

**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 7-8, 2018  
Bethesda, Maryland**

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**Record of the Proceedings**

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**CDC/HRSA ADVISORY COMMITTEE ON  
HIV, VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT  
November 7-8, 2018  
Bethesda, Maryland**

**Executive Summary**

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, Sexually Transmitted Diseases (STDs) and Tuberculosis (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) on November 7-8, 2018, in Bethesda, Maryland. Presentations were made on key issues related to the nation's response to HIV, sexually transmitted diseases (STD), and viral hepatitis.

**National HIV/AIDS Strategy (NHAS)/National Viral Hepatitis Action Plan**

The NHAS and the National Viral Hepatitis Action Plan will be updated in 2020. The new plans will run from 2020-2025. Updating will focus on: scientific and clinical advances; emerging challenges (e.g., opioid crisis); opportunities for integration; and the need to accelerate progress, conserve resources, and reduce health care costs. The Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) will engage stakeholders in the development of the new plans, which will be released in spring/summer 2020.

**Strategies for Serving Women, Infants, Children, and Youth Living with HIV**

The Ryan White HIV/AIDS Program (RWHAP) serves a significant number of women, children, and youth (age 13-24) living with HIV. The RWHAP supports multiple activities addressing this population including a newly developed toolkit of best practices for serving youth; an initiative focused on the use of social media to improve engagement and retention of youth living with HIV in care; resources to improve health outcomes for Black men who have sex with men (MSM); and an initiative to accelerate the elimination of perinatal HIV transmission. CHAC members also heard from two RWHAP recipients, Children's Hospital of Wisconsin and Johns Hopkins Pediatric, Youth, Adolescent, and Young Adult HIV/AIDS Program, about effective practices to engage and retain youth in care.

### **Data-Driven Methodology for the Allocation of RWHAP Part A Supplemental Funding**

HAB is exploring revision of the process for Part A supplemental funding, which accounts for one-third of Part A funding. HAB has convened a technical expert panel and conducted a feasibility study that identified five variables. Once the methodology is developed, HRSA and HHS approval is required and further stakeholder input will be sought to finalize the methodology. In order for the new methodology to be implemented, the RWHAP must be reauthorized and language regarding the annual, competitive supplemental process changed.

### **HRSA Initiatives in Response to the Opioid Crisis**

Currently, approximately 7 percent of RWHAP clients were infected due to injections drug use. Of these, 85.1 percent of these clients have achieved viral suppression. Success in achieving viral suppression varies across subpopulations. Young clients and those with no health coverage and unstable housing have lower rates of viral suppression. Providing services to these clients is a challenge for RWHAP recipients since many do not have services in place to meet the needs of patients with substance use disorder (SUD)/opioid use disorder (OUD). Only 39.5 percent of RWHAP recipients provide mental health services. In terms of substance use treatment, 17.9 percent of recipients provide these services—16.6 percent outpatient and 2.4 percent residential.

HAB held a technical expert panel in July 2018 to explore challenges in providing services to people living with HIV (PLWH) with OUD. HAB will develop resources for recipients based on the findings of the technical expert panel. In addition, HHS has announced more than one billion dollars in funding to address the opioid crisis. HRSA has provided over \$400 million to community health centers (CHCs) and other organizations for SUD treatment and behavioral health in primary care.

### **HRSA Telehealth Initiatives**

The Telehealth Strategic Plan calls for increasing the number of individuals and communities in HRSA's target populations that are served by telehealth. In addition, it encourages the use of telehealth technology to support department and agency priority areas, such as addressing the opioid crisis, and calls for increasing HRSA's visibility and leadership in the field of telehealth. In 2017, approximately 600 HRSA-funded CHCs were using telehealth. The RWHAP uses telehealth for training, clinical support (e.g., warmlines), and through Project ECHO, which increases access to specialists in HIV care and treatment, especially in rural and underserved areas. A RWHAP recipient, Medical Advocacy and Outreach in Montgomery, Alabama, shared its experience using telehealth to serve patients in rural areas.

### **Development of Guidance for Universal Hepatitis C Virus (HCV) Screening among Pregnant Women and All Adults**

CDC's Division of Viral Hepatitis is in the process of Grading of Recommendations Assessment, Development, and Evaluation (GRADEing) evidence for universal HCV screening among 1) pregnant women, and 2) all adults. There are many factors not addressed through the evidence review that need to be considered. These include whether testing should be aged-based; in what settings should testing be conducted; logistical issues such as provider burden; and necessary resources such as clinical decision support tools. CDC would like to engage experts to ensure a wide range of perspectives and input into the decision-making process and asked for recommendations from CHAC members.

## CHAC Workgroup Reports

**Hepatitis C Workgroup:** The workgroup has drafted, reviewed, and revised recommendations focused on: correctional facilities; Centers for Medicare and Medicaid Services (CMS); and federally qualified health centers (FQHCs). Some of these recommendations relate to the opioid crisis.

**HIV and Aging Workgroup:** The workgroup has conducted a literature review and interviews with subject matter experts to determine the need of PLWH as they age. CHAC members emphasized that it is important to focus on aging issues specific to PLWH.

**RWHAP Reauthorization Workgroup:** The workgroup has drafted questions related to RWHAP reauthorization. It will continue to consult with experts and review relevant documents and provide feedback to the CHAC.

**School-Aged LGBTQ Youth Health Workgroup:** The workgroup sent a letter with recommendations to CDC. CDC has responded to the letter. The workgroup has disbanded but will continue to work informally.

**Sexually Transmitted Diseases Workgroup:** The workgroup has been active on a range of issues including: better collaboration between CDC and HRSA; development of a national STD plan; continued focus on congenital syphilis; and addressing pricing of drugs to treat STDs.

### CHAC Actions

- Formation of a workgroup to make recommendations related to NHAS 2025.
- The Hepatitis C Workgroup will draft a letter to the HHS Secretary with the recommendations related to the opioid crisis.
- Include presentation on HRSA/CDC coordination on STDs at May 2019 CHAC meeting.

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HIV, VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT  
November 7-8, 2018  
Bethesda, 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, Sexually Transmitted Diseases (STDs) and Tuberculosis (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 on November 7-8, 2018, at the Doubletree by Hilton Hotel in Bethesda, Maryland.

The 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 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: Participant Directory](#)).

**Opening Session: November 7, 2018**

**Laura Cheever, MD, ScM**

Associate Administrator, HRSA, HAB  
CHAC Designated Federal Officer (DFO), HRSA

Dr. Cheever announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. She called the proceedings to order at 8:34 a.m. and welcomed the participants to the CHAC meeting. Dr. Cheever called roll and confirmed that the 15 voting members in attendance in addition to ex-officio members (or their alternates) constituted a quorum for CHAC to conduct its business on November 7, 2018.

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 to recuse themselves from voting or participating in these matters.

### CONFLICT OF INTEREST DISCLOSURES

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Richard Aleshire, MSW, ACSW (Washington State Department of Health)	No conflicts.
Jean Anderson, MD (Johns Hopkins Medical Institutions)	Recipient of funding from HRSA/Ryan White HIV/AIDS Program (RWHAP) and National Institutes of Health (NIH) and stock in Gilead and information technology (IT) companies.
Marvin Belzer, MD, FACP, FSAM (University of Southern California, Keck School of Medicine)	Recipient of funding from HRSA/RWHAP, CDC, Substance Abuse and Mental Health Services Administration (SAMHSA), and NIH.
Debra Hauser, MPH (Advocates for Youth)	Recipient of funding from CDC, VIVE, Gilead, and MAC AIDS.
Peter Havens, MD, MS (Children's Hospital of Wisconsin)	Recipient of funding from HRSA/RWHAP and NIH.
Devin Hursey (U.S. People Living with HIV Caucus)	Recipient of from HRSA/RWHAP.
Jennifer Kates, PhD (Kaiser Family Foundation)	No conflicts.
Amy Leonard, MPH (Legacy Community Health Services)	Recipient of funding from CDC and HRSA/RWHAP.
Jorge Mera, MD (W.W. Hastings Indian Hospital)	Recipient of funding from HRSA, SAMHSA, Gildead, Abbvie. Dr. Mera has also received speakers fees from Gilead and AbbVie.
Greg Millett, MPH (amfAR)	No conflicts.
Susan Philip, MD, MPH (San Francisco Department of Public Health)	Recipient of funding from HRSA/RWHAP, CDC and NIH, Luminostics, Roche Diagnostics and an unpaid public health advisor for GlaxoSmithKline.
Michael Saag, MD (University of Alabama at Birmingham, School of Medicine, UAB Center for AIDS Research)	Recipient of funding from HRSA/RWHAP, CDC, and NIH and a consultant for Merck, Gilead, and VIVE.
Linda Scruggs, MHS (Ribbon Consulting Group)	Recipient of funding from HRSA/RWHAP, CDC, VIVE, Gilead, and Merck.
Bradley Stoner, MD, PhD (Washington University School of Medicine)	Recipient of funding from HRSA, CDC and NIH.
Lynn Taylor, MD, FACP (University of Rhode Island)	Recipient of funding from HRSA/RWHAP.

### Approval of the May 2018 Draft CHAC Meeting Minutes

**CHAC Action**  
 Dr. Anderson called for a vote to approve the May 2018 meeting minutes. The CHAC unanimously approved the draft May 2018 meeting minutes with no changes or further discussion.

## DFOs Welcoming Remarks

### **Laura Cheever, MD, ScM**

Associate Administrator, HRSA, HAB  
CHAC DFO, HRSA

Dr. Cheever provided an update on CHAC membership.

- Peter Byrd, former CHAC co-chair, has resigned.
- Dr. Anderson will serve as CHAC co-chair.
- Steve Davis has resigned as the representative of SAMHSA. Ex-officio CHAC member Mitchell Berger will represent SAMHSA on the CHAC until a replacement is named.
- The Centers for Medicare and Medicaid Services (CMS) is in the process of naming an ex-officio CHAC representative. Richard Wild will continue to serve on the CHAC until a representative is named.
- HRSA has received multiple nominations for current CHAC vacancies and the nomination packages are being reviewed.

Theresa Jumento, PhD, MPA is coordinating CHAC-related activities for HRSA HAB. She replaces CDR Holly Berilla, MSW who has transitioned to another position in HAB.

### **RADM Jonathan Mermin, MD, MPH**

Director, CDC, NCHHSTP  
CHAC DFO, CDC

Dr. Mermin thanked Melanie Ross and Margie Scott Cseh for coordinating CHAC activities for CDC.

The terms of three CDC-nominated CHAC members (Dawn Fukuda, Amy Leonard, and Jorge Mera) expire on November 30. Dr. Mermin presented certificates of appreciation to these members. The 2018 draft nomination packages have been submitted to HHS.

## HRSA Update

### **George Sigounas, MS, PhD**

Administrator, HRSA

Dr. Sigounas thanked CHAC members for their work and noted the importance of collaboration—both across federal agencies and among federal agencies and stakeholders.

Current priorities for HRSA are value-based care and drug pricing, access to health care, and substance use treatment. These priorities are reflected in the work of HRSA's programs. Examples are listed below.

- The Bureau of Primary Health Care (BPHC) serves over 27 million people.
- HRSA's healthcare workforce programs serve more than 15 million people.
- HHS has announced more than one billion dollars in funding to address the opioid crisis. HRSA has provided over \$400 million to community health centers (CHCs) and other

organizations for substance use disorder (SUD) treatment and behavioral health in primary care.

- HRSA's Maternal and Child Health Bureau (MCHB) has implemented a very successful home visit program for pregnant women and parents of young children. The program served over 150,000 women and children and conducted over one million home visits in 2017.
- In June 2018 HRSA convened a meeting addressing maternal mortality and morbidity in western countries. Participants included federal partners, national experts, and representatives from six countries.

## Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) Report

**Tammy R. Beckham, DVM, PhD**  
Acting Director, OHAIDP

In addition to serving as Acting Director of OHAIDP, Dr. Beckham is serving as Acting Director of National Vaccine Program Office, which provides the opportunity to identify synergies, leverage resources, and create policies and strategies to reduce the burden of infectious diseases. OHAIDP is committed to identifying and promoting evidence-based, high-impact actions to address HIV, viral hepatitis, and sexually transmitted diseases (STDs).

Assistant Secretary for Health, Admiral Brett Giroir, MD leads development of HHS-wide public health policy recommendations and oversees 11 core public health offices, including OHAIDP. In addition, Dr. Giroir serves as Senior Advisor to the Secretary for Opioid Policy. In this capacity, he is responsible for coordinating HHS's efforts to fight America's opioid crisis.

Priorities for OHAIDP are listed below.

- The National HIV/AIDS Strategy (NHAS) and the National Viral Hepatitis Action Plan will be updated in 2020. OHAIDP will engage federal partners and non-federal stakeholders and allow ample opportunity for input. This includes listening sessions and a request for written comments. OHAIDP will reach out to the CHAC and others to help promote opportunities for input.
- OHAIDP is developing an inventory on PrEP and how to further scale up this intervention.
- OHAIDP is working with federal partners, including HRSA, CDC, SAMHSA, and NIH to align messaging around HIV viral suppression and prevention.
- OHAIDP oversees the Secretary's Minority AIDS Initiative Fund (SMAIF). In Fiscal Year (FY) 2018, \$50.2 million was awarded to 27 projects to address racial/ethnic disparities in HIV and improve health outcomes.
- The hepatitis C virus (HCV) Medicaid Affinity Group is in its second year. It is currently focusing on correctional facilities and data sharing.
- In March 2018, the National Academy of Medicine and OHAIDP held a workshop on infectious diseases and the opioid crisis.
- OHAIDP is launching a new evaluation project focused on the integration of efforts to address the opioid crisis and infectious diseases.

## HRSA HAB Report

### **Laura Cheever, MD, ScM**

Associate Administrator, HRSA, HAB  
CHAC DFO, HRSA

Dr. Cheever provided updates from HRSA HAB.

