

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



**CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and Treatment
May 8-9, 2012
Atlanta, Georgia**

Record of the Proceedings

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ATTACHMENT 1**List of Participants**

(The CDC Designated Federal Official conducted a roll call of the CHAC voting members and the non-voting *ex-officio* members on both May 8 and 9, 2012 and confirmed the presence of quorum on both days of the meeting.)

CHAC Members

Ms. Antigone Dempsey, co-Chair
 Dr. Jeanne Marrasso, co-Chair
 Dr. Carol Brosgart
 Dr. Kathleen Clanon
 Dr. William Cunningham
 Dr. Carlos del Rio
 Dr. Perry Halkitis
 Ms. Heather Hauck
 Dr. Marjorie Hill
 Mr. Ernest Hopkins
 Dr. Steven Johnson
 Ms. Maria Lago
 Mr. Kali Lindsey
 Dr. Kenneth Mayer
 Dr. André Rawls
 Dr. Britt Rios-Ellis

CHAC Ex-Officio Members

Dr. Pradip Akolkar
 Food and Drug Administration

Dr. William Grace
 National Institutes of Health

Ms. Kaye Hayes
 Office of HIV/AIDS Policy
 Department of Health and Human Services

Ms. Elizabeth Siegel McNamee (Alternate)
 Substance Abuse and Mental Health
 Services Administration

Ms. Lisa Neel (Alternate)
 Indian Health Service

Dr. Gretchen Stiers
 Substance Abuse and Mental Health
 Services Administration

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

CHAC Liaison Representative

Mr. Douglas Brooks
 Presidential Advisory Council on HIV/AIDS

Designated Federal Officials

Dr. Kevin Fenton
 CDC/NCHHSTP Director

Dr. Laura Cheever
 HRSA/HAB Deputy Associate Administrator

Federal Agency Representatives

Dr. Eddie Ades
 Ms. Sara Bingham
 Dr. Gail Bolan
 Dr. Matthew Burke
 Dr. Joanne Cono
 Dr. Hazel Dean
 Ms. Kim Distel
 Dr. John Douglas, Jr.
 Ms. Jessie Ford (ORISE Research Fellow,
 CDC)
 Ms. Shelley Gordon
 Ms. Gladys Lewellen
 Ms. Eva Margolies
 Dr. Jonathan Mermin
 Ms. Margie Scott-Cseh
 Ms. Riley Steiner
 Ms. Sandra Thurman
 Dr. John Ward
 Dr. Howell Wechsler
 Ms. Lynn Wegman
 Mr. Terry Wheeler
 Dr. Richard Wolitski
 Dr. Pascale Wortley

Members of the Public

Ms. Lucy Bradley-Springer
Mountain Plans AIDS Education and
Training Center,
National Alliance for HIV Education and
Workforce Development &
*Journal of the Association of Nurses in
AIDS Care*

Ms. Tenesha Burley
Altarum Institute

Mr. Graham Harriman
New York City Department of Health and
Mental Hygiene

Dr. Edward Hook III
University of Alabama at Birmingham &
Jefferson County Department of Health

Mr. Terrence Moore
National Alliance of State and Territorial
AIDS Directors

Mr. Richard Olson
Vertex Pharmaceuticals

Mr. Daniel Raymond
Harm Reduction Coalition &
National Viral Hepatitis Roundtable

Mr. Carl Schmid
The AIDS Institute

Dr. Ira Schwartz
Southeast AIDS Training and Education
Center

Mr. Michael Shankle
HealthHIV

Mr. Charles Stephens
AIDS United

Ms. Cathleen Teahan
Georgia AIDS Coalition

Ms. Dea Varsovczky
Urban Coalition for HIV/AIDS Prevention
Services

ATTACHMENT 2

Glossary of Acronyms

ACA	Patient Protection and Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
ADAPs	AIDS Drug Assistance Programs
AETC	AIDS Education and Training Center
ART	Antiretroviral Therapy
BHPr	Bureau of Health Professions
BPHC	Bureau of Primary Health Care
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CHAC	CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
CHCs	Community Health Centers
CMS	Centers for Medicare and Medicaid Services
CoAgs	Cooperative Agreement
DAAs	Direct Acting Agents
DASH	Division of Adolescent and School Health
DFOs	Designated Federal Officials
DHAP	Division of HIV/AIDS Prevention
DSTDp	Division of STD Prevention
DVH	Division of Viral Hepatitis
EBI	Evidence-Based Intervention
ECHPP	Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS
ED	U.S. Department of Education
EHRs	Electronic Health Records
FDA	Food and Drug Administration
FOA	Funding Opportunity Announcement
FPL	Federal Poverty Level
FQHCs	Federally Qualified Health Centers
GAO	U.S. Government Accountability Office
HAB	HIV/AIDS Bureau
HBV	Hepatitis B Virus
HCPs	Healthcare Professionals/Providers
HCV	Hepatitis C Virus
HHS	Department of Health and Human Services
HIT	Health Information Technology
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
IDSA	Infectious Disease Society of America
IDU/IDUs	Injection Drug Use/Injection Drug Users
IOM	Institute of Medicine
IPP	Infertility Prevention Project
LEAs	Local Education Agencies

LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
MAI	Minority AIDS Initiative
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MSM	Men Who Have Sex With Men
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NCQA	National Committee for Quality Assurance
NGOs	Non-Governmental Organizations
NHAS	National HIV/AIDS Strategy
NHSC	National Health Service Corps
NHSS	National HIV Surveillance System
NIH	National Institutes of Health
NQF	National Quality Forum
NSHC	National Sexual Health Coalition
NVHR	National Viral Hepatitis Roundtable
OASH	Office of the Assistant Secretary for Health
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
PACHA	Presidential Advisory Council on HIV/AIDS
PCMH	Patient-Centered Medical Home
PCPs	Primary Care Providers
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	Persons Living with HIV
PLWHA	Persons Living with HIV/AIDS
PrEP	Pre-exposure Prophylaxis
PWP	Prevention With Positives
QI	Quality Improvement
REACH	Racial and Ethnic Approaches to Community Health
RSR	Ryan White Services Report
SAEs	Serious Adverse Events
SAMHSA	Substance Abuse and Mental Health Service Administration
SEAs	State Education Agencies
SHPPS	School Health Policies and Practices Study
SPNS	Special Projects of National Significance
SVR	Sustained Virologic Response
TA	Technical Assistance
TAI	The AIDS Institute
UDS	Uniform Data System
USPSTF	U.S. Preventive Services Task Force
VHAP	Viral Hepatitis Action Plan
YRBS	Youth Risk Behavior Survey

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**CDC/HRSA ADVISORY COMMITTEE ON HIV,
VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT
May 8-9, 2012
Atlanta, Georgia**

Minutes of the Meeting

The Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP), and Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) convened a meeting of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC). The proceedings were held at the Westin Buckhead Atlanta Hotel in Atlanta, Georgia on May 8-9, 2012.

Opening Session: May 8, 2012

Kevin Fenton, MD, PhD, FFPH

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

Dr. Fenton conducted a roll call to determine the CHAC voting members, *ex-officio* members and liaison representatives who were in attendance. He asked the voting members to publicly disclose any conflicts of interest for themselves and/or their institutions.

- Carol Brosgart, MD: Consultant to the CDC Division of Viral Hepatitis (DVH), Senior Advisor to the CDC Foundation on science and policy matters, pre-clinical consultant to biotechnology companies on hepatitis C compounds in development, Board member of the San Francisco AIDS Foundation and the National Hispanic Medical Association, and owner of stock in 2 biotechnology companies
- Kathleen Clanon, MD: Recipient of Part C Ryan White funding from HRSA through the AIDS Education and Training Center
- William Cunningham, MD, MPH: Recipient of funding from the National Institutes of Health (NIH)

- Carlos del Rio, MD: Recipient of funding from CDC for STD laboratory research, recipient of funding from NIH, and Board member of the HIV Medicine Association
- Antigone Dempsey, MEd: Recipient of funding from a viral hepatitis contract and a technical assistance contract from the Substance Abuse and Mental Health Administration (SAMHSA)
- Perry Halkitis, PhD, MS: Recipient of funding from NIH
- Heather Hauck, MSW: Recipient of Parts B and D Ryan White funding from HRSA, recipient of funding from SAMHSA, and recipient of funding from the CDC Division of HIV/AIDS Prevention, Division of STD Prevention and DVH
- Marjorie Hill, PhD: Recipient of Ryan White funding from HRSA, recipient of funding from CDC and SAMHSA contracts, and recipient of unrestricted educational research grants from Bristol-Myers Squibb and Merck
- Steven Johnson, MD: Consultant to Bristol-Myers Squibb, Gilead and Merck, recipient of Parts A, B, C and F Ryan White funding from HRSA, and recipient of funding from NIH and SAMHSA
- Jeanne Marrazzo, MD, MPH: Recipient of research funding from Cepheid and Roche
- Kenneth Mayer, MD: Recipient of unrestricted educational research grants from Gilead, Bristol-Myers Squibb and Merck, recipient of grant funding from CDC, HRSA and NIH, and member of the Governing Council of the International AIDS Society
- Britt Rios-Ellis, PhD: Recipient of NIH funding through the Hispanic Advisory Group and co-Chair of the National Latino AIDS Action Network

Dr. Fenton verified that the voting members and *ex-officio* members constituted a quorum for CHAC to conduct its business on May 8, 2012. He called the meeting to order at 8:31 a.m. and welcomed the participants.

Dr. Fenton announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. He reminded the CHAC voting members of their individual responsibility to identify real or perceived conflicts of interest and recuse themselves from participating in these matters. He opened the floor for introductions. The list of participants is appended to the minutes as Attachment 1.

Dr. Fenton informed the participants of changes to CHAC's membership since the November 2011 meeting. He welcomed two new members to their first CHAC meeting: Ms. Heather Hauck (Director of the Maryland Department of Health and Mental Hygiene, Infectious Disease and Environmental Health Administration) and Dr. Marjorie Hill (Chief Executive Officer, Gay Men's Health Crisis). Detailed biographical sketches for Ms. Hauck and Dr. Hill were included in the meeting packets.

Dr. Jeanne Marrazzo is a Professor of Medicine at Harborview Medical Center in the University of Washington. She has served as a CHAC member since 2009 and recently was appointed to replace Dr. Edward Hook as the CHAC co-Chair for CDC. Ms. Kaye Hayes is the Executive Director of the Presidential Advisory Council on HIV/AIDS and has replaced Mr. Christopher Bates as the CHAC *ex-officio* member for the HHS Office of HIV/AIDS Policy.

For the current meeting, Ms. Elizabeth Siegel McNamee would replace Dr. Gretchen Stiers as the *ex-officio* member for SAMHSA and Dr. Richard Wild would replace Dr. Effie George as the *ex-officio* member for the Centers for Medicare and Medicaid Services (CMS).

Dr. Fenton announced that May is “Hepatitis Awareness Month.” He thanked the CHAC members and federal agency staff for their continued commitment and outstanding activities in addressing the viral hepatitis epidemic in the United States and worldwide. CDC would host several events throughout May 2012 in recognition of Hepatitis Awareness Month, including “Viral Hepatitis Testing Day.”

Dr. Fenton informed the participants that federal agencies and stakeholder groups across the country are preparing for the 2012 International AIDS Conference on July 22-27, 2012 in Washington, DC. He hoped that CHAC would participate and support the conference activities, particularly the scientific and policy presentations by CDC, HRSA and other federal agencies.

Antigone Dempsey MEd, CHAC co-Chair

Deputy Director, Knowledge, Transfer and Technical Assistance
HIV/AIDS Lead, Altarum Institute

Ms. Dempsey joined Dr. Fenton in welcoming the participants to the meeting. She announced that the format of the agenda was revised to reflect suggestions CHAC proposed during the November 2011 meeting to improve the organizational structure of future meetings. Most notably, the presentations were shortened to allow for more substantive discussions between CHAC and the federal agencies.

Following each presentation, the co-Chairs would moderate a discussion and solicit volunteers from CHAC to serve as a champion for any proposed resolutions. Summaries of the updates and presentations were distributed to CHAC in advance of the meeting to help the members prepare questions and discussion points in response to the request for advice. Ms. Dempsey concluded her opening remarks by reviewing the agenda for the CHAC meeting over the next 2 days.

Jeanne Marrazzo, MD, MPH, CHAC co-Chair

Professor of Medicine, Harborview Medical Center
University of Washington

Dr. Marrazzo was pleased to serve in her new role as the CHAC co-Chair. She explained that the format of the agenda was revised to allow CHAC to discuss and initially propose resolutions immediately following a presentation for a specific topic. Ideally, this approach would allow the members to begin formulating clearer recommendations to the federal agencies in “real time” by eliminating the need to wait for the formal business session on day 2 of the meeting.

To aid CHAC in this effort, Dr. Marrazzo noted that a 2-page document was distributed in the meeting packets with clear guidance on making resolutions and recommendations. The document cites the scope of work from the CHAC charter, clearly defines “recommendations” and “resolutions,” articulates the process for making recommendations/resolutions, and lists issues the members should consider while proposing recommendations/resolutions.

The document also provides a comprehensive description of Federal Advisory Committee workgroups, including their role, responsibilities, functions, activities, membership, meeting format, record keeping and reporting requirements, and duration.

Dr. Marrazzo confirmed that the CHAC co-Chairs and Designated Federal Officials (DFOs) would conduct an ongoing evaluation to determine the effectiveness, advantages and disadvantages of the revised organizational structure for CHAC meetings. During the business session on the following day, the members would be asked to offer their insights and perspectives to inform the evaluation process.

Laura Cheever, MD

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

Dr. Cheever joined her colleagues in welcoming the participants to the meeting. She thanked the CHAC members for continuing to dedicate their time to attending meetings, conducting workgroup activities, and providing sound advice.

On behalf of HRSA, Dr. Cheever presented certificates of appreciation to 3 CHAC members whose terms would end on June 30, 2012: Ms. Maria Lago, Dr. William Cunningham and Dr. André Rawls. However, these members could continue to serve for an additional 180 days until their replacements have been officially appointed by HHS.

On behalf of CDC, Dr. Fenton also presented a certificate of appreciation to Dr. Edward Hook for serving as both a CHAC member and co-Chair over the past 6 years. The participants applauded all of the outgoing members for their continued commitment and support to HIV, viral hepatitis and STD prevention and treatment.



CDC/NCHHSTP Director's Report

Kevin Fenton, MD, PhD, FFPH

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

Dr. Fenton covered the following topics in his Director's report to CHAC. At the agency level, CDC's FY2012 appropriation of \$1.11 billion for NCHHSTP's programs breaks down to 71% for domestic HIV, 14% for STD, 13% for TB, and 3% for viral hepatitis. The domestic HIV budget includes funding for the Division of Adolescent and School Health (DASH) that was formally integrated into NCHHSTP in January 2012.

The 25% cut in the DASH budget (or ~\$10 million) represents one of the largest reductions in CDC's FY2012 appropriation. The unprecedented budget cut led to the complete elimination or reduction of several DASH projects (e.g., the Healthy Passages research study, contracts for evaluation technical assistance (TA) and professional development, and school and classroom level components of the School Health Policies and Practices Study (SHPPS)).

Projects by 3 DASH grantees (e.g., the American Academy of Pediatrics, Rocky Mountain Center for Health Promotion and Education, and National Alliance of State and Territorial AIDS Directors) were scaled down in FY2012. Other funding reductions in the FY2012 DASH budget include a 50% cut in the global Youth Risk Behavior Surveillance System (YRBS) contract, a 15% cut in the national YRBS contract, and a 20% cut in cooperative agreements (CoAgs) to all states, territories, cities, tribes and non-governmental organizations (NGOs). CDC is exploring strategies with HHS and Congressional partners to reconstitute the DASH budget in FY2013.

