

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



**Virtual Meeting of the
CDC/HRSA Advisory Committee on
HIV, Viral Hepatitis and STD Prevention and Treatment
November 19-20, 2014**

Record of the Proceedings

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**CDC/HRSA ADVISORY COMMITTEE ON HIV,
VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT
November 19-20, 2014**

Minutes of the Virtual Meeting

The U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP), and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) convened a virtual meeting of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) on November 19-20, 2014.

CHAC is chartered to advise the Secretary of HHS, Director of CDC, and Administrator of HRSA on objectives, strategies, policies and priorities for HIV, viral hepatitis and STD prevention and treatment efforts for the nation.

Opening Session: November 19, 2014

Laura Cheever, MD, ScM

Associate Administrator, HIV/AIDS Bureau
Health Resources and Services Administration
CHAC Designated Federal Officer, HRSA

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

and/or institutional conflicts of interest for the public record and recuse themselves from voting or participating in these matters.

CONFLICT OF INTEREST DISCLOSURES	
CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Bruce Agins, MD, MPH (New York State Department of Health)	Recipient of multiple CDC and HRSA grants
Sanjeev Arora, MD, FACP (University of New Mexico Health Sciences Center)	No conflicts disclosed
Virginia Caine, MD (Marion County, Indianapolis Public Health Department)	Recipient of federal funding from HRSA for Ryan White
Guillermo Chacon (Latino Commission on AIDS)	Recipient of federal funding from CDC; member of Community Advisory Boards for Merck and ViiV Healthcare; member of the New York State AIDS Advisory Council
Tommy Chesbro, HR, CSE (Chesbro Consulting, LLC)	Contractor to John Snow, Inc. that receives federal funding from HRSA for the Ryan White Affordable Care Enrollment Technical Assistance Center; recipient of funding from Bisbee; teacher at a community college with a potential conflict; member of the National Minority AIDS Council that receives federal funding; contracted speaker for Merck
Kathleen Clanon, MD (Alameda County, Oakland Medical Center)	Recipient of federal funding from CDC and HRSA
Angelique Croasdale, MA (City of Hartford, Connecticut Department of Health and Human Services)	Recipient of federal funding from CDC and HRSA
Carlos del Rio, MD (Rollins School of Public Health Emory University)	No conflicts disclosed

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Dawn Fukuda, ScM (Massachusetts Department of Public Health)	Recipient of federal funding from CDC and HRSA; officer of the National Alliance of State and Territorial AIDS Directors that receives federal funding from CDC and HRSA
Marjorie Hill, PhD (Independent Consulting Services)	No conflicts disclosed
Steven Johnson, MD (University of Colorado School of Medicine)	Recipient of federal funding from HRSA for multiple Ryan White parts; member of the ViiV Healthcare Advisory Board
Jennifer Kates, PhD (Kaiser Family Foundation)	Paid lecturer at Johns Hopkins University and George Washington University; member of multiple advisory committees for HIV/AIDS organizations, including Funders Concerned About AIDS, AIDSvu and the San Francisco AIDS Foundation
Kali Lindsey (amfAR, The Foundation for AIDS Research)	No conflicts disclosed
Jeanne Marrazzo, MD, MPH (University of Washington)	Recipient of federal funding from CDC and the National Institutes of Health (NIH); care provider in a HRSA-funded Ryan White Clinic

Dr. Cheever confirmed that the voting members and *ex-officio* members in attendance constituted a quorum for CHAC to conduct its business on November 19, 2014. She called the proceedings to order at 10:15 a.m. EST and welcomed the participants to day 1 of the 23rd CHAC meeting.

Dr. Cheever described changes to CHAC's membership in terms of HRSA appointees.

- Dr. Kathleen Clanon's role changed from serving as a CHAC member to replacing Ms. Antigone Dempsey as the new CHAC co-Chair. Dr. Cheever thanked Dr. Clanon for undertaking this important position. A nomination package currently is being reviewed to appoint a new CHAC member to replace Ms. Dempsey.
- Dr. Mildred Williamson replaced Mr. Douglas Brooks as the CHAC liaison representative to the Presidential Advisory Council on HIV/AIDS. Dr. Williamson is the HIV/AIDS Section Chief for the Illinois Department of Public Health.

Jonathan Mermin, MD, MPH

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

Dr. Mermin also welcomed the participants to CHAC's second virtual meeting. He described changes to CHAC's membership in terms of CDC appointees.

- The terms of four CHAC members would expire on November 30, 2014: Dr. Perry Halkitis, Dr. Marjorie Hill, Dr. Jeanne Marrazzo, and Ms. Regan Hofmann. Dr. Mermin thanked the outgoing members for contributing strong support, tremendous expertise and helpful guidance to CDC during their tenures. A nomination package is being finalized for the new appointees who will replace the four outgoing CHAC members.

Kathleen Clanon, MD, CHAC co-Chair

Medical Director
Alameda County Health Care Services Agency

Jeanne Marrazzo, MD, MPH, CHAC co-Chair

Professor of Medicine, Harborview Medical Center
University of Washington

Drs. Clanon and Marrazzo joined their colleagues in welcoming the participants to the CHAC meeting. Dr. Marrazzo concluded the opening session by reviewing the November 19-20, 2014 CHAC meeting agenda.

HRSA/HAB Associate Administrator's Report

Laura Cheever, MD, ScM

Associate Administrator, HIV/AIDS Bureau
Health Resources and Services Administration
CHAC Designated Federal Officer, HRSA

Dr. Cheever covered the following topics in her Associate Administrator's report to CHAC. HAB created a framework to guide the future direction of the Ryan White HIV/AIDS Program (RWHAP) in the context of the Affordable Care Act (ACA) and the evolution of the U.S. healthcare system over time. The RWHAP framework is based on an overarching goal of achieving "zero new HIV infections" through comprehensive care systems and a public health approach. HAB is focusing on several key components to achieve this goal, including service delivery, policy at federal, state and local levels, need assessments, capacity development and quality.

HAB aligned the RWHAP framework for moving forward with the three goals of the National HIV/AIDS Strategy (NHAS): reduce new infections; improve health outcomes and increase the quality of life for persons living with HIV (PLWH); and decrease HIV-related disparities. The RWHAP impacts all three of these goals through: funding a comprehensive care system for low-income PLWH; engaging PLWH in the planning of services; and implementing a public health approach to care and treatment. HAB's ongoing activities to support its FY2015 priorities are highlighted below.

Priority 1 is integrating RWHAP and ACA. HAB will continue to monitor ACA implementation, develop and disseminate guidance on emerging issues as needed, and offer ongoing technical assistance (TA) to RWHAP providers and grantees. HAB will continue to engage and collaborate with the Centers for Medicare and Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight on key ACA issues, such as monitoring third-party payments, mail order pharmacies, prior authorization, provider lists for Essential Community Provider implementation.

HAB launched the "Affordable Care Act" portal on the HRSA.gov website to develop, co-host and archive webinars of relevant topics, including best practices, and post responses to frequently asked questions (FAQs). HAB will use key findings from its ACA-related cooperative agreements (CoAgs) to provide ongoing TA to grantees. John Snow, Inc. was awarded the "Supporting the Continuum of Care: Building Ryan White Program Grantee Capacity to Enroll Eligible Clients in ACA Health Coverage Programs" CoAg.

Cicatelli Associates was awarded the "Engaging in Marketplace Insurance Plans Under the Affordable Care Act" CoAg. Fenway Community Health was awarded the "Establishing AIDS Service Organization (ASO) Service Models" CoAg. Outcomes of the CoAgs will help grantees to connect clients to new health plans, connect medical providers to health plans, and connect ASOs to medical centers in order to maximize HIV Care Continuum services and client health outcomes.

HAB initiated a feasibility study of a new framework for the allocation of supplemental RWHAP Part A funding in response to need in September 2014. A similar analysis for RWHAP Part C funding will be conducted in 2015. Ongoing studies will be completed to clearly delineate the role of RWHAP in ambulatory care; preventive services in RWHAP sites; and changes in the needs of RWHAP clients after ACA implementation.

Priority 2 is implementing NHAS within the framework of the HIV Care Continuum and a focus on areas of greatest health disparities and stronger partnerships. The overarching purpose of the HIV Care Continuum is to engage and retain PLWH in care to improve health outcomes. HAB will conduct several activities in this effort.

A Part A-funded CoAg will focus on the development of a Learning Collaborative to share best practices in the HIV Care Continuum. Data will be compiled from Special Projects of National Significance (SPNS) Initiatives and provided to RWHAP grantees. The SPNS Initiatives focus on three key areas: (1) different use of staff to achieve better outcomes in the HIV Care Continuum; (2) integration of surveillance and RWHAP data to better target interventions to the HIV Care Continuum; and (3) dissemination of best practices for the HIV Care Continuum. Best practices will include “manualizing” successful SPNS Initiatives and implementing previous evidence-informed SPNS Initiatives for jails, outreach, and retention/reengagement in care.

In terms of health disparities, HAB has or will soon implement four program strategies to better address health disparities in youth: gather best practices and provide TA, assist grantees in the use of social media, improve health and insurance literacy, and build awareness and capacity in communities. HAB will target the four program strategies to key youth populations, including young men who have sex with men (MSM) and young women.

In terms of stronger partnerships, HAB and the CDC Division of HIV/AIDS Prevention (DHAP) issued a joint letter to grantees on integrated planning earlier in the year and held a follow-up meeting with stakeholders in July 2014. HAB and DHAP expect to release new guidance on integrated planning in 2015.

Priority 3 is advancing data utilization to demonstrate outcomes. HAB has made significant improvements in accelerating turnaround times for processing and distributing Ryan White Service Reports (RSR), AIDS Drug Assistance Program (ADAP) Data Reports, and state profiles. The collection of client-level data (CLD) for three consecutive years will be used to inform decisions to impact the HIV Care Continuum. CLD also will be better utilized to demonstrate outcomes and share HAB’s experiences. Key target audiences of CLD include HAB Project Officers for monitoring and grantees for gap assessments and monitoring of progress.

RSR data showed that RWHAP served 536,219 clients in 2012. Of these clients, 28% (or ~128,000 clients) were uninsured for non-ADAP services; 65% were uninsured in ADAP; 69% were at \leq 100% of the Federal Poverty Level (FPL); and 21% were at 101%-200% FPL. These data show that most uninsured RWHAP clients would be eligible for Medicaid expansion or Health Insurance Marketplace subsidies.

By service category, the top four services used by RWHAP clients in 2012 were outpatient ambulatory medical care (OAMC) (60.6%), medical case management (54.3%), non-medical case management (26.1%), and oral health (16.9%). By payer source, Medicaid was the payer for 26% of RWHAP clients in 2012 and no insurance accounted for 27.6% of clients. RSR defines “retained in care” as clients who had at least one OAMC visit before September 1, 2012 and at least 2 OAMC visits \geq 90 days apart. “Viral suppression” is defined as clients who had at least one OAMC visit, at least one viral load count, and a last viral load test $<$ 200. Overall, in 2012 the retention in care rate was 82.5%, and the viral suppression rate was 75%.

The lowest rates of retention in care or viral suppression were observed in young persons 19-24 years of age (by age); blacks and multi-racial persons (by race/ethnicity); and black MSM, young MSM 13-24 years of age, and young women of color 13-24 years of age (by hard-to-reach population). HAB's efforts to advance data utilization will focus on closing gaps in these disparities.

Priority 4 is enhancing national leadership through increased engagement of stakeholders and a stronger presence in key partner meetings. Most notably, a HAB track will be featured during the 19th Annual U.S. Conference on AIDS in September 2015.