- For FY 2019 HAB's appropriation is approximately \$2.3 billion, which is consistent with the level of funding since 2014.
- Policy Clarification Notice (PCN) #16-02: RWHAP Eligible Individuals and Allowable Uses of Funds has been updated. Eight service categories were revised based on feedback from recipients. The outreach services category replaces PCN #12-01.
- HAB issued PCN #18-01: Clarifications Regarding the Use of RWHAP Funds for Health Care Coverage Premium and Cost Sharing Assistance. This provides clarification on Medicare premiums and cost sharing and aligns policy across three PCNs that this one replaces, reducing burden on recipients.
- HAB has been working to address recipients' reporting burdens. A request for information resulted in over 100 comments related to the Core Medical Services Waiver, the RWHAP Services Report (RSR), and six-month recertification of RWHAP eligibility. In response to the feedback, HAB is looking at both policy clarifications and technical assistance.
- Aligned with the work with other federal partners, HAB has worked with recipients to communicate consistent messages related to viral suppression and how people living with HIV (PLWH) who have consistent viral suppression do not sexually transmit HIV. This means that PLWH who take their medication daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus. Sharing messages about viral suppression with PLWH may have a profound impact on how they feel about themselves and their life choices. It may also impact stigma and discrimination. In response, HRSA HAB has included updated viral suppression language in 2018 Notice of Funding Opportunities (NOFOs), released a Program Letter in October 2018 on the importance of viral suppression messaging, participated in an HHS-wide webinar on October 19, 2018, and hosted internal training with CDC and NIH for HRSA HAB, BPHC, and Regional Operations Staff.
- HAB will host the National Ryan White Conference on HIV/AIDS, December 9-14, 2018, at the Gaylord National Harbor Hotel in Maryland. More than 4,000 participants are expected.

Dr. Cheever also presented HAB activities in key areas including supporting the goals of the NHAS, building leadership, partnerships, supporting integration, and data utilization.

- HAB supports NHAS (NHAS) goals and has aligned its programs to support the goals. For example:
  - A Special Projects of National Significance (SPNS) initiative is focused on improving STI testing and treatment among PLWH and those at risk of HIV;
  - HAB is compiling best practice strategies and interventions; and
  - HAB is exploring approaches for measuring unmet need in Part A jurisdictions.
- HAB is promoting bi-directional learning between RWHAP and the President's Emergency Plan for AIDS Relief (PEPFAR) including evaluation of models and lessons

learned for domestic and global use and sharing between PEPFAR- and RWHAP-funded clinics.

- Through SMAIF, HAB's Building Leaders of Color initiative has reached more than 150 participants in 26 states and all 10 HRSA regions.
- Through the CHATT Project, HAB is building the capacity of planning councils and bodies.
- The Building Futures: Supporting Youth Living with HIV Project identified best practices and has compiled them in a toolkit.
- HAB partners across HRSA and HHS to address a variety of emerging issues. Examples of these emerging issues include: supporting coordinated viral suppression messaging; responding to the opioid crisis; screening and treatment for STDs; and meeting the goals of the NHAS.
- HAB is enhancing RWHAP recipient partnerships with CMS/Medicaid and CDC through HIV and HCV affinity groups.
- HAB is working with CDC- and SAMHSA-funded programs to address HCV in people of color living with HIV.
- RWHAP recipients are encouraged to use telehealth and other innovative service delivery models. These are explicitly allowed under the revised 16-02 policy.
- The SPNS Using Evidence-Informed Interventions to Improve Health Outcomes among PLWH (E2i) uses implementation science to support effective evidence-informed interventions.
- Addressing the HIV Continuum in Southern Metropolitan Areas, supported through SMAIF, is exploring best practices to improve health outcomes in four jurisdictions.
- HAB is supporting an initiative focused on integrating oral health and primary care of PLWH across RWHAP-funded clinics.
- HAB is encouraging greater use of data to drive improvements in care. These activities include performance measures, benchmarking and use of data dashboards that make data more meaningful and useful and reflect realities of patient populations, and chart abstraction that provide access to data not collected in the RSR but important in assessing patient needs and the quality of care.

Dr. Cheever announced a new senior advisor, Cytrice Bellamy. In addition, HAB is currently recruiting a Director for the Division of State HIV/AIDS Programs.

## CDC/NCHHSTP Report

### **RADM Jonathan Mermin, MD, MPH**

Director, CDC, NCHHSTP  
CHAC DFO, CDC

Dr. Mermin provided an update on key NCHHSTP activities.

- CDC has issued five-year cooperative agreements, totaling an estimated \$95 million, to 59 health departments. Activities include: STD surveillance; STD outbreak response; identification of people with STDs and linkage to treatment; partner services; promoting STD screening, diagnosis, and treatment among providers; partnerships development; and use of data for program improvement.

- The 2017 National Youth Risk Behavior Survey Results and Trend Report indicates that fewer high school students are having sex and using drugs but many are still at risk of HIV and STDs. For those that are sexually active, condom use has declined. In addition, one in seven reported misuse of prescription opioids.
- CDC is funding a five-year cooperative agreement to promote adolescent health through school agencies. The estimated \$85 million will support school-based surveillance and HIV/STD prevention. It will also support technical assistance and capacity building. These activities will reach 2.2 million students.
- CDC has calculated a new HCV prevalence estimate by analyzing blood test results from National Health and Nutrition Examination Survey (NHANES) data and groups not traditionally captured by the survey. The findings indicate that more than 2.4 million Americans were living with past or current HCV from 2013 through 2016. Almost all of these people can be cured, making screening and referral to treatment a top priority.
- CDC issued a health advisory in June 2018 on ongoing hepatitis A outbreaks in multiple states among people reporting drug use or homelessness. There were more than 7,200 of infections from July 2016 through October 2018 and there were 74 deaths. Cases are clustered in 12 states. In July 2018, CDC implemented an Incident Manager Structure to support states with outbreaks.
- The Advisory Committee on Immunization Practices issued new hepatitis A and hepatitis B vaccination recommendations—routine vaccination of homeless individuals for hepatitis A. Use of the new two-dose hepatitis B vaccine (Heplisav-B) is recommended for adults.
- A new Act Against AIDS initiative, *Transforming Health: Patient-Centered HIV Prevention and Care*, provides materials for health care providers to deliver HIV prevention, testing, and treatment to transgender people.
- A national directory of health service providers offering PrEP has been developed. It includes more than 1,800 public and private PrEP providers.
- CDC has awarded funding to enhance high-impact HIV prevention demonstration projects—20 health departments have been awarded an estimated \$14.6 million. Strategies include: improving PrEP adherence in specific populations; interventions addressing social and structural factors; innovative methods such as molecular epidemiology to limit HIV cluster growth; and telemedicine.
- Funding is available for FY2019 to support a capacity building network to improve the HIV prevention workforce. Activities include: national training; regional technical assistance; continuous quality improvement; organizational sustainability; and marketing and administrative support for the network.
- The latent tuberculosis (TB) infection treatment recommendations were updated. Over 85 percent of new TB cases in the United States are re-activation of latent cases. The recommendations call for the use of once-weekly isoniazid-rifapentine for 12 weeks (3HP) for treatment of latent TB infection.
- The [Pregnancy and HIV, Viral Hepatitis, STD, and TB Prevention website](#) has been updated. Updates have been made to data, CDC activities, and screening guidelines.

New NCHHSTP staff are Deron Cornell Burton, MD, JD, MPH, Associate Director for Health Equity and Director of the Office of Health Equity and Rachel Powell, Associate Director for Communications Science.

## Questions/Comments Related to HAB and NCHHSTP Updates

Dr. Belzer asked about how to approach the increase of STDs in the age of PrEP—there needs to be a balance between preventing HIV and preventing STDs. Dr. Mermin stated that it has always been a challenge in public health to get people to recognize and respond to risk. Given the overlap between HIV and STD, STD prevention, screening, and treatment services need to be easy and accessible. PrEP recommendations call for regular STD screenings, which can result in earlier identification. It is also necessary to make three-site STD testing easier, especially in terms of reimbursement. Dr. Bolan added that combined messaging is important (e.g., condom use) and there must be an ongoing focus on vaccines and treatment advances, such as PrEP and post-exposure prophylaxis (PEP) for STDs and long-acting implantable treatment for STDs.

Dr. Taylor asked if CDC could add information about hepatitis B vaccination for pregnant women to the website focused on pregnant women. Dr. Mermin stated that if there are existing guidelines related to the hepatitis B vaccine and pregnant women they will add it.

Dr. Taylor asked if CDC could add information related to preconception screening and treatment for syphilis. Dr. Mermin stated that Dr. Taylor should submit recommendations to the CDC for consideration.

Dr. Gaist asked if there has been any research related to the effectiveness of syringe exchange programs (SEP) in terms of their legal status, who operates them (i.e., health department or community-based organization [CBO]), and what type of services are offered (e.g., are they offering hepatitis A and B vaccines). SEPs may have a greater level of trust with the target population than other organizations in the community. Dr. Mermin stated that most SEPs are not being used to their full potential such as providing naloxone and vaccines. Given their connection to the target population, expanding services should be encouraged.

Ms. Leonard asked about how to ensure rapid antiretroviral treatment (ART) initiation with presumptive eligibility for the RWHAP. Some organizations will not prescribe ART if there are delays in the presumptive eligibility paperwork. There are estimates that up to 30 percent of those given presumptive eligibility will not be covered. Dr. Cheever stated that HAB is working on this issue. There are best practices focused on speeding up certification of RWHAP clients. HAB is also exploring how to manage the risk related to ineligible clients. Several recipients who have successfully implemented rapid initiation will be presenting at the Ryan White National Conference in December.

Ms. Scruggs stated that a more holistic approach is necessary—not just connecting HIV and STDs but looking at broader health issues. Community health workers (CHWs) should be talking to people about diabetes, hypertension, and more. In addition, PrEP navigators are necessary to help people on PrEP stay on PrEP. They should also use this connection to address broader health issues. Dr. Cheever stated that HAB has always promoted a patient-centered approach that addresses more than HIV treatment, particularly as aging client populations have increasing comorbidities. Dr. Mermin stated that STDs are still highly stigmatized—to some degree much more than HIV. Ms. Scruggs added that it was necessary to teach people to publicly disclose their HIV status—addressing stigma and helping them address it. This must also take place with STDs.

Mr. Hursey asked that given that in some jurisdiction transmission of HIV to another person is still criminalized, what is being done to maintain the privacy of PLWH in the collection of surveillance data and identification of HIV clusters. Dr. McCray stated that CDC works with partners so that they understand data are confidential at the national and state level. They cannot be subpoenaed without the consent of the individual. In addition, CDC is working with states to update their laws related to HIV and is also working with district attorneys.

Dr. Stoner asked if HHS is considering developing a national STD strategy, especially given the connection between STDs and the opioid crisis. Dr. Beckham stated that OHAIDP is considering developing a national STD plan.

Dr. Havens stated that STDs guidelines need to be elevated to the same level of HIV guidelines (e.g., treatment of partners). Discrete funding streams create challenges at the state and local level. An integrated approach focused on sexual health is needed. Dr. Cheever acknowledged the challenge of discrete funding streams. Steven Young stated that cost modeling research conducted several years ago related to the integration of federal HIV funds in jurisdictions showed that it might not be more cost effective but it could result in better care; this would require legislative authority to conduct a pilot program. Given better treatment now, the results may be even more compelling. Dr. Cheever stated that the RWHAP is constrained by the requirements of the legislation.

Dr. Taylor asked if there could be a performance measure related to screening RWHAP clients for HCV on an annual basis. Dr. Cheever stated that the RWHAP is required to follow existing HHS treatment guidelines. If guidelines are updated to call for annual screening this could be done.

## National HIV/AIDS Strategy: Framing for the Future

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

Ms Hauck introduced the presentations, which include an update on NHAS 2025 and initiatives and strategies from the field.

**Kay Hayes, MPA**  
HHS, OHAIDP

National public health strategies have multiple benefits. These include: engagement and collaboration with stakeholders; consistent priorities and communication across federal programs; increased focus on need; high-impact action; and monitoring of progress. Both the NHAS and the National Viral Hepatitis Action Plan run through 2020 and each have four broad goals. Updating each will focus on:

- Key Characteristics of National Strategies**
- Ambitious goals and targets
  - Efficient and effective strategies
  - Incorporate scientific advances
  - Leverage existing infrastructure
  - Improve accountability
  - Break down silos
  - Integrate best practices
  - Foster engagement

- Scientific and clinical advances;
- New challenges that have emerged (e.g., opioid crisis);
- Opportunities for integration; and

- Need to accelerate progress, conserve resources, and reduce healthcare costs.

Development of new strategies engages both federal partners and the wider stakeholder community. There will be both a federal steering committee and federal implementation workgroups. Subcommittees will be convened to updated goals and address special topics. Non-federal stakeholders will be able to participate in listening sessions and provide written comments in response to requests for information.

In updating the plans, HHS has identified topics of interest. These include: key changes to make to the strategies; opportunities to improve the national response; actions to improve efficiency and effectiveness; and monitoring and evaluation methods.

The timeline for developing the strategies.

- October 2018 – February 2019: Launch efforts with federal partners; engage stakeholders; review evidence.’
- January 2019 – March 2019: Review input and draft strategies; develop dissemination and communications plans.
- Spring/Summer 2020: Release updated strategies.
- Summer 2020: Develop federal/non-federal work plan; develop partner planning guide.

Listening sessions have already been conducted at the U.S. Conference on AIDS and with the National Alliance for State and Territorial AIDS Directors. A listening session will be conducted at the National Conference Ryan White Conference in December 2018.

**Clover Barnes, MBA**

District of Columbia Department of Health

As a result of a public/private partnership formed in 2015, the DC Department of Health has developed the 90/90/90/50 Plan. The plan, released in 2016, includes 42 tasks, eight demonstration projects, four public calls to action; and activity metrics. The plan includes multiple strategies:

- Sexual health and wellness framework;
- Youth oriented sexual health campaign (Sex is...) that addresses empowerment and social justice and includes youth advisory board;
- One-stop, comprehensive sex and wellness resource (Sexual Being);
- Undetectable = Untransmittable;
- Expanded PrEP access and support;
- Rapid ART;
- Health Equity; and
- Regional health systems (service-driven funding across jurisdictions).

<p><b>Goals: DC Plan</b></p> <ul style="list-style-type: none"> <li>• 90% of DC residents know HIV status</li> <li>• 90% of persons diagnosed with HIV enter treatment</li> <li>• 90% of persons in treatment achieve viral suppression</li> <li>• 50% decrease in new HIV infections</li> </ul>
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**Johanne Morne, MS**

New York State Department of Health

Ending the Epidemic is a three-point plan to move closer to the end of the AIDS epidemic in New York State. The goal is to use evidence-based tools related to prevention, access to care,

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surveillance, and data to reduce the number of new HIV infections to just 750 (from an estimated 3,000) by 2020 and achieve the first ever decrease in HIV prevalence in New York State. There is ongoing community input via advisory groups. The plan includes three-points:

- Identify persons with HIV who remain undiagnosed and link them to health care;
- Link and retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission; and
- Facilitates access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative.