CDC's proposed FY2013 program level budget includes an overall reduction of \$222 million that breaks down to a decrease of \$664 million in the budget authority, an increase of \$296 million through the Public Health Service Evaluation Transfer, an increase of \$68 million through the HHS Emergency Fund, and an increase of \$78 million through the Prevention and Public Health Fund.

In FY2013, NCHHSTP is expected to receive an increase of \$36 million above the FY2012 funding level that breaks down to a \$30 million increase for HIV prevention and national programs, a \$10 million increase for HIV school health programs, a \$10 million increase for viral hepatitis programs, and a \$5 million decrease for TB elimination programs.

Compared to FY2012, key increases in CDC's proposed FY2013 budget include \$129 million for chronic disease prevention, \$40 million for domestic HIV/AIDS prevention, \$23 million for health statistics, \$20 million for laboratory efficiencies, \$17 million for food safety, \$15 million for polio eradication, \$13 million for the National Healthcare Safety Network, \$6 million for tobacco programs, and \$5 million for the Million Hearts initiative.

Compared to FY2012, key decreases in CDC's proposed FY2013 budget include \$80 million for the Block Grant Program, \$80 million for Community Transformation Grants, \$54 million for the Racial and Ethnic Approaches to Community Health (REACH) Program, \$51 million for business services and facilities, \$48 million for the Strategic National Stockpile, \$44 million for National Institute for Occupational Safety and Health Education and Research Centers and the National Occupational Research Agenda, \$12 million for birth defects and developmental

disabilities, \$11 million for environmental health, \$7 million for preparedness activities, \$5 million for Johanna's Law, \$5 million for TB elimination, and \$2 million for infectious diseases.

CDC launched an iPad application to expand the reach of health information through new technology. The free application includes social media tabs and offers access to CDC's health articles, popular journals, health news updates, blogs and podcasts. Additional information on CDC's iPad application can be obtained from:

www.cdc.gov/mobile/Applications/CDCGeneral/promos/ipad_promo.html.

At the National Center level, the formal integration of DASH into NCHHSTP was completed in January 2012. Of 8 Associate Directors who support Dr. Fenton in the NCHHSTP Office of the Director, 7 of these positions have been filled with permanent staff. Recruitment efforts are underway to permanently fill the position of the Associate Director for Health Equity. Dr. Edwin Ades recently was appointed as the new Associate Director for Laboratory Science.

NCHHSTP released the *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis STD and TB*. The guidelines outline minimum standards to ensure the appropriate collection, storage, sharing and use of data across NCHHSTP's surveillance and program areas. The major function of the guidelines is to reduce barriers to collaboration, integration and data sharing among state and local partners. NCHHSTP widely publicized the release of the guidelines through webinars, training events, fact sheets and site visits. The guidelines are available at www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf.

NCHHSTP launched a new Internet-based "Atlas" (www.cdc.gov/nchhstp/atlas) to increase public access to its data across all programs. The Atlas includes interactive maps, graphs, tables, figures and surveillance data to illustrate the geographic patterns and trends of HIV/AIDS and STD over time at the state level and county level for specific data points. TB and viral hepatitis will be included in the Atlas later in 2012. NCHHSTP currently is aligning its efforts with those of another interactive Internet-based Atlas, "AIDS View," to obtain HIV data at deeper levels than states and counties.

NCHHSTP redesigned its website (www.cdc.gov/nchhstp) to highlight social media tools, improve access to overarching strategic priorities, create a more dynamic and streamlined visual experience, and ensure a flexible format for future growth. NCHHSTP's key upcoming events include Hepatitis Testing Day on May 19, 2012; National HIV Awareness Testing Day on June 27, 2012; and the 2012 International AIDS Conference on July 22-27, 2012. CDC will provide CHAC with a complete list of its symposia, satellite presentations and other major activities at the conference.

At the Division level, the Division of HIV/AIDS Prevention (DHAP) initiated several activities under a 5-year HIV prevention funding opportunity announcement (FOA). Year 1 funds were awarded to health departments in January 2012. The awards were based on the geographic burden of HIV in the United States and are aligned with the goals of the National HIV/AIDS Strategy (NHAS). New campaigns were launched, including the "Take Charge. Take the Test"

Campaign in 10 cities targeted to black women and the “Testing Makes Us Stronger” Campaign targeted to black gay/bisexual men.

DHAP released the 2010 HIV Surveillance Report and the Annual Report to highlight its accomplishments over the past year. DHAP is collaborating with HRSA to update postexposure prophylaxis guidelines and guidelines on incorporating HIV prevention into medical care of persons living with HIV (PLWH).

DASH recently released the new *Parent Engagement* booklet as a resource for schools to increase parent engagement in promoting positive health behaviors. DASH recently published “HIV, Other STDs, and Pregnancy Prevention Education in Public School Secondary Schools-45 States, 2008-2010” in *Morbidity and Mortality Weekly Report (MMWR)*. The report documented state trends in the percentage of secondary schools that taught all essential topics related to HIV/STD prevention and sexual health in 2008-2010. The report noted decreases in education of these topics in middle schools in 11 states and high schools in 1 state and increases in high schools in 2 states. The DASH documents are available at:

www.cdc.gov/healthyyouth/adolescenthealth/pdf/parent_engagement_factsheet.pdf
www.cdc.gov/mmwr/pdf/wk/mm6113.pdf.

The Division of Viral Hepatitis (DVH) hosted a symposium in December 2011 with >150 participants on the identification, screening and surveillance of hepatitis C virus (HCV) infections in the current era of improved therapy. Experts presented perspectives on testing for prevalent, current and acute HCV infection and the participants explored new strategies to address HCV in the United States. DVH is revising its HCV screening recommendations. In the December 23, 2011 edition of the *MMWR*, the Advisory Committee on Immunization Practices (ACIP) published its recommendations on vaccinating adults with diabetes against hepatitis B virus (HBV).

The Division of STD Prevention (DSTDP) published a paper in the *New England Journal of Medicine* in February 2012, “The Emerging Threat of Untreatable Gonococcal Infection.” DSTDP’s future activities to continue to raise awareness of multidrug-resistant gonorrhea include a Congressional briefing, the launch of the World Health Organization Global Action Plan, publication of an *MMWR* article, and public health grand rounds at CDC.

DSTDP conducted a number of activities to commemorate “STD Awareness Month” in April 2012 (e.g., participating in the “Get Yourself Tested” Campaign for the fourth year; developing a web page to provide guidance to physicians on discussing STDs and testing; offering a Twitter Townhall Chat with the CDC and DSTDP Directors; and creating a blog on STD awareness at www.AIDS.gov).

Dr. Fenton provided additional details on his Director’s report in response to specific questions by CHAC. The discussion focused on the intent and rationale of the cut to the YRBS budget and the potential impact of the \$54 million decrease in the REACH Program.

CHAC advised CDC to approach the HHS Office of Minority Health to determine its ability to fund a portion of the REACH Program due to the \$54 million decrease. The members noted that the REACH Program has played an important role in supporting projects to eliminate racial/ethnic disparities and help communities to understand the burden of HBV and other diseases.

CHAC also advised CDC to redesign the NCHHSTP Atlas to collect more granular data at city, zip code, metropolitan statistical area and Congressional district levels. Local policymakers and Congressional representatives would be more likely to take action based on data on the incidence of disease at the district level.

HRSA/HAB Deputy Associate Administrator's Report

Laura Cheever, MD

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

Dr. Cheever covered the following topics in her Deputy Associate Administrator's report to CHAC. HAB has established 4 priorities for FY2012. **Priority 1** is to continue to lead HRSA's efforts to implement NHAS. In this effort, HAB will continue to address 21 objectives and >42 program activities that were directed to HRSA in NHAS. HRSA and CMS established a collaborative with State Medicaid Directors, AIDS Directors and other HIV stakeholders to focus on HIV issues. HRSA and CMS will launch a TA series with these groups in the spring of 2012.

HRSA will launch a web-based training course in May 2012 to educate National Health Service Corps clinicians on NHAS, HIV/AIDS treatment, and HIV/AIDS resources in their jurisdictions. HRSA provided its programmatic perspectives to a contractor that was funded to evaluate the impact of the HHS 12 Cities Initiative. The Bureau of Primary Health Care (BPHC) awarded a CoAg to create a National Training Center for Health Centers to improve the health of lesbian/gay/bisexual/transgender (LGBT) populations.

HAB and the Bureau of Health Professions (BHP) awarded 3 TA grants to expand graduate medical residency programs by incorporating an HIV focus and training into Health Centers. HAB and BPHC will identify up to 30 non-Ryan White Health Centers to become HIV providers by receiving intensive capacity building TA.

HAB successfully competed for Minority AIDS Initiative (MAI) funding from the HHS Secretary to support 4 projects in the 12 Cities Initiative in FY2012: (1) capacity development and training for HIV care providers who serve American Indian/Alaska Native populations; (2) the "Text4Care" project in which mobile texting will be used to improve retention in care and medication adherence in youth and adult minorities living with HIV in Southern states; (3)

replication of a public health information exchange to support engagement in HIV care; and (4) the U.S.-Mexico Border Interagency Collaborative for HIV.

HAB will continue to participate in NHAS meetings and workgroups with its federal partners to improve collaboration, including CDC and the White House Office of National AIDS Policy. HAB will host 2 consultations in the near future focusing on women and black gay men.

Priority 2 is to continue to contribute to the science and knowledge about HIV/AIDS and Ryan White Programs. In this effort, HAB will publish the new *Guide for HIV/AIDS Clinical Care*; continue its in-depth quantitative study to better understand, expand and support the HIV clinician workforce; continue to collect and analyze client-level data from Ryan White grantees across all service categories; fund new Special Projects of National Significance (SPNS) Initiatives; and continue to collaborate with CDC on the Retention in Care Study.

Beginning in CY2009, HAB used Ryan White Services Report (RSR) data to identify quality issues and provide TA to grantees and sub-grantees. HAB currently is analyzing CY2010 RSR data to describe Ryan White clients and determine the quality of care. HAB has received approval from the Office of Management and Budget (OMB) for the ADAP Data Report.

HAB funded 3 new SPNS Initiatives in FY2012: (1) “Implementing Models of Care That Build and Maintain Sustainable Linkages to Mental Health and Substance Abuse Treatment and HIV/AIDS Primary Care Services for HIV-Positive Homeless Populations;” (2) “Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color;” and (3) “Health Information Technology (HIT) Capacity Building Initiative for Ryan White HIV/AIDS Program Providers.” The new SPNS initiatives address the NHAS goals to improve the proportion of Ryan White patients who are permanently housed and reduce health disparities in HIV/AIDS.

Priority 3 is to continue to fund, monitor and assist Ryan White grantees. In this effort, HAB will continue to provide TA and guidance to grantees on monitoring sub-grantees; continue to provide TA to grantees on fiscal, clinical and programmatic issues; and continue to maintain fiscal viability of grantees through direct grants to cities and states, including AIDS Drug Assistance Programs (ADAPs), community-based organizations (CBOs) and universities.

HAB released 2 new FOAs in FY2012 for Ryan White grantees. For Part B grantees, HAB released a new supplemental competitive FOA of \$35 million to expand ADAP. For Part C grantees, HAB released an FOA of \$3 million on April 25, 2012 via the President’s World AIDS Day Initiative to expand primary HIV medical care and support services to PLWH/AIDS (PLWHA). HAB will award up to \$500,000 to up to 10 Part C programs to expand services. The application deadline is May 25, 2012 and the grantees will begin conducting activities under the FOA on July 1, 2012.

The purpose of HAB’s “HIV Early Intervention Services Program for New Geographic Service Area” FOA is to identify and fund new Part C programs to provide HIV medical and psychosocial

services to 4 groups: newly diagnosed and identified PLWHA who are not in care; previously diagnosed PLWHA who have never been in care; PLWHA who have dropped out of care; and existing PLWHA clients.

HRSA is anticipating the results of the U.S. Government Accountability Office (GAO) study in the near future. GAO conducted the study over the time period of March 2011-May 2012 to examine HRSA's oversight of Ryan White grantees and sub-grantees, including HAB's the organizational structure and processes.

HAB is continuing to closely partner with states to ensure patients on ADAP waiting lists receive medications through Pharmacy Assistance Programs. As of April 20, 3,080 patients were on ADAP waiting lists in 8 states: Florida, Georgia, Idaho, Louisiana, Montana, Nebraska, North Carolina and Virginia. Many states have implemented cost containment measures to reduce the number of patients on ADAP waiting lists (e.g., lowering the Federal Poverty Level (FPL) or adding asset tests, reducing formularies, initiating or increasing co-pays, and negotiating lower drug costs).

HAB awarded funds to the University of California-San Francisco in March 2012 in a competitive process to serve as the AIDS Education and Training Center (AETC) National Evaluation Center. The grantee will use these funds to develop a methodology and tools to measure the impact and outcome of training, education and clinical consultation services, and distance-learning education aimed at improving care of PLWH. The evaluation activities will be learner-centered and contribute to the continuous quality improvement (QI) of the entire AETC program.

HAB will host the 2012 All Grantee Meeting and the 15th Annual Clinical Conference on November 27-29, 2012 in Washington, DC with a theme of "Navigating a New Era in Care." The overarching goal of the clinical conference will be for HAB to provide participants with a comprehensive overview of current clinical issues in HIV management and strategies in HIV medical care for prescribers and other providers who are actively involved in HIV care in Ryan White-funded clinics.

Priority 4 is to continue to maintain global HIV programs. In this effort, HAB will continue to support its Medical Education Partnership Initiative and Nursing Education Partnership Initiative; help strengthen healthcare systems through its Clinical Assessment for System Strengthening; and provide care, treatment and support services to PLWHA in Africa and the Caribbean.

HRSA, NIH and the U.S. Office of the Global AIDS Coordinator formed a federal partnership to support the Medical Education Partnership Initiative. The goal of this collaborative project is to provide direct support to African institutions to transform medical education in sub-Saharan Africa, strengthen and build clinical and research capacity, and enhance human resources for health.

The project is expected to increase the quality and quantity of healthcare professionals/providers (HCPs) by training and retaining faculty in their home countries to practice and

conduct research and better respond to the HIV/AIDS epidemic and related co-morbidities. The federal partners will award \$130 million to 13 institutions in 12 African countries over a 5-year project period.

HRSA will award ~\$1.2 million annually to 5 countries to support the Nursing Education Partnership Initiative over a 5-year project period. The aims of the project are to (1) expand the quantity, quality and relevance of the nursing and midwifery professions to address population-based needs and (2) strengthen nurse and midwifery training and education programs.

Each country will use its annual \$1.2 million award for 3-6 nursing and midwifery schools to apply specific interventions (e.g., develop faculty and curricula, establish a competency-based skills laboratory, combine nursing and midwifery training, create bridging programs, develop a clinical instructor's training program and master's degree program, provide distance learning and a virtual library, and promote institutional capacity building).

In addition to describing HAB's activities to support its 4 priorities in FY2012, Dr. Cheever also updated CHAC on HRSA's budget, reorganization and future activities. HRSA's FY2012 enacted budget of ~\$2.36 billion for the Ryan White Program includes increases of \$48 million for ADAP and \$9.5 million for Part C programs. HRSA's FY2013 President's budget for the Ryan White Program will include a \$66.7 million increase for ADAP, a \$20.5 million increase for Part C programs, and \$7.6 million decrease for Part D programs. ADAP has accounted for the majority of growth in the Ryan White Program since 1996.

Part A and Part B-ADAP programs account for 67% of the total Ryan White Program appropriation. The remainder of the budget is allocated to Part B-base funding (18%), Part C programs (9%), Part D programs (3%), AETCs (1%), dental programs (1%), and SPNS Initiatives (1%). Medications through ADAP (39%), medical care (25%), and case management (9%) account for the top 3 expenditures in the Ryan White Program budget.