Priority 5 is improving HAB's operations through enhanced hiring and travel processes and grantee surveys to strengthen customer satisfaction. Of all HRSA bureaus, HAB fills its vacant positions in the shortest amount of time. HAB is pleased that all four of its divisions now have permanent directors. The most recent appointments to HAB include Ms. Antigone Dempsey, Director of the Division of Policy and Data, and Mr. Harold Phillips, Director of the Division of HIV/AIDS Training and Capacity Development.

Dr. Cheever introduced a panel of HRSA staff to provide updates on activities outside of HAB that also are important and relevant to CHAC.

Rebecca Slifkin, PhD

Director, Office of Planning, Analysis and Evaluation
Health Resources and Services Administration

Dr. Slifkin provided an update on HRSA's activities related to ACA implementation. To date, HRSA has issued eight policy clarification notices and responses to >100 FAQs to provide grantees with guidance on the intersection between the Ryan White HIV/AIDS Program (RWHAP) and the ACA. HRSA is continuing to closely collaborate with CMS to address challenges facing PLWH in the Marketplace, particularly limited access to prescription drugs.

The CMS-HRSA partnership for ACA implementation has resulted in several positive impacts for PLWH. CMS issued a final rule in the spring of 2014 that requires qualified health plans in the Marketplace to provide an expedited 24-hour appeals exemption process for enrollees who are in a current course of treatment and on a non-formulary drug. CMS also regularly hosts webinars with certified ACA application counselors across the country and has engaged HRSA in educating assisters on how to help PLWH to enroll in the Marketplace.

HRSA currently is focusing on providing additional guidance and technical assistance to RWHAP grantees who provide premium assistance to clients receiving advance premium tax credits from the Marketplace. This provision of ACA will have implications for HRSA because RWHAP helps clients to pay for their premiums. HRSA recently issued a *Federal Register* notice with a request

for grantees to submit comments and suggestions on policy guidance that should be developed related to reconciling premium tax credits with advance credit payments for RWHAP clients. HRSA and the Internal Revenue Service intend to co-host a webinar on December 16, 2014 to provide grantees with clear guidance on this complex issue.

Rene Sterling, PhD, MHA

Senior Advisor, Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration

Dr. Sterling presented an update on Partnerships for Care (P4C). P4C is a three-year, multi-year project supported by the HHS Secretary's Minority AIDS Initiative (MAI) Fund (\$9.6 million) and BPHC's ACA funds (\$6.2 million). The overarching goal of P4C is to reduce HIV morbidity and mortality, particularly in racial/ethnic minorities. This goal will be achieved by strengthening partnerships between health departments and Health Centers and identifying promising models for HIV service delivery.

The models will have demonstrated capacity in better identifying undiagnosed HIV infection, establishing new access points for HIV services, and improving outcomes in the HIV Care Continuum. CDC-funded state health departments in Florida, Maryland, Massachusetts and New York will partner with up to 22 Health Centers that are eligible to receive HRSA supplemental funding. A P4C web page is featured on the CDC.gov website.

HRSA issued a competitive request for proposals and will award \$3.3 million to a contractor to conduct the following P4C activities: establish an HIV Training, Technical Assistance and Collaboration Center; track and monitor the progress of Health Centers; coordinate and provide training and onsite TA; establish a website to archive materials and facilitate information sharing; and develop a Health Center toolkit for integration of HIV into primary care. Efforts are underway to address procurement challenges related to awarding the contract. In the interim, BPHC staff is undertaking some of the contractor duties (e.g., tracking issues, facilitating partnerships, sharing promising practices and approaches across Health Centers, and developing a priority list).

Health department funding of \$2.6 million was awarded in July 2014 to conduct the following P4C activities: use HIV surveillance data, Health Center electronic health record data and other medical record data to improve HIV outcomes; expand partner notification, linkage, retention and reengagement activities; support training and TA activities for Health Centers; and develop sustainable partnerships with Health Centers. CDC launched a kickoff conference call with all grantees in July 2014 and held conference calls with each individual health department in September 2014. The health departments are finalizing their staffing plans and strategic plans to engage Health Centers. The final work plans will be submitted in December 2014.

Health Center funding of \$9.9 million was awarded in September 2014 to focus on the following P4C issues: workforce development, infrastructure development, service delivery, partnership development with state health departments, and project evaluation and quality improvement. BPHC launched a kickoff conference call with all grantees in September 2014 and currently is holding conference calls with each individual Health Center. The Health Centers are adjusting their work plans and budgets in response to BPHC's conditions of award. BPHC also is distributing monthly FAQs to the Health Centers.

Each Health Center is required to create a workforce development plan with the following components: a multidisciplinary HIV care team; provision of Health Center-wide training to ensure that all staff and Board members have knowledge and expertise at least at the "HIV 101" level; and access to HIV testing, other service providers and clinical consultation. Each Health Center is required to create an infrastructure development plan with the following components: a dedicated P4C/HIV program lead; formal, written referral agreements for outside services; system enhancements to routinely collect and report HIV-specific data; clear protocols and policies; and a continuity plan.

A federal cross-training team was formed for CDC and HRSA project staff to become more knowledgeable of the programs, authorities, organizational cultures, approaches and scopes of work of the other agency. Federal oversight of P4C by CDC and HRSA will include project management, grantee monitoring, and ongoing collaboration with HHS and HAB. Conference calls, site visits, progress reports and all-partner meetings will be used to achieve these goals.

Several factors will drive the project evaluation, including the P4C goals, objectives and requirements; process and outcome measures; and ongoing partner feedback. Efforts also will be made to align and adapt the draft P4C evaluation measures with existing measures: National Quality Forum-endorsed measures, RWHAP measures, CDC's measures on routine HIV testing in clinics, and Meaningful Use Stage 3 measures.

The next steps in P4C will be to award the HIV TA contract; update and distribute the draft evaluation measures to all partners for review and comment; submit the Health Center template to the Office of Management and Budget for review and approval; and convene an all-partners meeting in January 2015 to discuss the final evaluation measures. The P4C Evaluation Workgroup held its first meeting on November 17-18, 2014 with representation by CDC and HRSA staff, 4 health departments, 4 Health Centers, and 2 Health Center Controlled Networks.

CDC/NCHHSTP Director's Report

Jonathan Mermin, MD, MPH

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

Dr. Mermin covered the following topics in his Director's report to CHAC. At the agency level, CDC is continuing its leadership of and extensive involvement in the ebola virus disease outbreak in West Africa. As of November 14, 2014, 8,920 of the total 14,413 ebola virus disease cases were laboratory-confirmed. The deployment of 300 CDC staff includes 110 staff throughout the United States, 3 staff to other countries with reported ebola cases, and 187 staff to West Africa for surveillance, contact tracing, data management, laboratory testing and health education. CDC also activated its Emergency Operations Center to coordinate ebola-related assistance with partners.

CDC is operating under a continuing resolution that authorizes FY2015 appropriations through December 11, 2014 at the FY2014 enacted levels. The continuing resolution also provides additional funding to support the ebola outbreak response in Africa, including \$30 million to CDC's global health programs.

CDC established a new Laboratory Safety Improvement Workgroup that will be responsible for specific tasks. The moratorium on the movement of biological material outside of Biosafety Level 3 and 4 Laboratories will be addressed. The CDC Director will be advised on the resumption of transfers. As of October 15, 2014, 49 packages were submitted for review of the moratorium, 33 packages were released, 12 packages were released with provisions, 3 packages are under review, and 4 packages are pending submission.

Laboratory safety recommendations related to recent laboratory incidents at CDC will be implemented. Oversight will be provided of corrective actions and an inventory of biologic material in all CDC laboratories (*i.e.*, a "Clean Sweep"). Recommendations will be developed to establish a permanent single point of accountability for laboratory safety. Emphasis primarily will be placed on two major aspects of laboratory safety. First, the use of key control points (e.g., pathogen inactivation) by trained and supervised staff will be demonstrated. Second, redundant control/secondary verification of critical control points will be established via direct observation and cameras.

At the National Center level, NCHHSTP is pleased to announce changes in its leadership at the Office of Director level. Dr. Eugene McCray was appointed as the new Director of DHAP. Dr. Philip LoBue was appointed as the new Director of the Division of Tuberculosis Elimination. Dr.

Richard Wolitski was appointed as the new Senior Advisor for Indicator Monitoring and Program Improvement.

NCHHSTP deployed 102 staff to the ebola response, including 30 staff to Africa. An additional 38 NCHHSTP staff will be deployed in the near future. All NCHHSTP laboratories currently are active due to the release of three laboratories from the moratorium on the movement of biological material.

NCHHSTP established three goals for its draft Strategic Plan. The incidence of infection, morbidity and mortality, and health disparities across affected groups will be decreased for HIV, viral hepatitis, STDs and TB. Efforts are underway to develop indicators, targets and strategies to measure progress on achieving the Strategic Plan goals.

NCHHSTP published the latest edition of its State Health Profiles. NCHHSTP launched a new web page for TB, HIV and STD prevention programs. The new web page serves as a “one-stop shop” with tools and resources of legal assessments across all of NCHHSTP’s focus areas. NCHHSTP hosted Program Collaboration and Service Integration training session for public health officials in the U.S.-Affiliated Pacific Islands.

At the division level, DHAP issued updated recommendations for laboratory testing for the diagnosis of HIV infection. A fourth-generation assay detects 71%-84% of RNA-positive, third-generation-negative specimens. The new algorithm is positive nearly four days after RNA is positive on polymerase chain reaction (PCR). The algorithm also has the capacity to diagnose the majority of acute infections, allow for PCR confirmation rather than Western blot, and detect HIV-2.

DHAP issued the *2012 HIV Surveillance Report* in November 2014. The report showed that the annual estimated number of HIV diagnoses slightly decreased from 49,303 diagnoses in 2008 to 47,989 diagnoses in 2012. However, disparities were observed in certain populations. By risk group, HIV diagnoses steadily increased in the transmission category of male-to-male sexual contact, while decreases were reported in the transmission categories of heterosexual contact, injection drug use (IDU), and male-to-male sexual contact among IDUs. By age, HIV diagnosis rates increased by 10% in persons <24 years of age and by 5% in persons 24-34 years of age.

DHAP launched the “We Can Stop HIV One Conversation at a Time” Campaign in August 2014. The new national, bilingual communication campaign encourages Hispanics to openly speak about HIV with their family and friends. Although >220,000 Hispanics are living with HIV, studies have documented that conversations regarding HIV risk, prevention or testing are not common in this population. The campaign has received 76 million media impressions to date.

DHAP launched the “HIV Treatment Works” Campaign in September 2014 to encourage PLWH to take treatment and remain in care. The campaign was designed in full partnership with PLWH

and marks the first treatment-focused initiative CDC has ever conducted. The campaign includes online, print, television and outdoor advertisements, social media platforms, and a dedicated website with information and resources for PLWH. The campaign has received >185 million media impressions to date.

DHAP has strengthened its internal and grantee accountability through program improvement initiatives. The 2013 National HIV Prevention Progress Report and 2014 State HIV Prevention Progress Reports were released. Rapid Feedback Reports were developed and disseminated to grantees to monitor their progress in three Funding Opportunity Announcements (FOAs).

The Division of Adolescent and School Health (DASH) released the 2013 National Youth Risk Behavior Survey analysis in July 2014. The findings showed mixed progress on sexual risk behaviors of U.S. high school students. Most notably, fewer high school students have ever had sexual intercourse. Condom use has declined since 2002. The proportion of students with multiple sexual partners was relatively stable.