The plan also focuses on addressing social and structural challenges. These include addressing housing, decriminalization, and issues related to young people (e.g., parental consent).

Viral suppression is the key indicator in terms of quality of care. The 2020 goal is a viral suppression rate of 85 percent.

PrEP is a focus of the plan—16,000 are currently on PrEP and work is underway to increase access. PrEP detailing is a successful strategy for building provider confidence in prescribing PrEP and increasing the number of providers offering PrEP to patients. Work is also underway to increase access to post-exposure prophylaxis via a pharmacy pilot project. The plan also addresses HCV, increasing rates of STDs, and drug user health (i.e., harm reduction approach with SEPs as hubs for services). Health equity (i.e., stigma and discrimination) is also a focus.

Progress toward meeting the plan's goals are tracked via an interactive, real-time [data dashboard](#). This allows transparency and also facilitates ongoing community input.

### **Questions/Comments**

Ms. Hauck stated that the two local plans represent different ways to initiate these activities—DC grew out of a public/private partnership and New York's plan was initiated in the public sector with leadership from the Governor with significant input from the community. In addition, both plans emphasize the importance of innovation, policy change, and accountability in addressing the epidemic.

Ms. Hauck asked if there are new opportunities for federal agencies to collaborate with states and cities as plans are updated and implemented. Ms. Barnes stated the funding flexibility is important—especially in terms of implementing innovative activities. Ms. Morne stated that there needs to be the opportunity to foster grass roots innovation—not just rely on sanctioned best practices. Federal agencies also need to support integration of services.

Ms. Leonard stated that, as a person living with HIV, she is sensitive to language such as “Ending the Epidemic.” The goal is not to end AIDS—which means eliminating HIV and those that live with the virus and can reinforce the stigma associated with HIV/AIDS—but to end new infections. Ms. Barnes stated that PLWH and those at risk are included in all the activities related to development and implementation of the plan. Ms. Morne stated that Department of Health is conducting research related to the impact of stigma and working with providers to reduce stigma. The Department of Health has also conducted a review of all their materials/resources to remove stigma-laden language. Ms. Hayes stated that the Presidential Advisory Committee on HIV/AIDS (PACHA) held a summit focused on stigma reduction. Most of the work in this area has been done in other countries. Mr. Aleshire stated that in the

Washington State plan there was an emphasis on improving the health of PLWH. This helped to counter the language about “ending AIDS.”

Dr. Mermin asked why such a high proportion of the new infections in New York State are occurring in New York City while infections seem to be disproportionately dropping in the rest of the state. Ms. Morne stated that New York City has seen a decrease in the number of new infections and has implemented some innovative initiatives such as shifting from STD clinics to sexual health clinics.

Dr. Anderson asked Ms. Barnes and Ms. Morne to identify the single most important activity in the plans in terms of reducing new infections. Ms. Morne stated that access to stable housing is critical. She also added that it is possible to have a huge impact on transmission as was seen with perinatal transmission of HIV. Common and consistent goals allowed people to work together to almost eliminate perinatal transmission. Ms. Barnes stated that biomedical interventions (i.e., PrEP) have been extremely important. People need to be educated about PrEP and access must be expanded.

Mr. Millet raised the issue of achieving continuous viral suppression. A recent CDC analysis found that few people are able to achieve continuous viral suppression and rates are lower for African Americans than for Whites. Given that many PLWH now see their provider on an annual basis (guidelines for PrEP call for patients to see their provider every three months), consistent messages related to continuous viral suppression, especially in campaigns like U=U, are necessary.

Mr. Millet stated that Truvada’s patent ends in 2020. This presents an opportunity to greatly increase access to PrEP and plans should be developed to expand access to PrEP.

Mr. Millet stated that there should be better coordination between the NHAS and plans to end the HIV epidemic. In addition, current plans need to be reviewed to determine if progress is being made toward accomplishing goals, whether goals are still relevant, and what are the remaining gaps. Ms. Morne stated that in developing their plan, New York State looked for opportunities to align with the NHAS but also to ensure that state plans align with community priorities.

Mr. Millet stated that HIV infection is increasing in Latino men who have sex with men (MSM) and more information about this population is necessary.

Mr. Hursey stated that more diversity is necessary within organizations—from top to bottom. Representatives from the entire PLWH community should be involved in planning activities and employed at all levels of organizations providing services to PLWH.

Mr. Hursey stated that with U=U, the message focuses on PLWH achieving viral suppression. Preventing HIV infection should be everyone’s responsibility—both those that are positive and those that are negative. All the responsibility should not be placed on PLWH. Education efforts must also target people who are HIV negative. Ms. Leonard added that PLWH have a better understanding of the science related to viral suppression as an HIV prevention strategy—they trust the science. More work is necessary to educate people at risk.

Ms. Barnes emphasized the need to break down funding silos to allow communities to optimize resources and support service integration.

## CHAC Discussion on NHAS

Dr. Anderson asked members to provide input on the update of the NHAS as OHAIDP continues the process of engaging key stakeholders. What key ideas and messaging is necessary as federal agencies move forward in developing NHAS 2025? What action plans should HHS, HRSA, and CDC consider for the NHAS? How can federal agencies leverage current action plans in relation to future opportunities?

Dr. Havens stated that a National STD Strategy, similar to NHAS and the National Viral Hepatitis Action Plan, is necessary.

Dr. Havens emphasized the importance of flexible funding, especially including the BPHC. To screen and treat individuals with HIV, viral hepatitis, and STDs, it will be necessary to rely on primary care providers. Primary care providers must develop their capacity to deliver these services and address access issues such as stigma.

Dr. Stoner emphasized the importance of supporting adherence both for ART and PrEP. Behavioral interventions and re-linkage strategies (especially for PrEP) are necessary. Dr. Gaist added that there needs to be more focus on the integration of biomedical interventions and behavioral interventions.

Dr. Taylor emphasized the need for better coordination with correctional facilities, especially with transition plans. Continuity of care must be maintained for people both entering and leaving facilities (e.g., continuing methadone). Condoms should also be available in correctional settings. Dr. Cheever states that RWHAP funds can be used for transitional services and HAB's HCV workgroup is focusing on correctional health.

Dr. Taylor stated that more time is needed during medical visits, especially as PLWH age. There is not sufficient time to address the range of issues experienced by patients as they age.

Ms. Hauser stated that young people, especially young people of color, are often criminalized and stigmatized. This relates to who they are and the communities they come from and is not related to HIV. More research is necessary into the impact of this stigma and the trauma associated with it. The concept of "healing justice" could be an approach. Private (e.g., foundation) support should be sought to explore this issue.

Ms Hauser stated that in many communities sex education has decreased and there has been a rise in abstinence-focused education. Non-shaming, sex-positive education is necessary, especially in the age of PrEP.

Mr. Aleshire stated that laws relating to HIV need to be identified and revised. Washington State reviewed all laws related to HIV to identify where HIV was treated different from other STDs and provided recommendations to the state legislature for revisions. This recommendation could be included in the NHAS.

Dr. Mera stated that most STD screening is based on perceived risk. While this may be cost effective, targeting people based on risk can result in missed opportunities for identifying infections. HIV moved from risk-based screening to universal screening. Age-targeted screening for STDs may not be cost effective but it would be more effective in identifying infections.

Dr. Mera stated that PrEP should be more widely available in primary care, urgent care, and emergency department (ED) settings. He works in an HIV clinic and while they prescribe PrEP, they do not see many HIV-negative clients. PrEP should be made available in settings that see people at risk for HIV.

Dr. Kates stated that the NHAS should align with what is being done internationally, especially PEPFAR. In particular, attention should be paid to whether HIV is integrated into primary care or HIV-related services remain distinct. There also needs to be a commitment to PLWH and those at risk.

Dr. Philip stated that language should be harmonized across federal plans and state plans.

Dr. Philip stated that there needs to be resources and dissemination strategies to support the implementation of STD-related best practices.

Ms. Leonard stated that it is important to consider the age of target populations in terms of “generations” impacted by HIV/AIDS. People have different lived experiences depending on their age and when they were diagnosed. There has been criticism that older people are driving the discussion related to prevention and the voices of younger people are not being heard. National plans need to distinguish between different generations, both for those at risk and PLWH.

Ms. Hauser stated that there needs to be guidelines and protocols for providing PrEP to people under age 18 (i.e., address parental consent).

Mr. Hursey stated that PrEP also needs to be considered within broader national policy debates. For example, current discussion related to denying citizenship to people who receive public services. What are the implications for undocumented individuals receiving PrEP from a public-supported program?

## Examining Strategies for Serving Women, Infants, Children, and Youth Living with HIV

### **Captain Mahyar Mofidi, DMD, PhD**

Division of Community HIV/AIDS Programs, HRSA/HAB

There has been important progress in HIV trends for women, infants, children, and youth (WICY) living with HIV in the last two decades. However, challenges exist as well as disparities in specific populations. Key considerations are the update of NHAS, ensuring that funding follows the epidemic and the populations most impacted, and national focus on using data to inform program priorities. Efforts must also be focused on elimination of perinatal HIV transmission and monitoring and evaluation of efforts.

### **Stacy Cohen, MPH**

Division of Policy and Data, HRSA/HAB

An important population served since the early days of the RWHAP is WICY. The RWHAP serves a significant number of women living with HIV in the United States—58.3 percent in 2015. Among all RWHAP clients in 2016, 5.5 percent are 24 years of age or younger. An additional 17 percent are age 25-34. Among the youth (aged 13-24), over two thirds are male.

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In these men, the major transmission mode is male-to-male sexual contact. With women in this age group, 48 percent are infected through heterosexual contact and 49 percent were infected at birth. In 2016, only .9 percent of RWHAP clients were under 12 years of age. Of these, 2,378 were infants (less than 2 years of age) being served by the RWHAP. It is important to note that these children may or may not be infected with HIV.

Women served by the RWHAP have a slightly better retention in care rate (83.7%) than overall RWHAP clients. In terms of viral suppression, women are slightly below RWHAP clients at 84 percent vs. 84.9 percent. Youth have a lower rate. For RWHAP clients in 2016, youth 13-24, had a viral suppression rate of 71.1 percent.

While Part D is specified for WICY, the WICY population receives services from providers funded through multiple Parts. For women, the top RWHAP services accessed are outpatient ambulatory health services, medical case management, non-medical case management, and transportation. For youth, age 13-24, after outpatient ambulatory health services, medical case management, and non-medical case management, the top services are mental health, health education and risk reduction, and transportation.

### **Captain Mahyar Mofidi**

Division of Community HIV/AIDS Programs, HRSA/HAB

Capt. Mofidi provided an overview of the RWHAP Part D program, its historical roots, evolution over the last two decades, purpose, appropriations, and number of recipients. A new initiative, through a contract that HRSA HAB, is being implemented to understand how to strategically target RWHAP Part D resources to maximize national impact. Some of the questions being addressed are:

- What are the overarching considerations or directions for the RWHAP Part D program, specifically to better target its resources to maximize national impact at improving linkage, engagement in care, and health outcomes for the WICY populations?
- Given existing resources, what are the current gaps that the RWHAP Part D program is not meeting for the WICY population?
- Are there specific subpopulation challenges that should be approached differently with the RWHAP Part D funds?
- How should the RWHAP and the other Parts of the RWHAP be leveraged effectively to get improved results for the WICY population?

### **Monique Hitch, MSHA**

Division of Community HIV/AIDS Programs, HRSA/HAB

HRSA HAB has engaged in multiple activities to support the WICY population.

- **Building Futures: Supporting Youth Living with HIV.** This evaluation study focused on identifying barriers and best practices to support youth living with HIV accessing RWHAP-funded services. This project also worked to identify best practices in organizations that have been successful in serving youth. Best practices were identified, tested, and compiled in a toolkit.
- **SPNS Initiative of Social Media to Improve Engagement, Retention and Health Outcomes.** This initiative will implement and evaluate social media methods to engage young adults across the HIV care continuum.

- **Improving Health Outcomes for Black MSM.** HAB funded the NASTAD to develop the Center for Engaging Black MSM Across the Care Continuum (CEBACC). The CEBACC developed resources for both providers and MSM of color, many of which were focused on sexual health.
- **Accelerating the Elimination of Perinatal HIV Transmission.** This initiative, included in the President’s FY 2019 budget, focuses on the elimination of mother-to-child HIV transmission efforts, primarily through ongoing collaborations with health departments and the RWHAP Part D program. HAB and CDC will present a three-session institute on perinatal HIV transmission at the National Ryan White Conference in December 2018.

**Peter Havens, MD, MS**  
Children’s Hospital of Wisconsin

This nurse-based, network case management program focuses on vulnerable youth and women who are unable to be retained in care and achieve viral suppression. For these patients, clinic-based services are insufficient to keep them in care—they are on the edges of care. The program was initiated in 1991. The program engages a wide range of state and local partners and has multiple funding sources, including RWHAP Part B and D funds.

The program serves the entire state of Wisconsin and there are PLWH in every county but one. In Wisconsin, HIV disproportionately impacts African Americans. While HIV cases have been stable since 2008, cases among males, ages 13 – 29, have been increasing significantly since 2012. The majority of cases among these young males are in African Americans. For births to women with HIV, in 2017 half of these women lived in Milwaukee County.

- | <b>Eligible PLWH</b>  |
|---|
| <ul style="list-style-type: none"> <li>• Difficulty maintaining viral suppression</li> <li>• Difficulty attending clinic on regular basis</li> <li>• Mental health/cognitive issues</li> <li>• Multiple medical diagnosis</li> <li>• Need for medication management</li> <li>• Pregnant women</li> <li>• Children under 18 years of age</li> <li>• LGBTQ</li> </ul> |

The program is designed to avoid duplication of services by utilizing community-based nurses to deliver case management services throughout the state. Nurses are based at three sites. Routine care is provided to patients in their homes while specialized HIV care is provided less frequently. The home-based approach is essential given the transportation challenges facing many patients. The program was originally designed to serve children and youth but has been expanded to serve women and vulnerable youth over 18 years of age.

The program has been very successful—93.5 percent of patients served 2017-2018 have achieved viral suppression. Key approaches used by nurses include: constant communication with patients; meet patients where they are (e.g., at home, within community); listen to patients and help clinicians understand their challenges and past trauma that may impact ability to achieve viral suppression; and support medication management. Specialized approaches are required for some populations. For example, young people may need additional support transitioning to adult services. The nurse stays with the patient during these transitions. For pregnant women, the nurse and social worker travel to obstetrics and HIV appointments and conduct outreach to the local delivery hospital.

