	The motion was passed.
Next steps	<ul style="list-style-type: none"> Ms. Hauser will chair the new Youth Workgroup. Mr. Byrd and Ms. Leonard will serve as members. Ms. Hauser will serve as the point of contact for other CHAC members and external experts/stakeholders with an interest in serving on the workgroup. CDC/HRSA staff will be identified to provide the workgroup with technical expertise, logistical assistance, and administrative support. <p>The workgroup's first teleconference will focus on refining its charge and identifying specific tasks to fulfill the charge. The workgroup's first update to CHAC will be placed on the spring 2017 CHAC meeting agenda.</p>

TOPIC 3: ESTABLISHMENT OF A NEW CHAC HIV AND AGING WORKGROUP

The following recommendation was proposed for CHAC's consideration and formal action.

CHAC recommends the establishment of an HIV and Aging Workgroup. The workgroup's preliminary charge will be to engage in more in-depth discussions and draft guidance to further address the issues presented during the meeting by the HIV and aging panel.

Action	Description
Co-Chair's call for a vote	Ms. Amy Leonard properly placed a motion on the floor for CHAC to formally approve the recommendation. Dr. Jean Anderson seconded the motion.
Outcome of vote	The motion was passed.

Action	Description
Next steps	<ul style="list-style-type: none"> Mr. Byrd will chair the new HIV and Aging Workgroup. Mr. Aleshire, Dr. Anderson, Ms. Leonard and Mr. Haverkate (CHAC <i>ex-officio</i> member for IHS) will serve as members. Mr. Byrd will serve as the point of contact for other CHAC members and external experts/stakeholders with an interest in serving on the workgroup. CDC/HRSA staff will be identified to provide the workgroup with technical expertise, logistical assistance, and administrative support. <p>The workgroup's first teleconference will focus on refining its charge, identifying specific tasks to fulfill the charge, and clearly defining the target populations (e.g., long-term HIV survivors and/or older PLWH with a recent diagnosis). The workgroup will be as inclusive of the aging HIV population as possible. The workgroup's first update to CHAC will be placed on the spring 2017 CHAC meeting agenda.</p>

The Youth and HIV and Aging Workgroup members discussed the possibility of integrating their efforts to promote intergenerational dialogue and activities between HIV-positive/at-risk youth and PLWH 50 years of age and older. However, the workgroup members ultimately decided to operate separately at the outset to focus on and address the specific needs of their respective populations. The workgroups agreed to collaborate in the future to identify potential synergies and opportunities between their populations.

TOPIC 4: DRAFT HCV RESOLUTION

The draft HCV resolution was proposed for CHAC's discussion, consideration, and formal action.

CHAC recommends the implementation of a risk-based and age-based hepatitis C virus (HCV) screening program by all healthcare systems and providers as currently recommended by the Centers for Disease Control and Prevention (CDC). CHAC further recommends universal treatment of all people identified with HCV infection. Treatments should be selected that are appropriate to genotype, stage of liver disease, co-morbidities, and medication interactions as currently practiced in the best healthcare systems in the country (e.g., the U.S. Department of Veterans Affairs (VA) and Kaiser Permanente of the Mid-Atlantic States).

CHAC continues to underscore the urgency of a response to the growing epidemic of HCV in the United States. At this time, 2.7-3.9 million people are living with HCV in the

country and over 30,000 new HCV infections are reported to CDC each year. HCV is a major cause of cirrhosis and liver cancer and is the leading cause of liver transplantation in the nation. People born between 1945 and 1965 (i.e., the “birth cohort”) and PWID are at greatest risk for HCV infection. However, other groups also are impacted, such as veterans and women of reproductive age. The current estimated lifetime cost of care for people living with HCV is \$360 billion. [Annual healthcare costs for people living with HCV](#) may be as high as \$9 billion per year (C. Everett Coop Institute).

HCV represents a profound public health threat to the nation. HCV causes extensive morbidity, suffering and premature mortality. No vaccine is available at this time, but HCV can now be cured with a simple 12-week, all-oral treatment regimen approved by the U.S. Food and Drug Administration. Despite the availability of curative medications, uptake of an HCV cure in the United States is shockingly low. Insufficient uptake of HCV treatment results in both increased costs to the healthcare system and sustained HCV transmission. Low levels of HCV treatment are directly attributed to system-level access barriers that can be readily resolved today to prevent exponentially higher costs in the years ahead. The nation currently has a highly effective cure for HCV at its disposal that enables over 90 percent of people who complete treatment to eliminate detectable virus from their systems within 8 to 12 weeks. An opportunity is available at this time to dramatically reduce the impact of HCV in the United States. An obligation exists to act swiftly and decisively.

