

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



**Meeting of the CDC/HRSA Advisory Committee on HIV,  
Viral Hepatitis and STD Prevention and Treatment  
December 11-12, 2012  
Rockville, Maryland**

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**DRAFT Record of the Proceedings**

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**ATTACHMENT 1****List of Participants****CHAC Members**

Ms. Antigone Dempsey, co-Chair  
 Dr. Jeanne Marrazzo, co-Chair  
 Mr. Tommy Chesbro  
 Dr. Kathleen Clanon  
 Ms. Angelique Croasdale  
 Dr. Carlos del Rio  
 Dr. Perry Halkitis  
 Dr. Marjorie Hill  
 Ms. Regan Hofmann  
 Mr. Ernest Hopkins  
 Dr. Steven Johnson  
 Dr. Jennifer Kates  
 Mr. Kali Lindsey  
 Dr. Kenneth Mayer  
 Dr. Britt Rios-Ellis

**CHAC Ex-Officio Members**

Dr. Steven Cha (Alternate)  
 Centers for Medicare and Medicaid  
 Services

Dr. William Grace  
 National Institutes of Health

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

Dr. Karen Lee (Alternate)  
 Agency for Healthcare Research and  
 Quality

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

Ms. Lisa Neel  
 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. Deborah Parham Hopson  
 HRSA/HAB Associate Administrator

**Federal Agency Representatives**

Mr. Christopher Bates  
 Dr. Gail Bolan  
 Ms. Adan Cajina  
 Dr. Laura Cheever  
 Dr. Philippe Chiliade  
 Ms. Corinna Dan  
 Dr. Rupali Doshi  
 Dr. John Douglas, Jr.  
 Ms. Cherrie Dowdell  
 Ms. Teresa Durden  
 Dr. Margarita Figueroa-Gonzalez  
 Ms. Shelley Gordon  
 Dr. Cynthia Grubbs  
 Ms. Heather Hauck  
 Dr. Seiji Hayashi  
 Dr. Kathleen Irwin  
 Ms. Deborah Isenberg  
 Dr. Amy Lansky  
 Ms. Alice Litwinowicz  
 Ms. Faye Malitz  
 Ms. Tracy Matthews  
 Dr. Jonathan Mermin  
 Ms. Amaka Nwankwo-Igomu  
 Mr. Harold Phillips  
 Ms. Amy Pulver  
 Dr. Polly Ross  
 Ms. Margie Scott-Cseh  
 Ms. Adelle Simmons  
 Dr. Rebecca Slifkin

Mr. Reginald Smith  
Dr. Rene Sterling  
Ms. Caroline Talev  
Dr. Ronald Valdiserri  
Dr. John Ward  
Ms. Candace Webb  
Dr. Howell Wechsler  
Ms. Lynn Wegman  
Ms. Vera Yakovchenko  
Mr. Steven Young

**Members of the Public**

Dr. Lucy Bradley-Springer  
Mountain Plains AIDS Education and  
Training Center

Ms. Sarah Buchanan  
Health and Medicine Counsel of  
Washington

Ms. Katie Coester  
Elizabeth Glaser Pediatric AIDS Foundation

Ms. Catherine Connor  
Elizabeth Glaser Pediatric AIDS Foundation

Ms. Sarah Cook-Raymond  
Impact Marketing and Communications

Ms. Dominique Couch  
Member of the Public

Ms. Lindsey Dawson  
The AIDS Institute

Ms. Kate Heyer  
National Association of County and City  
Health Officials

Dr. Oscar Mairena  
National Alliance of State and Territorial  
AIDS Directors

Ms. Kimberly Miller  
HIV Medicine Association

Mr. Daniel Raymond  
Harm Reduction Coalition

Mr. Ace Robinson  
Consultant, National Minority AIDS Council,  
American Public Health Association