There are multiple challenges related to implementing this program. Nurses must have strong communication skills but it can be hard to find people with these skills. This care model is also

very expensive. Safety can be a consideration given that the nurses work in the communities. It is also time intensive due to the driving required to cover the state-wide service area. Homelessness among youth and stigma and bias remain pervasive. Partnerships with clinics demand energy to maintain.

**Nancy Campbell, LMSW**

Johns Hopkins Pediatric, Youth, Adolescent, and Young Adult HIV/AIDS Program

The program was initiated in 1985 with the goals to: 1) provide state-of-the-art, evidence-based, culturally sensitive, coordinated, and comprehensive patient- and family-centered HIV primary care; 2) provide access to early identification of HIV infection and facilitate linkage and engagement in care; and 3) improve treatment and prevention strategies for HIV through clinical research. Funding is provided by RWHAP Parts A, B, and D.

The program currently serves 132 patients, ages 1 – 26 years. Approximately half acquired HIV via perinatal transmission and 61 acquired HIV through sexual contact, with 43 infected via male-to-male sexual contact. Sixty-three (63) patients are male, 65 are female, and four are transgender (male to female). The patients face multiple challenges in their lives including poverty, dysfunctional families, unstable housing, and a history of abuse and/or trauma. They experience mental health issues, cognitive delays/declines, substance abuse, trust issues, stigma, adherence/medication burn out, and difficulty with interpersonal relationship. However, they are also very resilient, insightful, resourceful, and have a strong desire for education, employment, and a good life.

Key aspects of primary care include an LGBTQ friendly environment and knowledge of the needs of this population, transgender care, availability of PrEP for patients' partners, and an integrated team approach. Both medical and non-medical case management are provided. Medical case management includes individual treatment adherence sessions. Patients that have been out-of-care for more than two months are monitored. Transition to adult care services is an important focus of non-medical care management. Mental health services are integrated into the overall program. The program is also able to provide emergency financial and transportation assistance to patients. This includes rental and utility assistance and taxi/bus assistance.

Given that young adults are more willing to transfer to adult clinics knowing that their doctor will follow them, five years ago Access Care Early (ACE) was initiated. In collaboration with the adult clinic, a sub clinic was created for patients transferring from pediatric to adult care. The adult and pediatric medical providers and pediatric social workers work together. In 2018, 22 young adults transitioned and only three had problems with adherence/follow through. Key to the success of this program are: a structured protocol; partnering and coordinating between the youth clinic and the adult clinic; preparing the patient and increasing their readiness and ability to transition; team approach; and post-transition follow up.

Ongoing gaps exist. These include: limited housing resources for youth; support needs of parents with young children living with HIV; lack of transition clinics for young patients; and lack of home-based mental health programs with knowledge of HIV. Challenges include: recurrent STDs after diagnosis, time consuming work; and balancing clinical and administrative reporting duties.

## Questions/Comments

Dr. Mofidi noted the difference between the two programs presented. In Wisconsin they are using more of a public health rather than a clinic-based approach. Johns Hopkins has an integrated approach that also incorporates mental health. Both programs target hard-to-reach populations and have a strong commitment to meeting patients “where they are at.”

Mr. Millet stated that the data collected by the RWHAP is impressive—so much is known about these patients. It is especially impressive that data on transgender clients are collected

Mr. Millet stated that it is really a significant accomplishment that there are so few perinatal cases of HIV each year. There needs to be planning and messaging for when we get to zero perinatal infections—how it was accomplished, innovations, necessary resources, and the implications for the broader epidemic.

Mr. Millet stated that the resiliency of these WICY populations is important. Even for those that are homeless or facing other challenges the viral suppression rates are high.

Dr. Belzer stated that these Part D WICY programs are the exception—most young adults receive services from adult-focused providers. The RWHAP needs to explore ways to take young people that are not successful in staying in care and achieving viral suppression and provide them with wrap-around services.

Dr. Saag stated that there will always be some people that cannot be helped—achieving 100 percent viral suppression may not be possible. Dr. Havens stated that Part D support gives his program the flexibility to be responsive to clients’ needs. Long-acting biomedical interventions (e.g., patches or injections) could be beneficial.

Dr. Anderson asked if the RWHAP tracks mental health diagnosis and interpersonal violence in relation to achieving viral suppression. Interpersonal violence has been linked to lower viral suppression rates. Ms. Cohen stated that the RSR only tracks the services patients access. However, the chart abstractions would be able to make this connection. In addition, HAB has a project focused on best practices related to interpersonal violence and is also exploring interventions to address trauma that can be implemented in various RWHAP settings..

Dr. Taylor said that there should also be a focus on eliminating perinatal transmission of HCV and STDs. Since approximately 50 percent of pregnancies are unplanned there should be a focus on preconception counseling and care. There could also be a session at the National Ryan White Conference on birth control for women living with HIV. Ms. Hitch stated that the RWHAP needs to educate recipients about the importance of preconception counseling and care. Dr. Cheever stated that care of women of childbearing age could be added to the Clinical Conference.

Ms. Leonard stated that with behaviorally infected youth it is important to have linkages to appropriate (i.e., youth focused) services. Ms. Campbell stated that many of their patients were referred by adolescent clinics, Title X clinics, as well as the ED, hospitals, and by pediatricians. Few patients have been identified in community-based outreach such as health fairs.

Ms. Leonard asked if Wisconsin has a written protocol for home visits. Dr. Havens replied that they do not. Ms. Hitch stated that over the past four years approximately one-third of Part D recipients conducted home visits and some have written protocols.

Dr. Mera stated that there are also apps that can be used to communicate with clients (e.g., videos of the client taking medication). Dr. Havens stated that clients have different preferences when it comes to communication. Some prefer face-to-face meetings. Others prefer phone calls or texting.

Dr. Mermin noted that the Food and Drug Administration (FDA) has approved PrEP for anyone who weighs more than 77 pounds. This means that it can be prescribed for most adolescents.

Dr. Mera asked why all RWHAP recipients cannot provide wrap-around services to WICY clients like Part D recipients. Dr. Cheever stated that Part D is a small part of the RWHAP. Part D recipients have these additional resources that give them flexibility to address the needs of WICY patients. It is necessary to look for ways to leverage these specialized services across all RWHAP recipients.

Dr. Belzer stated that NIH's Adolescent Medicine Trials Network for HIV/AIDS Intervention (ATN) is conducting research on effective interventions to address disparities. Dissemination and implementation strategies should be in place for when these findings are ready to disseminate.

Ms. Hauser stated every RWHAP recipients should have a youth advisory board so that responsive services can be implemented. In addition, recipient staff need training on stigma and trauma to ensure welcoming services.

Dr. Havens stated that in the last year fewer than 40 infants were born with HIV in the United States—most of the children under 5 years of age living with HIV in the United States are either immigrants or were adopted abroad. Given this, are Part D funds targeting pregnant women still necessary? Dr. Mermin stated that it is necessary to think more broadly about the health of women in general and of pregnant women. Dr. Cheever stated that these Part D-support services need to be in place to prevent sentinel events—so that perinatal transmission remains extremely rare.

Dr. Havens stated that there should be more funding for nursing case management—from the RWHAP, CMS, etc.

Dr. Anderson stated that breast feeding by HIV-infected women is not recommended in the United States. However, some women with HIV are choosing to breast feed. Part D needs to address this issue. In some cases, the response to these women is very punitive (e.g., reporting them to child protective services). There needs to be a harm reduction approach to breast feeding.

Dr. Anderson stated that testing policies need to be in place to address acute HIV in pregnancy—the partners of pregnant women who test both positive and negative should be tested. This is an opportunity to identify infected partners and connect them to care.

Dr. Taylor stated that her program uses the emocha (emocha.com) app to communicate with patients. A listing of these tech-based interventions and tools should be compiled. Dr. Cheever

stated that there is a SPNS initiative focused on social media and best practices will be identified.

## **Data-Driven Methodology for the Allocation of RWHAP Part A Supplemental Funds**

### **Steven Young, MSPH**

Division of Metropolitan HIV/AIDS Programs, HRSA HAB

RWHAP Part A provides grants to 52 eligible metropolitan areas (EMAs) and transitional grant areas (TGAs) that are most severely impacted by the HIV epidemic—73 percent of PLWH live in these areas. For the grants, two-thirds of the funds are determined by formula based on the number of living cases of HIV in the jurisdiction. One-third of the funds (called supplemental) are determined by a competitive grant process. Service priorities and local resource allocations are determined by a legislatively required planning council.

For the supplemental funds, recipients submit annual applications where they document demonstrated need based on statutory requirements and their ability to effectively utilize available funds. HAB estimates that recipients' activities related to developing the applications and the objective review process to assess the applications costs approximately \$3 million. In addition, the objective review process is not optimally effective. The jurisdictions all submit high-quality applications responsive to the review criteria—the lowest score in the last funding cycle was 89. Applications are rated individually based on their own merits and not compared to other applications. As a result, funds are distributed with limited variation from the Part A formula award.

While the legislative language mandates this approach, it is important to note that it is not aligned with current approaches for responding to the epidemic and the changing health care landscape. For example, the process for documenting need does not take into consideration the HIV care continuum. In addition, it is not aligned with the NHAS, language in the FY2019 President's Budget (call for data-driven programmatic changes), HRSA's Program Management and Operation Goals, and the move toward performance-based funding and reimbursement.

In response, HAB convened a technical expert panel (TEP) to address the issue. The TEP reviewed existing approach and related metrics, options for new, data-driven methodologies, and proposed population- and program-specific domains including need, geography, data quality, and performance. A HAB funded feasibility study carried out the following activities:

- Assessed availability, quality, and potential utility of framework data sources;
- Developed a methodology to distribute the Part A supplemental funds based on the framework with identified data sources; and
- Built a SAS model with Excel front end to test various thresholds and scenarios to inform the final approach.

The original set of proposed data considerations included 19 potential variables. These were then reduced to five variables.

- Domain: Need: Diagnosed, not suppressed (variable: current address)
- Domain: Data Quality (variable: completeness on insurance status or viral load)

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- Domain: Performance (variable: viral load suppression, threshold and improvement)
- Domain: Geographic Adjustment (variables: high percent of uninsured adults, high cost by Medicare Wage Index)

The next steps for HAB are to finalize the limited set of data inputs/sources and determine thresholds and weights. HAB will also establish “guardrails” to prevent significant fluctuations in funding that could negatively impact the continuity of HIV services in the EMAs/TGAs, and run various and focused scenarios with pros and cons.

Once a methodology is finalized, HRSA and HHS review and approval is required. Following this approval, HAB will engage stakeholders to socialize actual variables, “guardrails,” and impact. Following stakeholder input, methodology and variables will be finalized.

In order for these changes to be made the RWHAP must be reauthorized and the language regarding the annual, competitive supplemental process changed. The proposed language to reflect the new methodology is, *“Part A supplemental funds to be awarded based on metrics of need and performance as determined by the Secretary.”*

### Questions/Comments

Dr. Havens asked what variables would result in more money for recipients. Mr. Young stated that the new methodology takes into consideration both needs and performance. It balances a higher number of people that have not achieved viral suppression with performance. Key considerations are to avoid providing a perverse incentive and not to reward jurisdictions that have not provided local funds to support HIV care services.

Dr. Kates asked how the new methodology addresses geographic differences, such as HIV in the south. Mr. Young stated that there are other discretionary funding streams. Dr. Cheever added that the new methodology takes into consideration lower rates of viral suppression.

Dr. Saag stated that a capitated approach that considers cost per patient might be more acceptable to recipients. Dr. Havens stated that with a per capita funding allocation it would be important to determine what funds would be included—just RWHAP, non-RWHAP funding, or all HIV-related funding. This could be a disincentive for seeking non-RWHAP funding.

Mr. Aleshire stated that with multiple RWHAP funding streams it is hard to determine why a jurisdiction is successful—it could be a result of Part A supported activities or it could be due to the AIDS Drug Assistance Program (ADAP) or other funds. In addition, there are state funds and research funds that add to the available resources. All these factors need to be balanced so that states are not penalized for using their own funds and seeking additional non-RWHAP funding. Mr. Young stated that RSR data are used to assess success. HAB is trying to move in a direction where a jurisdiction is responsible for all clients, regardless of funding. Dr. Cheever added that the purpose of the supplemental funding is to address need. Some jurisdictions may have less need because of a highly functional ADAP. While this may seem to be rewarding poor performance, feedback from the RWHAP community indicates that HAB should be tracking need (e.g., HIV in the south). This can also be balanced with quality bonuses.

## School-Aged LGBTQ Youth Health Workgroup

**Debra Hauser, MPH, CHAC Member**

President, Advocates for Youth

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The workgroup convened multiple times between 2015 and 2017. Based on these meetings, the workgroup drafted a letter with recommendations to CDC. CDC provided a response to the letter and many of these recommendations were included in CDC's Division of Adolescent and School Health's (DASH) most recent notice of funding opportunity (NOFO). The CHAC workgroup has decided to disband, but if needed could be reactivated. Many of the participants in the group will continue to meet on an informal basis.

## Recap Day One/Review Day Two

### **Jean Anderson, MD, CHAC Co-Chair**

Professor, Gynecology and Obstetrics, Johns Hopkins Medical Institutions

Dr. Anderson summarized some of the important themes that emerged during the presentations and discussions.

- What should the NHAS 2025 look like?
- There is broad support for coordinated messaging related to viral suppression.
- More strategies are required to support people who cannot achieve viral suppression.
- The rise in STDs needs to be addressed. A National STD Strategy is necessary.
- More youth-focused programs are necessary—meeting youth “where they are” and wrap-around services such as pre-conception services and trauma informed care.
- Services supporting youth as they transition to adult services are necessary.
- Stigma remains a significant barrier to creating welcoming services that support engagement and adherence.
- Perinatal transmission of HIV has almost been eliminated. Where do we go from here and how to frame this public health accomplishment?
- Best practices (community engagement, CHWs, integration of HCV and STD services in HIV in primary care) are necessary.
- PrEP next steps: increasing uptake, measuring success, what happens when Truvada goes off patent?
- Focus on behavioral strategies to support adherence to ART and PrEP.
- Meeting the needs of subpopulations (e.g., incarcerated individuals).
- Consistent language across guidelines (HIV, hepatitis, STD).
- Reduce funding silos.
- Attention to language, especially related to stigma (e.g., not end the epidemic but end new infections).
- Emphasize the importance of trauma-informed care.