Components of the existing healthcare infrastructure can be readily deployed to rapidly scale up treatment and provide an HCV cure to millions of Americans. Examples of the “screen and treat” approach to communicable diseases are highly effective, such as tuberculosis, acute rheumatic fever, cervical cancer, early onset Group B Streptococcal infection, and perinatal hepatitis B. These approaches can be readily applied to HCV screening and treatment. HCV treatment is straightforward and readily delivered in primary care with minimal specialist technical expert panel. Existing primary care agencies, HRSA/BPHC, and the CDC Division of Viral Hepatitis could be deployed to deliver training and technical assistance. Multiple service system infrastructures can be leveraged to deliver HCV care and treatment, including FQHCs, Medicaid providers, and RWHAP (including ADAPs). Kaiser Permanente of the Mid-Atlantic States (Jonas MC, 2016) and the [VA](#) have implemented the program recommended by CHAC. Other innovative program models also could be proposed to rapidly demonstrate highly effective best practices to accomplish HCV cure.

CHAC DISCUSSION: DRAFT HCV RESOLUTION

Content

- *Paragraph 2:* New language and a reference should be included to emphasize the importance of HCV screening.
 - Proposed revision: “Of all persons with HCV in the United States, 50 percent are unaware of their infection.”
- *Paragraph 2:* The word “all” should be added to clarify that the estimated cost of care is population-based rather than individually based.
 - Proposed revision: “The current estimated lifetime cost of care for all persons living with HCV is \$360 billion.”
- *Paragraph 2:* New language should be included to demonstrate the cost-savings of the HCV test and cure approach.
- *Paragraph 3:* This paragraph should serve as the new paragraph one.
- *Paragraph 3:* The use of the word “simple” to describe the 12-week treatment regimen is questionable due to side effects experienced by some patients. Dr. Havens explained that the treatment regimen of one daily pill does not include interferon or Ribavirin. As a result, patients do not experience horrible illness, depression, suicidal thoughts, or other treatment-related side effects. The word “simple” should remain in the resolution to encourage primary care settings to administer the regimen.
 - Proposed revision: The word “simple” should be deleted.
 - Proposed revision: “No vaccine is available at this time. Compared to previous treatments, HCV can now be cured with a simple 12-week, all-oral treatment regimen approved by the U.S. Food and Drug Administration.”
 - Proposed revision: “No vaccine is available at this time. HCV can now be cured with a well-tolerated 12-week, all-oral treatment regimen approved by the U.S. Food and Drug Administration.”
- *Paragraph 3:* The use of “highly effective cure” and “HCV cure” in the same sentence is redundant.
 - Proposed revision: “The nation currently has a highly effective cure for HCV at its disposal.”
- *Paragraph 4:* The change in the wording from “test and treat” to “test and cure” is appropriate for HCV, but examples of “screen and treat” for other communicable diseases should be modified. These approaches focus on prevention rather than cure.
 - Proposed revision: “Examples of the screen and cure approach to communicable diseases are highly effective, such as tuberculosis, chlamydia, and early onset Group B Streptococcal infection.”
- *Paragraph 4:* Several opportunities are described to reduce the impact of HCV in the United States, but CHAC’s advisory role should be strengthened in the resolution. The existing language appears to serve as clinical guidance rather than CHAC’s resolution for a national call to action.

- Proposed revision: “CHAC recommends” or “CHAC encourages” the immediate deployment of components of the existing healthcare infrastructure to rapidly scale up treatment and provide an HCV cure to millions of Americans.
- Proposed revision: “CHAC recommends that the federal government deploy resources and adopt a program similar to the VA and Kaiser Permanente of the Mid-Atlantic States.”
- *Paragraph 4:* The phrase, “minimal specialist consultation,” should be clarified.
 - Proposed revision: “Existing guidance regarding the delivery of this intervention does not require a specialist. Examples include [list of agencies/organizations].”
 - Proposed revision: “HCV treatment is straightforward and readily delivered in primary care with trained personnel.”
- *Paragraph 4:* The integration of HCV treatment into medical care should be referenced.