Mr. Carl Schmid  
The AIDS Institute

Mr. Michael Shankle  
HealthHIV

Ms. Pellavi Sharma  
Planned Parenthood Federation of America

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

Dr. Todd Wills  
University of South Florida

Ms. Daniella Yaloz  
National Alliance of State and Territorial  
AIDS Directors

## ATTACHMENT 2

### Glossary of Acronyms

ACA	Patient Protection and Affordable Care Act
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
ART	Antiretroviral Therapy
ATN	Adolescent Treatment Network
BPHC	Bureau of Primary Health Care
CAPUS	Care and Prevention in the United States
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
CM	(Non-Medical) Case Management
CMS	Centers for Medicare and Medicaid Services
CoAg	Cooperative Agreement
CY	Calendar Year
DASH	Division of Adolescent and School Health
DFO	Designated Federal Official
DHAP	Division of HIV/AIDS Prevention
DSTD	Division of STD Prevention
DTBE	Division of Tuberculosis Elimination
DVH	Division of Viral Hepatitis
ECHPP	Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS
ECPs	Essential Community Providers
EMRs	Electronic Medical Records
eUCI	Encrypted Unique Client Identifier
FACs	Federal Advisory Committees
FDA	Food and Drug Administration
FOA	Funding Opportunity Announcement
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GYT	Get Yourself Tested
HAB	HIV/AIDS Bureau
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Services
HIEs	Health Insurance Exchanges
HIT	Health Information Technology
HIVMA	HIV Medicine Association
HRC	Harm Reduction Coalition
HRSA	Health Resources and Services Administration

IDUs	Injection Drug Users
IOM	Institute of Medicine
MAI	Minority AIDS Initiative
MCM	Medical Case Management
MMP	Medical Monitoring Project
<i>MMWR</i>	<i>Morbidity and Mortality Weekly Report</i>
MSA	Metropolitan Statistical Area
MSM	Men Who Have Sex With Men
NACHC	National Association of Community Health Centers
NASTAD	National Alliance of State and Territorial AIDS Directors
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
NHAS	National HIV/AIDS Strategy
NHB	Non-Hispanic Black
NHSS	National HIV Surveillance System
NHW	Non-Hispanic White
NIH	National Institutes of Health
NQC	National Quality Center
NQF	National Quality Forum
OAMC	Outpatient Ambulatory Medical Care
ONAP	Office of National AIDS Policy
PACHA	Presidential Advisory Council on HIV/AIDS
PACs	Primary Care Associations
PCMHs	Patient-Centered Medical Homes
PCP	Primary Care Provider
PCSI	Program Collaboration and Service Integration
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	Persons Living with HIV
PLWHA	Persons Living with HIV/AIDS
PrEP	Pre-exposure Prophylaxis
QA/QI	Quality Assurance/Quality Improvement
RSR	Ryan White Services Report
RWP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Service Administration
SDH	Social Determinants of Health
SMS	Short Messaging Services
SPNS	Special Projects of National Significance
TAI	The AIDS Institute
UDS	Uniform Data System
USPSTF	U.S. Preventive Services Task Force
VA	Department of Veterans Affairs
VH	Viral Hepatitis
VHAP	Viral Hepatitis Action Plan
VHIG	Viral Hepatitis Implementation Group

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**CDC/HRSA ADVISORY COMMITTEE ON HIV,  
VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT  
December 11-12, 2012  
Rockville, Maryland**

**DRAFT Minutes of the Meeting**

The U.S. 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 the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) convened a meeting of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC). The proceedings were held on December 11-12, 2012 at the Hilton Rockville Hotel in Rockville, Maryland.