### **Discussion/Comments**

Dr. Stoner asked how CDC and HRSA can work together to address the STD, viral hepatitis, and HIV epidemics. Health equity is an important consideration—some communities need more support.

Dr. Belzer stated that it is important to look at the NHAS 2020 goals and see where we are. Progress has been made. It is necessary to look at what is working and factor this into the goals of the plan for 2025.

Dr. Havens stated that given the similarities, a single plan for HIV, viral hepatitis, and STDs might be the most effective approach.

Dr. Havens stated that Part D funding allows a great deal of flexibility to recipients. Could a recommendation be made for RWHAP and Medicaid to provide the same level of flexibility? Ms. Dempsey stated that there is flexibility in Medicaid funding. However, there are still 400,000 people that are not receiving care. This needs to be reflected in the NHAS. Organizations like the Kaiser Family Foundation are looking at policy and making recommendations.

Dr. Mera asked why the best practices identified by Part D have not been rolled out to all RWHAP recipients. Dr. Cheever stated that given multiple funding streams that the accomplishments cannot be directly attributed to Part D funding. It is necessary to leverage all funding.

Dr. Taylor emphasized the importance of flexibility in funding while still maintaining accountability. Dr. Mofidi states that there is flexibility in Part D but services still must meet programmatic requirements related to allowable services. Site visits ensure that recipients adhere to legislative requirements. Ms. Dempsey added that RWHAP patient advocacy activities support quality services.

#### **CHAC Action**

Dr. Anderson called for a vote to approve formation of a workgroup to make recommendations related to NHAS 2025.

Second: Debra Hauser

Passed unanimously

Mr. Millet will serve as chair for this workgroup. Members who are interested in participating should contact Theresa Jumento.

Dr. Cheever recessed the meeting at 4:50 p.m. on November 7, 2018.

### **Opening Session: November 8, 2018**

#### **Laura Cheever, MD, ScM**

Associate Administrator, HRSA, HAB  
CHAC DFO, HRSA

Dr. Cheever announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. She called the proceedings to order at 8:33 a.m. and welcomed the participants to the CHAC meeting. Dr. Cheever called roll and confirmed that the 13 voting members in attendance in addition to ex-officio members (or their alternates) constituted a quorum for CHAC to conduct its business on November 8, 2018.

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 to recuse themselves from voting or participating in these matters.

### CONFLICT OF INTEREST DISCLOSURES

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Richard Aleshire, MSW, ACSW (Washington State Department of Health)	No conflicts.
Jean Anderson, MD (Johns Hopkins Medical Institutions)	Recipient of funding from HRSA/RWHAP and National Institutes of Health (NIH) and stock in Gilead and information technology (IT) companies.
Marvin Belzer, MD, FACP, FSAM (University of Southern California, Keck School of Medicine)	Recipient of funding from HRSA/RWHAP, CDC, Substance Abuse and Mental Health Services Administration (SAMHSA), and NIH.
Peter Havens, MD, MS (Children's Hospital of Wisconsin)	Recipient of funding from HRSA/RWHAP and NIH.
Devin Hursey (U.S. People Living with HIV Caucus)	Recipient of from HRSA/RWHAP.
Jennifer Kates, PhD (Kaiser Family Foundation)	No conflicts.
Amy Leonard, MPH (Legacy Community Health Services)	Recipient of funding from CDC and HRSA/RWHAP.
Jorge Mera, MD (W.W. Hastings Indian Hospital)	Recipient of funding from HRSA, SAMHSA, Gildead, Abbvie. Dr. Mera has also received speakers fees from Gilead and AbbVie.
Greg Millett, MPH (amfAR)	No conflicts.
Susan Philip, MD, MPH (San Francisco Department of Public Health)	Recipient of funding from HRSA/RWHAP, CDC and NIH, Luminostics, Roche Diagnostics and an unpaid public health advisor for GlaxoSmithKline.
Michael Saag, MD (University of Alabama at Birmingham, School of Medicine, UAB Center for AIDS Research)	Recipient of funding from HRSA/RWHAP, CDC, and NIH and a consultant for Merck, Gilead, and VIVE.
Bradley Stoner, MD, PhD (Washington University School of Medicine)	Recipient of funding from HRSA, CDC and NIH.
Lynn Taylor, MD, FACP (University of Rhode Island)	Recipient of funding from HRSA/RWHAP.

### Public Comment

**Carl Schmid**  
The AIDS Institute

The AIDS Institute conducted an analysis to examine where current RWHAP funding is distributed and whether the funding tracks the HIV epidemic. The findings are intended to inform discussions about how RWHAP funding is being distributed and how funds can be better allocated in the future to achieve greater viral suppression in RWHAP clients across the country. The analysis examined FY 2017 funding awards by RWHAP Part and per HIV/AIDS case count. Funding was analyzed in the following ways:

- Per case above/below median for Parts A and B (including ADAP);

- Per case above/below median for Part B (ADAP);
- Total Part B and ADAP supplementals;
- Total Part C and total Part D;
- Per case above/below median for Parts A – D (including ADAP); and
- Per case above/below median for Parts A – D (including ADAP) multiplied by total number of cases.

States were ranked in three ways: Parts A – D, including ADAP, funding per case; Parts A – D, including ADAP, funding per case multiplied by total cases; and Parts A and B, including ADAP, funding per case. Medicaid expansion was also taken into consideration.

There are limitations to the analysis due to data. Data were not available for Part A awards and Part B emerging community awards that include multiple jurisdictions. Such awards were credited to only one state so some state funding amounts were higher than what the state received and others were lower. In addition, Mr. Schmid noted that any revision of funding should take into consideration other factors besides case counts. He also noted that HRSA does not currently have the flexibility necessary to change funding formulas. This will need to be done through reauthorization of the RWHAP legislation.

The findings of the analysis will be presented at the National Ryan White Conference in December 2018.

### **George Fistonich**

Infectious Disease Society of America (ISDA), HIV Medicine Association (HIVMA)

On behalf of the Infectious Diseases Society of America (IDSA), HIV Medicine Association (HIVMA), and Pediatric Infectious Diseases Society (PIDS), we thank you for the opportunity to provide public comments. We wish to express our continued concerns in addressing a number of urgent and emerging public health issues, especially infectious diseases related to the opioid crisis and the growing sexually transmitted infections epidemic. IDSA represents over 11,000 physicians, scientists and other healthcare professionals who specialize in infectious diseases (ID). HIVMA represents more than 5,000 clinicians and researchers working on the front lines of the HIV, viral hepatitis and other STD epidemics. PIDS represents 1,100 professionals dedicated to the treatment, control and eradication of infectious diseases affecting children.

### **Meaningfully Address the Growing STD Epidemic**

At last year's fall CHAC meeting, we called on the federal government to declare a national public health emergency and develop a national STD control strategy after CDC reported in 2016 the highest numbers of diagnosed STIs ever recorded. The CDC 2017 STD Surveillance Report demonstrated the fourth consecutive year of increased diagnoses of chlamydia, gonorrhea, primary, secondary and congenital syphilis, underscoring the growing need to prioritize treatment and prevention at the local and national levels. A national public health emergency, now also endorsed by the National Coalition of STD Directors, is needed now more than ever.

Following the report's release, IDSA and HIVMA leaders published an op-ed reiterating recommendations, and in a recent letter to the U.S. Surgeon General, Senator Patty Murray calls on "policymakers, health care professionals, and public health officials [to] do more to prioritize prevention, respond to the increase, and modify current practices, as necessary, to better address this challenge."

Minutes of the Meeting

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

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This year, we partnered with the National Coalition of STD Directors and Treatment Action Group to directly engage the manufacturer of benzathine G penicillin (BPG) following the serious drug shortage in 2017. While we appreciate the efforts by the manufacturer to resolve the shortage, ID and HIV providers and health departments have recently reported issues stocking the 2.4 million unit dosage of BPG. Furthermore, the cost of BPG remains a barrier to providers stocking the treatment and patients being able to afford it. Reimbursement from Medicare, Medicaid, and private insurance often is less than the cost of the drug, forcing some providers to stop treating syphilis with BPG at all. Persons who are diagnosed and not treated by their healthcare providers are at risk for loss to follow-up when referred to health departments for treatment. The ability to purchase BPG under 340B authority would enable healthcare providers outside of health departments to stock BPG and treat syphilis more rapidly. Rapid syphilis treatment would improve outcomes and decrease the time that untreated individuals are at risk for further transmitting the infection. Especially when diagnoses of syphilis, especially congenital syphilis, are skyrocketing, cost should not be a barrier accessing this older but highly effective treatment. Monitoring of prices and access by CHAC would ensure that issues with either price or access are identified early and responded to urgently.

Additionally, the cost of three site testing mouth, genital, and urinary systems, and rectum for chlamydia and gonorrhea can be another barrier to appropriate treatment and prevention. Because NAAT testing through major commercial vendors (Quest and LabCorp) costs \$600 or more for three site testing, many providers may avoid extragenital screening, which may miss additional chlamydia and gonorrhea diagnoses. The cost to large laboratories for running these tests is quite low, and because direct samples are run through instruments, the labor is minimal, making it difficult to justify charges of \$600 or more. In addition, direct billing to patients by laboratories means that healthcare providers frequently do not know how much their patients are being charged for these tests. Patients may respond by simply not being screened. It is crucial that CHAC monitor the pricing of these assays and explore mechanisms to make screening accessible and affordable if we are going to end this epidemic. The CHAC should also consider mechanisms to incentivize diagnostics companies to develop a collection device in which swabs from all three sites could be combined, so only one test would be required. Such a product could simplify testing and make testing more accessible for more patients.

Finally, clinicians in primary care settings are on the frontlines of the STD epidemic, but many lack knowledge of guidelines and recommendations about diagnosis, screening, and treatment of STDs, including those for syphilis, chlamydia, gonorrhea and HIV. With syphilis including congenital syphilis rapidly on the rise, providers must be reacquainted with its symptoms, best screening practices, and appropriate treatment to allow for timely diagnosis and effective treatment. This is also an opportunity to increase HIV screening by healthcare providers, a recommendation first made by CDC in 2006 but inadequately implemented, as well as to provide education on effective approaches to HIV prevention including pre- and post-exposure prophylaxis and HIV treatment as prevention.

#### Recommendations for the CHAC.

- Recommend that the Secretary of HHS declare the STD epidemic a Public Health Emergency to enable more aggressive and better-funded approaches to ending this epidemic.
- Commit to monitoring the price and availability of BPG and recommend that the HHS Secretary take all steps necessary to ensure that this crucial drug is available and affordable for all who need treatment for syphilis. To facilitate, we request that CHAC

recommend that the Secretary ensure all healthcare providers, in public and private sectors, who treat STDs can purchase BPG under the authority of the 340B Drug Pricing Program.

- Commit to monitoring the price of diagnostic assays for chlamydia and gonorrhea and recommend that the HHS Secretary take all steps necessary to ensure that these vital tests are available and affordable to allow healthcare providers outside of public health systems to increase diagnosis and treatment of these STDs.
- Work with CDC and HRSA to ensure that primary care providers are sufficiently educated about STDs (especially syphilis, chlamydia, gonorrhea, and HIV), including best practices for screening and treatment, as well as symptom recognition. As part of this educational effort, all providers should know best practices HIV PrEP and PEP as well as the benefits of treatment as prevention.

### **Expand Critical Interventions to Reduce Opioid-related Infectious Diseases**

This year, our organizations developed and advocated policy recommendations to monitor better the scope and begin to reverse trends of infectious diseases linked to opioid use disorder. Recent legislative actions authorized under the SUPPORT for Patients and Communities Act of 2018 (H.R.6) provide opportunities to begin tackling these major issues; however, additional programming and funding will also be required.

H.R.6 authorized a new program at CDC to improve surveillance and education regarding infections associated with injection drug use. The legislation highlights explicitly viral hepatitis, HIV, and infective endocarditis and asks that CDC implement a national system to determine incidence of infective endocarditis, a sentinel infection associated with injection drug use. While we advocated for Congress to appropriate the full \$40 million per year authorization, less was approved. CDC received an additional \$5 million in FY 2019 to carry out similar programming through the NCHHSTP. It is crucial that CDC uses this funding to expand high-impact, evidence-based approaches to ID prevention, including syringe service programs and screening and linkage to care for HIV and viral hepatitis, and we look forward to working together to ensure these critical funds are allocated effectively. We also urge the CDC to evaluate systems and methods for public health departments to collect data on infective endocarditis to allow for early detection and prevention of injection drug-related infectious diseases outbreaks.

Adequate workforce continues to be an urgent concern for infectious diseases and HIV medicine. H.R.6 also authorized a new loan forgiveness program at HRSA for providers treating patients with substance use disorder. Given the growing and critical role that infectious diseases and HIV providers play in preventing and treating infections in individuals with substance use disorders, we look forward to working with the appropriate offices to ensure that implementation of this program includes providers treating infectious diseases of patients with substance use disorders. Finally, we continue to urge for Ryan White-funded clinics and their comprehensive, patient-centered care model to be fully leveraged by making available non-Ryan White funding to treat individuals with substance use disorders who are HIV-negative but require co-treatment of substance use disorders and other serious complex conditions, like viral hepatitis.

Recommendations for the CHAC.

- Advise CDC to use H.R. 6 funding to expand high-impact, evidence-based approaches to ID prevention, including syringe service programs and screening and linkage to care

for HIV and viral hepatitis, as well as to implement a national program for surveillance of infective endocarditis.

- Advise HRSA to ensure that loan forgiveness programs under H.R. 6 specifically include providers who treat infectious diseases and HIV in persons with substance use disorders.
- Advise HRSA to work with SAMHSA to leverage the expertise and infrastructure of clinics participating in the RWHAP. By providing increased opportunities for non-RWHAP funding to provide comprehensive and coordinated care and treatment to HIV-negative persons with substance use disorders, other concomitant infectious diseases such as viral hepatitis infection can be more effectively treated.

### **Supporting the Undetectable Equals Untransmittable (U=U) Message**

HIVMA recently released a resource for medical providers to encourage discussion of the medical, individual, and public health benefits of people living with HIV achieving and maintaining a durably undetectable viral load to stop HIV transmission. We were pleased to see HRSA issue a recent Dear Colleague letter to RWHAP medical providers encouraging viral suppression messaging in all health settings where PLWH are served. Knowing that durable viral suppression prevents HIV transmission has profound impact and is critical to ending the epidemic and to leading healthy lives. We look forward to working together to amplify these messages by encouraging providers nationwide to talk to their patients.