Target Audiences

- The resolution should be submitted to the HHS Secretary as CHAC’s straightforward, aspirational goal: “CDC’s age- and risk-based guidelines should be followed for HCV testing. Persons with positive test results of active hepatitis C disease should be provided with appropriate evaluation and treatment.”
- An explicit linkage should be made to the national opioid epidemic to clearly define CHAC’s rationale for the resolution and make the statement more powerful.
- CHAC was divided on the best framework for the target audiences of the resolution.
 - *Some CHAC members:* The resolution should be broadened to address HIV, HCV and STDs. Instead of focusing on HCV only, the expanded resolution should be designed to provide information on CHAC’s priorities.
 - *Other CHAC members:* The resolution should be limited to CHAC’s focus and sense of urgency on HCV and the delivery of a straightforward message that will greatly benefit the country: “The simple HCV test and cure approach is being implemented at this time and should be expanded nationally.” This message will be diluted with the addition of new HIV and STD language.

Action	Description
Co-Chair’s call for a vote	Dr. Peter Havens properly placed a motion on the floor for CHAC to formally approve the draft HCV resolution. Dr. Bruce Agins seconded the motion.
Outcome of vote	The motion was passed.

Action	Description
Next steps	<ul style="list-style-type: none"> • The Co-Chairs, in consultation with Dr. Havens, will revise the draft HCV resolution based on CHAC’s input. The revised draft will be circulated to the CHAC members for their final review. • The Co-Chairs will finalize and include the HCV resolution in a letter to the current HHS Secretary (Sylvia Mathews Burwell). <p>The Co-Chairs will modify the aforementioned letter and send a similar letter to the new HHS Secretary after his/her appointment is confirmed by Congress. The purpose of the second letter will be to introduce CHAC and highlight the HCV resolution as a high-priority issue.</p>

TOPIC 5: WORKFORCE DEVELOPMENT

A draft resolution was proposed for CHAC’s discussion, consideration, and formal action.

The U.S. healthcare system is facing a growing challenge regarding the physician shortage in this nation that can adversely impact the care of PLWH, people with viral hepatitis, and people with STDs. According to the American Association of Medical Colleges, a shortage of 12,500 to 31,100 primary care physicians will occur by 2025. The April 2011 Institute of Medicine report, “HIV Screening and Access to Care,” projected that in the U.S. HIV care workforce and the primary care workforce generally, there will be a shortage of providers needed to handle the number of people in the United States who need to be tested and treated for HIV infection. A more recent CDC study (Weiser, *et al.*, CID 2016) and [HRSA study](#) highlighted the shortage of current and future HIV clinicians in the United States.

This has been reflected in the looming crisis regarding the shortage of ID physicians forecasted to occur in the near future. Recent match results from the National Resident Matching Program for the ID subspecialty showed an ongoing decline in the number of fellowship positions filled. For ID programs, only 65 percent of available fellowships were allocated during the 2016 match. This translates into a decreasing manpower pool and fewer ID specialists available to provide care to PLWH, people with viral hepatitis, and people with STDs.

Complicating this issue, 40 percent of practicing physicians are older than 55 years of age and approximately 33 percent of the nursing workforce is over 50 years of age. If 33 percent of these physicians retire in the next 10 years, caseloads for physicians who

specialize in HIV treatment could increase and make the specialty less attractive for young healthcare providers.

As the healthcare workforce ages, the U.S. population is expected to rise by 18 percent by 2030 with nearly 33 percent of the U.S. population consisting of racial/ethnic minorities. In addition, the population over 65 years of age is expected to increase at three times this rate. With healthcare reform expected to bring millions more patients into the system, the demand and need for more trained providers care will be significant.

Twenty percent of the U.S. population is rural. Rural communities generally have fewer primary care providers, nurses, physician assistants, and specialists. The loss or shortage of even one healthcare provider could have a far-reaching impact. Given the health disparities related to HIV/AIDS, viral hepatitis, and STDs as well as recent census data on the growing diversity in the country in relation to racial/ethnic minorities, the lack of minority providers with the above expertise reveals that the percentage of minority healthcare professionals enrolled in public medical institutions has stagnated over time.

Because physician training can take up to a decade, a physician shortage in 2025 must be addressed in 2016 to ensure that the best and most diversified healthcare workforce in the world is available to provide quality health improvement.

Therefore, CHAC recommends the expansion of federal funding to provide grants and loans for startup costs associated with developing new community-based training sites in underserved communities.