DASH issued new program guidance to its funded state and local education agencies in September 2014. The aim of the current five-year CoAg to reduce adolescent sexual risk behaviors and adverse health outcomes, including HIV, other STDs and teen pregnancy, is based on the scientific literature and expert input. The program guidance serves as a clear, useful and evidence-based resource for grantees to conduct their required CoAg activities.

The Division of STD Prevention (DSTDP) partnered with the National Public Health Information Coalition to develop and release the STD Communications Toolkit. The toolkit offers materials and resources to help STD program managers and communication staff in state and local health departments provide clear information about STDs to both healthcare providers and the general public. DSTDP issued STD fact sheets in new languages for the first time, including Chinese, Vietnamese, Russian and Haitian Creole.

The Division of Viral Hepatitis (DVH) recently launched the second phase of the national “Know Hepatitis B” Campaign. The multilingual communication campaign promotes testing for hepatitis B virus (HBV) in Asian Americans and Pacific Islanders. Since DVH and Hep B United created and launched the campaign in the summer of 2013, nearly 60 million media impressions have been generated and print, radio, television and digital placements have been made in English, Chinese, Korean and Vietnamese.

DVH published an evaluation report, *Accomplishments of the Viral Hepatitis Prevention Coordinator Initiative, 2008-2012*. CDC’s Public Health Grand Rounds on June 17, 2014 focused on the “25th Anniversary of the Discovery of the Hepatitis C Virus: Looking Back to Look Forward.” The webcast of this event is available on the CDC.gov website. DVH is continuing to conduct hepatitis C virus (HCV) activities, such as ongoing meetings with partners, scientific evaluation,

and broader promotion of the CDC and U.S. Preventive Services Task Force (USPSTF) HCV Screening Guidelines for the 1945-1965 birth cohort and other persons at increased risk.

CHAC discussed the following topics with Drs. Cheever and Mermin on the HRSA and CDC updates.

- Slight increases in the rates of HIV diagnoses in persons ≥ 35 years of age in 2012.
- Data sources CDC will use to conduct surveillance on pre-exposure prophylaxis (PrEP) uptake (e.g., National HIV Behavioral Survey (NHBS) data, pilot program data and pharmaceutical records).
- Factors contributing to significant regional variations in viral load suppression rates (e.g., populations served, poverty levels and other risk factors in individual states).
- The rationale for retention in care and viral load suppression rates that are higher in RSR data than national estimates published in the HIV Treatment Cascade: a denominator of all HIV-infected persons in the United States versus clients who present to a Ryan White Clinic at least once.
- Major barriers to states collecting reliable data and tracking problems related to limited access to prescription drugs among PLWH.
- The need to modify HAB's existing data systems to capture data on the strong correlation between unstable housing or homelessness and non-viral load suppression.
- HAB's close collaboration with and ongoing input to CMS on states that submit ACA Section 1115 Waivers to Medicaid expansion.

Panel Presentation: Youth and HIV

A panel of speakers presented a series of overviews on activities that are underway nationally to guide CHAC's discussion and development of guidance on HIV in youth. The overviews included summaries of epidemiologic, behavioral and clinical data on access to and retention in care as well as descriptions of potential prevention, intervention and treatment models in the field.

Stephanie Zaza, MD, MPH, CAPT USPHS

Director, Division of Adolescent and School Health, NCHHSTP
Centers for Disease Control and Prevention

Dr. Zaza summarized CDC's national data to demonstrate HIV-related risk behaviors in high school students. CDC launched the National Youth Risk Behavior Survey (YRBS) in 1991 with an independent, three-stage cluster sample design. The YRBS design includes a selection of schools with a probability proportional to their size and a random selection of classes. All students in the selected classes are included in YRBS, but black and Hispanic students are oversampled.

YRBS serves as a nationally representative sample of public and private school students in grades 9-12 throughout the United States.

CDC makes strong efforts to ensure that YRBS is administered as a completely anonymous and voluntary survey. Local procedures are followed to obtain parental permission for students to participate in YRBS. YRBS is a self-administered and computer-scanned questionnaire with ~99 questions that can be completed in one 45-minute class period.

Results of the 2013 YRBS are highlighted as follows. Overall, 46.8% of high school students reported ever having sexual intercourse. Similar results were observed by gender with sexual intercourse reported by 46% of females and 47.5% of males. However, striking differences were observed by race/ethnicity with sexual intercourse reported by 60.6% of blacks, 49.2% of Hispanics, and 43.7% of whites. An increase was observed by age and over time with sexual intercourse reported by 64% of students in grade 12.

Overall, 15% of high school students reported sexual intercourse with ≥ 4 persons during their lifetime. By gender, multiple sexual partners were higher in males (16.8%) than in females (13.2%). By race/ethnicity, multiple sexual partners were substantially higher in blacks (26.1%) than in Hispanics (13.4%) and whites (13.3%).

Overall, 34% of high school students reported being “currently sexually active” as defined by having sexual intercourse with at least one individual during the 3-month period before YRBS. By gender, current sexual activity was slightly higher in females (35.2%) than in males (32.7%). By race/ethnicity, current sexual activity was substantially higher in blacks (42.1%) than in Hispanics (34.7%) and whites (32.8%).

Overall, 59.1% of currently sexually active high school students reported using a condom during last sexual intercourse. By gender, condom use was higher in sexually active males (65.8%) than in sexually active females (53.1%). By race/ethnicity, condom use was higher in blacks (64.7%) than in Hispanics (58.3%) and whites (57.1%). CDC compiled 1991-2013 YRBS data to summarize sexual risk behavior trends in high school students over time. The major causes for concern included relatively no changes in students who ever had sexual intercourse and decreases in condom use in female and black students.

Overall, only 1.7% of high school students reported ever injecting any illegal drug. By gender, IDU was higher in males (2.2%) than in females (1.3%). By race/ethnicity, IDU was higher in Hispanics (2.2%) than in whites (1.5%) and blacks (1.3%). Overall, 22.4% of sexually experienced high school students reported ever being tested for HIV. By gender, HIV testing was substantially higher in females (27%) than in males (17.7%). By race/ethnicity, HIV testing was markedly higher in blacks (28.4%) than in Hispanics (21%) and whites (20.2%).

CDC examined disparities in sexual minority status by combining two samples of YRBS data collected in 2009 and/or 2011 from sites that added questions about sexual identity. The existing

YRBS sample design and administration procedures were applied to a dataset that included 10 states and 10 large urban city school districts. Students were asked to best describe their sexual identity: heterosexual/straight, gay/lesbian, bisexual or unsure.

CDC's analysis of the supplemental YRBS dataset found that compared to heterosexual students in both the state and district school samples, gay, lesbian and bisexual students had disproportionately higher rates in the following areas: being in a physical fight on school property; being threatened or injured with a weapon on school property; carrying a weapon on school property; skipping school due to safety concerns while going to, leaving from or at school; and being bullied on school property.

CDC's surveillance data showed that 22% of persons 13-24 years of age and 29% of persons 25-34 years of age accounted for the majority of 47,746 diagnoses of HIV infection reported in 2012. These data included persons with an HIV diagnosis regardless of the stage of disease at diagnosis. The results were statistically adjusted to account for reporting delays, but not for incomplete reporting.

Rates of HIV diagnoses in 2008-2012 were highest in persons 25-34 years of age and lowest in persons ≥ 55 years of age. However, rates of HIV diagnoses in 2008-2012 increased to 15.2% in persons 13-24 years of age and to 4.8% in persons 25-34 years of age. Decreases in rates of HIV diagnoses were observed in persons in other age groups.

The estimated incidence of new HIV infections in MSM 13-24 years of age increased to 22% from 2008 to 2010. HIV incidence among MSM in other age groups remained relatively stable over this time. By race/ethnicity, the incidence of new HIV infections was substantially higher in black MSM 13-24 years of age than in Hispanics and whites in all other age groups.

The 2009 NHBS dataset showed that HIV infection was 9% in both younger and older IDUs overall. By age, HIV infection was lower in younger IDUs 18-29 years of age (4.1%) than in older IDUs ≥ 30 years of age (9.5%). Further analyses of the NHBS dataset showed that younger IDUs represent a new generation of an at-risk population. Younger IDUs had lower HIV prevalence, but their behaviors will increase the risk of HIV infection. Compared to older IDUs, for example, younger IDUs are more likely to engage in receptive sharing of syringes and unprotected sex. Continued efforts are needed to strengthen HIV prevention efforts in this population.

Several published studies have documented IDU as the principle driver of incident HCV infections. HCV antibody prevalence is 30%-70% in IDUs overall and 10%-36% in younger IDUs 18-29 years of age. HCV incidence is 16%-42% per year in IDUs. National reporting of new HCV infections increased by 50% from 2007 to 2012, but 17 states accounted for a 200% increase. Recent studies show that IDUs account for ~70% of new HCV infections.

The demographics of HCV incidence have changed over time. During the 1990s, for example, anti-HCV prevalence was higher in men, African Americans, urban residents and persons 40-49 years of age. However, new HCV cases primarily are in white males and females 18-29 years of age who reside in non-urban and suburban areas and misuse antecedent prescription opioids. In the 2013 YRBS, 17.8% of high school students reported using prescription drugs prescribed for others.

Antigone Dempsey, MEd

Director, Division of Policy and Data, HIV/AIDS Bureau
Health Resources and Services Administration

Ms. Dempsey summarized HRSA's data on young PLWH who access RWHAP services. RSR data showed that 536,219 persons received at least one RWHAP-funded service in 2012. Based on CDC's 2011 data, RWHAP served 60% of persons diagnosed with HIV infection in the United States (or 888,921 persons). Among RWHAP clients, 82.5% were retained in care and 75% had achieved viral load suppression in 2012.

Young persons in the 13-18, 19-24 and 25-30 age groups account for 14.6% of all RWHAP clients (or 78,000 persons). By age, the 19-24 age group accounts for the most significant disparities in HIV among RWHAP clients compared to the other two young-age groups. By race/ethnicity, black RWHAP clients in all three young-age groups are disproportionately affected by HIV.

By transmission category, the risk of HIV is the same for MSM and heterosexual contact in all other age groups. However, perinatal transmission accounts for the highest risk of HIV in the 13-18 age group, while MSM transmission accounts for the highest risk of HIV in both the 19-24 and 25-30 age groups. By race/ethnicity and age, blacks in the 19-24 age group have the lowest rates of viral load suppression compared to racial/ethnic groups in the other two young-age groups.

Resa Matthew, PhD, MPH

Director, Division of Adolescent Development and Support
Family and Youth Services Bureau (FYSB)
Administration for Children and Families

Dr. Matthew presented an overview of the FYSB Runaway and Homeless Youth (RHY) Program. The mission of FYSB is to support organizations and communities that work everyday to end youth homelessness, adolescent pregnancy and domestic violence. Dr. Matthew presented a video of a young woman who shared her personal story of previously being homeless, victimized and abused and her improved quality of life after receiving assistance from an FYSB-supported organization.

FYSB's philosophy is based on two guiding principles. First, interventions that are grounded in evidence and can be tailored to the risk and protective factors of youth are promoted. Second,

trauma-informed services and environments are provided that allow youth to heal and recover from violence, abuse and neglect. FYSB recently celebrated the 40th anniversary of the RHY Act that was established in 1974 to help runaway and homeless youth leave the streets. FYSB expects the RHY Act to be reauthorized for another five-year cycle.

FYSB's organizational structure includes two divisions that oversee three programs. The Division of Adolescent Development and Support oversees the RHY Program and the Adolescent Pregnancy Prevention Program. The Family Violence Prevention and Services Division oversees a program by the same name. FYSB's funding streams to support the RHY Program are outlined below.