Recommendation for CHAC.

- We appreciate messaging by CDC and HRSA about HIV treatment as prevention (U=U), and we ask CHAC to continue to endorse evidence-based messaging and education to ensure that all healthcare providers, as well as people living with HIV, know that undetectable viral load stops sexual HIV transmission.

Thank you for your consideration of our views. Please call on us as a resource as CHAC considers how to enhance the federal response to the HIV, STI, and opioid epidemics. We can be reached through HIVMA senior policy manager George Fistonich at [gfistonich@hivma.org](mailto:gfistonich@hivma.org), IDSA public health policy officer Colin McGoodwin at [cmcgoodwin@idsociety.org](mailto:cmcgoodwin@idsociety.org), and PIDS executive director Christy Phillips at [cphillips@idsociety.org](mailto:cphillips@idsociety.org).

## **HRSA Initiatives in Response to the Opioid Crisis: Update and Future Considerations**

**Antigone Dempsey,**

Division of Policy and Data, HRSA HAB

At the last CHAC meeting there were presentations by CDC and HRSA about their opioid-related work. HAB is also working on this issue. HAB's Behavioral Health Workgroup is focusing on the opioid crisis. HAB encourages RWHAP recipients to leverage their resources to respond to the opioid crisis.

Currently, approximately 7 percent of RWHAP clients were infected due to injection drug use. Of these, 85.1 percent of these clients have achieved viral suppression. Success in achieving viral

suppression varies across subpopulations. Young clients and those with no health coverage and unstable housing have lower rates of viral suppression.

Providing services to these clients is a challenge for RWHAP recipients since many do not have services in place to meet the needs of patients with substance use disorder/opioid use disorder (OUD). Only 39.5 percent of RWHAP recipients provide mental health services. In terms of substance use treatment, 17.9 percent of recipients provide these services—16.6 percent outpatient and 2.4 percent residential.

**Glen Clark**

Division of State HIV/AIDS Programs, HRSA HAB

**Elise Young**

Division of Community HIV/AIDS Programs, HRSA HAB

In July 2018, HRSA HAB convened a TEP to address the following questions:

- What are the successes/facilitators, barriers/gaps, and opportunities for addressing opioid addiction in the context of the RWHAP?
- What barriers and facilitators exist at the clinic level for addressing opioid addiction needs for RWHAP clients and patients?
- What are the barriers and facilitators that exist at the EMA/TGA and state levels to address the opioid crisis in metropolitan areas, state jurisdictions, and rural areas?

Participants included representatives from HRSA (HAB, MCHB, BPHC, Bureau of Health Workforce, Office of Regional Operations, Federal Office of Rural Health Policy, Office of Planning, Analysis, and Evaluation, federal partners (CDC SAMHSA, Office of the Assistant Secretary for Health) and the community (service providers, state and local health departments, National Association of State Alcohol and Drug Abuse Directors, Harm Reduction Coalition).

Participants identified barriers confronting PLWH with OUD. These include: defining the population (i.e., who is at risk); data gaps that make it difficult for providers to recognize who is at risk; stigma related to opioid use; negative attitudes toward medication assisted treatment (MAT); need to increase clinical training about OUD; and workforce shortages (e.g., behavior health providers). Facilitators for supporting PLWH with OUD include: leveraging telemedicine; adopting a systems approach across sectors; housing, transportation, and food supports; use of peers; education and training for all staff (i.e., receptionist to executive director); and innovative strategies for working with active addiction.

HAB will present the findings from the TEP at the National Ryan White Conference in December 2018 and obtain input from attendees. Based on the findings and input, HAB will develop resources for clinicians and pathways for technical assistance for RWHAP recipients and subrecipients

**Questions/Comments**

Dr. Mera asked if there are effective strategies for breaking down clinicians' resistance to prescribing MAT. In his organization, the clinicians did not want to prescribe MAT for various reasons such as perceived lack of time and that behavioral health services were not available on the same day as the medical appointment. Mr. Clark stated that there are various reasons for

push back so responses must be tailored. To provide technical assistance it is necessary to go onsite and assess the situation.

Dr. Mera stated that given how common OUD has become, primary care providers need to accept that this is an issue that should be addressed in primary care.

Dr. Mera stated that the limit on the number of patients that can be treated with buprenorphine by a clinician in the first year (30) is a significant limitation. In his clinic, there were 700 patients waiting for treatment. Mr. Berger stated that after one year treating 100 patients, physicians can apply to increase their patient limit to 275. Dr. Mera stated that a more rapid scale up is necessary.

Dr. Mermin stated that it is necessary to reduce the burden on both providers and patients. Treatment that requires fewer visits (e.g., buprenorphine extended-release injection) should be more widely available. Ms. Dempsey stated that HAB can work to promote awareness of these options.

Dr. Taylor stated that it is necessary to change the perception of MAT. Many people see it as substituting one drug for another. Other medical conditions are not stigmatized in this way. MAT to treat opioid addiction is like prescribing insulin to a diabetic.

Dr. Taylor stated that there is strong evidence that MAT is effective without the required counseling.

Dr. Taylor stated that barriers to MAT should be reduced. For example, people fear going into withdrawal and don't want to be in a waiting room, waiting to see the clinician for a prescription or a counseling appointment, when they are in withdrawal. In addition, evidence supports not withholding MAT from patients taking benzodiazepines.

Dr. Taylor stated the RWHAP providers should prescribe naloxone.

Mr. Millet asked if RWHAP collects data on indicators of OUD such as endocarditis or HCV. Mr. Glenn stated that the RSR collects data on services accessed but that the chart extraction project will look at patients with OUD and clinical indicators.

Mr. Millet stated the amfAR has conducted a geocoding study on access to MAT and/or syringe exchange programs. The study determined that these services are not geographically accessible for many people.

Mr. Millet stated that the RWHAP data related to clients infected as a result of injection drug use is quite positive in terms of health outcomes—the majority of these clients have achieved viral suppression, even people with unstable housing or without health care coverage.

Dr. Saag stated that there was a significant increase in overdoses starting in 2014 and asked whether a cause has been identified. Mr. Berger stated that SAMHSA and others in and outside of HHS are studying the causes of the opioid crisis. Dr. Saag suggested that it may be a result of clinicians not renewing an opioid prescription and the patient obtaining illegal opioids.

Dr. Saag stated that methadone must be obtained at specialized clinics. Making methadone more accessible should be explored. Dr. Taylor added that methadone overdose can be lethal

and that methadone is long acting—which was the rationale for the specialized clinics. She stated that in other countries methadone is available from pharmacies.

Dr. Stoner stated that AIDS Education and Training Centers (AETCs) should be working with clinicians to make MAT more available. Often the AETC trainings focus on basic information (e.g., data on the opioid crisis). The training needs to be addressing the stigma related to MAT and moving clinicians toward prescribing MAT. Dr. Cheever stated that access to training is not the only barrier. A SPNS initiative on buprenorphine identified the importance of a champion to break down stigma in an organization. BPHC has given community health centers a small amount of funding to help them address issues related to MAT. The RWHAP has some flexibility with Part C and D supplemental funds for one year of funding. However, many recipients are not interested in one-year funding. Finding new funding for such activities is complicated but HAB is working to address this.

Dr. Mera stated that behavioral health services are important. Many of these patients have multiple problems. It is better to have these addressed by a behavioral health professional, or navigator, than have the clinician work to address them. Behavioral health services can be a major facilitator in a clinic and free up clinicians' time. However, he also noted that some patients do not want behavioral health services. In his clinic, giving patients the choice resulted in more patients accessing MAT. Mr. Berger stated that behavioral health services in relation to MAT are important and SAMHSA is working to increase access.

Dr. Mera stated that there should be guidelines stating that if a patient has OUD they should not be taken off opioids unless MAT is prescribed.

Dr. Mera stated that technology such as apps (e.g., MOCHA) and telemedicine can help to increase access to treatment and improve patient outcomes.

Mr. Millet stated that methamphetamine is still a problem. Many people are addicted to more than one drug. Some people on MAT are using methamphetamine. Use of methamphetamine increases the risk of HIV. A CDC study on overdose deaths found that many people had multiple drugs in their system. There are also many cocaine overdoses and cocaine laced with fentanyl is becoming more prevalent. Dr. Cheever noted that much of the available funding is specific to opioids and cannot be used to address other drug addictions.

Dr. Taylor stated that training should be available for RWHAP providers on cultural competency related to OUD and how to deliver services that are sensitive to the needs of these patients. For example, some clinics have a rule that if a patient is more than 20 minutes late their appointment is cancelled. These patients have many challenges in their lives. They need more flexibility such as drop-in appointments. It is also important to train all staff to be welcoming and nonjudgmental. A phlebotomist complaining about the difficulty of accessing a patient's veins can be a negative experience for the patient and they might drop out of care. Dr. Cheever stated that the RWHAP encourages providers to use their data to determine why certain populations are not engaging in care and to develop solutions.

Dr. Anderson stated that the number of RWHAP clients with a history of injection drug use (7 percent) seems very low. Ms. Dempsey stated that this is self-reported data collected at the time of enrollment in RWHAP. Clients can only select one transmission category. Data related to use of non-injection drugs and drug use after enrollment in the RWHAP are not collected. Dr.

Cheever added that RWHAP providers need training on the management of chronic pain. She noted that it is a challenge to treat patients with chronic pain while avoiding addiction.

Mr. Hursey emphasized the importance of cultural competency training related to OUD. When he worked as a peer educator, he did not have lived experience in substance use disorder and needed training on how to work with patients with a history of drug use.

Dr. Belzer stated that patients with OUD are challenging patients—they are needy and feel stigmatized. Clinicians need effective strategies and training on how to care for these patients. Mr. Berger stated that SAMHSA has treatment improvement resources (e.g., Treatment Improvement Protocol 63, Medications for Opioid Use Disorder). Dr. Cheever added that behavioral health services are important and the RWHAP and RWHAP recipients should leverage and/or link to SAMHSA resources.

Dr. Taylor stated that people who are struggling with substance use disorder are sometimes diagnosed with psychiatric disorders and prescribed medication. If they do receive treatment for drug use and are in recovery, these diagnoses remain. Dr. Cheever added that substance use disorder can also mask psychiatric disorders, such as bipolar disorder.

## HRSA Telehealth Initiatives

### **William England, PhD, JD**

Federal Office of Rural Health Policy, Office for the Advancement of Telehealth, HRSA

Telehealth is defined as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include: Internet; videoconferencing; store-and-forward imaging; streaming media; and terrestrial and wireless communications. HRSA initiated telehealth-related activities in 1988. In 1995, the Joint Working Group on Telemedicine, later FedTel, was created. In 2017, the HRSA Telehealth Workgroup formed. By 2018, the HRSA telehealth inventory found telehealth in over 1,000 awards. Currently HRSA has made telehealth-related awards in all 50 states and eight territories. Also in 2018, the HRSA Telehealth Strategic Plan was completed with action items for all bureaus.

The Telehealth Strategic Plan calls for increasing the number of individuals and communities in HRSA's target populations that are served by telehealth. In addition it encourages the use of telehealth technology to support department and agency priority areas, such as addressing the opioid crisis, and calls for increasing HRSA's visibility and leadership in the field of telehealth.

The Office for the Advancement of Telehealth (OAT) focuses on Telehealth Network Grants, the Telehealth Resource Centers, Centers of Excellence, and licensure and portability issues. FY 2018 funding for OAT is \$23.5 million. The 12 regional Telehealth Resource Centers focus on advancing the effective use of telehealth and supporting access to telehealth services in rural and underserved communities. A wide range of resources are available and these have been compiled in the HRSA Telehealth Compendium. The National Telehealth Technology Assessment Resource Center is designed to create better-informed consumers of telehealth technology by offering a variety of services in the area of technology assessment to help providers select appropriate technology for their telehealth programs. The Center for Connected Health Policy focuses on advancing state and national telehealth policies that promote better

systems of care, improved health outcomes, and provide greater access to quality, affordable care. It tracks state telehealth laws and policies (e.g., Medicaid programs, reimbursement)).

OAT also collects data related to telehealth, including data related to why telehealth is not being used. The most common reason is technology issues, followed by the provider not seeing a need for telehealth (these providers are primarily in urban areas). Many other providers report that they are in the process of implementing it or researching telehealth. Cost of implementation is also a significant issue. Broadband issues remain a barrier in rural areas.

Other Federal agencies are working to expand telehealth. In October 2018, CMS announced that it is working to promote beneficiary access to telehealth, but the Medicare fee-for-service program (Medicare Advantage) telehealth benefit is narrowly defined and includes restrictions on where beneficiaries receiving care via telehealth can be located. A new proposed rule would give Medicare Advantage plans more flexibility to offer government-funded telehealth benefits to all their enrollees, whether they live in rural or urban areas. It would also allow greater ability for Medicare Advantage enrollees to receive telehealth from places like their homes, rather than requiring them to go to a health care facility to receive telehealth services. Plans would also have greater flexibility to offer clinically-appropriate telehealth benefits that are not otherwise available to Medicare beneficiaries.

**Shannon McDevitt, MD, MPH**

Office of Policy and Program Development, HRSA BPHC

In 2017, 600 BPHC-funded community health centers (CHCs) were using telehealth—approximately half of all CHCs. BPHC has supported the adoption of telehealth by allowing the use of supplemental funding over the last three years. However, barriers exist. These include the culture of the service area, the culture within the CHC, and competing priorities. In addition there is confusion over regulations, state laws, and challenges with reimbursement. Currently, CHCs are not reimbursed for serving as a site during telehealth interactions in the majority of states.

CHCs are using telehealth to provide mental health, primary care, and care for chronic conditions. An example of how telehealth is implemented is the hub and spoke model. For example, a PLWH is seen by a nurse practitioner in a health clinic. The nurse practitioner determines that the patient needs an evaluation and receives consent from the patient to make a video of the examination. After the examination, the video and data are sent to a specialist (e.g., infectious disease physician) at the “hub.” The specialist watches the video and assesses the information. A prescription can then be sent directly to the patient’s home.

HRSA is deeply invested in telehealth. For example, BPHC recently sent a letter to state and regional health care associations emphasizing the need to connect CHCs to telehealth in their jurisdictions and providing them with resources. In addition, BPHC promotes telehealth in its weekly primary healthcare digest. BPHC has also developed multiple resources to support the implementation of telehealth.