CHAC recommends the appropriation of federal funding to ensure that provider training in the areas of HIV/AIDS, viral hepatitis, and STDs is available for rural community healthcare providers and minority healthcare professionals, including physicians, nurse specialists, physician assistants, and dentists.

CHAC recommends the establishment of a Workforce Development Commission or a National Advisory Committee to monitor the progress and effectiveness of workforce planning models for healthcare organizations.

CHAC DISCUSSION: DRAFT WORKFORCE DEVELOPMENT RESOLUTION

CHAC pointed out that the resolution does not adequately address two major issues.

- The lack of diversity among healthcare professionals from racial/ethnic minority groups is appalling. The HRSA workforce study found that black HIV providers account for only eight percent of the healthcare workforce and Hispanic HIV providers account for only seven percent of the healthcare workforce.
- Rural communities are experiencing severe shortages of ID specialists, physicians, nurse practitioners and other providers to treat HIV, viral hepatitis, and STDs.

Action	Description
Co-Chair's call for a vote	Dr. Carlos del Rio properly placed a motion on the floor for CHAC to formally approve the draft workforce development resolution. Dr. Peter Havens seconded the motion.
Outcome of vote	The "spirit and intent" of the draft resolution was approved.
Next steps	<ul style="list-style-type: none"> • Drs. Agins, Caine and del Rio will form a small writing group to revise the draft resolution based on the two major concerns expressed by CHAC. Mr. Byrd will serve as an additional member to provide input on workforce diversity issues and to retain the institutional memory of the writing group in 2017. The six-month extended terms of Drs. Agins, Caine, and del Rio will expire on December 30, 2016. <p>CDC and HRSA committee management staff will schedule a teleconference prior to the May 2017 meeting for the CHAC members to take a formal vote on the revised draft workforce development resolution. The revised draft will be circulated to the CHAC members well in advance of the teleconference in preparation of their formal vote.</p>

TOPIC 6: FUTURE AGENDA ITEMS

Ms. Fukuda led CHAC in a review of the future agenda items that were proposed over the course of the meeting.

PRESENTER	AGENDA ITEM
Guest Speakers from the PEPFAR Stigma Consultation & PACHA Stigma Summit	<p>Presentation on HIV stigma and discrimination: state-of-the-art stigma research, metrics, interventions and tools; the impact of stigma on HIV prevention and care; and studies on internalized, social and clinical stigma</p> <ul style="list-style-type: none"> • Potential guest speakers: University of Alabama at Birmingham, San Francisco Transgender Law Center, and PACHA
CDC/DHAP & Guest Speakers	<p>Update on PrEP:</p> <ul style="list-style-type: none"> • Overviews by CDC communications and scientific staff on messaging on condom-less sex in the context of PrEP Key findings from ongoing PrEP research, particularly the limited reach of PrEP in only 10 percent of the target population and the low rates of PrEP uptake among YBMSM • Overviews by PrEP programs in the field: <ul style="list-style-type: none"> ➢ The New York State Department of Health (NYSDOH) has administered PrEP to over 10,000 individuals to date. NYSDOH is compiling its experiences and best practices related to PrEP delivery and plans to publish these data in the future. Dr. Agins will serve as CHAC's point of contact to invite Ms. Lyn Stevens at NYSDOH as a guest speaker. ➢ The District of Columbia has served as a leader on the use of PrEP in women.
Peter Byrd, HIV and Aging Workgroup chair Debra Hauser, Youth Workgroup chair	<p>First update by the HIV and Aging Workgroup</p> <p>First update by the Youth Workgroup</p>
CDC/DASH	<p>Update on adolescent and school health programming, particularly since the new Administration might revert back to an abstinence-only curriculum:</p> <ul style="list-style-type: none"> • Prevention efforts targeted to youth • Important components of a youth-based sex education program (interpersonal violence, school-based bullying, ability to obtain PrEP, access to care, and frequency of testing)
CDC/DSTDP & CHAC	<p>Panel presentation, CHAC's extensive discussion, and formal resolution to the HHS Secretary on the record high STD rates in the United States</p>

PRESENTER	AGENDA ITEM
TBD	Overview of the intersection with interpersonal violence (Editor's note: Dr. Anderson needs to provide additional clarification on this agenda item.)
TBD	Overview of preconception care issues among women living with HIV
TBD	Overview of the return on investment, cost-effectiveness, and econometric analyses of HIV, HCV, and STD interventions and innovations

Closing Session

Dr. Cheever thanked the CHAC members for their productive and robust discussions over the course of the meeting. She particularly commended CHAC on its thoughtful resolutions and excellent guidance to HRSA on increasing housing and employment opportunities for PLWH and developing an initiative to address the aging PLWH population. The participants joined Dr. Cheever in applauding Ms. Gordon and LCDR Holly Berilla for their outstanding leadership in planning and organizing the in-person CHAC meeting in Rockville.