HRSA published a *Federal Register* notice and directly informed Ryan White grantees of HAB's reorganization that became effective on April 3, 2012. The reorganization will better position HAB to respond to the complexities of the Ryan White Program, the broader healthcare system, and changes in the domestic HIV epidemic since 1997. To support the reorganization, HAB will increase TA to grantees, better integrate policy activities across all programmatic divisions, improve integration of lessons learned from international activities into the domestic program, and increase promotion of SPNS findings into AETC training.

The major changes in HAB's reorganization include renaming the "Division of Science and Policy" to the "Division of Policy and Data;" renaming the "Division of Community Based Programs" to the "Division of Community HIV/AIDS Programs" to cover Part C, Part D and dental programs; and renaming the "Division of Training and Technical Assistance" to the "Division of HIV/AIDS Training and Capacity Development" to cover domestic and international AETCs, global programs and SPNS Initiatives. The "Division of Service Systems" was divided into the "Division of Metropolitan HIV/AIDS Programs" to cover Part A programs and the

“Division of State HIV/AIDS Programs” to cover Part B programs and ADAP. All of the programmatic divisions have been assigned full-time staff for TA and policy issues.

HRSA’s future directions will be to assure a smooth transition into the Patient Protection and Affordable Care Act (ACA) for Ryan White clients who will receive expanded coverage; complete reauthorization of the Ryan White Program in the fall of 2013; continue to implement NHAS; continue to support QI through HIV/AIDS care both in the United States and President’s Emergency Plan for AIDS Relief (PEPFAR) programs; continue to support the HIV/AIDS care workforce both in the United States and PEPFAR programs; and document results and disseminate best practices.

Dr. Cheever provided additional details on her Deputy Associate Administrator’s report in response to specific questions by CHAC. The discussion focused on services that most likely will be impacted by the \$7.6 million reduction in the Part D budget in FY2013.

At the conclusion of the updates from CDC and HRSA, Ms. Dempsey moderated CHAC’s panel discussion with Drs. Fenton and Cheever. The discussion topics included:

- interagency collaboration and coordination between CDC and HRSA to prepare for approval by the Food and Drug Administration (FDA) of pre-exposure prophylaxis (PrEP) for one or more populations;
- plans at the federal level to disseminate strong and clear guidance on PrEP, particularly with respect to the potential impact of PrEP on persons with chronic HBV or other co-infections;
- the inclusion of education and treatment adherence components in HRSA’s new SPNS Initiatives;
- CDC’s plans to release updated guidance on the role of antiretroviral treatment in reducing transmission as a result of data from the *Vitalsigns* Report and findings from the HIV Prevention Trials Network 052 Study;
- HAB’s 39 new full-time equivalents and institutional knowledge and experience retained by Project Officers to support the reorganization;
- the potential impact of funding decreases in SPNS Initiatives on services for special populations;
- HRSA’s efforts at the federal level to ensure individual ADAPs provide medications to patients who are co-infected with HCV;
- plans by CDC and HRSA to give clear guidance and direction to the field regarding the integration of community-based providers in ACA implementation, particularly their role and future relationships with medical homes and larger healthcare systems;
- CDC’s collaborative efforts with the Infectious Society of America to broadly raise awareness of multidrug-resistant gonorrhea and HRSA’s activities to educate Ryan White providers on this issue, particularly since gonorrhea cases are being reported in HIV care settings and among men who have with men (MSM); and
- the most significant challenges the federal agencies expect to face in the next 6 months:

- CDC: effective and successful promotion of CDC's science, leadership and partnerships both domestically and globally during the 2012 International AIDS Conference and implementation of FOAs for youth sexual health programs;
- HRSA: ACA implementation and the HAB reorganization.

CHAC advised CDC and HRSA to be more transparent in communicating their ongoing activities and future plans to the field in terms of integrating community-based providers into ACA implementation.

Update on CDC's Viral Hepatitis Activities

John Ward, MD

Director, Division of Viral Hepatitis
Centers for Disease Control and Prevention

Advice Requested from CHAC by DVH:

- What are the merits of HCV testing for persons born in 1945-1965?
- What strategies can CDC implement to identify and engage key stakeholders?
- What are effective strategies for CDC to implement its proposed expanded recommendations for HCV testing to include persons born in 1945-1965?
- What are effective approaches for CDC and HRSA to collaborate in the dissemination and implementation of the expanded guidelines?

Dr. Ward presented an update on CDC's ongoing and future activities to enhance hepatitis prevention, treatment and care in the United States. The HHS Viral Hepatitis Action Plan (VHAP) serves as a useful framework to establish priorities; clearly identify roles, responsibilities and activities of various HHS agencies; and provide opportunities for interagency collaboration. VHAP also outlines 6 critical areas that need improvement to advance hepatitis prevention, treatment and care:

- educate providers and communities to reduce health disparities;
- improve testing, care and treatment to prevent liver disease and cancer;
- strengthen surveillance to detect viral hepatitis transmission and disease;
- eliminate transmission of vaccine-preventable viral hepatitis;
- reduce viral hepatitis cases caused by drug-use behaviors; and
- protect patients and HCPs from healthcare-associated viral hepatitis.

CDC's completed and upcoming HBV prevention activities in 2011-2012 include publication of ACIP's recommendations on HBV vaccination for persons with diabetes, publication of updated recommendations on HBV vaccination for HCPs, updated guidelines on the management of HBV surface antigen-positive HCPs (in press), and endorsement by the National Quality Forum (NQF) of the HBV birth dose as a national performance standard for birthing facilities (in press).

CDC awarded funds in 2011 to improve the delivery of prevention services by strengthening the capacity of CBOs and assessing current capacity to deliver HCV screening and vaccination in immigrant care settings. CDC created Geographic Information System maps to better target and identify gaps in viral hepatitis prevention services in various jurisdictions across the country.

Several recent studies have reported that the incidence of hepatocellular carcinoma has tripled since 1975 with an average annual percentage change in incidence of 3.5% from 2001 to 2006. Hepatocellular carcinoma (HCC) is the fastest growing cause of cancer deaths and in 50%-60% and 10%-15% of HCC respectively is associated with HCV and HBV. Vital records data show that HCV-associated deaths increased by ~50% from 1999 to 2007 and surpassed the number of HIV-related deaths. In 2007, >70% of registered deaths from HCV infection were among persons 45-64 years of age.

CDC's 1998 HCV screening recommendations were based on risk and medical indications (e.g., past or present injection drug use (IDU), signs of liver disease, receipt of blood or organs prior to June 1992, receipt of blood products made prior to 1987, a history of chronic hemodialysis, infants of HCV-infected mothers, and HIV infection). CDC estimates that 45%-85% of HCV-infected persons are unidentified.

CDC has taken steps over the past year to shift from a risk-/medical-based approach to a prevalence-based strategy to focus HCV testing on persons born in the United States in 1945-1965. The rationale for the change is that the prevalence of HCV is 5.3 times higher in this birth cohort than other age groups (e.g., 3.29% versus 0.55%). Moreover, the birth cohort represents 75% of 3.2 million persons who have been infected with HCV and 73% of all HCV-associated mortality. The infected population can benefit from treatment and care due to modifiable disease co-factors. For example, 60% of the birth cohort consume ≥ 2 alcoholic drinks per day and 80% lack hepatitis A virus (HAV) and HBV vaccination.

HCV therapy can eliminate infection through HCV clearance or a sustained virologic response (SVR). Therapy is effective, but has a risk of serious adverse events (SAEs) and is not indicated in end stage disease. The 48-week regimen of pegylated interferon/ribavirin was the previous standard of care, but resulted in SAEs and an SVR of only ~40%. Oral regimens of direct acting agents (DAAs) can shorten the treatment course and improve outcomes. The 24-week regimen of pegylated interferon/ribavirin plus the first 2 DAAs was licensed and approved in May 2011. The regimen results in an SVR of ~70%.

An all-oral regimen of DAAs is safe and can shorten treatment based on clinical trial data. Recent studies have reported that 2 DAAs resulted in an SVR of 40% at 12 weeks in prior null responders and caused no SAEs. At this time, at least 22 investigational agents in many classes and other types of agents are in Phase I/II/III trials. Some studies reported >90% clearance at 12 weeks, but these studies were small with largely non-cirrhotic patients. Other studies reported less frequent administration of agents once or twice daily and improved safety profiles. The new FDA endpoint for approval is an SVR at 12 weeks rather than at 24 weeks.

CDC's draft HCV screening recommendations for the 1945-1965 birth cohort are summarized as follows. All adults born during 1945 through 1965 should receive one-time testing for HCV without prior ascertainment of an HCV risk factor. All persons with identified HCV infection should receive brief alcohol screening and intervention as appropriate followed by referral to appropriate care and treatment services for HCV infection and related conditions as indicated. CDC ranked both recommendations as strong with moderate quality of evidence.

CDC estimated that HCV testing and appropriate care and treatment of the 1945-1965 birth cohort would identify 809,000 additional cases, prevent 82,000-121,000 deaths from HCV per year, and gain a societal cost per quality-adjusted life year of \$15,700-\$35,700. The cost-effectiveness of HCV testing and treatment of this birth cohort compares quite favorably to other well-accepted clinical interventions (e.g., screening for cancer, hypertension, cholesterol and influenza).

CDC's position is that HCV testing for the 1945-1965 birth cohort is justified based on the high prevalence of HCV, the growing burden of HCV-associated morbidity and mortality, and the large proportion of persons in the cohort who are untested and unaware of their HCV. Moreover, HCV care and treatment can cure infection and prevent transmission and adverse health outcomes. The efficacy and safety of HCV treatment will continue to improve with the licensure of new therapy.

CDC's draft HCV screening recommendations for the 1945-1965 birth cohort currently are undergoing the HHS clearance process. A public comment period was opened in May 2012. The recommendations will be revised based on comments submitted and published in the *MMWR*. CDC will use multiple resources and strategies to implement, broadly publicize and raise awareness of the revised guidelines, including the "Know More Hepatitis" Campaign.

The University of Washington and the University of Alabama at Birmingham will use their CoAg funds from CDC to provide professional training on hepatitis. The grantees will offer distance-based learning for clinicians and public health professionals, continuing medical and nursing education case studies, the *Hepatitis C Screening, Management and Care Primer*, webinars, and curricula for medical education programs.

The "Know More Hepatitis" Campaign will be used to decrease stigma, increase awareness and educate the public on risk factors for HBV and HCV. A website will be developed in recognition of Hepatitis Testing Day on May 19, 2012. The website will include an online hepatitis risk assessment tool for persons to easily assess their risk for HAV, HBV and HCV. The tool primarily will be targeted to insured individuals (e.g., "Baby Boomers," Asian Americans, and persons with past risk behaviors or events).

Individuals can use the tool in the privacy of their homes or in a physician's office. Moreover, the tailored printout of CDC's recommendations can be used for persons to foster dialogue with

their providers. Dr. Howard Koh, the HHS Assistant Secretary of Health, will continue to serve as a champion and spokesperson for hepatitis at the HHS level.

CDC's future activities to enhance hepatitis prevention, treatment and care in the United States include (1) expanding capacity for hepatitis testing and linkage to care; (2) strengthening hepatitis surveillance by increasing reporting of chronic hepatitis and using large data sets to identify trends in the clinical setting; and (3) engaging a diverse group of stakeholders (e.g., federal partners, professional societies, primary care providers (PCPs) and NGOs). CDC developed an observational cohort study with >12,000 patients in clinical care to monitor implementation of the recommended services.

Update on HRSA's Quality Improvement Strategy and Hepatitis Activities

Matthew Burke, MD

Senior Clinical Advisor, Office of Quality and Data
Bureau of Primary Health Care
Health Resources and Services Administration

Advice Requested from CHAC by BPHC:

- Is evidence available to support a convergent, standardized indicator that could be broadly adopted in Federally Qualified Health Centers (FQHCs) or at least provided to FQHCs with a high volume of HIV, STD and viral hepatitis cases?
- What are best practice dissemination strategies?
- What telehealth and payment policies are necessary to promote the adoption and maintenance of novel treatment paradigms?

Dr. Burke presented an update on BPHC's QI strategy and hepatitis activities. BPHC's mission is to improve the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent and quality primary healthcare services. The 1,100 HRSA-funded Health Centers and their satellite sites represent >8,000 unique delivery sites across the United States and territories.

Of 19.5 million patients served by Health Centers in 2010, 93% were <200% of the FPL, 38% were uninsured, 62% were racial/ethnic minorities, 50% were 25-64 years of age, ~1 million were homeless, 863,000 were farmworkers, and 173,000 were public housing residents. Compared to the U.S. population, the proportion of persons ≤200% of the FPL, racial/ethnic minorities and uninsured persons is overrepresented in Health Centers.

In 2010, Health Centers served 58,594 HCV patients and 12,333 HBV patients. HBV testing was provided to 256,133 patients, while HCV testing was provided to 162,320 patients. BPHC is aware of the critical need to increase HBV/HCV testing and care in Health Centers. BPHC

plans to achieve this goal by collaborating with its federal partners and key stakeholders, clarifying and strengthening policies, and providing and supporting opportunities for TA.

BPHC developed a QI strategy that is based on access to comprehensive services, integrated services and an integrated health system. The 5 components to implement the strategy are highlighted as follows. The program/policy component of the QI strategy includes aligning activities with VHAP and NHAS; developing program guidance on testing and treatment; integrating patient-centered medical homes (PCMH) and behavioral health into all Health Centers; tracking all diagnoses in the Uniform Data System (UDS); and collaborating with federal partners on the development of measures.

BPHC is transforming service delivery in Health Centers through data, HIT, Meaningful Use, PCMH, patient safety and risk management, and local health systems integration. BPHC established a goal in 2012 for 13% of all 1,100 Health Centers to have at least 1 site that is formally recognized as a non-federal PCMH. BPHC will increase this goal to 25% of Health Centers in 2013 and continue to promote PCMH national recognition.

Health Centers will be expected to take a comprehensive and integrative approach to providing quality care for persons living with hepatitis; improve the quality of care through enhanced access, planning, management and monitoring of patient care; and adhere to standards established by the National Committee for Quality Assurance (NCQA).

The funding component of the QI strategy includes the allocation of \$150 million for new Health Center access points and \$20 million for Health Center Controlled Networks for research at the patient level, implementation and demonstration projects. BPHC will fully support the NCQA survey process for all Health Centers to participate in the Patient Center Medical Health Home Initiative.

BPHC will award 1-year PCMH supplemental grants of \$25 million to 904 Health Centers to cover the costs associated with receiving NCQA PCMH recognition. BPHC and CMS will jointly fund 3-year demonstration projects for 500 Health Centers to offer advanced primary care in FQHCs. The demonstration projects will target services to Medicare beneficiaries and evaluate the effectiveness of the PCMH model in improving care, promoting health and reducing the cost of care.

The TA component of the QI strategy includes partnerships, collaboration with experts and national CoAgs. BPHC offers webinars for Chief Medical Officers in Health Centers, compiles and disseminates best practices to grantees, and leverages expertise of external stakeholders. BPHC currently is collaborating with the joint SAMHSA/HRSA Center for Integrated Health Solutions and SAMHSA on the development of 2 TA webinars focusing on viral hepatitis and behavioral health as well as substance abuse screening, brief intervention and referral to treatment. Moreover, the National Training and Technical Assistance for LGBT Health is targeting efforts to Health Centers.

The data/information component of the QI strategy includes changes to UDS reporting on HIV and hepatitis, implementation of the Health Center Patient Survey to collect patient-level data, and research by the Community Health Applied Research Network.

The partnership/collaboration component of the QI strategy includes BPHC's coordination and communication with a diverse range of partners at national, state and local levels: National Association of Community Health Centers, National Training and Technical Assistance for LGBT Health, Association of Asian Pacific Community Health Organizations, SAMHSA/HRSA Center for Integrated Health Solutions, federal agencies, primary care associations, state HIV/AIDS Directors, state Hepatitis Coordinators, NGOs, CBOs, hospitals, Health Centers, and HIV and hepatology specialists.