**Sherilyn Crooks, PA-C**

Office of HIV Training and Capacity Development, HRSA HAB

The mission of the Office of Training and Capacity Development (OTCD) is to strengthen and transform health care systems by supporting the development of leadership, evaluation,

training, and capacity development to assure the provision of high-quality HIV/AIDS prevention, care, and treatment. It is made up of three programs: AETC Program; SPNS; and the Global HIV Program.

The majority of OTCD telehealth activities are conducted through the AETCs. The National Clinical Consultation Center provides free, expert consultation to health care providers through phone and e-consultation. Various “warmlines” focus on HIV management, HCV, perinatal HIV, post-exposure prophylaxis, and substance use.

Via the AETCs, OTCD has implemented Project ECHO (Extension for Community Healthcare Outcomes). The model is designed to increase access to specialists in HIV care and treatment, especially in rural and underserved areas. This virtual community of practice allows for case consulting and mentoring. There are mini-didactic clinical sessions accompanied by interactive discussions of individual provider cases. Interactive polling is also conducted to assess provider knowledge. An example is an ECHO collaborative in Jamaica and the Caribbean that includes 22 clinics.

HAB provides online learning opportunities to clinicians via the National HIV Curriculum as well as an online curriculum on HIV/HCV co-infection. There are multiple modules that allow self-paced learning. Continuing education credits are available.

### **Michael Murphree, LICSW**

Medical Advocacy and Outreach

Medical Advocacy and Outreach (MAO), which was formed in 1987, is based in Montgomery, Alabama, and covers 28 counties in the state. It provides HIV-related care; case management; PrEP and PEP; patient and provider education; food, housing and medication assistance; HIV and HCV testing; and outreach. This year it expanded beyond HIV-related services to include primary care, dental, behavioral health counseling, and wellness education.

In 2014 there were over 12,400 PLWH in the state and over 480 new cases were diagnosed in 2015. There are also high mortality rates for other disease such as stroke, diabetes, and cardiovascular disease. Much of the state is rural and there are very high rates of poverty. Additional challenges include a shortage of primary and specialty care clinicians, hospital closings in rural areas, limited transportation options, high numbers of uninsured in rural areas, stigma toward healthcare in rural areas (e.g., value privacy and independence), and technology limitations in rural areas.

In response to these needs and challenges, MAO relied on teams of four clinicians travelling in vans to rural sites. However, this resulted in staff spending a significant amount of time travelling—sometimes two hours each way—and were seeing only a small number of patients.

In 2010 MAO began to explore using telehealth and launched telehealth services in 2012. MAO implemented a telehealth direct care model. The physician is at the hub site and a nurse is with the patient at the satellite site. They are connected via videoconferencing and the nurse uses tools such as Bluetooth stethoscopes. Patients can request face-to-face appointments with a physician if that is their preference.

MAO is now providing the following services via telemedicine: medical care; individual psychotherapy and addictions counseling; pharmacological management; social work services;

and follow-up telehealth consultations with other providers. The model has been expanded to much of the service area and MAO is exploring the possibility of having nurses provide services to patients in their homes.

Currently approximately 25 percent of patients receive services via the telehealth model. For patients receiving care via telehealth, over 90 percent report that they are extremely satisfied with the services. For patients with HIV receiving care via telehealth, over 95 percent have achieved viral suppression and 94 percent have been retained in care.

Collaboration is essential to this model. MAO has received funding from AIDS United, Alabama Department of Health, and CDC. In the delivery of health services it collaborates with multiple local providers.

### **Questions/Comments**

Dr. Mermin asked whether there are limitations of telehealth related to licensure. Dr. England stated that interstate commerce laws limit clinicians from practicing across state lines. The Veterans Administration has been able to address this issue. HRSA is working with the Federation of State Medical Boards, which has developed a model that allows physicians to practice in multiple states. Dr. England noted that clinicians do need to pay a fee to each state to practice in the jurisdiction. Various disciplines (e.g., physicians, psychologists) have models for practicing telehealth across jurisdictions. Dr. England added that there are many other considerations that vary from state to state, such as written consent for telehealth treatment. HRSA is tracking all states related to telehealth (e.g., reimbursement and other legal issues).

Dr. Anderson stated that state borders are a significant issue. Data indicate that patients receiving care in another state are difficult to retain in care. She asked how the CHAC should frame a recommendation related to expanding the use of telehealth. Dr. England stated that this has been an issue for more than 30 years and it is very complicated.

Dr. Mera asked about the clinics that stated they did not need telehealth and whether this is a valid assessment of whether it is feasible and would improve the quality of care. Dr. McDevitt stated that many CHCs do not understand the benefits of telehealth and the available modalities. More education and technical assistance are necessary.

Dr. Havens asked whether MAO is receiving fee-for-service payments. Mr. Murphree stated that RWHAP/Medicaid/Medicare pay at parity. Blue Cross/Blue Shield is also paying at parity. Private insurance has recognized that this is quality care and there are few providers accessible to these patients. These services keep these patients from seeking care in the ED.

## **Development of Guidance for Universal HCV Screening among Pregnant Women and All Adults**

**Paul Weidle, PharmD, MPH**

Division of Viral Hepatitis, NCHHSTP, CDC

CDC's Division of Viral Hepatitis is in the process of Grading of Recommendations Assessment, Development, and Evaluation (GRADEing) evidence for universal HCV screening among 1)

pregnant women and 2) all adults. The Population, Intervention, Comparator, Outcome (PICO) questions addressed by this process are:

- Does universal screening for HCV infection among pregnant women, compared to risk-based screening, reduce morbidity and mortality among mothers and their children?
- Does universal screening for HCV infection among adults aged 18 years and older compared to risk-based screening reduce morbidity and mortality?

As part of this process, a systematic literature review was conducted. There are few studies that directly compare universal screening to risk-based screening, resulting in limited evidence. For pregnant women, 1,498 titles/abstracts were reviewed and only one study was eligible to GRADE. For adults, 4,838 titles/abstracts were reviewed and review of full text is underway.

There are many factors not addressed through the evidence review that need to be considered. These include:

- When should testing take place (e.g., age-based, no defined age)?
- Should the recommendations be setting-/provider-/prevalence-based?
- What are the logistical issues to be considered or overcome (e.g., provider burden)?
- Will final guideline wording translate easily into clinical decision support tools?

CDC would like to engage experts to ensure a wide range of perspectives and input into the decision-making process. The CHAC can play a role in obtaining this input and identifying stakeholders to participate in a CHAC workgroup. Stakeholders include: patients, primary care providers; federal partners; professional organizations, and others.

Next steps in the process are: 1) complete evidence review and provide findings to CHAC workgroup by February 2019; 2) CHAC workgroup reviews evidence and formulated recommendations (February – May 2019); and 3); presentation and discussion of workgroup recommendations at May 2019 CHAC meeting. Following discussions, CHAC members would make a final consensus endorsement/opposition of workgroup recommendations to be considered by the CDC.

## **Questions/Comments**

Dr. Havens stated that the CHAC HCV Workgroup has been expanded and already includes many of the stakeholders identified by Dr. Weidle. CDR Sarah Schillie from the CDC is already involved with the workgroup. The workgroup has already developed some initial recommendations related to screening pregnant women. There has been a high level of interest in this topic and it is important to engage all stakeholders. Dr. Weidle asked that the workgroup provide input on the factors not addressed through the evidence review (see above). Dr. Mermin stated that as the process progresses, CDC will identify the appropriate role for the CHAC workgroup and that CDC can provide a report on the process at the May 2019 CHAC meeting.

Dr. Taylor raised the issue of conflict of interest in reviewing the recommendations given that the medications that may be used to treat pregnant women are produced by Gilead and that Gilead has funded the clinical trials of treatment of pregnant women with HCV. Dr. Haven stated that it is necessary to identify who should be involved in vetting workgroup members for conflict of interest.

Dr. Taylor stated that for pregnant women with HCV infection, treatment of the hepatitis C is not their most important health concern. HCV is a marker for drug use. These women need treatment for their substance use disorder, they need MAT.

## Hepatitis C Workgroup Update

### **Peter Havens, MD, MS**

Children's Hospital of Wisconsin

The workgroup has been focused on integrating HIV and hepatitis diagnosis, treatment, and prevention into the federal response to the opioid crisis. This work started at the May 2018 CHAC meeting with CHAC proposing to provide guidance regarding the national response to increases in HIV and viral hepatitis in people who inject drugs in the United States. Successful models of care have been developed by the RWHAP and these should be integrated into the response to the opioid crisis. The workgroup has drafted, reviewed, and revised recommendations focus on: 1) correctional facilities; 2) CMS; and 3) federally qualified health centers (FQHCs).

### **Corrections/Department of Justice**

Any jurisdiction that receives federal funding for law enforcement should be required to follow out the following activities.

- Test all prisoners for HIV, initiate treatment for those infected, and arrange for ongoing treatment at the time of release from the correctional facility.
- Test all prisoners for HCV and treat all prisoners with current infection (antibody and RNA positive).
- Test all prisoners for hepatitis B virus (HBV), evaluate need for treatment and arrange for ongoing treatment at the time of release from the correctional facility.
- Vaccinate all prisoners for hepatitis A virus (HAV) and HBV.
- Offer integrated services for care of prisoners with opioid use disorder, including MAT/OST and harm reduction programs that include access to brand new needles and syringes via needle/syringe exchange programs and pharmacy over-the-counter sales of syringes without a prescription.

### **Centers for Medicare and Medicaid Services**

- CMS needs to continue Medicaid benefits during short-term incarceration so that patients with HIV, HCV, and HBV can receive uninterrupted, appropriate treatment.
- CMS needs to modify current restrictions on HCV treatment so that all persons with HCV can be treated at the time of diagnosis. This can perhaps best be done by working with HCV affinity groups.

### **Bureau of Primary Health Care**

- The BPHC should require that FQHCs establish a system of care to diagnose and treat all persons with HCV. This could follow the model of the RWHAP described above, and would include:
  - Administrative activities

- Establish quality measures for a system of HCV care;
- Require reporting by FQHCs to assure compliance to the quality measures; and
- Review the distribution of FQHC HCV services based on CDC data showing greatest need re: opioid and HCV epidemic activity.
- Programmatic activities
  - Develop screening/diagnostic programs with a designated single point of contact to receive/review results, a patient navigator or community health worker to get patients into care, and a drug use counselor for support from the time of HCV diagnosis;
  - Ensure availability of clinicians trained in HCV evaluation and treatment options who can prescribe appropriate medications and follow-up testing, and evaluate for and provide care for cirrhosis, with a pharmacist to support the treatment program; and
  - Employ a case manager or pharmacist to procure the medications.
- Include nurses, pharmacists, treatment case managers, and/or community health workers to follow patients through to the end of therapy and support medication adherence.

### Other Considerations

- MAT/opioid substitution therapy (OST), and harm reduction through syringe and needle exchange programs need to be integrated into this Federal effort in community and correctional settings.
- Opioid treatment centers should have easy access to vaccines, and develop on-site programs to deliver such vaccines. This may require development of novel vaccine distribution programs to assure an adequate vaccine supply for such use.

Dr. Havens noted that the American Association for the Study of Liver Disease (AASLD) and IDSA have made the following recommendation: All pregnant women should be tested for HCV infection, ideally at the initiation of prenatal care.

### Questions/Comments

Dr. Havens asked to whom should the CHAC send the recommendations related to the opioid crisis. Dr. Cheever stated that a letter should be sent to the Secretary, who will distribute the recommendations to the appropriate agency for response.

Dr. Stoner asked if all the recommendations are equally important or if they should be prioritized. Dr. Havens stated that they are all equally important.

### **CHAC Action**

Dr. Anderson made a motion that a letter presenting the recommendation related to the opioid crisis be sent to the HHS Secretary. CHAC members will have 10 days to provide comments on the current document and submit them to Dr. Havens.

Seconded: Dr. Taylor

Passed unanimously.

## STD Workgroup Update

**Susan Philip, MD, MPH**

San Francisco Department of Health

**Bradley Stoner, MD, PhD**

Washington University School of Medicine

Drs. Philip and Stoner provided an update on the workgroups activities.

- Conducted workgroup conference call to review clinical practice guidelines.
- Conducted workgroup conference call related to 2017 surveillance data to identify priority areas.
- Explored opportunities for CDC/HRSA alignment related to STDs and to increase support for providers through resources such as the HRSA-supported NCCC and the CDC-supported prevention network. This alignment could also include performance measures.
- Considered a CHAC recommendation for a national STD plan and how to move this forward.
- Continued to focus on congenital syphilis.
- Addressed drug pricing issues and the need to engage FDA and other agencies, especially around 340B pricing. Penicillin G Benzathine has become more available but this has resulted in increased cost. Availability must be increased and cost reduced. This must be addressed by HRSA and CDC.

While the workgroup considered disbanding following development of the clinical practice guidelines, it decided to remain active given the probability of STD-related issues arising.

### Questions/Comments

Dr. Havens stated that current rates of congenital syphilis are similar to the highest rates of perinatal HIV. However, there does not seem to be similar concern or an urgency to address congenital syphilis—which can result in significant harm to the infant. Dr. Stoner stated that CDC has been working on this issue.

Dr. Cheever stated that HAB could do a presentation at the next meeting on collaborative activities with CDC.

### CHAC Action

Include presentation on HRSA/CDC coordination on STDs at May 2019 meeting.

## RWHAP Reauthorization Workgroup Update

**Jennifer Kates, PhD**

Kaiser Family Foundation

**Greg Millet, MPH**

AmfAR

The workgroup was established in May 2018 and is charged with proposing recommendations for submission to and consideration by the HHS Secretary and HRSA/HAB. Key issues to consider:

- Why reauthorize? What are the advantages and disadvantages of reauthorizing?
- What happens if RWHAP is not reauthorized?
- If it is reauthorized, what changes should be made?
  - Expand the scope (e.g., to include HCV, PrEP)?
  - Change funding methodologies?
  - Account for the Affordable Care Act?
  - Modernize and standardize legislative language/definitions?
  - Incorporate a goal of ending the AIDS epidemic?
  - Other issues?

HRSA has provided language to justify reauthorization.