Dr. Agins, Dr. Caine, and Mr. Chacon informed the participants of their honor and privilege in serving as CHAC members. The three outgoing members thanked the CDC/HRSA leadership and staff, CHAC co-chairs, and colleagues for their camaraderie and generosity in sharing their expertise.

The next CHAC meeting will be an in-person, CDC-focused meeting in Atlanta. CDC committee management staff will poll the CHAC members to confirm the meeting date of May 9-10, 2017, or May 31-June 1, 2017.

With no further discussion or business brought before CHAC, Dr. Cheever adjourned the meeting at 2:18 p.m. on November 17, 2016.

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

Date

Peter Byrd, 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



Attachment 1: Participants' Directory

CHAC Members Present

Mr. Peter Byrd, Co-Chair
Ms. Dawn Fukuda, Co-Chair
Dr. Bruce Agins
Mr. Richard Aleshire
Dr. Jean Anderson
Dr. Virginia Caine
Mr. Guillermo Chacon
Ms. Angelique Croasdale
Dr. Carlos del Rio
Ms. Debra Hauser
Dr. Peter Havens
Ms. Amy Leonard
Dr. Jorge Mera
Dr. Susan Philip
Ms. Linda Scruggs

CHAC Members Absent

Dr. Sanjeev Arora
Dr. Jennifer Kates

CHAC Ex-Officio Members Present

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

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

Mr. Richard Haverkate
Indian Health Service

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

Dr. Lisa Kaplowitz
(Alternate for Dr. Melinda Campopiano)
Substance Abuse and Mental Health
Services Administration

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

Dr. Andrey Ostrovsky
Centers for Medicare & Medicaid Services

CHAC Ex-Officio Member Absent

Dr. Melinda Campopiano
Substance Abuse and Mental Health
Services Administration

CHAC Liaison Representative Absent

Dr. Mildred Williamson
Presidential Advisory Council on HIV/AIDS

CHAC Designated Federal Officers

Dr. Laura Cheever
Associate Administrator, HRSA/HAB

Dr. Jonathan Mermin
Director, CDC/NCHHSTP

Federal Agency Attendees

Dr. Andria Apostolou
LCDR Holly Berilla
Dr. Gail Bolan
CDR Tarsha Cavanaugh
Ms. Stephanie Chan
Ms. Iris Chen
Ms. Stacy Cohen
Ms. Corinna Dan
LCDR Cathleen Davies
Ms. Antigone Dempsey
Mr. Julian Diaz
Dr. Emeka Egwim
Mr. Steven Fry
Ms. Shelley Gordon
Ms. Amy Griffin
Dr. Irene Hall
Ms. Anne Hanessian
Ms. Heather Hauck
Ms. Connie Jorstad
Ms. Theresa Jumento
Ms. Amelia Khalil
Ms. Niki Keiser
Ms. Amelia Khalil
Dr. Pamela Klein
Dr. Amy Lansky
Dr. Rebecca Levin
Mr. James Macrae
CAPT Tracy Matthews
Dr. Eugene McCray
Dr. John Moore
Ms. Morgan Moore
Ms. Pamela Nicholson
Ms. Dora Ober
Dr. Deborah Parham Hopson
Mr. Mark Pepler
LCDR Alyson Rose-Wood
Ms. Helen Rovito
Ms. Amy Schachner

Ms. Margie Scott-Cseh
Dr. Judith Steinberg
Dr. Deirdra Stockmann
Ms. April Stubbs-Smith
Ms. Abigail Viall
Dr. John Ward
Mr. Michael Williams
Ms. Sharon Wong
Ms. Rachel Yalowich
Mr. Steven Young

Guest Presenters/ Members of the Public

Mr. Tez Anderson
Let's Kick ASS-AIDS Survivor Syndrome

Ms. Katie Burk
San Francisco Department of Public Health

Dr. Robert Carroll
IQ Solutions

Mr. David Harvey
Director, National Coalition of STD Directors

Dr. Richard Havlik
AIDS Community Research Initiative of
America

Mr. Frank Hood
The AIDS Institute

Dr. Annie Luetkemeyer
University of California, San Francisco

Ms. Carolyn Massey
Older Women Embracing Life, Inc.