**Opening Session: December 11, 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.

- Kathleen Clanon, MD: Recipient of federal grant support from HRSA/HAB
- Angelique Croasdale, MA: Recipient of federal funding from CDC and HRSA/HAB
- Carlos del Rio, MD: Recipient of federal research funding from CDC and the National Institutes of Health (NIH); recipient of federal Ryan White Clinic funds from HRSA/HAB; non-compensated Board member of the HIV Medicine Association; advisory committee member for Gilead and Pfizer; Board member of the International Antiviral Society-USA
- Jeanne Marrazzo, MD, MPH: Recipient of pharmaceutical research funding from Cepheid and Roche

- Marjorie Hill, PhD: Recipient of federal funding from CDC, HRSA and the Substance Abuse and Mental Health Administration (SAMHSA); recipient of pharmaceutical funding from Bristol-Myers Squibb, Gilead, Merck, OraSure and Walgreens
- Steven Johnson, MD: Consultant to Bristol-Myers Squibb, Gilead and Merck; recipient of federal funding from NIH through the AIDS Clinical Trials Group; recipient of federal Ryan White funding from HRSA; Board member of the International Antiviral Society-USA
- Kenneth Mayer, MD: Recipient of unrestricted pharmaceutical research grants from Gilead, Bristol-Myers Squibb and Merck; recipient of federal research funds from CDC, HRSA and NIH
- Britt Rios-Ellis, PhD: Recipient of federal funding from NIH, including the National Institute on Minority Health and Health Disparities

Dr. Fenton verified that the voting members and *ex-officio* members constituted a quorum for CHAC to conduct its business on December 11, 2012. He called the proceedings to order at 8:34 a.m. and welcomed the participants to day 1 of the CHAC meeting.

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.

Dr. Fenton announced changes to the CHAC membership since the May 2012 meeting. He presented certificates of appreciation to two CDC-appointed CHAC members whose terms ended on November 30, 2012: Mr. Ernest Hopkins and Dr. Kenneth Mayer. CDC forwarded draft nomination packages to the White House liaison to replace the two outgoing members and hopes that the nominees will be formally approved in the near future. The participants joined Dr. Fenton in applauding the tremendous contributions and valuable advice of Mr. Hopkins and Dr. Mayer during their tenures as CHAC members.

Ms. Heather Hauck resigned as a CHAC member in July 2012 due to her new position in HRSA/HAB. Dr. Carol Brosgart resigned as a CHAC member in August 2012 due to her new position at the CDC Foundation to support implementation of the Viral Hepatitis Action Plan by the CDC Division of Viral Hepatitis. The participants joined Dr. Fenton in thanking the two former members for their excellent service to CHAC.

Ms. Kaye Hayes is the Executive Director of the Presidential Advisory Council on HIV/AIDS (PACHA) at the HHS Office of HIV/AIDS and Infectious Disease Policy. She has replaced Mr. Christopher Bates as the *ex-officio* member for the HHS Office of HIV/AIDS Policy. Dr. Stephen Cha is the Chief Medical Officer at the Centers for Medicare and Medicaid Services (CMS). He would serve as the alternate *ex-officio* member for CMS in the absence of Dr. Effie George.



Drs. Karen Lee and Iris Mabry-Hernandez, Medical Officer for the U.S. Preventive Services Task Force (USPSTF), would serve as alternate *ex-officio* members for the Agency for Healthcare Research and Quality in the absence of Dr. Jennifer Crowell.

**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 CHAC meeting and opened the floor for introductions (*Attachment 1: List of Participants*). She provided an overview of the format and organizational structure of CHAC meetings for the benefit of the new members. For each presentation, summary sheets are distributed to the members in advance of meetings that describe the background, key issues for action and advice requested from CHAC. The agenda is developed based on the theme for each meeting.

The first meeting of the year is held in the spring in Atlanta and primarily is devoted to “prevention” presentations by CDC. The second meeting of the year is held in late fall/early winter in the Washington, DC area and primarily is devoted to “care and treatment” presentations by HRSA.