The Street Outreach Program provides street-based aid, outreach and prevention services to homeless youth who have been subjected to or are at risk of sexual exploitation and abuse. In FY2014, FYSB awarded 109 grantees a total of \$17 million to conduct these activities over a three-year funding cycle. In FY2013, street outreach workers made contact with homeless or at-risk youth >668,000 times.

The Basic Center Program addresses the immediate needs of runaway and homeless youth <18 years of age by providing an array of services (including shelter, food, medical care and counseling) for up to 21 days. This period of time is expected to be expanded to up to 30 days in the reauthorization of the RHY Act. In FY2014, FYSB awarded 299 grantees a total of \$53.35 million to conduct these activities over a three-year funding cycle. In FY2013, Basic Centers provided emergency shelter to >33,800 youth on the streets.

The Transitional Living Program and Maternal Group Homes provide longer-term residential services to homeless youth <22 years of age, including shelter, life skills, career counseling and educational opportunities. In FY2014, FYSB awarded 200 grantees a total of \$43.65 million to conduct these activities over a five-year funding cycle. In FY2013, Transitional Living Programs helped 3,322 homeless youth transition to their own lives.

FYSB's support network includes the RHY Training and Technical Assistance Center and the National Runaway Safeline that answered 236 calls per day in FY2013. FYSB programs serve multiple subpopulations: lesbian/gay/bisexual/transgender/questioning (LGBTQ) youth, foster care runaways, trafficked youth, pregnant and/or parenting youth, and youth involved with the juvenile justice system. Key risk factors of these vulnerable subpopulations include survival sex, higher levels of victimization, sexual abuse and rape, and commercial sexual exploitation.

A group of 11 Street Outreach Program grantees collected data from 656 youth 14-21 years of age in order for FYSB to better understand and meet the service needs of street youth. The study design included computer-assisted interviews, focus groups and convenience sampling. Respondent-driven sampling was moderately successful in this population and generated only a small number of participants. The results of the study are set forth below.

Results of the Street Outreach Program Data Collection Study

Data Variable	Total
DEMOGRAPHICS	
19-21 years of age	70%
Female	54%
Lesbian/gay/bisexual	30%
Transgender	6.8%
HOMELESS EXPERIENCE	
Kicked out of or left home due to family conflict	74%
Average length of time of homelessness	23 months
Average age of first homeless experience	15 years of age
BEHAVIORAL HEALTH	
Struggle with depression	62%
Reported alcohol use	73%
Reported marijuana use	65%
Reported other drug use: intravenous drugs, inhalants, cocaine or methamphetamines	38%
VICTIMIZATION	
Robbed	41%
Threatened with a weapon	41%
Reported being sexually assaulted or raped	15%
BASIC NEEDS	
Needed shelter	55%
Needed employment	71%
Needed educational services	55%
Needed transportation to shelters	67%
Needed clothing	60%
SEXUAL PARTNERS, SEX EXCHANGES, SEXUAL BEHAVIORS	
Median number of lifetime sexual partners	6 (range of 0-100)
Reported knowing all sex partners	48%

Results of the Street Outreach Program Data Collection Study

Reporting having sex with some strangers	21%
Reported having sex with strangers only	2%
Had sex in exchange for money	24%
Had sex in exchange for shelter	28%
Had sex in exchange for food	18%
Had sex in exchange for protection (This exchange was more common in females than in males.)	12%
Had sex in exchange for drugs	11%
Asked by an intimate partner to have sex with others in exchange for money	10%
Had sex in exchange for food, money, shelter, drugs or protection:	
• LGBTQ youth	50%
• Heterosexual youth	29%
Engaged in vaginal sex	79%
Engaged in oral sex	80%
Engaged in anal sex	39%
Never used a condom during vaginal sex	16%
Never used a condom during oral sex	55%
Never used a condom during anal sex	30%
HIV AND OTHER STDs	
Reported being tested during their lifetime	75%
Reported having an STD	20%
Unsure about having an STD	5%
Informed of a positive HIV test result by a medical professional	2%
Worried about the possibility of having an STD	11%

The results of the data collection study showed that runaway and homeless youth congregate and sleep in locations of opportunity: streets, park benches, private vehicles, bus/train/subway stations, airports, homeless camps or business offices after hours. Outreach workers, particularly those who conduct outreach with mobile vans, were found to have the most success in reaching this population in terms of performing rapid HIV testing, offering pre-/post-test counseling, and providing sexual health education.

Drop-in centers and shelters with medical clinics also were found to be effective in addressing the needs of runaway and homeless youth. Moreover, school liaisons who are designated under the McKinney-Vento Homeless Education Assistance Improvements Act can be used to identify and

refer homeless youth in school systems. The executive summary of the Street Outreach Program Data Collection Study is available on the FYSB website.

Overall, youth require tailored intervention services and support. Coordination among service providers should be improved to increase the focus on sexual health education for youth. Linkages between local communities and governmental agencies that serve the same youth populations should be strengthened. More data collection, analysis and evaluation should be conducted to better target resources to the most vulnerable subpopulations of youth. Screening and testing should be enhanced, particularly for LGBTQ youth.

Catherine Gallagher, PhD

Professor of Criminology, Law and Society
George Mason University
Cochrane Collaboration Policy

Dr. Gallagher described opportunities for HIV/AIDS prevention, intervention and treatment in juvenile justice system (JJS) youth. JJS youth are at higher risk of HIV/AIDS, but no surveillance system has been established to capture, monitor and track the scope of the problem in this population nationally.

Legal, policy and guideline restrictions limit interaction with JJS youth, particularly if legal versus physical custody of a minor child has not been specified. Moreover, the inclusion of new interventions in JJS is extremely difficult due to system-level complexities. Interventions for JJS youth must be systematic, generalizable to other populations, and have a high level of scientific rigor.

The number of JJS youth has declined since 2008 overall, but youth <18 years of age still account for ~1.5 million arrests per year nationally. Interventions for JJS youth include diversions and probation with community supervision. On average, 383,000 youth are on probation each day. The number of youth who were in locked facilities on a given day substantially decreased from ~110,000 in 2000 to 61,000 in 2011. Detention centers or “short-stay” facilities have the highest volume of youth and are given the most attention in terms of targeting interventions. On average, 21,090 youth are in detention centers each day. Long-term secure facilities or “youth prisons” currently house 16,662 youth.

Youth spend the least amount of time in the 606 U.S. detention centers and spend the most amount of time in the 155 U.S. long-term secure facilities. As a result, interventions must be tailored to match the amount of time JJS youth spend in these facilities. JJS youth on probation and in locked facilities have a substantially higher relative risk of nearly all health conditions than youth in the general population and non-JJS youth at high risk, particularly IDU, HBV, HCV and chlamydia.

Ad-hoc data have been collected on risks in JJS youth, but no national prevalence data have been gathered on HIV/AIDS and other conditions in this population. For example, low HIV/AIDS rates have been reported in JJS youth, but these data are based on outdated studies that were conducted in the 1990s among similar populations in the same geographic region of the country. A full-scale surveillance study based on the current national population of JJS youth is likely to document much higher HIV/AIDS rates.

Data were collected and analyzed to determine whether detention centers and long-term secure facilities meet basic standards for the delivery of services and care to JJS youth. The analysis showed that only a few state-owned, long-term facilities provide girls with a gynecological examination and counseling on reproductive health.

The CDC Vaccines for Children Program provides vaccines to these facilities at no charge, but facilities that house 23,000 JJS youth each day do not give vaccines to this population. Infectious diseases are tested in only 16% of facilities and only a few facilities provide pregnancy testing for their full female populations. The 3% of facilities that offer HIV/AIDS testing provide this service only at the specific request of an individual JJS youth.

Results of the data analysis and other factors show that JJS settings present an opportunity to introduce new health interventions, including follow-up education, testing and treatment. Most notably, reliable and well-defined national prevalence data have not been collected for JJS youth. JJS complexities are a tremendous challenge to including new interventions in these settings.

Behaviors of JJS youth are closely integrated with structural, organizational and family contexts. Uncertainty regarding legal versus physical custody limits the level of service and care that facilities can provide to JJS youth. Sufficient data have been gathered to make improvements in JJS settings, but facilities are unwilling or do not have adequate critical mass to implement new health interventions for youth.

Kevin Jones, MEd, MPH

Director, Evaluation and Training
Metro TeenAIDS

Mr. Jones presented an overview of MetroTeenAIDS (MTA) programs that are designed to engage youth in Washington, DC. MTA was founded in 1988 to deliver a variety of youth-related services: HIV, STD and pregnancy testing; school and after-school services; TA and capacity building; peer education, learning and mobilization; family wraparound services; and policy development. MTA's key accomplishments in FY2014 are highlighted below.

- Provision of >1,500 HIV tests and 1,600 STD tests to youth
- Attendance by >750 youth in school-based training events that feature a Comprehensive Sex Education Curriculum

- Attendance by 500 youth in a 24-week after-school program
- Provision of capacity building and TA to nearly 500 adult providers to better serve youth
- Outreach to 605 youth through the Peer Education Program
- Attendance by 221 parents in training sessions to better communicate with youth about youth development issues and sexual health
- Development of local policies to better address youth-related issues

Of 8,962 persons MTA reached through programming in FY2014, services were directly provided to 3,987 clients. In terms of demographics, the MTA population includes blacks (77%), Hispanics (~11%), heterosexuals (~46%), youth 13-24 years of age (~72%), and HIV-positive persons (1.3%). Mr. Jones highlighted three MTA programs that potentially could be scaled-up nationally as models to better engage and outreach to youth.

Program 1: The REALTalk Program is designed as a tiered participation program to provide youth with professional, workforce and leadership development training to advance their health, education and employment goals. Most youth initially serve as volunteers to fulfill court-mandated community service or high school graduation requirements, but many youth eventually advance through the program as tier 1 community messengers, tier 2 peer representatives, and tier 3 peer ambassadors (a paid position).

Based on the specific tier achieved in the peer-led, peer-based and peer-driven program, youth will be extensively engaged to conduct several activities: work in school-based settings, perform HIV testing, provide outreach, participate in training sessions, lead community events, increase awareness of post-secondary employment opportunities, conduct health and wellness screenings, distribute safer sex resources and materials, and disseminate information on personal and professional education opportunities.

MTA established several indicators to guide its impact and outcome evaluation of both the participants and overall program.

- A decline in school dropout rates
- Increased school attendance rates
- A population of youth that is better educated and more aware of social and health issues
- An increase in positive relationships with peers and organizations
- Development of a team of youth volunteers with the necessary skills to make an impact in their communities
- Capacity to scale-up the program as a broader “Peer Health and Professional Education Program”

Program 2: Care Advocacy Services are designed with the three major components of linkage to care, navigation and RWHAP services for youth. The program includes a 90-day intervention to link newly diagnosed youth to medical care; 12-month intensive case management services for

youth who are newly diagnosed, need to be reengaged in care or recently were released from incarceration; and medical case management to ensure retention in care and viral load suppression.

The program is based on six types of care: client-centered care, community-based care to remove barriers to engagement, intensive care to address the specific needs of individual clients, relationship-based care with a care advocate, independent-focused care to achieve and sustain viral load suppression through adulthood, and collaborative care with community partners to ensure a seamless service delivery system.

MTA contracts medical providers to offer case management to its entire client population, including youth and HIV-positive pregnant women. These clients also have the option of enrolling in MTA's family wraparound services that focus on entire families affected by HIV. MTA expanded the program to provide mental health services to youth.