Jesse Milan, Jr., Esq.
AIDS United

Dr. Kimberly Page
University of New Mexico Health Sciences
Center

Ms. Britten Pund
NASTAD

Mr. Carl Schmid
The AIDS Institute

Mr. Jeff Taylor
The Reunion Project-Palm Springs

Mr. Nicholas Taylor
The AIDS Institute

Ms. Hanna Tessema
AIDS Community Research Initiative of
America

Ms. Gretchen Weiss
NACCHO



Attachment 2: Glossary of Acronyms

Acronym	Full Name
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
ART	Antiretroviral Therapy
ASO	AIDS Service Organization
BPHC	Bureau of Primary Health Care
CARS	Community Approaches to Reducing STDs
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CEBACC	Center for Engaging Black Men Who Have Sex With Men Across the Care Continuum
CHAC	CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CMS	Centers for Medicare & Medicaid Services
CoAg	Cooperative Agreement
DASH	Division of Adolescent and School Health
DFO	Designated Federal Officer
DHAP	Division of HIV/AIDS Prevention
DOL	U.S. Department of Labor
DOT	Directly Observed Therapy
DSTD	Division of STD Prevention
DVH	Division of Viral Hepatitis
ED	Emergency Department
ELR	Electronic Laboratory Reporting
End Hep C SF	San Francisco HIV Elimination Initiative

Acronym	Full Name
FACA	Federal Advisory Committee Act
FBO	Faith-Based Organization
FDA	U.S. Food and Drug Administration
FOA	Funding Opportunity Announcement
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HAB	HIV/AIDS Bureau
HBV	Hepatitis B Virus
HCA	Health Care Authority
HCV	Hepatitis C Virus
HHIAG	HIV Health Improvement Affinity Group
HHS	U.S. Department of Health and Human Services
HIVRN	HIV Research Network
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
ID	Infectious Disease
IDSA	Infectious Diseases Society of America
IDU	Injection Drug User
IHS	Indian Health Service
LGBTQ	Lesbian/Gay/Bisexual Transgender/Questioning
LKA	Let's Kick ASS-AIDS Survivor Syndrome
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
MDRP	Medicaid Drug Rebate Program
MMP	Medical Monitoring Project
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MSM	Men Who Have Sex With Men
NASHP	National Academy for State Health Policy
NASTAD	National Alliance of State and Territorial AIDS Directors
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NCSD	National Coalition of STD Directors
NHAS	National HIV/AIDS Strategy
NMCD	New Mexico Corrections Department
NMDOH	New Mexico Department of Health
NQC	National Quality Center

Acronym	Full Name
NYSDOH	New York State Department of Health
OHAIDP	Office of HIV/AIDS and Infectious Disease Policy
OWEL	Older Women Embracing Life, Inc.
PACHA	Presidential Advisory Council on HIV/AIDS
PCP	Primary Care Physician/Provider
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
Project ECHO	Extension for Community Healthcare Outcomes
PTSD	Post-Traumatic Stress Disorder
PWID	People Who Inject Drugs
QI	Quality Improvement
RSR	Ryan White HIV/AIDS Program Services Report
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SMAIF	Secretary's Minority AIDS Initiative Fund
SPNS	Special Projects of National Significance
SSP	Syringe Services Program
STD	Sexually Transmitted Disease
SVR	Sustained Virologic Response
SWOT	Strengths, Weaknesses, Opportunities, Threats
TA	Technical Assistance
TB	Tuberculosis
TCQ	Training of Consumers on Quality
TRP	The Reunion Project
UNM	University of New Mexico
USPSTF	U.S. Preventive Services Task Force
VA	U.S. Department of Veterans Affairs
VHAP	Viral Hepatitis Action Plan
VHPC	Viral Hepatitis Prevention Coordinator
WILLOW	Women Involved in Life Learning from Other Women
WSDOH	Washington State Department of Health
YBMSM	Young Black Men Who Have Sex With Men
YRBS	Youth Risk Behavior Surveillance/Survey