The CHAC business session was revamped to make the process of developing resolutions (e.g., policy statements) and recommendations (e.g., action-oriented items) more productive and efficient. CHAC members are asked to volunteer as “champions” to draft the wording of and provide leadership for the resolution/recommendation. The champions present the draft language during the business session for CHAC’s review, discussion, proposed amendments and formal vote. However, caution is taken in making resolutions/recommendations because the champions and other CHAC members contribute their individual time and effort outside of meetings to address these topics.

Ms. Dempsey announced that the meeting would be bittersweet due to Dr. Fenton’s departure from CDC as the NCHHSTP Director and the CHAC Designated Federal Official (DFO). She asked the participants to join her in honoring Dr. Fenton’s outstanding accomplishments over his seven-year tenure.

**Jeanne Marrazzo, MD, MPH, CHAC co-Chair**

Professor of Medicine, Harborview Medical Center  
University of Washington

Dr. Marrazzo added that the meeting format was revised to shorten the number and length of presentations and allow more time for CHAC to discuss key issues, consider future agenda items, and draft resolutions/recommendations. She confirmed that the CHAC co-Chairs and DFOs would continue to solicit input from the members to further enhance the structure and overall process of meetings.

**Deborah Parham Hopson, PhD, RN, FAAN**  
Associate Administrator, HIV/AIDS Bureau  
Health Resources and Services Administration  
CHAC Designated Federal Official, HRSA

Dr. Parham Hopson joined her colleagues in welcoming the participants to the CHAC meeting. She explained that HRSA is continuing to strengthen its understanding of the implications of the Affordable Care Act (ACA) on all programmatic activities across the agency.

Dr. Parham Hopson pointed out that biographical sketches of four new HRSA-appointed CHAC members were included in the meeting packets. She asked the participants to join her in formally welcoming the new members:

- Bruce Agins, MD, MPH: Medical Director, AIDS Institute, New York State Department of Health
- Tommy Chesbro, MHR, CSE: Owner, Chesbro Consulting, LLC
- Angelique Croasdale, MA: Project Manager, Ryan White Part A Program, City of Hartford
- Jennifer Kates, PhD: Vice President/Director, Global Health and HIV Policy, Kaiser Family Foundation

### **HRSA/HAB Associate Administrator's Report**

**Deborah Parham Hopson, PhD, RN, FAAN**  
Associate Administrator, HIV/AIDS Bureau  
Health Resources and Services Administration  
CHAC Designated Federal Official, HRSA

Dr. Parham Hopson covered the following topics in her Associate Administrator's report to CHAC. HAB held the Ryan White All Grantee Meeting on November 27-29, 2012 with a theme of *Navigating a New Era in Care* and a focus on technical assistance, administrative oversight, fiscal management and clinical HIV care. In addition to 214 workshops, the All Grantee Meeting also featured a "Meet the CHAC" session.

The Government Accounting Office conducted investigations of several HRSA bureaus in 2012, but the two investigations that were most relevant to HAB focused on monitoring of Parts A and B grantees and sub-grantees of the Ryan White HIV/AIDS Program (RWP) and the Minority AIDS Initiative (MAI). HAB released the *2012 Ryan White HIV/AIDS Program Progress Report: Ahead of the Curve* on its website.

HAB is continuing to monitor the implementation of ACA to ensure a seamless transition into ACA for RWP clients who will receive expanded coverage. In this effort, HAB is educating RWP providers and programs on ACA opportunities for persons living with HIV (PLWH) at state and county levels. Although HHS and HRSA are taking steps to determine changes in RWP that might be driven by ACA, full implementation of ACA will not eliminate the need for RWP.

In October 2009, RWP was reauthorized through September 2013. HAB launched an RWP planning strategy that included extensive engagement of external stakeholders. HAB identified several potential options for reauthorization. For example, option 1 would be to take no action, allow the reauthorization to expire, and continue RWP based on an appropriation. Option 2 would be to slightly modify RWP through reauthorization or an appropriation. Option 3 would be to significantly change RWP through full reauthorization.