Program 3: The LGBTQ Youth Health Innovation Laboratory is designed to improve the health and wellness of this population in Washington, DC. The program focuses on building a sustainable, systemic and multi-sector approach based on existing Centers of Excellence, best practices and other models to reach, engage and support LGBTQ youth.

Broad community support is targeted to meaningful and sustainable wellness of LGBTQ youth. Efforts are made to increase political will to develop policies that support wellness of LGBTQ youth. A range of valid and reliable measures of sexual orientation, gender identity, health and wellness developed by organizations that serve LGBTQ youth or collect youth-related data are consistently used to measure progress. Funding will be expanded to sustain the program over time.

MTA collaborates with partners and extensively engages LGBTQ youth to develop a case definition of "health and wellness" for the program. MTA's other efforts to advance the program include strengthening the skills, experience and expertise of staff, forming a Thought Leader Advisory Board, establishing workgroups with community partners to conduct LGBTQ-related projects, identifying fellowship and internship opportunities, and regularly publishing and distributing a report card to local agencies and organizations on progress in addressing LGBTQ issues.

MTA expects the program to result in several key outcomes. A definition of "health and wellness" that is relevant to and resonates with youth will be developed. Best practices for serving LGBTQ youth will be generated. Community capacity will be built to implement best practices. Data collection efforts will be improved to assess health disparities and identify the unique needs of LGBTQ youth. Health and wellness research specifically targeted to LGBTQ youth will be promoted. Advocacy for LGBTQ youth will be strengthened through policy development. A rigorous evaluation will be conducted to assess progress in achieving these goals.

CHAC discussed the following topics with the youth and HIV panel of speakers.

- Barriers to HIV testing of youth, particularly LGBTQ youth (e.g., 3,987 MTA clients in FY2014, but only 1,500 HIV tests performed).
- Potential opportunities to link LGBTQ youth to PrEP and post-exposure prophylaxis (PEP) services.
- The need to collect data and pilot existing incentive programs to assess their efficacy in increasing HIV testing, retention in care and viral load suppression in youth.
- The possibility of CDC and HRSA scaling-up the MTA intensive case management model for HIV-negative youth to ensure this population remains negative over their lifetime.
- The need for new policies to clarify whether PrEP is a prevention strategy or treatment that would require consent for youth <18 years of age.
- The need to eliminate the “opt-in” requirement that serves as a tremendous barrier to HIV testing in youth.

Drs. Clanon and Marrazzo advised CHAC to consider the topic of youth and HIV more holistically to identify broad themes that potentially could be formalized as resolutions to the HHS Secretary, CDC Director and HRSA Administrator for consideration and action.

Data on Youth and HIV

- Rigorous qualitative and quantitative data on youth and HIV should be collected. For example, young PLWH have anecdotally reported their interest in discontinuing their medication and the use of condoms. Solid data are needed to promote treatment adherence in young PLWH to prevent further transmission of HIV.
- HRSA data from RWHAP and SPNS Initiatives should be published to document lessons learned, successes and best practices in achieving outstanding viral load suppression rates in youth in federally-funded clinical settings.
- CDC and HRSA should separate HIV data for the 13-18 age group to clearly distinguish between perinatal transmission and transmission through behavioral risks.

Potential Youth and HIV Interventions for Scale-Up

- A youth and HIV analysis should be performed on broader environmental issues, positive protective factors, resiliency, vulnerability and risks that are unique to youth.
- PrEP should be offered as a more accessible and available community intervention rather than a medical intervention administered in clinics. Youth typically do not present to clinical settings for care. Moreover, many existing programs that provide PrEP do not address the unique needs of youth, particularly those covered under their parents' health plans.
- CDC/DHAP and HRSA/HAB should include youth and HIV as one of the topics in its new integrated planning process for the HIV Care Continuum.

- A pilot project should be conducted to assess the feasibility and efficacy of implementing a new biomedical intervention for youth in a non-traditional setting, such as the juvenile justice system, and integrating the intervention with existing services.
- Successful interventions conducted by the Office of Refugee and Resettlement for international survivors of trafficking should be adapted for youth survivors of trafficking in the United States. Funding from the President's Strategic Plan for Trafficking that was released in January 2014 should be leveraged to support this effort.

Dr. Mermin advised CHAC to limit its formal guidance to CDC and HRSA to a few youth and HIV issues that should be prioritized to achieve the greatest benefit and most significant impact. He described examples for CHAC to consider in this regard.

- A large proportion of HCV-positive persons in the United States (e.g., ~30%) have encounters with the criminal justice system at some point in their lifetime. These settings would be ideal for routine HIV screening and treatment of the HCV-positive population.
- LGBT youth account for 40% of runaway and homeless youth on the street who are at high risk for HIV and STD infection. Interventions that would be beneficial to and most effective in this youth subpopulation should be identified for national scale-up.
- Emphasis should be placed on vulnerable youth subpopulations that would benefit most from PrEP or PEP services, HIV screening and education.

Public Comment Session

Emily McCloskey

Manager, Policy and Legislative Affairs
National Alliance of State and Territorial AIDS Directors (NASTAD)

Ms. McCloskey made the following comments for CHAC's consideration. The NHAS goal of achieving a more coordinated national response to the HIV epidemic explicitly states that the federal government should make short- and long-term efforts to simplify grant administrative activities. These efforts should include standardized data collection, consolidated FOAs and integrated grantee reporting requirements for federal HIV programs.

State health departments are facing increasing pressure due to both human and financial resource constraints. For example, NASTAD's reporting burden analysis in 2011 found that health departments were required to report to the federal government 98 separate times in one year. The burden of federal reporting requirements (FRRs) has resulted in a number of adverse outcomes: unnecessary reporting redundancies across funding streams; limited harmonization of reporting elements across agencies; limited communication and data-sharing across funding

streams and federal agencies; and minimal acknowledgment and understanding of health department operations and data systems.

FRRs are continuing to divert health department resources and attention away from efforts to support an appropriate and essential public health response. This burden also serves as a barrier to program and service integration that is important to both federal agencies and state health departments.

Additional reductions that are coordinated across programs and funding streams are urgently needed to promote consistency, eliminate duplication of reporting efforts, and allow health departments to prevent more new infections and provide PLWH with a higher quality of service. Because health departments increasingly are integrating HIV, viral hepatitis, STD and TB prevention services, divergent and separate reporting requirements continue to be burdensome and unnecessarily redundant.

Both NASTAD and state health departments continue to be concerned about the undue burden of increased FRRs. As a result, NASTAD revised its FRR chart to illustrate the number of FRRs associated with HIV, viral hepatitis, STD and TB programs. NASTAD will soon release an update to its 2011 reporting burden analysis to track changes in FRRs in response to the NHAS goals.

Preparation for the CHAC Business Session

Kathleen Clanon, MD, CHAC co-Chair
Medical Director
Alameda County Health Care Services Agency

Jeanne Marrasso, MD, MPH, CHAC co-Chair
Professor of Medicine, Harborview Medical Center
University of Washington

Drs. Clanon and Marrasso moderated a discussion for CHAC to consider issues from the updates and panel presentation on day 1 that would warrant formal action during the Business Session on the following day.

Champions	Topic	Basis for Resolution/Recommendation
Ms. Dawn Fukuda Mr. Kali Lindsey	Youth and HIV	CHAC acknowledges the need to collect rigorous data, target resources and develop innovative models to regularly monitor youth and HIV. CHAC

agrees that the focus initially should be placed on three key domains in this effort.

- PrEP uptake in youth
- An analysis of resiliency, positive protective factors and vulnerability of youth
- Youth subpopulations of concern: runaway and homeless youth, juvenile justice system youth, and LGBTQ youth

With no further discussion or business brought before CHAC, Dr. Clanon recessed the meeting at 4:12 p.m. EST on November 19, 2014.

Opening Session: November 20, 2014

Laura Cheever, MD, ScM

Associate Administrator, HIV/AIDS Bureau
Health Resources and Services Administration
CHAC Designated Federal Officer, HRSA

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

Dr. Cheever reminded the CHAC voting members of their responsibility to disclose any potential individual and/or institutional conflicts of interest for the public record and recuse themselves from voting or participating in these matters. None of the CHAC voting members publicly disclosed any individual or institutional conflicts of interest for the record that were new or different than those declared on day 1 of the meeting.

Dr. Cheever confirmed that the voting members and *ex-officio* members in attendance constituted a quorum for CHAC to conduct its business on November 20, 2014. She reconvened the proceedings at 10:02 a.m. EST and welcomed the participants to day 2 of the meeting. Dr. Cheever introduced two speakers to provide brief updates in response to CHAC's previous requests for additional information.

Dr. Elinore McCance-Katz, the CHAC *ex-officio* member for the Substance Abuse and Mental Health Administration, announced that NIH convened a conference in September 2014 to discuss the role of opioids in the treatment of chronic pain. Responses to key questions developed for the conference showed that the current evidence base is minimal on the efficacy of opioids in chronic pain treatment. A summary of the conference was distributed to CHAC for review.

Ms. Lynn Wegman, Deputy Director of the HAB Division of Community HIV/AIDS Programs, provided a status report on the consolidation of RWHAP Parts C and D. HAB will soon release an FOA for Part D alone, but support for the consolidation of Parts C and D in the FY2015 President's budget is ongoing. HAB also is soliciting input from grantees and stakeholders on the best strategies to ensure seamless consolidation in the future and continued support for women, infants, children and youth.

Kathleen Clanon, MD, CHAC co-Chair

Medical Director

Alameda County Health Care Services Agency

Dr. Clanon also welcomed the participants to day 2 of the CHAC meeting. She thanked the panel of speakers for their extremely informative presentations on youth and HIV on the previous day. The overviews helped the champions to draft a resolution on this issue that would be presented during the Business Session for CHAC's consideration, discussion and formal action. Dr. Clanon closed the opening session by reviewing the day 2 agenda.

Panel Presentation: HIV Community Health Workforce for Engagement in Care

A panel of speakers presented a series of overviews on opportunities to expand the role of the HIV community health workforce to successfully engage, link and retain clients in care.

Meseret Bezuneh, MEd

Chief, Health Careers Pipeline Branch, Bureau of Health Workforce
Health Resources and Services Administration

Ms. Bezuneh presented an overview of the HHS Interagency Workgroup on Community Health Workers (CHWs). ACA explicitly defines the role of CHWs in preventive services, health homes and state innovation models. In response to this language, the HHS Secretary's Workforce Initiative formed the interagency workgroup to achieve three overarching goals.

- Identify enhanced training and employment opportunities for CHWs
- Expand training and employment opportunities for CHWS in healthcare support, mental/behavioral health, team-based care, care coordination and health insurance navigation
- Pursue programmatic and policy strategies to promote expanded use of CHWs

The workgroup is co-led by HRSA and the Office of Minority Health and includes ~80 members from 15 HHS agencies, centers and offices. The workgroup uses various platforms to share information on an ongoing basis: the CMS Innovation CHW Learning Collaborative, the CDC

Chronic Disease State Policy Tracking System and State Law Fact Sheet, CHW Training Initiatives by Area Health Education Centers, Policy Toolkits by the Office of Rural Health, CHW competencies defined by the U.S. Department of Labor, and the U.S. Section of the U.S.-Mexico Border Health Commission Office of Global Health Affairs.

The workgroup has focused on a number of important topics since its establishment, including support of CHWs in HHS programs and policies, an inventory of CHW programs within HHS agencies, resource development, and an environmental scan through listening sessions. The workgroup held a listening session with roundtable discussions and suggestion boards during the Unity Conference in May 2014 to meet with and obtain input from CHWs. The workgroup currently is compiling and analyzing consistent themes from the listening session.