At the conclusion of the viral hepatitis updates from CDC and HRSA, Ms. Dempsey moderated CHAC's panel discussion with Drs. Ward and Burke. The discussion topics included:

- plans by the federal agencies to shift the focus from prevalent infections to incident infections to (e.g., sexual transmission of HCV, the role of harm reduction strategies to decrease risk, the implications of screening and re-screening algorithms, and approaches to regularly educate clinicians on the risk of hepatitis);
- the need for more rigorous studies and data to better understand and track the incidence of HCV in HIV-positive MSM;
- potential strategies to apply the treatment as prevention concept for HCV, particularly with advancements in the development of effective and tolerable oral regimens;
- the need to clearly distinguish between and characterize HBV and HCV as two separate diseases due to differences in their epidemiology, approaches, vaccination and affected populations;
- the need for stronger emphasis on HBV screening (e.g., incorporate joint opt-out HBV/HIV testing into healthcare settings and promote HBV vaccination);
- the lack of experts in the public and private healthcare workforce to adequately address emerging HCV treatment issues due to the rapid expansion of testing, integration of HCV treatment into Community Health Centers (CHCs) and primary care settings, and development of new HCV treatment guidelines and standards;
- efforts by state and local health departments to educate the Federal Bureau of Prisons and county jails on the critical need for hepatitis screening, treatment and care in these settings, particularly due to the high rate of "jailhouse" tattoos among inmates and the high risk for HCV among young IDUs who are incarcerated;
- important factors that should be considered to inform behavioral research in the field in the context of HCV prevention, particularly among gay/bisexual men (e.g., the promotion of HCV as an STD in this population);
- CDC's discussions with CMS and private insurers on strategies to inform and educate providers on reimbursement mechanisms that will be available to implement the revised HCV recommendations; and

- the need for DVH and DHAP to collaborate in advancing prevention goals through intensive HCV screening and treatment of HIV-infected gay/bisexual men and IDUs to reduce transmission.

CHAC advised BPHC to provide strong leadership and clear guidance to Health Centers on integrating HBV/HCV treatment and care in these settings. For example, the Health Centers could use the updated UDS system to gather retrospective data on the number of foreign-born patients, the number of patients in the 1945-1965 birth cohort, and the number of patients with a diagnosis of cirrhosis, end-stage liver disease, hepatocellular carcinoma or liver failure. Health Center clinicians could use the UDS data to improve testing, evaluation and linkage to care prior to HBV/HCV morbidity or mortality of their patients.

Update on the Institute of Medicine (IOM) Report

Carlos del Rio, MD, CHAC Member

Professor and Chair, Hubert Department of Global Health
Rollins School of Public Health, Emory University

Advice Requested from CHAC by Dr. del Rio:

- What are the most significant challenges that grantees and HCPs face with regard to data collection and reporting?
- What actions should CDC and HRSA take to overcome these challenges?

Dr. del Rio presented an update on the IOM report, *Monitoring HIV Care in the United States: Indicators and Data Systems*. The IOM is an independent, nonprofit organization that works outside of the government to provide unbiased and authoritative advice and evidence-based recommendations to decision-makers and the public. The IOM serves as an advisor to the nation and its committees are formed to avoid conflicts of interest. IOM studies may be mandated by Congress or requested by federal agencies and independent organizations.

IOM studies are initiated and completed in a structured and stepwise process: define the scope of the study; select and approve the committee; convene committee meetings to gather information, deliberate on issues and draft a report with evidence-based recommendations; distribute the draft report for external peer review and approval; release the final report; and communicate the study findings.

The White House Office of National AIDS Policy commissioned the IOM to convene a committee to fulfill a three-part charge: (1) recommend data and indicators to assess the impact of NHAS and ACA on HIV care; (2) assess available public and private data systems that capture HIV care information; and (3) recommend strategies to supplement and maximize the usefulness of existing data systems.

The IOM committee would produce 2 reports as part of its charge. Report 1 would identify indicators and data elements for HIV care and supportive services to monitor the impact of NHAS and ACA; identify the best sources of public and private data to assess core indicators; determine potential barriers to data collection; discuss the role of HIT; and address the analysis and dissemination of data. Report 2 would outline strategies to obtain nationally representative estimates of health insurance and healthcare access among PLWH.

To fulfill its charge, the IOM committee used existing targets, indicators, quality measures and treatment standards as the bases for the recommended indicators. These sources included NHAS, PEPFAR, Healthy People 2020, NQF and HHS guidelines. The committee also reviewed public and private data systems that are pertinent to HIV care; identified critical points along the care continuum; reviewed the literature; listened to presentations by CDC and other experts; remained mindful of the need to minimize reporting burden and cost; and limited the scope of the study to adults diagnosed with HIV.

The IOM committee reviewed CDC data that showed <50% of HIV-infected persons are in care. Most notably, only 300,000 of 1 million persons who know their HIV-positive status have a suppressed viral load. The committee extensively reviewed the mediators of HIV care (e.g., mental health, substance use, housing, food/nutrition and transportation).

Of the 14 core indicators the IOM committee recommended to HHS, 9 were indicators for clinical HIV care and 5 were indicators for mental health, substance use and supportive services. The committee also recommended 15 additional indicators for more comprehensive assessment of care quality (e.g., 10 indicators for clinical HIV care and 5 indicators for mental health, substance use and supportive services).

The IOM committee incorporated its recommended indicators into all points along the continuum of HIV care (e.g., testing, diagnosis, linkage to and engagement in care, treatment and virologic suppression). The committee concluded that the indicators had the capacity to track HIV care at jurisdiction, county, state and national levels.

The IOM committee reviewed 32 diverse data systems for monitoring care that were public versus private or proprietary and HIV-specific versus non-HIV-specific. The data systems maintained surveillance, claims, health outcome and HIV program data. Of the 32 data systems, 12 provided a collective platform for tracking and measuring the core indicators based on representation of the population, data elements captured and accessibility of data.

Of the federal HIV-specific data systems included in the review, 2 were from CDC (National HIV Surveillance System (NHSS) and Medical Monitoring Project); 2 were from HRSA (Ryan White Services Report and Ryan White AIDS Drug Assistance Program Reports); and 1 was from the Veterans Administration (Clinical Case Registry: HIV). Of the federal non-HIV-specific data systems included in the review, 2 were from CMS (Medicaid Statistical Information System and Medicare Chronic Condition Data Warehouse) and 1 was from CDC (National Vital Statistics Information System).

To enhance national HIV surveillance, the IOM committee advised CDC to issue guidelines or criteria for NHSS reporting to include all CD4 and viral load test results; capture longitudinal data in NHSS on initiation and ongoing prescribing and dispensing of antiretroviral therapy (ART); and obtain information from NHSS on the sexual orientation, sources of coverage for medical treatment, and current geographic markers of residence.

The HIV-specific private or proprietary data systems included in the review were by the North American AIDS Cohort Collaboration on Research and Design, Centers for AIDS Research Network of Integrated Clinical Systems, and HIV Research Network. The non-HIV-specific private or proprietary data system included in the review was by Kaiser Permanente.

The IOM committee also reviewed additional data systems and collected data from other public and private sources. These data sets included the Resource Patient Management Systems (Indian Health Service), electronic medical records (Federal Bureau of Prisons), Housing Opportunities for Persons with AIDS (U.S. Department of Housing and Urban Development (HUD)), Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS (ECHPP) (CDC), 12 Cities Project (HHS), Nationwide Health Information Network Exchange (Office of the National Coordinator for Health Information Technology (ONC)), and Health Care Cost Institute.

The IOM committee's major conclusions regarding its review of the 32 data systems are highlighted as follows. All of the data systems have limitations in terms of data elements and representation of populations. Comprehensive expansion of these data systems would be impractical. Modest changes in individual data systems would improve their usefulness.

Many demographic data elements that are essential to understanding challenges in HIV care among groups disproportionately affected by the epidemic are not routinely collected or are not gathered with a sufficient level of detail. Electronic health records (EHRs) capture clinical outcome data, but provide limited data on populations and supportive services. Other data systems include little or no outcome data.

The IOM committee's recommendations on data system are highlighted as follows. Relevant federal agencies should review and modify federal data systems identified by the committee to better enable their use for monitoring progress toward achieving the NHAS goals. Relevant federal agencies should use existing data from private data systems, including EHR data, to monitor HIV care. Federal agencies should share data pertaining to HIV care with private healthcare systems and providers.

HHS and OMB should continue to expand demographic data elements captured by federal data systems to permit calculation of the recommended indicators based on the following factors: age, race/ethnicity, sex/gender/sexual orientation, geographic area of residence, income, and primary means of reimbursement for medical services.

The IOM committee's major conclusions regarding barriers to data collection are highlighted as follows. Federally-funded HIV/AIDS grantees are overburdened by reporting obligations. An HHS effort is underway to identify a set of HIV-related metrics that would be used across funding agencies to reduce the reporting burden on grantees. Numerous federal laws, state statutes and regulations exist at this time on the proper use and disclosure of patient information.

Varying interpretations may generate discrepancies in data sharing and reporting across states and impede the availability and quality of data. Additional barriers to data collection include reimbursement policies and practices, variation in reporting requirements, incomplete reporting by providers, lack of mechanisms for health departments to share data across jurisdictions, shifts in care coverage and across HCPs, state variations in implementation of ACA, anonymous HIV testing, and staffing, administrative and budgetary constraints.

The IOM committee's recommendations on barriers to data collection are highlighted as follows. HHS should maintain and institutionalize existing efforts to streamline data collection and reduce reporting requirements for federally-funded HIV/AIDS grantees. HHS should issue clear guidance to the HIV care community to clarify specific patient information that is permissible to share in light of federal and state privacy laws.

The IOM committee's major conclusions regarding HIT are highlighted as follows. The effective use of HIT can facilitate data collection and improve care. Education, TA and financial incentives for providers may promote more widespread adoption of HIT. Increased exchange of health-related information among providers has the potential to improve care coordination and longitudinal tracking of care. The existing infrastructure is lacking to support data system interoperability. Different sources of HIV care and coverage have their individual HIT systems. The disparate architecture and vocabulary pose a challenge to exchanging data across systems.

The IOM committee's recommendations on HIT are highlighted as follows. HHS should review existing mechanisms for health information exchange to provide a platform to increase data sharing among entities. HHS and ONC should provide TA and policy guidance to state and local health departments, providers and other agencies serving PLWHA to improve the interoperability of data systems that are relevant to monitoring HIV care and supportive services.

The IOM committee's major conclusions regarding data analysis and dissemination are highlighted as follows. The ability to use data from multiple systems to make valid inferences about the recommended indicators across different populations and over time presents a range of analytic and logistical challenges that will change over time. "Stakeholders" should include policymakers, health departments, HIV care providers, patients and researchers. The data have multiple uses and the potential to improve the quality of HIV care through informing policy decisions to support the development of research projects.

The IOM committee's recommendations on data analysis and dissemination are highlighted as follows. At least once every 2 years, HHS should reevaluate mechanisms for combining data elements to estimate key indicators, including relevant statistical methodologies. To facilitate this process, HHS should form a new "Center of Excellence" with representation by a broad group of experts. At least once every 2 years, HHS should update the public on the HIV care indicators, access and supportive services to foster improvements in the quality of HIV care and monitor progress toward meeting the NHAS goals.

HHS Secretary Kathleen Sebelius issued a memorandum in April 2012 following the release of the IOM report. The memorandum stated that the IOM's core indicators merited careful consideration in HHS's efforts to develop common measures to assess progress in achieving the NHAS goals.

The memorandum further stated that within 90 days, HHS operating divisions should work with the Office of the Assistant Secretary for Health (OASH) to finalize a set of common core HIV/AIDS indicators in a manner consistent with the IOM recommendations. The full report, project information and materials used by the committee are available on the IOM website (www.iom.edu).

Overview of HHS's Efforts to Implement Core Indicators and Reduce Data Burden

Richard Wolitski, PhD

Senior Advisor of Strategic Indicators, Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention

Dr. Wolitski presented an overview of HHS's efforts to implement core HIV indicators and reduce data burden. The Office of HIV/AIDS and Infectious Disease Policy is working under the auspices of OASH to lead HHS's efforts in implementing common core indicators, streamlining data collection, and reducing the data reporting burden of grantees.

HHS's efforts support the NHAS goals and this effort has been coordinated with the IOM committee's study process. Most notably, HHS and its agencies made presentations to assist the committee in gathering information and will develop core indicators that will take into account the IOM recommendations. HHS began focusing on this issue in 2011 by assessing data collected across federal agencies in support of ECHPP; establishing a department-wide Federal Agency Indicators Workgroup; and convening a technical consultation in September 2011 with representation by federal agencies, state and local health departments, CBOs, academia and other stakeholders.

These early efforts led to consensus across HHS to develop core indicators in 7 domains: HIV diagnosis, early diagnosis, initial linkage to HIV medical care, sustained engagement in HIV

medical care, initiation of ART, viral load suppression, and housing status of clients of HHS-funded programs.

The April 2012 memorandum by the HHS Secretary outlined 3 major activities and deadlines for HHS and its agencies to respond to the IOM recommendations. Within 90 days (or by July 11, 2012), the agencies will finalize a set of indicators that are consistent with the 7 core domains and informed by the IOM recommendations. In the subsequent 90 days (or by October 11, 2012), the agencies will develop an implementation plan to deploy the core indicators, streamline data collection, and reduce the data burden of grantees. Within 15 months of finalizing the core indicators (or by July 11, 2013), the agencies will fully deploy the operational plan.

HHS convened a federal workgroup to develop the core indicators and create a plan to obtain input from external stakeholders. At the agency level, CDC has already initiated efforts to reduce the reporting burden of grantees based on the goals established by the HHS Secretary.

For example, DHAP aims to reduce the number of variables prevention program grantees report to CDC by 51%-61%. The frequency of grantee data reporting to CDC was cut from quarterly to semi-annually (or a 50% reduction in data submission requirements). DHAP's reporting system is 70% more efficient because grantees can now submit HIV testing data through the EvalWeb system in 2.5 minutes instead of scanning paper forms in 8 minutes.

At the conclusion of the presentations on integrating HIV prevention and care data systems, Dr. Marrazzo moderated CHAC's panel discussion with Drs. del Rio and Wolitski. The discussion topics included:

- the need to identify and maximize optimal features that retain PLWH in care;
- the potential of including incarcerated persons in the housing status indicator to track and monitor continuous HIV care in correctional settings;
- the percentage of HIV-positive persons who are virologically suppressed and receive care from publicly-funded programs rather than from private insurance;
- demographics of the HIV-positive population that receives primary care through the Ryan White Program;
- efforts by the Federal Agency Indicators Workgroup to review the IOM recommendations and determine whether to accept, reject or act on the guidance;
- the need to designate agency authorities, leadership, organizations and resources to assure accountability to and responsibility for implementing the IOM recommendations;
- the need to incorporate SAMHSA's substance abuse and mental health issues into the HIV care indicators;
- the possibility of including peer navigators in the viral load suppression indicator;
- the ability of the indicators to fully reflect the needs of PLWH;
- efforts to avoid the unintended consequence of the indicators compromising, reducing or restricting essential services for PLWH;

- the need to harmonize the indicators to collect demographic data elements with the same terminology (e.g., “African American” versus “black”); and
- plans for stewardship and oversight to ensure that the indicators remained aligned with changes to guidelines over time.

CHAC advised HRSA to consult with the Department of Labor to explore the possibility of jointly funding a new SPNS Initiative to determine the effectiveness of peer navigators in locating, linking and retaining PLWH in care. Findings from this project could greatly inform the viral load suppression indicator.