To solicit feedback from key stakeholders (e.g., grantees, PLWH and advocates) on the future of RWP in terms of adopting one of the three options, HAB hosted four virtual listening sessions in the South, Northeast, West and Midwest regions in July 2012; opened a portal on the Regulations.gov website for stakeholders to submit written comments to HAB; and held three meetings with national partners.

All of the comments submitted by stakeholders are available on the HAB website, but major themes were identified. Strong support was expressed for continuation of RWP. The need to increase the focus on continuity of care, retention in care, and streamlined wraparound and support services was emphasized. Concerns were raised about the impact of variability in ACA implementation on different jurisdictions. The need for increased flexibility was emphasized in terms of the 75%/25% requirement for core/support services, payer of last resort and the administrative cap. A waiver process has been established.

HAB's priorities in 2013 will aim to advance the goals of the National HIV/AIDS Strategy (NHAS) and help to achieve an AIDS-free generation. HAB's activities in 2013 to accomplish this goal will include engaging and retaining PLWH in care; refining and publishing RWP client-level data; preparing HAB staff and RWP grantees for full implementation of ACA; and engaging in discussions regarding continuation of RWP and the President's Emergency Plan for AIDS Relief (PEPFAR).

HAB will continue to focus on its existing activities in 2013, including Quality Initiatives, Special Projects of National Significance (SPNS), the UCARE<sub>4</sub>LIFE initiative to reach adolescents living with HIV through texting, HIV workforce studies (e.g., Medical and Nursing Education Partnership Initiatives), and dissemination and inclusion of lessons learned between global and domestic programs. HAB will continue to fund and monitor RWP and PEPFAR grantees.

HAB data collected from the Ryan White Services Report (RSR) estimated that 546,156 clients received at least one RWP-funded service in calendar year (CY) 2010. By gender, ~69% of RWP clients were male, ~31% were female, and <1% were transgender. By race/ethnicity,

~47% of RWP clients were non-Hispanic black (NHB), ~28% were non-Hispanic white (NHW), and ~22% were Hispanic. By age, ~1 in 3 RWP clients were in the 40-49 age group, 24% were in the 50-59 age group, and 19% were in the 30-39 age group.

HAB developed 62 HIV performance measures covering different aspects of care and treatment to ensure that RWP grantees deliver the highest quality care to clients. RWP grantees can select specific performance measures to implement, but HAB has submitted five measures for national endorsement through the National Quality Forum (NQF):

1. frequency of HIV medical visits,
2. gaps in HIV medical care,
3. prescriptions of HIV antiretroviral therapy (ART),
4. HIV viral load suppression, and
5. newly enrolled in HIV medical care.

After the NQF Infectious Disease Endorsement Maintenance Steering Committee determined that measures 1-4 were suitable for endorsement, the measures were forwarded to the NQF Consensus Standards Approval Committee for review. HAB is collaborating with CMS and the HHS Office of the National Coordinator for Health Information Technology to include measures 1-4 in Stage 3 Meaningful Use criteria (e.g., improved outcomes) that will be launched in 2016. All 62 HIV performance measures can be viewed at:

<http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>.

HAB awarded a five-year cooperative agreement (CoAg) to the New York State AIDS Institute over the project period from August 2012 to June 2017 to conduct the National Quality Center (NQC). The NQC infrastructure will be used to provide training and technical assistance, quality management coaching, learning collaboratives for 135 grantees representing 38 states, and the In+Care Campaign ([www.incarecampaign.org](http://www.incarecampaign.org)).

HAB funded three new SPNS Initiatives in 2012: (1) "Enhancing Access to and Retention in HIV Primary Care for Transgender Women of Color" (2012-2017); (2) "Building a Medical Home for Multiple Diagnoses HIV-Positive Homeless Populations" (2012-2017); and (3) "Replication of Public Health Information Exchange to Support Engagement in HIV Care" (2012-2015). If the FY2013 President's budget request is approved, RWP funding will slightly increase from ~\$2.4 billion in the FY2012 enacted budget to ~\$2.5 billion.