*“The Administration looks forward to working with Congress to reauthorize the RWHAP to ensure that Federal funds are allocated to address the changing landscape of HIV across the United States.*

*The Budget request proposes statutory changes through Ryan White HIV/AIDS Program authorization to the RWHAP Part A and B funding methodologies. These changes would allow HRSA to utilize a data driven framework to distribute RWHAP Part A and B funding to ensure that funds are allocated to populations experiencing high or increasing levels of HIV infections/diagnoses, such as minority populations, while continuing to support Americans that are already living with HIV across the nation. This approach would reduce burden for recipients and increase HHS’s ability to effectively focus resources for HIV care, treatment, and support needs in funded cities and states based on need, geography, data quality, and performance.*

*The Budget request also proposes statutory changes to the Ryan White authorization intended to simplify, modernize and standardize certain statutory requirements and definitions to be consistent across the RWHAP Parts and to reduce burden when an organization receives funding from multiple RWHAP Parts. These changes would align and consolidate the slightly differing provisions and eliminate those provisions that are no longer current.”*

The workgroup has questions for the CHAC’s consideration.

- What should the CHAC provide to HHS and HRSA?
- Should the CHAC adopt a position on reauthorization?
- Reauthorization principles?
- Recommended language changes?
- Other issues?

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The workgroup will continue to consult with experts and review relevant documents and provide feedback to the CHAC.

### Questions/Comments

Dr. Stoner asked whether ADAP falls all under reauthorization and whether the workgroup will focus on the role of ADAP in achieving the goals of NHAS. Dr. Kates stated that ADAP cannot currently be used for PrEP. To fund PrEP through RWHAP would require a change in legislation since RWHAP is focused on PLWH. There is also a need to look at the role of CHCs in PrEP.

## HIV and Aging Workgroup Update

### **Richard Aleshire, MSW, ACSW**

Washington State Department of Health

### **Susan Robilotto, DO**

Division of Metropolitan and State HIV/AIDS Programs, HRSA HAB

The purposes of the workgroup is to understand the potential effects of aging with HIV and behavioral and physical health issues using data from the RSR and interviews with leading experts. The workgroup will also work to determine areas where the RWHAP can leverage resources to support PLWH. Initial steps include a literature review and interviews with subject matter experts including physicians, researchers, geriatricians, case managers, and community-based providers.

Questions for subject matter experts are listed below.

- Describe your staffing model and approach to clinical services for older adults living with HIV?
- Describe your recent research and findings as it pertains to older adults living with HIV?
- What are the top three challenges or issues your program faces with providing HIV care services to older adults?
- What are the top three challenges or issues revealed in research/ your research with respect to the provision of HIV care services to older adults?
- What successful strategies have you identified for addressing HIV, social, behavioral health, and other services through your program for older adults?
- How can the Ryan White HIV/AIDS Program better support programs to meet the age-specific needs of older adults living with HIV?

In addition to these questions, the workgroup has suggested questions for specific specialties.

Considerations related to geriatricians and pharmacists that HAB could explore are listed below.

- Understand their common roles and responsibilities within the clinic;
- Understand limitations of roles and responsibilities within the clinic;
- Learn the availability of professionals throughout United States; and
- Study the different models for including these professionals and/or their skills within the health care team.

In addition, CDC and HRSA need to explore ways to make connections with community-level providers. To explore these connections the workgroup recommends:

- Gain familiarity with existing resources for the aging population; and
- Refer to and utilize existing resources for the aging population.

### **Questions/Comments**

Dr. Havens asked how would the list of things to do for geriatric PLWH be different from a list provided to primary care providers caring for geriatric patients. There are current guidelines for aging patients. Maybe for PLWH general recommendations should just be applied at a younger age? Mr. Aleshire stated that there are some items that are specific to PLWH. Dr. Anderson stated that she added some items related to frailty (bone health) and PAP screening since women living with HIV should be screened more frequently. Mr. Aleshire added that some screenings are recommended earlier and more frequently for PLWH,

Dr. Cheever stated that aging issues should be addressed in primary care and that addressing the needs aging PLWH is a new issue for HIV clinics. HAB needs to work with RWHAP recipients to help them develop services that address aging.

Dr. Havens stated that these considerations be added to existing federal treatment guidelines. Dr. Cheever stated that this would have to be done by federal committee responsible for updating treatment guidelines.

Ms. Leonard asked about the importance of mental health care for aging PLWH, which is not reflected in the presentation. Mr. Aleshire stated that the workgroup is considering this issue.

Mr. Millett stated that there is no need to reinvent the wheel in terms of recommendations for this aging PLWH. While there are issues of drug interaction, chronic inflammation, and bone health, these should all be addressed in existing guidelines.

Dr. Taylor stated that visits for PLWH are becoming more spaced out. However, geriatric patients need more frequent appointments and many RWHAP clinics do not have geriatricians on staff. There needs to be a way to connect these patients to geriatric care. Connecting them through telehealth would be a good use of resources and good for patients.

Mr. Hursey stated that the long-term impact of ART needs to be studied, as does the impact of bone density, mental health, and cognitive decline as PLWH age.

Dr. Cheever stated that the workgroup's work is very helpful to HAB as it works with recipients to better serve aging RWHAP clients. It is necessary to think of services like home visits by occupational therapists to evaluate the safety of the home.

## **Business Session**

Dr. Anderson opened the business session by reminding CHAC members that two motions have already been approved, one to form a CHAC workgroup on the NHAS and another to send a letter to the Secretary with the recommendations of the HCV workgroup. She opened the session up for further discussion.

Dr. Mera stated that if there was an FDA-approved treatment for HCV in pregnant women there would be no discussion about universal screening or pregnant women. While the conflict of interest related to Gilead is valid, this should not drive the discussion of whether universal screening of pregnant women is a valid approach. Dr. Mermin stated that women need to know if they have HCV and pregnancy is an opportunity to screen.

Dr. Taylor stated that at the last CHAC meeting there was discussion of the bottleneck between screening and confirmatory testing of HCV infection. One-step HCV testing is available and being used in Australia. Is there a way to move the FDA toward approval of this testing? She asked if FDA could make a presentation on availability of diagnostic tools at the May 2019 meeting. Dr. Mermin stated that it takes time and is costly to gain FDA approval, especially since these test are in a more difficult class than other diagnostic tests since they were developed for screening the blood supply. The high cost prohibits companies from submitting applications for approval. FDA has had meetings and received recommendations to reduce the regulations. If the final rule has been made a presentation would be appropriate.

Dr. Taylor added that she does not support screening for pregnant women until there is a recommendation that all adults are screened and this screening is done in the context of access to full reproductive health care. In Kentucky, there is now a law requiring screening of pregnant women but there are barriers to accessing treatment for Medicaid recipients. There is also limited access to MAT. In general, there is very limited access to HCV treatment but pregnant women are considered more worthy than other women such as women not of child-bearing potential. The message that is being conveyed is that in terms of screening, HIV and HVC are the same. This is not true. HCV is a marker for other conditions such as injections drug use. All of these conditions, drug use, alcohol addition, smoking, should be treated. For these women, HCV is often the least pressing of their health concerns. They are not the population most in need of treatment.

Dr. Anderson stated that one of the arguments for screening pregnant women is that it is a point of contact with the health care system. It is not related to treatment but is more an issue of identification and linkage to care.

Dr. Stoner stated that since blood is being drawn, HCV screening should be conducted.

Dr. Taylor stated that these screenings may result in pregnant women being prioritized for treatment for HCV rather than all women being treated. If there are limited resources, given that these younger women are not at high risk for advanced liver disease, it seems as though women of childbearing potential may be treated to decrease the already low rate of perinatal transmission rather than treating them for their own health benefit. There should be universal screening for all adults.

Dr. Mera stated that screening of pregnant women may lead to screening of all adults. AASLD and IDSA both recommend it.

Dr. Havens asked for clarification on CDC's position. Is CDC asking for universal screening for all adults as well as screening for pregnant women? Dr. Mermin stated that CDC is focused on aged-based screening for adults and recommended populations due to risk. CDC will need to develop guidelines and will consult the CHAC in the development of these guidelines.

## Closing Session

Dr. Cheever thanked CHAC members for their service. The meetings for 2019 are:

May 22-23, Atlanta

November 13-14, Rockville.

The CHAC meeting was adjourned at 1:45 pm ET.

### **CHAC CO-CHAIRS' CERTIFICATION**

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

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Jean R, Anderson, MD, Co-Chair      (Date)  
CDC/HRSA Advisory Committee on HIV,  
Viral Hepatitis and STD Prevention and  
Treatment

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



## Attachment 1: List of Participants

### CHAC Members Present

Dr. Jean Anderson, Co-Chair  
Mr. Richard Aleshire  
Dr. Marvin Belzer  
Ms. Debra Hauser  
Dr. Peter Havens  
Mr. Devin Hursey  
Dr. Jennifer Kates  
Ms. Amy Leonard  
Dr. Jorge Mera  
Mr. Greg Millett  
Dr. Susan Philip  
Dr. Michael Saag  
Ms. Linda Scruggs  
Dr. Bradley Stoner  
Dr. Lynn Taylor

### CHAC Member Absent

Ms. Dawn Fukuda, Co-Chair

### CHAC Ex-Officio Members Present

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

Mitchell Berger  
Substance Abuse and Mental Health  
Services Administration

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

Mr. Richard Haverkate  
Indian Health Service

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

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Dr. Richard Wild  
(Alternate for Dr. Andrey Ostrovsky)  
Centers for Medicare & Medicaid Services

### CHAC Ex-Officio Members Absent

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

### CHAC Designated Federal Officers

Dr. Laura Cheever  
HRSA/HAB Associate Administrator

Dr. Jonathan Mermin  
CDC/NCHHSTP Director

### Federal Agency Attendees

Ms. Stacey Atkins  
Ms. Cyntnice Bellamy  
Ms. Pamela Belton  
CDR. Holly Berilla  
Dr. Gail Bolan  
Ms. Jillian Causey  
Ms. Stephanie Chan  
Andre Chappel  
Mr. Gary Cook  
Ms. Corrina Dan  
Ms. Shanna Dell  
Ms. Antigone Dempsey  
Mr. Michael Evanson  
Mr. Nathan Fecih  
LCDR Jessica Fox  
Ms. Tanya Geiger  
Mr. Jim Haner  
Ms. Anne Haresian  
Ms. Heather Hauck  
Dr. Letha Healey  
Mr. Steven Holmand  
Ms. Connie Jorstad

Ms. Amelia Knalil  
Dr. Eugene McCray  
Ms. Tracy Matthews  
J. Morris  
Ms. Chan Nguyen  
Ms. Alexa Ofori  
Mr. R. Chris Redwood  
Ms. Melanie Ross  
Ms. Margie Scott-Cseh  
Dr. Judith Steinberg  
Ms. April Stubbs-Smith  
Ms. Caroline Talev  
Ms. Tanchica Terry  
Ms. Kelly Weld

### **Guest Presenters**

Ms Clover Barnes  
District of Columbia Department of Health

Dr. Tammy Beckham  
Acting Director, HHS, OHAIDP

Ms. Nancy Campbell  
Johns Hopkins Medical Center

Mr. Glenn Clark  
Division of State HIV/AIDS Programs,  
HRSA HAB

Ms. Stacy Cohen  
Branch Chief, HRSA/HAB Division of Policy  
and Data

Ms. Sherrilyn Crooks  
Office of HIV Training and Capacity  
Development, HRSA HAB

Dr. William England  
Federal Office of Rural Health Policy, Office  
for the advancement of Telehealth

Ms. Kaye Hayes  
HHS, OHAIDP

Ms. Monique Hitch,  
DCHAP, HRSA HAB

Dr. Shannon McDevitt  
Bureau of Primary Health Care, HRSA

Dr. Mahyar Mofidi  
DCHAP, HRSA HAB

Ms. Johanne Morne  
New York State Department of Health

Mr. Michael Murphree  
Medical Advocacy and Outreach

Ms. Susan Robilotto  
HRSA, HAB

Dr. George Sigounas  
HRSA Administrator

Dr. Paul Wiedle  
Division of Viral Hepatitis, NCHHSTP, CDC

Ms. Elise Young,  
Division of Community HIV/AIDS Programs,  
HRSA HAB

Mr. Steven Young  
Division of Metropolitan HIV/AIDS  
Programs, HRSA HAB



## Attachment 2: Glossary of Acronyms

ADAP	AIDS Drug Assistance Program
ADR	ADAP Data Report
AETC	AIDS Education and Training Center
ART	Antiretroviral Therapy
BPG	Penicillin G Benzathine
BPHC	Bureau of Primary Health Care
CBO	Community-based Organization
CDC	Centers for Disease Control and Prevention
CEBACC	Center for Engaging Black MSM Across the Care Continuum
CHAC	CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
CHC	Community Health Center
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
DASH	Divisional of Adolescent and School Health
DFO	Designated Federal Officer
E2i	Evidence-Informed Interventions to Improve Health Outcomes among PLWH
EMA	Eligible Metropolitan Area
ED	Emergency Department
FACA	Federal Advisory Committee Act
FY	Fiscal Year
GRADE	Grading of Recommendations Assessment, Development, and Evaluation
HAB	HIV/AIDS Bureau
HCV	Hepatitis C Virus
Heplisav-B	Hepatitis B Vaccine
HIV	Human Immunodeficiency Virus
HIVMA	HIV Medicine Association
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
ID	Infectious Disease
IDSA	Infectious Disease Society of America
IPV	Intimate Partner Violence
IT	Information Technology
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Questioning
MAO	Medical Advocacy and Outreach
MAT	Medication Assisted Therapy
MCHB	Maternal and Child Health Bureau
MOCHA	Methodist Hospital Cancer Health Application

MSM	Men Who Have Sex with Men
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention
NHAS	National HIV/AIDS Strategy
NHANES	National Health and Nutrition Examination Survey
NIH	National Institutes of Health
NOFO	Notice of Funding Opportunity
OAT	Office for the Advancement of Telehealth
OHAIDP	Office of HIV/AIDS and Infectious Disease Policy
OTCD	Office of Training and Capacity Development
ODU	Opioid Use Disorder
PCN	Policy Clarification Notice
PEP	Post-exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PICO	Population, Intervention, Comparator, Outcome
PIDS	Pediatric Infectious Diseases Society
PLWH	People Living with HIV
PrEP	Pre-exposure Prophylaxis
RSR	RWHAP Services Report
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services
SMAIF	Secretary's Minority AIDS Initiative Fund
SPNS	Special Projects of National Significance
STDs	Sexually Transmitted Diseases
SUD	Substance Use Disorder
TB	Tuberculosis
TEP	Technical Expert Panel
TGA	Transitional Grant Area
WICY	Women, Infants, Children and Youth