CHAC also encouraged CDC to rapidly disseminate findings from its review of the 2011 Gardner, *et al.* study, *The Spectrum of Engagement in HIV Care and Its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection*, by race/ethnicity and various populations. These data will be extremely helpful in determining and targeting resources to communities most in need. CHAC further advised CDC to incorporate its findings into the NCHHSTP Atlas to allow for state-by-state comparisons of CD4 and viral load reporting.

Report on the Youth HIV/STD Prevention and Sexual Health External Expert Review

Kali Lindsey, CHAC Member

Director, Government Affairs and Communications
National Minority AIDS Council
Co-Chair, External Expert Review Panel

Advice Requested from CHAC by Mr. Lindsey:

- What are CHAC’s general observations on the recommendations proposed by the Panel?
- What strategic surveillance, research, programmatic and policy priorities should NCHHSTP consider in order to enhance youth HIV/STD prevention and sexual health?
- What is CHAC’s guidance on the role of youth sexual health priorities in terms of NCHHSTP’s general priorities?

Mr. Lindsey reported on the key outcomes of the Youth HIV/STD Prevention and Sexual Health External Expert Review. CDC convened the Panel because DASH’s recent integration into NCHHSTP provides a unique opportunity to assess synergies, gaps and duplications and also to leverage opportunities across NCHHSTP. Due to the constrained fiscal environment and DASH’s 25% budget cut in FY2012, CDC recognizes the importance of identifying essential activities for promoting youth sexual health.

CDC established three key objectives for the External Expert Review. The Panel would be expected to:

1. understand current activities related to youth HIV/STD prevention and sexual health taking place within HHS and CDC divisions outside of NCHHSTP;
2. review and prioritize NCHHSTP's activities related to youth HIV/STD prevention and sexual health given current resources; and
3. develop and prioritize recommendations for NCHHSTP's youth HIV/STD prevention and sexual health activities given various budgetary scenarios.

CDC held the External Expert Review on March 21-23, 2012 with 26 experts from academia, clinical settings, NGOs, CBOs and foundations. The NCHHSTP divisions nominated the Panel members. CDC distributed a comprehensive briefing book with overviews and abstracts of its youth HIV/STD prevention and sexual health programs to assist the Panel in prioritizing activities prior to the review.

CDC made a series of presentations during the review to set the context and describe NCHHSTP's youth HIV/STD prevention and sexual health portfolios. The Panel divided into breakout groups to propose and prioritize "limited-resource" and "blue-sky" scenarios. The Panel co-Chairs synthesized the deliberations into a report that will be finalized and distributed in the near future.

The Panel's overall assessment is highlighted as follows. Strong support was expressed for DASH's activities to reach youth/adolescents due to their high rates of STDs; reach particularly vulnerable or high-risk youth (e.g., LGBT/questioning (LGBTQ) youth); reach youth/adolescents through schools and other settings; support research; develop activities based on the best available evidence; and disseminate evidence-based practices to the field. Most of CDC's current youth-related programs have value and should be continued, but CDC should include the Panel's recommendations for improvement.

Funding is inadequate at this time to support several important activities targeting youth, particularly YRBS and SHPPS. Current political and economic realities provide opportunities for CDC to exercise more leadership in defining policies and programs to advance sexual health equity among youth. Programmatic efforts should be optimized through increased coordination and cost sharing across divisions. Overall, NCHHSTP does not address youth/adolescents proportionately to the rates of STDs in these populations.

The Panel voted on, prioritized and made recommendations on CDC's youth HIV/STD prevention and sexual health projects and activities in 4 major domains. The outcomes of this exercise are outlined below.

Project/Activity	No. of Votes
SURVEILLANCE	
YRBS	24
Middle school YRBS	14
School Health Profiles	10

Global YRBS	8
Large database analysis	6
SHPPS	5
College YRBS	4

The Panel's surveillance recommendations were for CDC to collect and provide data in 4 key categories: (1) behavior and STD data by more detailed age groups and geographic units; (2) behavior and incidence data that can be linked to particular large programmatic initiatives in different geographic areas; (3) behavior data for younger populations, particularly middle school students; and (4) behavior, pregnancy and STD data for college students or young persons of college age.

CDC should increase the number of cities that participate in YRBS because these data are not collected by all 12 cities with the highest prevalence rates. A "socioeconomic status and income measure" should be added to YRBS if a valid indicator can be identified. Appropriate measures of the quality of relationships should be added to YRBS due to the high prevalence of HIV/STD infections that occur within primary partnerships.

Project/Activity	No. of Votes
RESEARCH, RESEARCH TRANSLATION AND EVALUATION	
Evaluation of the impact of NCHHSTP's programs	20
Research synthesis and translation	17
Translational research on strategies	13
Translational research on school-ready programs	9
Basic research on social determinants of health	7
Translational research on populations	5
Randomized controlled trials to develop and test additional programs (e.g., efficacy trials)	5
Policy evaluation	2

The Panel's research and evaluation recommendations were for CDC to make evaluation research of DASH the highest priority. Research activities that are focused on youth within DASH and across NCHHSTP should be clarified. Evaluation research, research translation and research focused on youth should be scaled up.

A primary research agenda should be developed in collaboration with NIH that focuses on highly-vulnerable populations, including LGBT youth and youth in alternative or juvenile detention settings. Interventions recommended by State/Local Education Agencies (SEAs/LEAs) should be evaluated to improve access to school-ready programs and comprehensive sexuality education strategies.

Project/Activity	No. of Votes
PROGRAM, TRAINING AND CAPACITY BUILDING	
CoAgs with SEAs, LEAs, Territorial Education Agencies, and Tribal Governments	22
CoAgs with National NGOs	13
Infertility Prevention Project (IPP)/STD services for young women	12
Young MSM Project (CBO pilot projects and teen programs)	9
School-based screening programs	6
Capacity building with evaluation TA contracts and evidence-based intervention (EBI) dissemination	6

The Panel's program, training and capacity building recommendations were for CDC to integrate the prevention of coercion and sexual violence into prevention programs. For jurisdictions without an SEA or LEA HIV Coordinator, CDC should consider providing regional coordinators, leveraging funds from multiple sources (e.g., DASH and DSTDP), funding a half-time position with the state matching the other half, and drawing upon the expertise of existing Regional Training Centers.

CDC should develop and translate EBIs for school settings and create programs and services for college-age young adults, including education in Historically Black Colleges and Universities and with the Pan Hellenic Council. This group coordinates activities among black fraternities and sororities.

Project/Activity	No. of Votes
POLICY, PARTNERSHIPS AND COMMUNICATIONS	
Comprehensive sex education	19
Removal of barriers to confidential care of adolescents, particularly those <18 years of age, and the inclusion of EHRs	16
Improved communications on youth programs across CDC and NCHHSTP	15
Young men's health	8
Advocacy for school-based clinics to include sexual and behavioral health	8
Improved access to condoms, particularly in schools	4

The Panel's policy, partnerships and communications recommendations were for CDC to adopt the following policy statement for the agency: "CDC should develop and provide leadership to the field on an evidence-informed, culturally-inclusive policy agenda that focuses on youth under 18 years of age and promotes adolescent health and wellness."

CDC should promote and fund the development of a comprehensive, age-appropriate sex education curriculum that takes a holistic sexual health promotion approach rather than disease-specific prevention approach. Guidance should be developed for school-based health clinics. Pathways to engage youth participation in informing the advancement of sexual health equity

should be identified. Out-of-school youth and youth in juvenile corrections and other settings should be included in the policy agenda.

“Sexual health” should be further defined. Strategies for programs and services to improve sexual health outcomes over time should be clearly articulated. “Youth” should be clearly defined. Strategies should be developed that are effective for youth populations at the time of their development and vulnerability. Common youth goals and indicators that can be annually or regularly measured should be developed through a clear working relationship across all NCHHSTP divisions. Existing committees and workgroups should be assessed and refocused to maximize strategic partner development and broad improvement of youth sexual health.

In addition to providing CDC with guidance in the 4 major domains, the Panel also proposed “blue-sky” scenarios. These recommendations were intended for CDC to accelerate HIV/STD prevention and promote sexual health for adolescents and youth if resources were unrestricted over the next 5 years.

CDC should provide funding and programmatic efforts that reflect the relative incidence of HIV and other STDs among youth. CDC should provide leadership on launching a large national initiative that focuses on youth, supports a positive approach to human sexuality, and shifts the focus from fear of acquiring an STD. Research should be increased on methods to improve the definition of “sexual health” that extends beyond disease elimination.

Efforts should be based on the best available science to expand the existing evidence base for interventions and programmatic activities. Support should be provided for families and a youth development approach that is broader than STD prevention. Efforts should be made to ensure that programs and research target the highest impacted groups.

The Panel made a number of overarching recommendations to CDC. NCHHSTP should increase its emphasis on youth. NCHHSTP and DASH should increase their leadership in defining and supporting effective policies and programmatic activities for youth. An evidence-informed, culturally-inclusive policy agenda that focuses on youth <18 years of age and addresses adolescent health and wellness should be articulated. CDC’s primary prevention research priorities should be clearly defined and expanded, including programs for highly vulnerable and impacted populations.

Partnerships should be established with other National Centers and divisions to coordinate programs and leverage funding. NCHHSTP’s youth-focused programs should be evaluated, including interventions recommended by SEAs and LEAs. More detailed or new information that could be put to better and immediate use in program and research development should be collected.

Surveillance activities should be expanded to include different groups (e.g., middle school and college-age youth). A partnership should be established with CMS to improve the availability of sexual health preventive services in School Health Center expansion. CoAg with SEAs, LEAs,

NGOs and IPP Programs should be expanded. Capacity building through evaluation TA, EBIs and professional development should be scaled up or cut.

Ms. Dempsey moderated CHAC's discussion with Mr. Lindsey on the report by the Youth HIV/STD Prevention and Sexual Health External Expert Review Panel. The discussion topics included:

- the role of psychosocial burdens (e.g., discrimination and stigma) in increasing health disparities among youth;
- the need to divide the "adolescent" and "emerging adult" groups;
- the importance of engaging families in the youth sexual health dialogue to minimize homophobia and sexual risk behaviors among youth;
- the need to address bullying and abuse of youth as a result of gender variance and sexuality;
- the need for research to determine the impact of bullying and abuse of youth on negative sexual health behaviors; and
- the surprising result of only 4 votes by the Panel for "improved access to condoms in schools" as a policy recommendation.

CHAC made several suggestions for the Panel co-Chairs to consider in their ongoing efforts to finalize and submit the report on CDC's youth HIV/STD prevention and sexual health portfolio.

- Specific recommendations should be made on including human papillomavirus (HPV) vaccination in CDC's youth HIV/STD prevention and sexual health portfolio. This intervention is the most effective biomedical prevention strategy for STDs among pre-adolescents and adolescents.
- Foreign-born youth should be highlighted as an additional vulnerable population that may be at higher risk for sexual health-related diseases due to their economic status, mixed-origin/mixed-language families, and absence of HBV vaccination abroad.
- The final report should include a pie chart to provide advocates and the field with a clear illustration and clarification of the allocation of DASH's resources.
- A recommendation should be made for CDC to partner with SAMHSA and HUD to address the impact of substance abuse, mental health and housing issues on adolescent health, particularly marginalized and sexual minority youth.
- A strong recommendation should be made for CDC to develop culturally-appropriate youth HIV/STD prevention and sexual health programming to account for differences in cognitive and physical development stages between youth and adults. Instead of attempting to incorporate youth into NCHHSTP's existing programs, NCHHSTP should design youth programming in close partnership with youth at the outset.
- A strong recommendation should be made to maintain or increase funding for school-based clinics. These clinics serve as the only opportunity for a large proportion of youth, including out-of-school youth, to obtain confidential prevention interventions and care.

- The report should highlight gangs, sexual trafficking and incarcerated youth as additional opportunities to advance youth sexual health.

Update on Ryan White Reauthorization and ACA Implementation

Laura Cheever, MD

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

Advice Requested from CHAC by HRSA:

- What potentially will be the most significant challenges with the Ryan White Program and ACA implementation in 2014?
- What are CHAC's recommendations on potential strategies to compile information on wraparound services in light of varying services covered under Medicaid state-by-state?
- What is the best approach to position Ryan White grantees for the current and impending healthcare environment (e.g., medical homes and CHC expansion)?

Dr. Cheever presented an update on HRSA's ongoing activities to prepare for Ryan White reauthorization in 2013 and ACA implementation in 2014. The Ryan White Program was signed into law in 1990 and received its first appropriation in 1991. Reauthorizations occurred in 1996 for 4 years, 2000 for 5 years, 2006 for 3 years as the "Ryan White HIV/AIDS Treatment Modernization Act," and 2009 for 4 years as the "Ryan White HIV/AIDS Treatment Extension Act of 2009."

ACA provisions that impacted Ryan White in 2011 included Pre-Existing Conditions Insurance Plans and ADAP's role in True Out-of-Pocket Expenses for Medicare. HAB widely publicized the ACA provisions through a grantee letter, calls with advocates and the community, and guidance informing grantees that ADAP costs would cover eligible patients in the Medicare Part D "donut hole" and Part D would then assume costs. At this time, states are calculating their cost-savings as a result of the donut hole.

HRSA has taken steps to position Ryan White grantees for anticipated changes in the healthcare environment. Incentives were offered for grantees to be formally recognized and certified as medical homes to maintain and enhance Ryan White delivery systems. HAB funded a national CoAg in 2011 to provide capacity building for grantees to become a medical home. Ryan White grantees partnered with existing CHCs or took steps to become Health Centers. BPHC awarded planning grants to 6 HIV-based organizations to become full-service CHCs in 2011.

HRSA has taken steps to improve HIV care capacity in primary care settings. HAB funded a new AETC to build HIV care capacity in minority communities through 30 CHCs that are not

funded by Ryan White. BPHC issued 2 Program Assistance Letters to emphasize HRSA's expectation for CHCs to provide HIV testing, care and treatment to clients as part of their primary care. BPHC funded a national CoAg to increase LGBT cultural competence in CHCs. BPHC is partnering with SAMHSA to increase behavioral health capacity within CHCs. Efforts are underway throughout HRSA to continue to build the primary care workforce.

HRSA has reviewed experiences and lessons learned in individual states to better understand the impact of ACA implementation on Ryan White clients. The Medicaid expansion to 133% of the FPL will have a major impact. HRSA has strengthened its existing partnership with CMS to examine the rollout of state plans and ensure that these plans have adequate capacity to meet the needs of and provide care to HIV-infected clients. HRSA provided training and TA to support CMS's release of the "State Medicaid Director's Waiver Toolkit."

HRSA funded 2 studies in FY2011 to assess anticipated gaps in care after ACA is fully implemented and determine gaps that Ryan White will need to fill. HRSA also examined state insurance plans to better understand the impact on Ryan White. Local needs assessments were conducted to identify gaps in Ryan White and gaps that will remain in the existing Medicaid program after ACA implementation (e.g., the number of prescriptions allowed through some Medicaid programs; coverage of oral health and substance abuse treatment services; support services to link clients to care; and provider training through AETCs).

At the White House level, the Administration is working toward Ryan White reauthorization. At the department and agency levels, HHS and HRSA leadership is determining necessary changes in Ryan White that might be driven by ACA. At the bureau level, HAB is spearheading a plan to solicit stakeholder feedback on Ryan White reauthorization. HAB is convening a series of meetings with representatives from major national HIV/AIDS advocacy groups to discuss the future of Ryan White and programmatic challenges.

HAB requested feedback from grantees and the broader HIV/AIDS community on anticipated changes and potential strategies to improve Ryan White in the future. HAB launched a new website (<http://hab.hrsa.gov/reauthorization>) for stakeholders to submit written comments on Ryan White Parts A-F and participate in regional virtual listening sessions to ask questions and offer feedback about Ryan White reauthorization.