Dr. Parham Hopson concluded her update by announcing that HAB has expanded its staff with new Project Officers, Branch Chiefs and other personnel to improve the delivery of services to RWP grantees.

- Dr. Rupali Doshi: Medical Officer, Office of the Associate Administrator
- Cynthia Grubbs: Acting Director, Office of Operations and Management & Executive Officer

- Heather Hauck: Director, Division of State HIV/AIDS Programs
- Dr. Polly Ross: Deputy Director, Division of Community HIV/AIDS Programs

## 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, several changes in CDC's leadership have occurred over the past few months. Dr. Rima Khabbaz, Deputy Director for Infectious Diseases and Director of the Office of Infectious Diseases at CDC, will serve as the Acting Director of NCHHSTP over the next 3-6 months until Dr. Fenton's permanent replacement has been officially appointed. Dr. Thomas Frieden, Director of CDC, has made a strong commitment to launch and complete the national search for the new NCHHSTP Director as quickly as possible.

Dr. John Douglas, the NCHHSTP Chief Medical Officer, will serve as the Acting DFO for CHAC during the national search. The new NCHHSTP Director could serve as the CHAC DFO for CDC or designate senior staff to fill this role. Dr. Fenton encouraged the CHAC members to submit names of potential candidates to CDC.

Dr. Anne Schuchat is serving as the Acting Director for the CDC Center for Global Health while a search is being conducted to permanently replace Dr. Kevin DeCock in this position. Dr. Denise Cardo is serving as the Acting Director of the CDC Office of Surveillance, Epidemiology and Laboratory Services to permanently replace Dr. Stephen Thacker who retired from this position.

CDC is operating under a continuing resolution through March 27, 2013, but the continuing resolution does not address the January 2, 2013 sequester mandated by the 2011 Budget Control Act. If this issue is not resolved in a timely manner, CDC will closely collaborate with its federal partners within and outside of HHS to implement measures to mitigate the impact.

CDC recently published a *Vitalsigns* Report on HIV among youth in the United States with several key findings. First, one in four new HIV infections occurs in youth 13-24 years of age. Second, ~1,000 youth per month were infected with HIV in 2010. Third, 60% of youth who are living with HIV have no knowledge of their infection.

The *Vitalsigns* Report also highlights major challenges with the concentration of HIV among young gay/bisexual men and young men who have sex with men (MSM) of color, particularly

African American MSM. CDC will soon release new data on HIV incidence in the United States to provide more details on trends in new infections and highlight the disproportionate burden of disease among youth. The *Vitalsigns* Report is available at: [www.cdc.gov/vitalsigns/pdf/2012-11-27-vitalsigns.pdf](http://www.cdc.gov/vitalsigns/pdf/2012-11-27-vitalsigns.pdf).

At the National Center level, NCHHSTP made several key accomplishments to support its six cross-cutting priorities to implement a more integrated and holistic approach to preventing HIV, STD, viral hepatitis and TB. Priority 1 is “program collaboration and service integration” (PCSI). *Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, STD and TB* were released ([www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf](http://www.cdc.gov/nchhstp/programintegration/docs/PCSIDataSecurityGuidelines.pdf)).

An integrated funding opportunity announcement (FOA) was released for Pacific Island jurisdictions to eliminate the burden of reporting and managing data across multiple FOAs. A new Internet-based “Atlas” was launched to increase public access to NCHHSTP data across programs ([www.cdc.gov/nchhstp/atlas](http://www.cdc.gov/nchhstp/atlas)).