CHW Practice

- The role and scope of CHW practice
- Standardization of CHW training, practice and definition
- Development of CHW competencies
- Best practice models for CHWs
- Quality improvement of CHWs

The Role of CHWs in Broader Society

- CHW relationships with federal, state and local governments
- Threats to CHW practice
- Recognition of CHW competencies
- Fiscal mechanisms to support CHWs
- CHW relationships with other healthcare team members

The workgroup's next steps will be to continue to monitor and compile lessons learned from states that are taking action in terms of CHW certification, training and competencies. The benefits of certifying and credentialing CHWs will be reviewed. Evaluation studies will be conducted to determine the impact of CHWs on quality of care and cost-effectiveness. Career development resources will be provided. Strategies will be identified to integrate CHWs into inter-professional teams. Workforce data on CHWs will be collected.

Joseph Interrante, PhD

Chief Executive Officer
Nashville CARES

Dr. Interrante presented an overview of the strategic role of PLWHA in meeting the NHAS goals in middle Tennessee. Nashville CARES is a community-based ASO that serves 17 counties, including the Nashville metropolitan statistical area/transitional grant area (MSA/TGA). The human and financial resources of Nashville CARES include a 24-member Board of Directors, 80 employees, 400 volunteers who dedicate nearly 20,000 hours, and a \$15.6 million budget.

The Nashville CARES population of ~65,000 clients received services in four major categories in FY2014: prevention education, HIV testing and screening, care completion and essential support services, and insurance assistance. Demographics of the Nashville CARES client population include African Americans (51%), Hispanics (5%), women (27%), MSM (51%), and persons at ≤100% FPL (60%). The HIV prevalence in the Nashville CARES client population is 46% in African Americans, 6% in Hispanics, 22% in women, and 56% in MSM.

Nashville CARES is continuing to address key challenges in reaching the NHAS goals. New HIV infections have decreased by 17% in the greater Nashville MSA/TGA since 2009, but 26% of persons had late diagnoses in 2012 and 26% of PLWHA were not linked to care within 6 months in 2013. Although 65% of PLWHA receive HIV medical services annually, retention in care rates continue to be low at 42%-45%.

Although >70% of clients who receive care in RWHAP-funded clinics achieve optimal viral suppression (OVS), health disparities persist due to a low OVS rate of only 40% in PLWHA overall. Of all clients who receive medical case management services, only 50%-60% achieve OVS. Of the total Nashville CARES client population, 200-300 persons are not in medical care in any given year.

Despite these challenges, Nashville CARES has identified several opportunities to have a significant impact on improving health outcomes and reaching the NHAS goals in the Nashville MSA/TGA as a whole. Nashville CARES is the only service provider serving all 17 counties in the Nashville MSA/TGA and agency clients represent >75% of all PLWHA who receive services in the region. On the other hand, only 50-60% of medical case management clients achieve OVS and about 200-300 clients are not in medical care in any given year. Thus, by improving outcomes for agency clients, CARES can improve the MSA as a whole.

To that end, the Nashville CARES Board of Directors approved a five-year strategic plan in June 2014 with three key goals: (1) reduce the number of new reported HIV infections by 50%; (2) decrease the community viral load rate of the client population by 60%; and (3) increase the number of clients who consistently achieve OVS by 75% regardless of their background. The strategic plan goals will be achieved by focusing on the HIV Care Continuum and providing education, advocacy and support to persons living with or at risk of HIV.

Changes in the Nashville CARES service delivery paradigm are highlighted as follows. The focus on health outcomes has shifted from access to data-driven models of engagement/ retention in care and treatment adherence. An interdisciplinary team delivery model is now used that focuses on strengths, problem-solving, trauma-informed care, stages of change and harm reduction. OVS-informed triage is now used to inform the intensity of services delivered to individual clients. A proactive approach to retention in care is now implemented and supported by data from lost-to-care analyses, multivariate regression analyses, and indicators for preventive interventions.

Both client-level and aggregate viral load data are now collected from state and local health departments to measure outcomes.

Nashville CARES has a longstanding philosophical commitment to the meaningful involvement of PLWHA. PLWH account for 25% of Nashville CARES staff. However, the role of PLWHA peers has evolved to maintain pace with the delivery of new interventions over time: first-person education, prevention with positives, and linkage to care. PLWHA peers currently are implementing the “IAMSTRONG” Program that focuses on treatment adherence and optimal health through OVS.

Nashville CARES collaborated with partners to develop IAMSTRONG in 2012 with a target of serving 1,500 clients per year. Several CDC-approved strategies for treatment adherence are included in the program, such as peer support, navigator training, motivational interviewing and adherence action plans. The program was piloted in 2013 and showed promise in several areas. Compared to non-program participants, for example, IAMSTRONG participants were 4 times more likely to attend their last medical visit and 5 times more likely to achieve OVS. Due to the successful outcomes of IAMSTRONG, the entire staff has been trained in delivering the IAMSTRONG protocol to promote optimal health and healthy outcomes in the client population. Plans for program expansion include a drop-in CARES Café, cloud application and PrEP application.

Nashville CARES is now placing stronger emphasis on the cultural competency of PLWHA peers in its service delivery system, particularly in the context of retention in care and treatment adherence. At the community level, PLWHA peers are playing a critical role in minimizing HIV/AIDS-related stigma and psychosocial barriers in the target population that are much more persistent in the South than in other areas of the country. At the organizational level, PLWHA peers are now fully integrated into all aspects of the Nashville CARES service delivery system.

- Staffing of the HEARTLine (HIV Education and Advocacy Response Team) for point-of-entry services
- Intake of and updates to client information
- Provision of individual client services (e.g., early intervention services, medical case management, behavioral health services, and linkage to care)
- Participation on multidisciplinary service teams
- Delivery of point-of-contact services
- Responsibility for the semi-annual RWHAP new certification and re-certification process
- ACA enrollment
- Management of Insurance Assistance Program benefits for clients
- Implementation of IAMSTRONG

Nashville CARES is exploring the possibility of CHW certification as a strategy to sustain the role of PLWHA peers over time and obtain reimbursement for these services. However, several

challenges and issues must be considered in this effort. PLWHA peers who are successful in achieving optimal health and become employed no longer have time to volunteer. This heightens the importance of having peer roles as employed staff.

Rigorous policies and procedures should be developed to explicitly clarify confidentiality and privacy issues, dual relationships of PLWHA as both peers and clients, and service delivery to PLWHA in their role as peers. Protocols should be established to track and monitor the health of PLWHA peers to assure their compliance with stress reduction techniques and self-care.

Efforts should be made to harmonize the diversity in funding streams and definitions of the community health workforce: “wellness advocates,” “navigators,” “community health workers,” “persons living with HIV/AIDS peers,” and “medical case management associates.” Nashville CARES will continue to focus on replacing “I” with “we” to advance from “illness” to “wellness.”

Matthew Golden, MD, MPH

Professor of Medicine, University of Washington

Director, University of Washington Public Health Capacity Building Center

Dr. Golden presented an overview of efforts by the King County, Washington Field Services Program (FSP) to promote engagement in and linkage to HIV care. The mission of the King County FSP is to diminish the occurrence, morbidity and mortality associated with HIV/STD. FSP established two key goals to fulfill this mission: (1) prevent both new infections and the clinical consequences of infections and (2) align prevention and clinical objectives without a hierarchy.

Public health has a critical role in promoting HIV/STD care, particularly population-based care, and providing a linkage to surveillance. Successful systems require some level of planned redundancy and multiple “fail-safe” mechanisms to prevent or correct errors. Engagement is a shared responsibility that requires efforts from both the public health and clinical communities for population-based and clinical achievements.

FSP’s integration of linkage to and reengagement in care is part of a broader effort to modernize public health HIV outreach. For example, FSP’s “traditional” field services primarily focused on partner notification, syphilis/HIV treatment and the collection of descriptive epidemiologic data. FSP’s “expanded” field services are focusing on the following objectives at this time.

- Integration of HIV testing in outreach to persons with bacterial STD. (This approach has increased the HIV testing rate of MSM with bacterial STDs to >90% throughout Washington State. SMS text messaging reminders also are being used to increase the frequency of HIV testing.)
- Promotion of PrEP in persons with rectal gonorrhea and early syphilis
- Linkage to health insurance
- Linkage to HIV care

- Re-linkage to HIV care
- Improved collection of surveillance data

Compared to national data and recent surveillance data collected from 19 states, King County has higher rates of HIV diagnoses (92%), PLWH linked to care (85%), PLWH retained in care (79%), and PLWH who achieved viral load suppression (69%). FSP is divided into disease-/population-specific teams: HIV partner services, syphilis, HIV re-linkage to care, gonorrhea and chlamydia in MSM with a focus on HIV testing, and gonorrhea and chlamydia in heterosexuals with a focus on expedited partner therapy.

FSP's HIV activities are linked to surveillance. Disease intervention specialists (DISs) receive information on all newly reported HIV cases several times per week. Initial partner service interviews are conducted via telephone with ~2 full-time DISs handling ~300 new HIV cases per year. Linkage to care is an explicit outcome of partner services due to the mission of FSP to prevent both HIV/STD and morbidity and mortality associated with these infections. Cases are not closed until the DIS confirms patient contact with an HIV medical provider. All cases are reviewed during monthly meetings attended by the DIS, DIS supervisor, surveillance staff and program director.

All newly diagnosed HIV patients are given the option to attend the FSP "One-on-One Clinic" within the STD Clinic that serves as a clinical site to facilitate linkage to care. Patients can present to an HIV specialist within 2 days of the diagnosis for services and counseling regarding their prognosis, sexual risk and plans for care; CD4 count and viral load testing; and partner services. The One-on-One Clinic has a participation rate of ~33% of all newly diagnosed HIV patients in King County. This model emphasizes the importance of conducting public health outreach with an associated clinical infrastructure. Mississippi and other public health departments across the country have implemented similar early intervention programs.

The 2013 Bocour study reported that recipients of partner services in New York City had a higher rate of linkage to care within 3 months (79%) compared to non-recipients of partner services (66%). FSP reported similar results. Partner services currently facilitate linkage to care within 3 months for >90% of persons with new HIV diagnoses in King County.

The FSP Care and Antiretroviral Therapy Promotion Program uses multiple data sources to re-engage clients in care: surveillance data of PLWH with no laboratory data for 12 months, but with a detectable viral load ≥ 6 months post-HIV diagnosis; information from STD partner services or STD clinics; and referrals from local medical providers. After FSP obtains patient information and consent from medical providers, structured interviews are scheduled with patients to identify barriers to care and devise a plan for re-linkage and treatment. FSP sends a letter to the patient's medical provider and case manager to summarize the outcomes and conducts follow-up after one month.

FSP conducted a case investigation to better characterize the PLWH population in King County. The investigation showed that of 13,327 PLWH ever reported in King County, 54% of cases out of care had relocated from the area or died and 19% of cases were overestimated. The out-of-care cases included 1,196 relocations to other areas, 959 local residents, 180 deaths, and 210 cases with an unknown status. Based on the case investigation, FSP calculated a smaller and more accurate denominator of 5,975 PLWH in King County.

At the local level, FSP increased its viral load suppression goal from 50% to 69% based on an adjustment for relocation. FSP also reviewed surveillance data to compare the percent of its out-of-care PLWH population due to relocation or death (54%) to similar populations in other jurisdictions: Multnomah County, Oregon (72%), Alaska (36%), San Francisco (32%), and Denver, Colorado (27%). At the national level, the viral load suppression goal would increase from 36% to 46% based on surveillance data from 19 states.