Overall, HRSA will continue to strengthen collaborations with federal and national partners, prioritize services, utilize other resources in the community, improve quality, equitably distribute limited resources, document results, and disseminate best practices. HRSA opened a public comment period on Ryan White reauthorization that will close on July 31, 2012. HRSA will analyze, compile and present the public comments to HHS for review.

Dr. Marrazzo moderated CHAC's discussion with Dr. Cheever on HRSA's activities to prepare for Ryan White reauthorization and ACA implementation. The discussion topics included:

- strategies to demonstrate to Congress decreased quality and quantity of HIV care expertise outside of Ryan White medical homes and gaps that will remain in state Medicaid programs after ACA implementation (e.g., the lack of dedicated pharmacies, neurologists, gynecologists, and providers with experience in creating stigma-free environments for their patients);
- the role of HIV medical homes in ACA;
- HRSA's efforts to train new HIV providers;
- HRSA's timeline and decision points to continue activities in a health reform environment if Ryan White is re-appropriated, but not reauthorized;
- HRSA's plans to better characterize Ryan White's billable services in a insurance-based system;
- HRSA's actions in response to a recommendation by an external committee to use the National Health Service Corps (NHSC) to provide training in HIV care;
- the status of HRSA's 2-page document to help Ryan White grantees understand critical ACA implementation issues and identify agencies at federal, state and local levels that would be responsible for these issues;
- HRSA's messages, treatment as prevention campaign, and data to emphasize the critical role of HIV care and treatment in public health;
- plans by HRSA, CDC and other federal agencies to prepare for the impact on public health and the healthcare system resulting from ACA's exclusion and non-coverage of certain populations (e.g., undocumented persons and legal resident aliens in the United States for <5 years);
- HRSA's programmatic funding streams to (1) potentially offer ART to HIV-positive persons at higher CD4 counts and (2) develop metrics to encourage providers to place stronger emphasis on prevention with positives (PWP);
- HRSA's plans to educate Ryan White providers on the need for an interdisciplinary effort to fully integrate prevention of HIV-uninfected persons at risk into traditional treatment and care settings for HIV-positive persons; and
- HRSA's plans to engage national groups (e.g., the Ryan White Workgroup of the Federal AIDS Policy Partnership and the HIV Healthcare Access Workgroup) in its upcoming meetings with CMS to discuss Ryan White reauthorization.

CHAC made several suggestions for HRSA to consider in its ongoing activities to prepare for Ryan White reauthorization and ACA implementation.

- HRSA currently is gathering data on living HIV cases. To better inform reauthorization, however, HRSA also should collect utilization data from states and jurisdictions on current Ryan White clients to more effectively determine severity of need.
- HRSA should regularly update Ryan White planning councils and committees at state and local levels on the comments submitted on Ryan White reauthorization and ACA implementation. More transparent communication and feedback will help these groups to make appropriate decisions for their patients and improve health outcomes.

- HRSA should collect and disseminate cost containment data, particularly for HIV drug prescriptions, to inform ACA implementation. These data will help HIV care providers to make decisions on prescribing generic drugs and using co-formulations of individual medications. The data also will assist insurers in preparing for cost containment of HIV medications in the future.
- HRSA should develop a “full-service” and “minimum-needs” package of services and support for HIV patients who do and do not require a full range of treatment and care. This tiered approach would be useful in targeting limited resources to patients at highest need and generating cost-savings. HRSA should fund a demonstration project for AETCs to establish and clearly define characteristics of “minimum-need” HIV patients who could be served by FQHCs in a safe and effective manner and “full-service” HIV patients who would require specialized treatment and care in Ryan White medical homes.
- HRSA should showcase and promote Ryan White as a sound investment and an evidence-based model of care that has the potential to change history by ending the domestic HIV epidemic. HRSA should inform Congress that Ryan White has the capacity to achieve this goal in addition to filling gaps in ACA. Overall, HRSA and its federal partners should shift from the traditional public health imperative of caring for HIV patients to a more aggressive, imaginative and inspiring focus on investing in ending the HIV epidemic in the United States over the next 10-15 years.

Ms. Lynn Wegman is the HRSA/HAB Acting Director of Policy. She urged CHAC to compile its thoughtful, insightful and creative suggestions on Ryan White reauthorization into a formal position paper and submit the document to HRSA. As a Federal Advisory Committee with a charter to advise HRSA and HHS leadership on HIV treatment and care, she confirmed that CHAC’s expert-driven position paper would be considered and reviewed at the highest level of government.

Ms. Wegman clarified that HRSA also would welcome comments from individual CHAC members in their roles as experts in the field, members of the public, and interested citizens or advocates. She reminded CHAC that the public comment period on Ryan White reauthorization would close on July 31, 2012.

Preparation for the CHAC Business Session

Antigone Dempsey MEd, CHAC co-Chair
Deputy Director, Knowledge, Transfer and Technical Assistance
HIV/AIDS Lead, Altarum Institute

Ms. Dempsey led CHAC in a review of topics that would be discussed during the business session on the following day and champions who volunteered to be responsible for drafting and proposing formal resolutions/recommendations to CHAC on these issues.

Based on the discussions on day 1 of the meeting, Ms. Dempsey noted that the champions planned to propose resolutions/recommendations for the following topics: viral hepatitis, integration of HIV prevention and care data systems, youth HIV/STD prevention and sexual health, and Ryan White HIV/AIDS Program Reauthorization. However, she pointed out that CHAC was free to propose additional resolutions/recommendations based on the remaining presentations or other key outcomes from day 2 of the meeting.

In preparation of the business session, Ms. Dempsey encouraged CHAC to again review the handout with guidance on proposing resolutions/recommendations and forming workgroups. However, any proposed workgroups that were formally approved by CHAC would need strong leadership, oversight and commitments by the champions because CDC and HRSA have limited resources to support activities outside of the biannual CHAC meetings.

Dr. Fenton thanked the CHAC members for their thoughtful and constructive input on the agenda items for day 1 of the meeting. His position was that the new meeting format would allow CHAC to formulate more creative, impactful and “winning” resolutions/recommendations. He noted that during the business session on the following day, both CDC and HRSA looked forward to CHAC’s formal guidance on the presentations, new meeting format and other important issues.

With no further discussion or business brought before CHAC, Ms. Dempsey recessed the meeting at 4:50 p.m. on May 8, 2012.

Opening Session: May 9, 2012

Kevin Fenton, MD, PhD, FFPH

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

Dr. Fenton conducted a roll call to determine the CHAC voting members, *ex-officio* members and liaison representatives who were in attendance. None of the voting members publicly disclosed any conflicts of interest for themselves and/or their institutions that were new or different than those declared on day 1 of the meeting.

Dr. Fenton verified that the voting members and *ex-officio* members constituted a quorum for CHAC to conduct its business on May 9, 2012. He reconvened the meeting at 8:40 a.m. and welcomed the participants.

Dr. Fenton reminded the participants that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. He reminded the CHAC

voting members of their responsibility to identify individual potential conflicts of interest and recuse themselves from participating in these matters.

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

Dr. Marrazzo joined Dr. Fenton in welcoming the participants to day 2 of the CHAC meeting. She summarized the major themes from the presentations and CHAC's discussions on the previous day. The updates by the federal agencies highlighted their major challenges at this time (e.g., CDC's unprecedented 25% cut in the DASH budget and HRSA's activities to simultaneously prepare for Ryan White reauthorization in 2013 and ACA implementation in January 2014). CHAC expressed concerns that after Ryan White reauthorization and ACA implementation, the quality of HIV care would decline and capacity to track key health metrics for PLWHA would decrease.

Despite these challenges, CHAC applauded the federal agencies on their outstanding progress. For example, HHS swiftly responded to the IOM recommendations on integrating HIV prevention and care data systems. CDC has taken leadership at the federal level to address the controversial issue of youth HIV/STD prevention and sexual health. CDC also is making tremendous efforts to enhance viral hepatitis prevention, treatment and care in the United States with improved surveillance and provider education and training.

Public Comment Session

Charles Stephens
Regional Organizer, AIDS United

Mr. Stephens informed CHAC that he was interested in obtaining answers to 2 questions from CDC rather than making public comments. First, what is the status of adding gender identity and sexual orientation questions to YRBS and other national surveys that target young persons? Second, has CDC considered engaging the U.S. Department of Education (ED) in the youth policy agenda, particularly to address comprehensive sex education?

Drs. Fenton and Howell Wechsler, Director of DASH, responded to Mr. Stephens' questions as follows. First, the number of states and cities that participate in YRBS and collect data on sexual orientation is continuing to increase. CDC hopes that the 2011 *MMWR* publication on sexual health outcomes among LGBT youth will inspire even more states and local jurisdictions to begin collecting youth sexual orientation data, particularly highly impacted areas in the South and Midwest.

CDC does not collect national gender identity data at this time due to technical issues with surveillance methods and an extremely small population size that does not allow for meaningful analyses. However, states and local jurisdictions are free to ask questions and collect data on gender identity in their individual surveys.

For example, the District of Columbia gathered and used gender identity data to develop a fact sheet with data on the percentage of gay/lesbian students who engaged in certain behaviors. However, similar analyses could not be performed on transgender students due to the small size of this population. DASH will consider adding questions on gender identity in YRBS at the national level if a sufficient number of states and cities collect more data on this issue.

Second, DASH has attempted to establish a good working relationship with ED for the past 20 years. Over the past year, however, ED has aggressively downplayed its role in and focus on health issues. The demotion of the ED Office of Safe and Drug Free Schools to a smaller entity has increased DASH's difficulty in establishing a strong partnership with ED. Moreover, ED is closely supervised by Congress and is restricted from conducting activities outside of its mandate.

Graham Harriman, MA

Interim Director, Care Treatment and Housing Program
New York City Department of Health and Mental Hygiene

Mr. Harriman made the following comments for CHAC's consideration. The current system of care must be preserved, particularly for CBOs that serve the most marginalized individuals. These persons will continue to need assistance from CBOs regardless of efforts to make the system of care more standardized or corporate in a health reform environment. The unique relationship between CBOs and communities must be sustained.

To help maintain and support retention of the CBO/community relationship in a health reform environment, HRSA should adopt CDC's new testing algorithm that does not require Western blot for confirmatory HIV testing. Elimination of the Western blot in CBOs that are sub-grantees of HRSA-funded grantees would greatly advance HIV testing in communities.

The experience of New York City is that many medical and mental health providers have no interest in PWP due to their traditional culture of treating individual patients rather than offering prevention interventions to PLWH to advance public health, decrease transmission, and enable PLWH to live full and healthy lives. As a result, a number of providers in New York City are reluctant to ask their patients about risk behaviors.

To overcome this barrier, federal agencies should frame PWP as a holistic opportunity to reduce HIV, STD, HBV/HCV, and mental health issues related to shame and disclosure. A system-level approach would be extremely beneficial in helping providers in New York City and other jurisdictions and states to adopt and institutionalize PWP principles.

Lucy Bradley-Springer, PhD, RN, ACRN, FAAN

Principal Investigator & Director

Mountain Plans AIDS Education and Training Center

Dr. Bradley-Springer made the following comments for CHAC's consideration. The National Alliance for HIV Education and Workforce Development is a membership organization of 11 Regional AETCs and 4 National AETCs. AETCs have been a critical component in the national response to HIV since 1987.

The role of AETCs will become even more important in a health reform environment due to changes in the delivery of HIV care and overall health care in the United States. For example, many HCPs have expressed their lack of need, desire or time to learn about HIV, but the proportion of HCPs who must learn to care for patients in the HIV epidemic will continue to increase after ACA implementation. AETCs have the expertise, willingness and capacity to train and educate even the most reluctant providers.

The most significant challenge over the next few years will be for AETCs to develop, train, educate and support a full-service healthcare team to address STD, hepatitis, mental health and other psychosocial issues that contribute to HIV transmission. In addition to providing training and education, AETCs also will need to build skills and promote collaboration across a diverse group of non-traditional providers to address critical issues brought to light by the cascade of care. These providers include physicians, physician assistants, nurses, nurse practitioners, behavioral health experts, prevention adherence/retention specialists, case managers, social workers, peer navigators, dental health providers, and pharmacists.

AETCs are aware that the entire healthcare team should have up-to-date knowledge of evolving treatment guidelines, emerging healthcare benefits, and the shifting landscapes of healthcare reform and Ryan White reauthorization. Moreover, all members of the healthcare team should maintain their skills to help patients take advantage of positive changes in the next few years. AETCs are ready, willing and able to provide assistance in this process by targeting funding to the full spectrum of care providers, including those who do not exist at this time.

AETCs currently are training generalists in primary care settings to offer HIV testing, take an assessment, and provide linkages to care for patients with a positive diagnosis. Although the activities of AETCs are restricted by their HRSA funding and CoAg language, many AETCs are attempting to expand training to medical residency programs, nurse training programs and basic HCP programs and more strongly focus on treatment as prevention due to scientific advancements in this area. Overall, AETCs are able to embrace the feasible goal of ending the HIV epidemic and meet future challenges in a health reform environment.

Daniel Raymond

Policy Director, Harm Reduction Coalition

Chair, National Viral Hepatitis Roundtable

Mr. Raymond made the following comments for CHAC's consideration. The National Viral Hepatitis Roundtable (NVHR) sent a letter on April 11, 2012 to the CHAC co-Chairs and Dr. Fenton to commend CHAC on formally adding viral hepatitis to its name, charter and scope of work. The hepatitis advocacy community welcomes the opportunity to collaborate with CHAC and the federal agencies to advance discussions and work toward implementation of VHAP.

Recent data show that annual mortality from HCV-related causes exceeds HIV mortality. This trend is a result of a neglected epidemic that has insufficient resources and weak leadership to apply lessons learned from HIV to HCV. The integration of viral hepatitis into CHAC's discussions will emphasize the urgency of prioritizing viral hepatitis and generate strategic value. Lessons learned, challenges, tools and strategies for HIV and STD will play an important role in viral hepatitis.

An upcoming paper by the Antiretroviral Therapy Cohort Collaboration will report that HIV mortality among persons with a documented risk history of IDU is twice the mortality of persons infected with HIV through other routes of transmission. In its efforts to prepare for Ryan White reauthorization, HRSA should ensure that care systems play an important role in decreasing disparities in mortality between HIV-positive IDUs and non-IDUs.

Similar challenges exist in HCV because a care and treatment system that is responsive to the needs of persons with histories of addiction and behavioral health issues has not been mobilized to date. However, these challenges can enable HIV and viral hepatitis communities to jointly take advantage of opportunities for learning and evolving. Most notably, the resurgent epidemic of acute HCV among young IDUs poses challenges and opportunities for both viral hepatitis and HIV prevention.

NVHR urged CHAC to undertake the charge of weaving viral hepatitis throughout all of its discussions on HIV/STD prevention, treatment and care. NVHR also asked the federal agencies to fill vacancies on CHAC with new members who have expertise in viral hepatitis.

Carl Schmid

Deputy Executive Director, The AIDS Institute

Mr. Schmid made the following comments for CHAC's consideration. During the November 2011 CHAC meeting, The AIDS Institute (TAI) provided comments on the need for proper tools and resources for ACA to be implemented in order to provide care and treatment to PLWHA and help prevent HIV. However, little progress has been made over the past 6 months.

Although health reform was passed 2 years ago and HRSA has held 2 meetings with the HIV community, Ryan White grantees still have minimal direction on how to proceed with health reform implementation. Mr. Schmid quoted the comments he made to CHAC during the November 2011 meeting.

“Health reform will drastically change things. Most Ryan White clients will be able to access their care and treatment paid for by Medicaid and some will be able to buy health insurance through the exchanges. While most health reform changes will not occur until 2014, some elements have already begun and planning to make sure it works for people with conditions like HIV is well underway. There is much uncertainty out there, not all is known, but we are concerned with the lack of dialogue and planning that is occurring between HRSA and its outside partners. Health reform implementation is now! Much is already occurring, such as development of the essential health benefits. Health reform is a great transformational moment for us, but if not done correctly our entire system of care for people with HIV can be dismantled. It is not going to be an easy process and huge changes must occur. Understandably, there is a huge level of angst out there, and there is an urgent need for leadership.”