Collaborations were established with multiple HHS agencies to publish a *Morbidity and Mortality Weekly Report (MMWR)* article summarizing guidelines and recommendations on integrated approaches for the prevention and control of HIV, STDs, viral hepatitis and TB for persons who illicitly use drugs ([www.cdc.gov/mmwr/pdf/rr/rr6105.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr6105.pdf)). A PCSI consultation was held to discuss surveillance systems for HIV, STDs, TB and viral hepatitis; explore new opportunities with ACA and health information technology (HIT); and determine approaches for dissemination of strategic information for infectious diseases.

Priority 2 is “promotion of health equity and reduction in health disparities.” Language was included in all new FOAs that will require grantees to address structural and social determinants of health (SDH) in all NCHHSTP-funded activities. A special *Public Health Reports* Supplement was published focusing on data systems and their use in addressing and monitoring SDH related to the four infectious diseases.

Efforts are underway to build capacity with internal CDC staff and external partners to ensure health equity and SDH are incorporated into programming. The NCHHSTP SDH website was enhanced. The eighth year of NCHHSTP’s “Third Thursday Lunch” and “Learn Health Equity” series was completed.

Priority 3 is “prevention through healthcare.” A summary was released on the consultation, “Prevention Through Healthcare: Enhancing Health Departments’ Preparedness and Response” ([www.cdc.gov/nchhstp/PreventionThroughHealthcare/index.htm](http://www.cdc.gov/nchhstp/PreventionThroughHealthcare/index.htm)). A collaboration was formed with HRSA to support partnerships between state health departments and Community Health Centers (CHCs) to improve the quality and coordination of care for persons living with HIV/AIDS, viral hepatitis, STDs or TB. An internal caucus recently was held to explore strategies for CDC and its grantees to become more active in the nexus between public health and primary care.

Priority 4 is “partnerships.” New health communication and social marketing campaigns were launched. The “Get Yourself Tested” (GYT) Campaign was updated and generated a 10% increase in testing at STD clinics. Year 2 of the “Act Against AIDS” Campaign had >1.6 billion media impressions. The new “Testing Makes Us Stronger” Campaign” was launched. The “KNOW MORE HEPATITIS” Campaign is currently under development.

Disease-specific strategic initiatives at the federal level included coordination on implementation of NHAS and collaborations with multiple HHS operating divisions on the Viral Hepatitis Action Plan (VHAP). Public-private partnerships included collaboration with the CDC Foundation on the National Viral Hepatitis Action Coalition, CDC’s Sexual Health Coalition, and the National Chlamydia Coalition’s launch of the web-based Chlamydia Resource Exchange.

Priority 5 is “global health protection and health systems.” A demonstration project was initiated to assess the feasibility of integrated antenatal services, including maternal syphilis testing. A collaboration was established with the CDC Division of Global HIV/AIDS to assess HIV incidence in Western Kenya to improve linkage to HIV care.

A collaboration was formed with the World Health Organization to implement a Global Youth Risk Behavior Surveillance System in developing countries. Leadership was provided on research that identified a screening approach to increase the diagnosis of TB in PLWH. Training on TB infection control was provided to >100 staff in India, Vietnam, Cambodia and Thailand.

Priority 6 is “workforce development and capacity building.” The “Coaching and Leadership” Initiative was piloted to build leadership, management, administrative and supervision skills of NCHHSTP team leaders. The first NCHHSTP speed-mentoring event was hosted with a theme of *Developing Leadership*. The “Federal Job Shadowing Day for Historically Black Colleges and Universities in Georgia” was held in March 2012. The “5<sup>th</sup> Annual NCHHSTP Summer Fellows Forum” was hosted with participation by >60 fellows.

NCHHSTP was extremely pleased with the outstanding contributions and coordination of federal partners across HHS and external stakeholders that resulted in the tremendous success of the XIX International AIDS Conference in July 2012. NCHHSTP’s strong role at the conference included leading or co-leading three sessions, presenting >50 poster sessions, and making 10 oral presentations and oral poster sessions that highlighted the syndemics of HIV with STDs, hepatitis and TB.