FSP's surveillance-based evaluation for re-engagement in care initially focused on a total of 1,442 PLWH in King County with CD4 counts <500 and detectable viral loads. Of the total population, 50% of PLWH were not eligible due to relocation to another area, existing virologic suppression, incarceration or death. Of the remaining 50%, provider consent was given to contact only ~33% of their HIV-positive patients. Of PLWH who were contacted, 42% were successfully re-linked to care. Based on a surveillance-based model of re-engagement in care, FSP found only 18% of initiated cases that were out of care. The number needed to investigate to link one patient to care was ~16 in the surveillance-based model.

FSP's clinic-based evaluation for re-engagement in care initially focused on a total of 753 PLWH in the largest RWHAP-funded clinic in King County with no laboratory data for >12 months. Of the total population, 54% of PLWH were eligible and 46% were ineligible due to relocation to another area or transfer of care. Further investigation decreased the eligible population from 54% to 21%. Of the 5% of PLWH contacted, 3% were re-linked to care. The evaluation showed that 79% of PLWH who presumably were out of care actually were in care or had relocated to another area. The number needed to investigate to link one patient to care was ~20 in the clinic-based model after the initial match with health department data.

Other jurisdictions also conducted a surveillance-based evaluation for re-engagement in care. Of 524 PLWH with no laboratory data in Tennessee, only 17% of cases found were out of care. Of 797 PLWH who received public social services and had no laboratory data for 9 months in New York City, 60% of cases found were out of care. The number needed to investigate to link one patient to care in New York City was 3.3 in the surveillance-based model.

FSP will finalize its evaluation of the King County data by the end of 2014, but preliminary findings and conclusions of surveillance-based re-engagement in care are summarized as follows. Surveillance data overestimated a large proportion of the out-of-care population. Many of these PLWH relocated to another area, actually were in care or were deceased. As a result, the HIV

care cascade might be better than current national estimates indicate. The cost per person successfully linked to care is likely to be high.

The New York City experience demonstrated that using additional data sources to confirm residency improves efficiency, but this approach also reduces population-level coverage. Surveillance-based re-linkage to care will become more efficient as data improve over time. Most notably, case investigations and a national data feedback system should be designed to identify persons who have relocated to other areas. The advantages and disadvantages of various re-linkage to care models should be compared.

Type of Model	Advantages	Disadvantages
Health Department Model	<ul style="list-style-type: none"> • Population-based • Capacity to improve surveillance 	<ul style="list-style-type: none"> • Substantial overestimation of out-of-care PLWH • High cost • High cost • Lack of program capacity to implement a DIS-based model • Requirement to release health department surveillance data to CBOs • Not population-based • Frequently inefficient and timelier
DIS-Based Model	<ul style="list-style-type: none"> • Existing security and quality control of the DIS workforce in terms of surveillance data 	
CBO-Based Model	<ul style="list-style-type: none"> • Low-cost, community-based 	
Collaborative Health Department/Clinic Model	<ul style="list-style-type: none"> • Ability for clinics to serve their individual patient populations • The use of surveillance data to improve efficiency • Collaborative approach • Timelier than health departments 	
Clinic or Case Management Model	<ul style="list-style-type: none"> • Simple design 	

Overall, the integration of linkage to care into HIV partner services is effective and efficient, aligns care and prevention objectives, and minimizes the number of discussions patients need to have with providers and staff following their HIV diagnoses. Linkage to care should be an explicit outcome of DIS investigations, but this change will require updated DIS training.

Surveillance-based re-linkage to care is feasible, but is costly per re-linked case. However, all re-linkage programs are likely to be costly. Re-linkage to care programs improve surveillance

data. Efficiency is likely to improve as surveillance data is enhanced over time. These programs should be included in a portfolio of engagement-promoting activities to complement facility-based efforts.

CHAC discussed the following topics with the HIV community workforce panel of speakers.

- Necessary components for PLWHA peers to be successful in engaging and re-linking persons to care and assuring treatment adherence: a baseline level of education, rigorous training to strengthen work skills, and ongoing supervision.
- The rationale for the low rates of new HIV infections in King County among young persons and MSM compared to other parts of the country.
- Use of the Ryan White CAREWare system as an additional data resource to identify out-of-care PLWHA.

Panel Presentation: Improved Impact and Performance-/Need-Based Funding

A panel of federal staff presented overviews of activities that are underway at CDC and HRSA to improve program impact and performance-/need-based funding.

Richard Wolitski, PhD

Senior Advisor for Indicator Monitoring and Program Improvement, NCHHSTP
Centers for Disease Control and Prevention

Dr. Wolitski presented an overview of CDC's national, state and grantee reports to monitor and improve the impact of HIV prevention goals. Indicators help CDC to agree on the most important priorities, clearly define goals and targets, monitor and report on progress, increase accountability, and improve programs and results. The measurable NHAS goals and CDC indicators also allow CDC to monitor progress over time.

In addition to monitoring improvements in HIV prevention nationally, CDC also tracks progress at state, city, local agency and grantee levels. CDC publishes several reports in this regard. CDC released the first National HIV Prevention Progress Report in December 2013 with the following features: a synthesis of surveillance system data to describe progress in 21 indicators that are measured over time; a comparison of indicators with the 2015 HIV prevention goals and annual targets; and baseline and available results for 2011. CDC will publish the second National Report in June 2015.

The first National Report documented progress in some areas based on 2011 data, but showed persistent challenges in other areas.

- 62% of annual targets (or 13 of 21 indicators) were met or exceeded, including 7 NHAS indicators. The most significant improvements occurred in awareness of HIV status and reductions in HIV infections among IDUs.
- 24% of indicators (or 5 of 21 indicators) showed no change or moved away from annual targets. The areas of most concern were new HIV infections and risk behaviors in MSM and low linkage to care rates in African Americans and Hispanics.
- 14% of indicators (or 3 of 21 indicators) could not be compared with annual targets.

The National Report displayed graphs to illustrate progress each year in achieving national goals. For example, the goal of increasing the percentage of PLWH who know their serostatus to 90% has shown consistent improvement with a steady increase from ~81% in 2006 to 86% in 2011. In 2011, 6 of 7 PLWH knew their serostatus, while 1 of 7 PLWH did not know their serostatus.

CDC released the first State HIV Prevention Progress Report in September 2014 with the following features: a synthesis of surveillance system data to describe progress in 6 indicators that are aligned with national goals related to the HIV Care Continuum and a presentation of results relative to other states and the 2015 HIV prevention goals. The first State Report serves as a baseline for future reports.

The State Report displayed maps and graphs to compare progress in HIV prevention by state and across the nation. For example, the national death rate among persons with diagnosed HIV infection in 2010 was 24/1,000. The 2015 national goal has been established at 21.7/1,000. Significant disparities were reported across states overall with Maine accounting for the lowest death rate among PLWH of 4.3/1,000 and Louisiana accounting for the highest rate of 34.5/1,000. Southern states also reported disproportionately higher rates compared to other parts of the country.

Because significant investments have been made at the federal level to assure access to HIV care, PLWH in all states should have the same opportunities to live long and healthy lives. State variations in making progress in HIV prevention can be attributed numerous factors: differences in the burden of HIV infection, public health priorities, economic resources of the state, ability for PLWH to access healthcare systems in states, data completeness and quality, existing infrastructures for HIV services, community response to HIV, and demographic diversity of PLWH in specific states.

CDC uses descriptive progress reports, monitoring and evaluation data, and site visits to track the progress of grantees in HIV prevention. However, standards to evaluate performance historically have varied across grantees and have not been aligned with national goals in a consistent manner. To fill this gap, CDC is taking steps to incorporate core performance standards into all FOAs and provide grantees with Rapid Feedback Reports (RFRs) to document their progress in meeting FOA performance goals. Grantees also can use the RFRs to compare their performance with other grantees.

The RSRs are program improvement tools that are only distributed to grantees to assist with identifying capacity building needs and developing program improvement plans. In the Young MSM and Transgenders of Color FOA, for example, the percent of grantees that met the target of testing 600 clients for HIV was only ~33% in year 1. Grantee performance greatly varied in meeting the target of 4% of clients with a newly confirmed HIV-positive test result. Most grantees exceeded the target of linking 70% of newly diagnosed clients to HIV medical care within 90 days.

Overall, CDC is implementing a more integrated approach to monitor progress in HIV prevention at national, state and grantee levels. Indicators are being used to monitor and improve progress; identify areas where more progress is needed; compile lessons learned and successes from areas with the best outcomes for national scale-up and dissemination; and provide better TA and capacity building to areas and grantees with poorer outcomes.

Steven Young, MSPH

Director, Division of Metropolitan HIV/AIDS Programs, HAB
Health Resources and Services Administration

Mr. Young presented an overview of a new framework HRSA is exploring to allocate funds to grantees that would be responsive to need and consider performance-based awards. RWHAP Part A includes three funding streams: a funding formula for living cases of HIV/AIDS; MAI funds for living minority cases of HIV/AIDS; and supplemental funding that is awarded through an annual competitive application process and is subject to an objective review.

Jurisdictions must comply with numerous legislative requirements in order to receive a Part A supplemental award: appropriate use of formula funds, responsive use of resources, absence of unobligated balance penalties, and commitment of local resources. However, identified need and involvement of the affected community and PLWH collectively account for 66 points in the objective review process.

HRSA has estimated a cost of ~\$3 million in terms of staffing and other activities to conduct the annual review. With the exception of Columbus, Ohio that received its first Part A supplemental award in 2013, all other grantees are well established with strong capabilities and mature programs. The application scores of grantees are not significantly different (e.g., a range of 86-99 in 2013).

The HHS Assistant Secretary for Planning and Evaluation Expert Panel held a meeting in January 2014 to obtain input on improvements in Part A supplemental funds. The participants included HRSA, CDC, RWHAP grantees, national organizations and academia. Key outcomes of the four meeting objectives are summarized below.

Objective 1 was to measure the unmet need in RWHAP. “Unmet need” is defined in legislation as PLWHA who are not in primary care (e.g., no receipt of antiretroviral therapy, CD4 count or viral load test). Based on this definition, jurisdictions calculate their population sizes based on the number of PLWA and PLWH and estimate their patterns of care based on the percentage of PLWA and PLWH receiving primary care. HRSA estimated the national unmet need in FY2013 based on data from Part A and B jurisdictions. The analysis showed that the national unmet need was 34% in Part A jurisdictions and 36% in Part B jurisdictions.

Objective 2 was to review the seven HHS measures, unmet need and Severity of Need Index (SONI). “Severity of need” is defined in legislation as the degree to which providing primary medical care to PLWH in any given area is more complicated and costly than in other areas based on a combination of adverse health and socioeconomic circumstances of the populations to be served.

HRSA gathered extensive input from a broad range of stakeholders to identify components to include in the SONI calculation: the total number of cases, minus the federal insurance reduction, multiplied by the geographic cost index based on labor and facility/rent, plus indirect measures of need (e.g., prevalence rate, percent of the population at <100 FPL, and the death rate among PLWA over the past 5 years/average number of reported PLWA over the past five years).

Objective 3 was to explore a new framework for the allocation of Part A supplemental funds. In this effort, the meeting participants were asked to review data across jurisdictions spanning the HIV Care Continuum and program evaluation data of performance. However, the participants were cautioned against penalizing programs with lesser need due to their success in preventing new HIV infections or increasing viral load suppression rates.

The meeting participants agreed on new framework that would be linked to the HIV Care Continuum. The framework categorizes the 1.1 million PLWH in the United States into three distinct groups. Group A would include 200,000 PLWH who are unaware of their HIV status. Group B would include 600,000 PLWH who are aware of their HIV status, but are not virally suppressed. Group C would include 300,000 PLWH who are aware of their HIV status and are virally suppressed. Funding calculations would be based on the program’s performance and progress in advancing through the HIV Care Continuum. Program evaluation metrics would be used for assessment.