During the November 2011 CHAC meeting, TAI suggested the formation of a small ongoing workgroup with external partners and HRSA/HAB staff to ensure the smooth implementation of ACA. The workgroup has held 2 meetings to date, but grantees still have not been given directions to proceed. Instead, further discussions have been held on reauthorization of the Ryan White Program. These discussions must occur, but discussions of and progress on ACA implementation must occur first.

Tools and resources for reimbursement of HIV testing also are needed. Under ACA, HIV testing and other preventive services can be reimbursed by various payers (e.g., Medicare, Medicaid and private insurers). However, CDC has provided limited information to its grantees on strategies to take advantage of these new coverage options. Many of these options are in effect at this time.

In the current era of budget constraints at all levels, the development of these reimbursement mechanisms as soon as possible is particularly important to ensure that appropriated dollars can be used for testing of persons outside of medical settings, individuals without access to a payer, or other non-reimbursable preventive services. If the U.S. Preventive Services Task Force recommends a positive grade for routine HIV testing later in the summer of 2012, then the need will be even greater.

Update by the CHAC Sexual Health Workgroup

Antigone Dempsey MEd, CHAC co-Chair

Deputy Director, Knowledge, Transfer and Technical Assistance
HIV/AIDS Lead, Altarum Institute

Advice Requested from CHAC by the Sexual Health Workgroup:

- What is CHAC's feedback on the workgroup's revised definition of "sexual health?"
- Should implementation efforts focus on health departments and HCPs?

Ms. Dempsey presented an update on activities by the CHAC Sexual Health Workgroup. CHAC unanimously passed a resolution during the November 2011 meeting. CHAC strongly endorsed the ongoing activities of the workgroup. CHAC recommended continued escalation or scale-up of sexual health activities with a focus on developing and implementing packages of interventions for appropriate populations and settings as well as indicators for application across the lifespan.

CHAC was in favor of designing the interventions and indicators to provide optimal sexual health care, normalize the dialogue around sexual health, and measure the impact of the Sexual Health Plan. CHAC recommended that the co-Chairs write a letter to HHS, CDC and HRSA leadership to support and disseminate messages regarding the importance of a public health approach to advancing sexual health in the United States.

Ms. Dempsey described actions the workgroup has taken in response to CHAC's unanimous resolution. The workgroup drafted a joint CHAC/Presidential Advisory Council on HIV/AIDS (PACHA) letter to the HHS Secretary. The draft letter outlines the workgroup's activities; emphasizes the importance of a sexual health framework to address HIV, STD, viral hepatitis, family planning and partner violence; and asks the HHS Secretary to endorse the framework.

The draft letter was presented to PACHA during its meeting in February 2012. PACHA plans to vote on and approve the letter the following week. After the letter is finalized and jointly signed by the CHAC co-Chairs and PACHA Chair, the letter will be sent to the HHS Secretary with copies to the CDC Director and HRSA Administrator.

The workgroup finalized the "sexual health" definition. The definition was distributed to CHAC in the pre-meeting materials for review and comment and would be presented to CHAC for a formal vote during the business session. The definition is outlined below.

- Sexual health is a state of well-being in relation to sexuality across the lifespan that involves physical, emotional, mental, social, and spiritual dimensions.
- Sexual health is an inextricable element of human health and is based on a positive, equitable and respectful approach to sexuality, relationships and reproduction that is free of coercion, fear, discrimination, stigma, shame and violence.
- Sexual health includes the ability to understand the benefits, risks and responsibilities of sexual behavior; the prevention of disease and other adverse outcomes; and the possibility of fulfilling sexual relationships.
- Sexual health is impacted by socioeconomic and cultural contexts (including policies, practices, and services) that support healthy outcomes for individuals and their communities.

The workgroup resolved 2 major issues in finalizing the definition. The workgroup questioned whether "healthy reproductive outcomes" should be more explicitly addressed in the definition. The workgroup did not agree on the "potential for healthy reproductive outcomes." The

language explicitly implies that the purpose of sex is reproduction. This implication is not true for all persons who aspire to be sexually healthy because of sexual orientation, choice and age.

The workgroup did not agree on the “potential for reproductive health.” The language is too vague. The workgroup did not agree on the “promotion of reproductive health.” The language promotes reproduction as the purpose of sex. The workgroup’s final decision was not to modify the definition to more explicitly address healthy reproductive outcomes.

The workgroup questioned whether the “potential for long-term committed relationships (including marriage)” should be more explicitly addressed in the definition. “Marriage” was considered overtly value-based because some persons are barred from marriage due to legal or economic considerations and an increasing number of Americans are choosing not to marry. “Long-term committed relationships” also was considered to be value-based.

Although many individuals may aspire to be part of a long-term committed relationship, this language implies that other types of relationships (e.g., not long-term or not committed) were less valued. The workgroup’s final decision was not to modify the definition to more explicitly address long-term committed relationships, including marriage.

The National Sexual Health Coalition (NSHC) made a presentation to the workgroup about the startup of its organization. NSHC’s core leadership team includes representation by the Center for Excellence of Sexual Health at Morehouse School of Medicine, NVHR, Project Inform, National Campaign to Prevent Teen and Unintended Pregnancy, and Partnership for Prevention. Ms. Ashley Coffield, the NSHC Project Coordinator, was invited to join the workgroup as a regular member.

The workgroup considered several issues that must be addressed to implement the sexual health framework. Activities should be conducted to complement NSHC’s work. Changes should be presented as sequential steps to change thinking by using the stages of change model. A focus on structural changes will be important in this effort. Sexual health metrics should be included as performance indicators and in EHRs.

Sexual health should be integrated into provider education systems (e.g., medical and nursing). The possibility of convening a summit should be considered to discuss strategies on reinvigorating sexual health training in schools. A number of potential stakeholders should be considered in implementing the sexual health framework, but the initial focus of the workgroup and CDC should be on health departments and HCPs.

Recommendations for health departments to implement the sexual health framework should be categorized in 3 groups based on the readiness for change model. “Pre-contemplative” health departments would include those that are not yet considering action. “Ready for action” health departments would include those that are considering action. “In action” health departments would include those with ongoing sexual health activities. Other guidance for health departments include the potential development of a survey of programs by the National

Coalition of STD Directors, a compilation of best and emerging practices, and creation of a *Sexual Health Implementation Guide*.

HCPs are an important audience to implement the sexual health framework based on the importance of clinical prevention. Patients have expressed their interest and willingness to discuss sexual health issues, but responses by HCPs can be limited due to their lack of training, discomfort in engaging patients in sexual health dialogue, or limited time and resources. Implementation of the sexual health framework among HCPs may vary by setting (e.g., primary care versus more traditional sexual health settings). The workgroup will leverage expertise from BPHC and HCPs who serve on the workgroup to address evidence-based practices and training issues.

The workgroup agreed that primary care settings are important for implementation of the sexual health framework. Sexual health is a critical component of comprehensive primary care. Patients have a strong interest in discussing their sexual health with PCPs. Primary care settings will serve broader populations and play a stronger role in the delivery of all types of care in a health reform environment.

To create a climate that is conducive to addressing sexual health in primary care settings, the importance and value of addressing sexual health questions and concerns as part of the patient's clinical encounter should be emphasized. Simple and brief entry points can be created for PCPs to initiate discussions with their patients and take a sexual health history with key questions: "When is the last time you were sexually active?" "What questions or concerns do you have about your sexual health?" The workgroup drafted a summary of recommended sexual health preventive services for primary care settings.

The workgroup's next steps will be to continue its discussions with CDC and HRSA on implementation of the sexual health framework; identify opportunities for coordinating efforts with NHSC; and perform a strengths/weaknesses/opportunities/threats analysis to complete 6 "trends and issues" papers relating to the sexual health landscape.

Dr. Marrazzo moderated CHAC's discussion with Ms. Dempsey on activities by the Sexual Health Workgroup. The discussion topics included:

- concerns regarding the limited amount of time CHC providers have to discuss sexual health with their patients during a 15-minute HIV visit;
- opportunities for patients to discuss their sexual health during the broader primary care visit with other members of the healthcare team rather than with the individual provider;
- guidance, education and training that will be needed for primary care settings and CBOs to address sexuality in the context of physical, emotional, mental, social and spiritual well-being;
- the frequency of taking a sexual health history (e.g., during the patient's annual primary care visit or at more frequent intervals); and

- the need to reference “families” in the revised sexual health definition (e.g., “individuals, their families and communities”) to decrease stigma.

CHAC made several suggestions for the Sexual Health Workgroup to consider during its ongoing activities over the next 6 months.

- The workgroup should review existing models to inform the implementation of the sexual health framework among HCPs. The Fenway Institute has developed 2 monographs (www.fenwayinstitute.org) to (1) emphasize the importance of providers asking their patients about sexual orientation and gender identity during clinical encounters and (2) describe the actual steps involved in this effort.
- The workgroup should identify speakers to make presentations on the use of EHRs and other technologies to reduce the burden on providers. For example, efforts are underway to examine the effectiveness of patients reporting health outcomes to their providers through electronic tablets. During biannual clinical encounters, providers need only 12 minutes to ask patients a finite number of questions about their sexual behavior, substance use, adherence to HIV medication and other outcomes.
- The workgroup should not place much emphasis on exploring strategies to address the limited amount of time providers have to discuss sexual health with their patients. Providers actually have sufficient time to ask their patients simple questions during the clinical encounter (e.g., “Have there been any changes in your sex life since the last visit?”). This approach would help to normalize sexual health conversations between providers and patients.
- The workgroup should review successful systems-based interventions that could be replicated for sexual health. For example, patients in diverse care settings were able to view a video on HIV testing while waiting for their providers, complete a computerized risk assessment, and request a discussion with the provider on HIV testing. This model could be easily replicated for sexual health.
- The workgroup’s implementation strategy of the sexual health framework among HCPs should include a recommendation to expand medical school curricula to train students on taking a sexual health history. New providers with appropriate education and training in medical school would be extremely comfortable in taking a sexual health history at the outset of their careers. The workgroup should solicit expertise from professional societies, training schools and primary care organizations to support the development of tools and curricula.
- The workgroup should closely collaborate with NHSC to develop a Sexual Health Strategic Plan to specifically outline roles and responsibilities for implementation issues, such as guidance, training and education that will need to be provided. Other issues that should be clearly defined in the strategic plan include different time intervals for providers to take a sexual history based on the specific population. For example, CDC’s revised guidelines recommend HIV testing of gay men at 3 and 6 months.
- In the development of its recommendations, the workgroup should be mindful that health departments in some states and local jurisdictions will have limited ability, authority and resources to implement all aspects of the sexual health framework. However, health

departments in general most likely will embrace and utilize the sexual health framework in their HIV, STD and viral hepatitis activities.

- The workgroup should collaborate with professional societies to engage schools of medicine and nursing in replicating and implementing models of best practices in highly impacted jurisdictions. For example, the University of Maryland-Baltimore launched a pilot program with all of its schools to develop interdisciplinary curricula for sexual health and HIV testing that will be implemented by students in community-based settings.

Update by the PACHA/CHAC Disclosure Workgroup

Douglas Brooks, MSW

Senior Vice President, Community, Health and Public Policy

Justice Resource Center

CHAC Liaison Representative, Presidential Advisory Council on HIV/AIDS

Advice Requested from CHAC by the PACHA/CHAC Disclosure Workgroup:

- What is CHAC's input on the proposed approach to convene a Disclosure Summit to address the action items in NHAS?
- What are CHAC's suggestions on experts and leaders to invite to the summit?

Mr. Brooks covered the following topics in his update to CHAC on recent activities conducted by the PACHA/CHAC Disclosure Workgroup. The White House released NHAS in 2010 with a number of action steps for federal agencies, PACHA and CHAC. PACHA was tasked with developing recommendations on strategies to promote and normalize safe and voluntary disclosure of HIV status in various contexts and circumstances.

CHAC was tasked with soliciting public input and making recommendations on normalizing and promoting safe and voluntary disclosure of their HIV status. HRSA was tasked with publishing the recommendations developed by PACHA and CHAC. Due to the similarity in their charges, PACHA and CHAC agreed to form a joint workgroup. Mr. Douglas Brooks and Ms. Antigone Dempsey were appointed as the liaisons and Disclosure Workgroup co-Chairs for PACHA and CHAC, respectively.

The workgroup acknowledged that no simple strategies exist to normalize and promote safe and voluntary disclosure of HIV status. HIV criminalization laws, stigma, discrimination and denial cause significant barriers for persons and create unsafe environments for disclosure. Moreover, safe and voluntary disclosure is impacted and influenced by an individual's past experiences and personal factors (e.g., stigma, discrimination, family norms, race/ethnicity, gender, sexual orientation, socioeconomic/education status, gender identity, and the intersection of syndemics, such as substance abuse and violence).

Disclosure is an ongoing and fluid experience that impacts many domains of an individual's life (e.g., friends, family, sexual partners, work, medical providers and school). This complex task needs a nuanced and carefully planned approach with outcomes that do not cause unintended negative consequences.

To fulfill its charge, the workgroup has proposed to convene a 3-day Disclosure Summit with a well-formulated context and clearly defined outcomes. The number of invitees to the summit would be limited to 20 thought leaders from cross-cutting and diverse public and private disciplines: PLWHA and community advocates, social scientists, medical ethicists, researchers, business representatives, health providers, education leaders, attorneys and policymakers.

The summit will serve as a working meeting with the following structure. The attendees will gather input from presentations made by experts and researchers who are working on HIV disclosure, stigma and discrimination. A panel of PLWHA will be convened as well. This session will be ground in theory, expertise and experience.

Attendees will participate in facilitated and thoughtful discussions to produce 2 major deliverables for the summit: (1) a set of principles for safe and voluntary disclosure of HIV status in the United States, particularly the "first do no harm" principle; and (2) 2 short-term and 3 long-term policy recommendations for promoting safe and voluntary disclosure of HIV status in the United States. Attendees will agree on the set of principles and propose strategies to disseminate and educate the public on the recommendations.

The short-term recommendations should result in the broadest and deepest impact in a relatively short period of time. Examples of short-term recommendations would be for all HHS-funded programs to assure anti-stigma training for providers and for the U.S. Department of Justice to develop and release a state guide for advocates to support the elimination of HIV criminalization laws. The long-term recommendations most likely will require additional collaboration, partnerships and education to Congressional staff.

The workgroup plans to present its preliminary principles and policy recommendations during the 2012 International AIDS Conference in July 2012. As a result, the summit will be held in June 2012. Private and public support is needed to cover the \$26,000 cost of the summit: \$20,000 for travel, hotel and per diem for 20 participants; \$3,000 for meeting support and note taking; and \$3,000 for marketing and production. Ms. Dempsey made an in-kind contribution of Altarum Institute's facilities in Washington, DC for the meeting room and audiovisual equipment.

Dr. Marrazzo moderated CHAC's discussion with Mr. Brooks on activities by the PACHA/CHAC Disclosure Workgroup. The discussion topics included:

- the need for the workgroup to develop a positive theme and vision to clarify endpoints and specify accomplishments to advance the disclosure agenda (e.g., normalize disclosure, empower persons to disclose, or change the context for disclosure to effectively occur);

- the possibility of replacing “disclosure” with “positive empowerment;”
- the need for the workgroup to strengthen coordination and communication with the Sexual Health Workgroup; and
- the need for the summit recommendations to address internal barriers in addition to structural barriers to disclosure.