HRSA funded a study in September 2014 to assess the feasibility of the new framework. A sample of states, TGAs and eligible metropolitan areas will be selected to evaluate the quality and quantity of existing data and current program capacity to operate in an electronic model. A methodology will be developed based on the framework to measure and quantify need in the distribution of supplemental Part A funds. HRSA and CDC established a memorandum of understanding to assist with data requests.

Objective 4 was to consider the treatment paradigm, changing financing situation, changing epidemiology, HIV Care Continuum and availability of data in proposing recommendations. HRSA released a new FOA in FY2015 that requires jurisdictions to link the use of their Part A funds and implementation plans to the HIV Care Continuum.

HRSA will release an FOA in January 2015 to facilitate real-time engagement of all Part A programs. In year 1, a new Learning Collaborative will target all 52 jurisdictions to support the identification and utilization of available data and implementation of evidence-based models, interventions, approaches and best practices with success in making improvements in the HIV Care Continuum.

In years 2-3, the Learning Collaborative will target 10 jurisdictions each year with a need or interest in making significant improvements in the HIV Care Continuum. Ongoing and future activities conducted by the Part A jurisdictions are aligned with those in the White House HIV Continuum of Care Implementation Plan.

Update by the Hepatitis C Virus Workgroup

Sanjeev Arora, MD, FACP

Professor, Department of Internal Medicine
University of New Mexico Health Sciences Center
CHAC Member & Workgroup Chair

Dr. Arora covered the following topics in his update to CHAC on the workgroup's recent activities. The workgroup has held two teleconference meetings since the May 2014 CHAC meeting to discuss several important issues. Current data estimate that 2.7 million persons are living with HCV in the United States. Of the total HCV-positive population, ~83% of persons have not been treated.

The recent introduction of Harvoni to the U.S. market will increase the cure rate of HCV to 90%-95% for most patients. Because Harvoni and other new HCV medications are extremely expensive and are being denied by managed care organizations, patients are encountering tremendous difficulties in accessing treatment. Moreover, providers and other clinical staff are being inundated with the fears and concerns of their HCV patients.

The American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD/IDSA) issued joint guidelines because HCV guidelines that payers currently use are viewed as overly stringent. Moreover, individual payers use different guidelines. For example, most Medicaid programs will not treat patients with stage 1 and 2 fibrosis.

Payers found the new guidelines to be biased and are not complying with the recommendations. For example, payers claimed that AASLD/IDSA members who developed the guidelines had conflicts of interest in terms of financial interests in pharmaceutical companies. Payers noted that AASLD/IDSA relied on expert opinion and did not apply the rigorous GRADE process used by CDC and USPSTF in reviewing the evidence to develop the new HCV Screening Guidelines.

The workgroup's position is that new guidelines issued by the government will improve access to HCV treatment. Federally-endorsed guidelines for HIV could serve as a helpful model in this effort. The new federal guidelines should cover the follow topics: assessment and awareness of HCV, HCV testing, evaluation of patients with HCV, patient selection for HCV treatment, culturally-responsive HCV care, HCV treatment regimens with doses and durations, patient follow-up during HCV treatment, and long-term follow-up.

The workgroup pointed out that the time and expense associated with developing new HCV treatment guidelines might be the contributing factors for NIH declining to undertake this effort. As a result, the workgroup expressed an interest in applying lessons learned from the development of HIV guidelines by a Federal Advisory Committee to create new HCV treatment guidelines. The workgroup is continuing to identify other entities within the federal government that have a focus on HCV treatment.

The workgroup outlined the pros and cons of CHAC's role in developing new federal HCV treatment guidelines. On the one hand, an urgent public health issue would be addressed. On the other hand, CHAC has no resources to support an elaborate and resource-intensive process that is required to develop a new set of guidelines. Moreover, CHAC might not have sufficient prominence in the medical payer community to influence or change reimbursement practices. The development of new HCV treatment guidelines might be outside of the scope of CHAC's charter.

CHAC Business Session

Kathleen Clanon, MD, CHAC co-Chair

Medical Director

Alameda County Health Care Services Agency

Jeanne Marrazzo, MD, MPH, CHAC co-Chair

Professor of Medicine, Harborview Medical Center

University of Washington

Drs. Clanon and Marrazzo opened the business session and called for CHAC's review, discussion and/or formal action on the following topics.

Topic 1: Draft CHAC Meeting Minutes

A motion was properly placed on the floor by Dr. Marjorie Hill and seconded by Dr. Bruce Agins for CHAC to approve the previous meeting minutes.

CHAC unanimously adopted the Draft May 21-22, 2014 Meeting Minutes with no changes or further discussion.

Topic 2: New Federal Hepatitis C Treatment Guidelines

Dr. Arora presented the Hepatitis C Treatment Guidelines resolution for CHAC's consideration, deliberation and formal action.

CHAC recommends sending a letter to the HHS Secretary to formally endorse the development of new federal HCV Treatment Guidelines. The letter should include CHAC's strong statement regarding the serious adverse health consequences of patients when access to HCV treatment is delayed. The letter should describe the difficulties that clinicians are facing in treating their HCV patients. The letter should emphasize the need for the new federal HCV Treatment Guidelines to be regularly updated and include tools to improve clinical practice.

Co-Chair's Call for a vote	Motion properly made by Dr. Sanjeev Arora for CHAC to adopt the HCV Treatment Guidelines resolution Motion seconded by Ms. Dawn Fukuda
Outcome of vote	Motion withdrawn
Next steps	The HCV Workgroup will engage in further discussion on the development of new federal HCV Treatment Guidelines and specific issues that should be covered. The workgroup will draft a letter to the HHS Secretary that will be circulated to CHAC for review, discussion and a formal vote during the May 2015 meeting. Significant time will be set aside on the next agenda to discuss HCV treatment issues.

Topic 3: Youth and HIV

CHAC TABLED the Youth and HIV resolution. Ms. Dawn Fukuda and Mr. Kali Lindsey will circulate the draft resolution for CHAC’s review. The CHAC Designated Federal Officers will schedule a teleconference prior to the next meeting for CHAC’s discussion and formal vote on the resolution.

Topic 4: Agenda Items

Drs. Clanon and Marrazzo moderated CHAC’s discussion, review and summary of new agenda items that were raised over the course of the meeting.

NEW AGENDA ITEMS	
Presenter(s)	Topic
CDC (Gail Bolan)	Overview of efforts to prioritize PrEP uptake in HIV-negative MSM due to extremely high rates of bacterial STDs in this population
CDC & CHAC	Extensive discussion on the evolution of HCV treatment, the status of developing new federal HCV Treatment Guidelines, and CHAC’s potential role in this effort
NEW AGENDA ITEMS	
HRSA (Laura Cheever)	Overview of HAB’s new study on changes in the needs of RWHAP clients after ACA implementation
HRSA (Steven Young)	Key outcomes of new HIV Care Continuum activities by the RWHAP Part A grantees
Guest Presenter (New York State Office of Health Insurance Program)	Overview of preliminary lessons learned, early experiences and innovations from New York State’s ACA Section 1115 Waiver to Medicaid expansion

Topic 5: Action Items

Drs. Clanon and Marrazzo led CHAC in a review of the action items that were raised over the course of the meeting.

NEW ACTION ITEMS	
Responsibility	Action Step
(HRSA) Rene Sterling	Distribute the draft P4C evaluation measures to CHAC for review and comment
(FYSB) Resa Matthew	Provide CHAC with the following materials: <ul style="list-style-type: none">• The link to the Street Outreach Program Data Collection Study after the full report is finalized and released in January 2015• The needs assessment of LGBTQ youth service providers and administrators and the comprehensive literature review of services needed by LGBTQ youth after these data are finalized and released in 2015

Closing Session

The participants joined Dr. Mermin in applauding Dr. Marrazzo for her outstanding leadership as the CHAC co-Chair. CDC and HRSA hoped Dr. Marrazzo would continue to provide her valuable expertise in improving federal practice and policy related to HIV, viral hepatitis and STD prevention and treatment.

The next CHAC meeting would be CDC-focused and held in person on May 19-20 or 20-21, 2015 in Atlanta. CDC would poll the CHAC members to confirm the exact date. With no further discussion or business brought before CHAC, Dr. Marrazzo adjourned the meeting at 12:32 p.m. EST on November 20, 2014.

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

Date

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

Date

Jeanne Marrazzo, MD, MPH, Co-Chair
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and
Treatment



Participants' Directory

CHAC Members Present

Dr. Kathleen Clanon, co-Chair
Dr. Jeanne Marrasso, co-Chair
Dr. Bruce Agins
Dr. Sanjeev Arora
Dr. Virginia Caine
Mr. Guillermo Chacon
Mr. Tommy Chesbro
Ms. Angelique Croasdale
Dr. Carlos del Rio
Ms. Dawn Fukuda
Dr. Marjorie Hill
Dr. Steven Johnson
Dr. Jennifer Kates
Mr. Kali Lindsey

CHAC Members Absent

Dr. Perry Halkitis
Ms. Regan Hofmann
Dr. Britt Rios-Ellis

CHAC Ex-Officio Members Present

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

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

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

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

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

Ms. Lisa Neel
Indian Health Service

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

CHAC Ex-Officio Member Absent

Dr. Stephen Cha
Centers for Medicare and Medicaid
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Glossary of Acronyms

AASLD/IDSA	American Association for the Study of Liver Diseases/Infectious Diseases Society of America
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
ASO	AIDS Service Organization
BPHC	Bureau of Primary Health Care
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CHAC	CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
CHWs	Community Health Workers
CLD	Client-Level Data
CMS	Centers for Medicare and Medicaid Services
CoAgs	Cooperative Agreements
DASH	Division of Adolescent and School Health
DHAP	Division of HIV/AIDS Prevention
DISs	Disease Intervention Specialists
DSTDP	Division of STD Prevention
DVH	Division of Viral Hepatitis
FAQs	Frequently Asked Questions
FOAs	Funding Opportunity Announcements
FPL	Federal Poverty Level
FRRs	Federal Reporting Requirements
FSP	Field Services Program
FYSB	Family and Youth Services Bureau
HAB	HIV/AIDS Bureau
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HEARTLine	HIV Education and Advocacy Response Team
HHS	U.S. Department of Health and Human Services

HRSA	Health Resources and Services Administration
IDU; IDUs	Injection Drug Use; Injection Drug Users
JJS	Juvenile Justice System
LGBTQ	Lesbian/Gay/Bisexual/Transgender/Questioning
MAI	Minority AIDS Initiative
MSA	Metropolitan Statistical Area
MSM	Men Who Have Sex With Men
MTA	Metro TeenAIDS
NASTAD	National Alliance of State and Territorial AIDS Directors
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NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NHAS	National HIV/AIDS Strategy
NHBS	National HIV Behavioral Survey
NIH	National Institutes of Health
OAMC	Outpatient Ambulatory Medical Care
OVS	Optimal Viral Suppression
P4C	Partnerships for Care
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PLWH; PLWHA	Persons Living with HIV; Persons Living with HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
RFRs	Rapid Feedback Reports
RHY	Runaway and Homeless Youth
RSRs	Ryan White Service Reports
RWHAP	Ryan White HIV/AIDS Program
SONI	Severity of Need Index
SPNS	Special Projects of National Significance
TA	Technical Assistance
TGA	Transitional Grant Area
USPSTF	U.S. Preventive Services Task Force
YRBS	Youth Risk Behavior Survey