CHAC Business Session

Antigone Dempsey MEd, CHAC co-Chair

Deputy Director, Knowledge, Transfer and Technical Assistance
HIV/AIDS Lead, Altarum Institute

Jeanne Marrazzo, MD, MPH, CHAC co-Chair

Professor of Medicine, Harborview Medical Center
University of Washington

Ms. Dempsey and Dr. Marrazzo opened the business session and called for CHAC’s review, discussion or formal action on the following topics.

Topic 1: Adoption of the Draft CHAC Meeting Minutes

Ms. Dempsey entertained a motion for CHAC to approve the previous meeting minutes. A motion was properly placed on the floor and seconded by Drs. Carlos del Rio and André Rawls, respectively, for CHAC to approve the previous meeting minutes. **CHAC unanimously adopted the Draft November 15-16, 2011 Meeting Minutes with no changes or further discussion.**

Topic 2: Viral Hepatitis

Champions: Carol Brosgart, MD; William Cunningham, MD, MPH

The following motion was properly placed on the floor and seconded by Dr. Carol Brosgart and Ms. Maria Lago, respectively.

CHAC recommends that the Hepatitis Workgroup be reconstituted, co-chaired by Dr. Carol Brosgart and Ms. Heather Hauck, and supported with Ms. Hauck’s resources at the Maryland Department of Health and Mental Hygiene. The workgroup membership should include other CHAC members and external partners:

- a State Health Department Adult Viral Hepatitis Coordinator;
- a physician from the Infectious Disease Society of America Hepatitis Task Force;
- a member of the American Association for the Study of Liver Diseases;

- potentially a public health or HIV physician with experience in HIV/HBV and HIV/HCV co-infection;
- at least 2 community members from NVHR (1 with an HBV focus and 1 with an HCV focus); and
- 1 staff member from CDC/DVH and 1 staff member from HRSA.

The short-term goals of the workgroup over the next year would be to:

- identify opportunities within CDC/HRSA to improve and coordinate prevention, screening, linkage to care and treatment for individuals with chronic HBV and chronic HCV;
- assess the current state and adequacy of surveillance measures for both acute and chronic hepatitis, core indicators and quality measures to (1) determine whether existing measures are adequate to evaluate gaps, barriers and progress in implementing CDC's pending draft HCV screening recommendations for the 1945-1965 birth cohort and other elements of VHAP and (2) assess missed opportunities for earlier diagnosis to prevent morbidity and mortality; and
- evaluate the implications of ACA on VHAP.

CHAC unanimously approved the recommendation.

The following motion was properly placed on the floor and seconded by Dr. Carol Brosgart and Mr. Ernest Hopkins, respectively.

CHAC endorses CDC's pending draft HCV routine screening recommendations for the 1945-1965 birth cohort as an important supplement to the ongoing HCV risk-based screening recommendations that were published in 1998 to identify ~70%-80% of persons infected with chronic HCV and at risk of HCV disease progression and associated morbidity and mortality. CHAC encourages CDC and HRSA to address outreach and engagement to reduce barriers to testing, linkage to care and treatment.

CHAC unanimously approved the resolution.

The following motion was properly placed on the floor and seconded by Dr. Carol Brosgart and Ms. Maria Lago, respectively.

Given the burden of both chronic HBV and chronic HCV and the rapidly changing treatment arena, CHAC recommends that the HHS Secretary explore the feasibility of establishing a new "HHS Viral Hepatitis Guidelines Committee" for the treatment of chronic HBV and chronic HCV as soon as possible.

CHAC unanimously approved the recommendation.

The following motion was properly placed on the floor and seconded by Dr. Carol Brosgart and Mr. Ernest Hopkins, respectively.

CHAC recommends active implementation of CDC's pending draft HCV routine screening recommendations for the 1945-1965 birth cohort and VHAP that was issued in May 2011. CHAC requests that CDC, HRSA and HHS (Dr. Ronald Valdiserri, Deputy Assistant Secretary for Health, Infectious Diseases) report to CHAC at each 6-month meeting on progress in implementation and achievement of the goals of VHAP.

CHAC unanimously approved the recommendation.

The following motion was properly placed on the floor and seconded by Drs. Carol Brosgart and Britt Rios-Ellis, respectively.

CHAC recommends that the HHS Secretary, upon nominations from CDC and HRSA, fill upcoming available seats on CHAC with individuals with experience and expertise in viral hepatitis.

CHAC unanimously approved the recommendation.

Topic 3: Integration of HIV Prevention and Care Data Systems

Champions: Carlos del Rio, MD; Kenneth Mayer, MD; William Cunningham, MD, MPH

The following motion was properly placed on the floor and seconded by Drs. Carlos del Rio and André Rawls, respectively.

CHAC recommends that a letter be issued to commend the HHS Secretary for rapidly taking action on implementing common core indicators, streamlining data collection, and reducing undue reporting burden on HIV/AIDS prevention, treatment and care program grantees.

CHAC unanimously approved the recommendation.

Topic 4: Youth HIV/STD Prevention and Sexual Health

Champions: Kali Lindsey; Britt Rios-Ellis, PhD; Antigone Dempsey, MEd (Alternate as needed)

The following motion was properly placed on the floor and seconded by Mr. Kali Lindsey and Mr. Ernest Hopkins, respectively.

Families offer important and valuable opportunities to foster the development of sexual health and equity among youth. A focused effort to engage families in sexual health education at a young age can improve resiliency and help youth develop healthier

sexual behavior regardless of sexual orientation or gender. To promote these principles, CDC should:

- support the development, evaluation and dissemination of tools and effective strategies for families of pre-adolescent and adolescent children around homophobia and transphobia prevention to help these families avoid trauma and the development of discriminatory attitudes during key stages of the adolescent experience; and
- facilitate the inclusion of family-based interventions that improve the frequency, quality and breadth of sexual health communications.

CHAC unanimously approved the resolution.

The following motion was properly placed on the floor and seconded by Mr. Kali Lindsey and Dr. Carlos del Rio, respectively.

CDC and HRSA should consider mixed-origin and mixed-language families wherein adolescents and parents/guardians have experienced divergent contexts of sexual education and development.

CHAC unanimously approved the recommendation.

Topic 5: Ryan White HIV/AIDS Program Reauthorization
Champion: Kathleen Clanon, MD

The following motion was properly placed on the floor and seconded by Dr. Kathleen Clanon and Mr. Ernest Hopkins, respectively.

CHAC recommends the establishment of a new workgroup to develop a series of recommendations for CHAC's deliberation and potential adoption regarding the reauthorization of the Ryan White Program that reflects the evolving needs in the context of ACA implementation. The workgroup's timeline to conduct its activities will be June 2012-May 2013. The workgroup's membership will include Kathleen Clanon as chair and Heather Hauck, Ernest Hopkins, Steven Johnson and Kali Lindsey as members. Dr. Clanon will host the workgroup's first teleconference.

CHAC unanimously approved the recommendation.

In response to Dr. Marrazzo's comments, the new Ryan White Reauthorization Workgroup agreed to discuss concerns regarding the retention of quality of care in HIV care settings in light of ACA implementation in 2014. The workgroup will propose health metrics and quality of care indicators (e.g., biomedical outcomes and extragenital STD screening) that CHAC should recommend to HRSA. The workgroup will begin addressing these issues during its first teleconference in June 2012.

The following motion was properly placed on the floor and seconded by Ms. Heather Hauck and Mr. Ernest Hopkins, respectively.

CHAC recommends that HRSA continue to collaborate with CMS to finalize and disseminate the 2-page ACA implementation fact sheet to grantees and consumers. The fact sheet will direct these audiences to key ACA implementation issues by local, state and federal governments and pathways for public input that the law requires.

CHAC unanimously approved the resolution.

Topic 6: Sexual Health Definition
Champion: André Rawls, PhD, JD

The following motion was properly placed on the floor and seconded by Dr. André Rawls and Ms. Antigone Dempsey, respectively.

CHAC recommends formal adoption of the “sexual health” definition that was developed and revised by the Sexual Health Workgroup, but with the following amendment to the last sentence: “Sexual health is impacted by socioeconomic and cultural contexts, including policies, practices and services, that support healthy outcomes for individuals, families and communities.”

CHAC unanimously approved the resolution.

Topic 7: HIV Workforce Issues
Champion: Kenneth Mayer, MD

The following motion was properly placed on the floor by Dr. Kenneth Mayer.

CHAC recommends the establishment of a new workgroup to review the scope of current work of AIDS Education Training Centers (HRSA), STD/HIV and Viral Hepatitis Prevention Training Centers (CDC), and Addiction Technology Transfer Centers (SAMHSA). The new workgroup will develop a set of recommendations on HIV provider capacity in order to maximize the effectiveness of federally-funded Training Centers in an era of health reform.

The motion was withdrawn and replaced with an agenda item.

Topic 8: Future Agenda Items

Dr. Marrazzo moderated a discussion for CHAC to propose presentations, overviews or updates to place on future meeting agendas.

- **Guest Presenters:** Progress report by members of the IOM Committee (Paul Volberding or Jennifer Kates) on indicators and data systems to monitor HIV care in the United States
- **Federal Agencies & Grantees:** Panel presentation by Federal Training Centers funded by HRSA, CDC and SAMHSA:
 - BHPPr will participate on the panel to describe its ongoing activities to strengthen the primary care workforce.
 - In addition to their activities on the prevention, treatment and care of HIV, STD and viral hepatitis, the Training Centers will be asked to also discuss their projects related to sexual health.
 - An agenda item that was proposed during the November 2011 meeting will be included in the panel presentation. Ms. Rebecca Spitzgo, Associate Administrator of the Bureau of Clinician Recruitment and Service & Director of NHSC, will present an overview of NHSC.
 - Depending on the status of the clearance process, HRSA will report the findings of its large national survey on both the current and projected HIV workforce.
- **CDC:** Update on implementation of PrEP in light of FDA's meeting on May 10, 2012 to approve Truvada
- **Federal Agencies:** Panel presentation on HIV, STD and viral hepatitis prevention and treatment interventions, linkage to care activities, and data collection efforts:
 - Update by SAMHSA on its programs that affect prevention and engagement in care
 - Update by the Federal Bureau of Prisons on care in correctional settings in terms of the provision, continuation or disruption of treatment and care
- **Federal Agencies:** Presentation on the state of the HIV, STD and viral hepatitis epidemics in the United States
- **CDC:** Presentation on HCV in HIV-positive populations to inform the development of educational programming. (The data should cover incident HIV and the natural history of incident HIV in HIV-positive and HIV-negative MSM.)
- **CMS & George Washington University:** Presentation on ACA and implementation issues related to HIV prevention and care services
- **CDC:** Progress report on treatment as prevention policies, practices, recommendations and research gaps
- **CMS:** Presentation on innovation grants that have been awarded for HIV, STD and viral hepatitis
- **CDC:** Update on HPV activities
- **Indian Health Service:** Update on HIV, STD and viral hepatitis prevention and treatment programs and activities in Indian Country
- **Guest Presenters:** Panel presentation by a diverse group of community-based providers to give their perspectives on HIV, STD and viral hepatitis prevention and treatment activities in the field
- **Guest Presenters:** Update on HIV, STD and viral hepatitis prevention and treatment programs and activities along the U.S.-Mexico Border

- **CHAC:** Discussion on the integration of biomedical, behavioral and structural components to achieve maximum impact in prevention, treatment and care of HIV

Topic 9: Future Action Items

Dr. Marrazzo moderated CHAC's discussion on future action items.

- The CHAC co-Chairs will have a teleconference with the CDC and HRSA DFOs 2 months following each meeting to discuss the status of formal recommendations and resolutions.
- CDC and HRSA will develop, distribute and regularly update a tracking document for CHAC to easily monitor the status of each formal recommendation/resolution. The tracking document will highlight the date the recommendation/resolution was made, actions taken by the agencies to date, and any incomplete areas.
- CHAC will explore creative strategies to increase its engagement and interaction with community members during the 2012 International AIDS Conference. CDC will organize a teleconference for CHAC to begin this discussion.
- Ms. Dempsey will work with HRSA to organize the "Meet the CHAC" session during the Ryan White All-Grantees meeting on November 27-29, 2012. She will solicit volunteers to participate in the session in terms of presenting updates on CHAC's activities and answering questions from grantees during the listening session.
- CDC will determine whether the CDC Foundation can provide resources to support an International AIDS Society-CHAC grant for attendance at the biennial HIV and Hepatitis Testing Summit on November 26-28, 2012 in Washington, DC. Dr. Brosgart will provide the CHAC co-Chairs with more information on this issue.
- Following each meeting, CDC and HRSA will post the PowerPoint slide sets on a website for CHAC members to download.
- Dr. Perry Halkitis, Mr. Kali Lindsey and Dr. Britt Rios-Ellis volunteered to serve as new CHAC voting members on the Sexual Health Workgroup to replace members whose terms have expired.
- Dr. Rawls noted that CHAC unanimously approved a recommendation during the November 2011 meeting to form a new "Treatment as Prevention" Workgroup, but no action has been taken on this issue to date. Ms. Dempsey pointed out that because champions are a new feature of the CHAC business session, roles and responsibilities were not assigned to formally establish the new workgroup and initiate activities after the previous meeting. However, responsible champions, the tracking document, and regular teleconferences between the co-Chairs and DFOs would be used to assure that actions are taken on future recommendations formally approved by CHAC. Dr. Marrazzo added that 3 of CHAC's 4 active workgroups are expected to address treatment as prevention in their deliberations. After these workgroups presented their updates at the next meeting, she planned to ask CHAC whether the establishment of a new Treatment as Prevention Workgroup would still be warranted.

Topic 10: Input on the Revised Meeting Format

Dr. Marrazzo moderated a discussion for the CHAC members to give their thoughts and perspectives on the revised organizational structure of the meeting. CHAC's overall position was that the new format resulted in one of the most dynamic, productive and successful meetings in CHAC's history.

Most notably, the relocation of the public comment session from the afternoon to the morning allowed CHAC to ask questions and more effectively engage members of the public in interactive discussions. Moreover, the public comments were extremely helpful and useful in informing CHAC's deliberations during the business session.

The shorter presentations, longer discussion periods and pre-meeting materials also allowed CHAC to obtain more details from the speakers and develop more substantive resolutions and recommendations. The CHAC members thanked the co-Chairs, DFOs and agency staff for applying their suggestions from the November 2011 meeting and creating a dynamic format and an excellent organizational structure.

Dr. Fenton confirmed that the co-Chairs and DFOs would continue to explore strategies (e.g., Twitter and website announcements) to increase and promote public participation in CHAC meetings. For interested members of the public who are unable to attend meetings in person, the co-Chairs and DFOs are examining whether live Facebook chats or other mechanisms could be used for individuals or organizations to submit comments to CHAC, the federal agencies and presenters in real time during meetings. Dr. Fenton was pleased that the number of persons who made public comments increased from 1 individual during the November 2011 meeting to 5 individuals during the current meeting.

Closing Session

Dr. Edward Hook noted that he was privileged and honored to have served on CHAC as both a member and co-Chair since 2006. He was extremely proud of CHAC's growth and progress over the past six years in terms of conducting important activities, producing outstanding work products, and advising the federal agencies on issues that are critical to the nation. Dr. Hook thanked the federal agencies for providing him with an opportunity to work with his talented and engaged CHAC colleagues.

Ms. Dempsey and Dr. Marrazzo thanked the champions for their hard work after the meeting to propose well-constructed and thoughtful resolutions/recommendations. Since the champions and their teams devoted long hours to this effort, the co-Chairs confirmed that day 2 of each meeting would begin at 9:00 a.m. rather than 8:30 a.m.

The next CHAC meeting would be held on either November 8-9 or November 15-16, 2012 in the Washington, DC area. The CHAC Committee Management Specialist will poll the members via e-mail to confirm the exact date and location.

With no further discussion or business brought before CHAC, Ms. Dempsey adjourned the meeting at 2:07 p.m. on May 9, 2012.

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

Date

Antigone Hodgins Dempsey, MEd, 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