CDC’s media outreach efforts to support the conference produced 151 unique media stories and 1 billion media impressions. Overall, the conference provided an opportunity for HHS at the department level and CDC at the agency level to become involved in a new national conversation on HIV/AIDS.

At the division level, the NCHHSTP Division of HIV/AIDS Prevention (DHAP) awarded year 1 funds in January 2012 for the five-year health department CoAg. The awards were based on the geographic burden of HIV. The new “Let’s Stop HIV Together” Campaign was launched and featured PLWH, their friends and families to raise HIV awareness and promote an anti-stigma culture. The “Take Charge. Take the Test” Campaign aimed at African American women is included in this initiative.

DHAP used MAI funds from the HHS Secretary to award \$44.2 million under the three-year “Care and Prevention in the United States” (CAPUS) demonstration project to expand HIV prevention services for minority communities with a high prevalence of HIV. The project also will address social and structural drivers that influence the treatment cascade to produce a greater impact. DHAP is collaborating with HRSA to update guidelines on incorporating HIV prevention into medical care of PLWH and on post-exposure prophylaxis.

The NCHHSTP Division of Adolescent and School Health (DASH) recently released the new “Parent Engagement” resource to help schools to increase the engagement of parents in promoting positive health behaviors:

[www.cdc.gov/healthyouth/adolescenthealth/pdf/parent\\_engagement\\_factsheet.pdf](http://www.cdc.gov/healthyouth/adolescenthealth/pdf/parent_engagement_factsheet.pdf)).

DASH published an *MMWR* article, “HIV, Other STD and Pregnancy Prevention Education in Public School Secondary Schools-45 States, 2008-2010.” In terms of state trends in the percentage of secondary schools that taught all essential topics from 2008 to 2010, the article reported a decline in middle schools in 11 states, a decline in high schools in 1 state, and an increase in high schools in 2 states ([www.cdc.gov/mmwr/pdf/wk/mm6113.pdf](http://www.cdc.gov/mmwr/pdf/wk/mm6113.pdf)).

The NCHHSTP Division of Viral Hepatitis (DVH) issued new hepatitis C virus (HCV) screening guidelines in the August 17, 2012 edition of the *MMWR*. The guidelines recommended one-time hepatitis screening for all persons in the United States born in 1945-1965. The CDC Advisory Committee on Immunization Practices issued recommendations in the December 23, 2011 edition of the *MMWR* that supported hepatitis B virus (HBV) vaccination for adults with diabetes. DVH led the successful launch of the first “National Hepatitis Testing Day” that featured >100 testing events across the country to help identify and link infected persons to necessary treatment.

The NCHHSTP Division of STD Prevention (DSTDP) published revised guidance for treatment of gonorrhea in an August 2012 *MMWR* article. The purpose of the guidance was to respond to increased drug resistance and raise awareness of drug resistance. DSTDP conducted several activities to support STD Awareness Month, including participating in the GYT Campaign; launching a web page to educate physicians on discussing STDs and testing with their patients; and hosting the “STD Awareness” blog ([www.AIDS.gov](http://www.AIDS.gov)). DSTDP played a key role in launching the new Global Congenital Syphilis Partnership.



The NCHHSTP Division of Tuberculosis Elimination (DTBE) issued new recommendations in the *MMWR* on treating latent TB, "Use of an Isoniazid-Rifapentine Regimen with Direct Observation to Treat Latent *Mycobacterium tuberculosis* Infection." DTBE issued the *Reported Tuberculosis in the United States* publication that reported 10,528 new TB cases in the United States in 2010 and the 19<sup>th</sup> consecutive year of decline in new cases. DTBE launched a new TB website in Spanish.

Dr. Fenton concluded his update by confirming that the meeting would be bittersweet due to his departure from CDC as the NCHHSTP Director over the past seven years. However, he noted that his departure is timely because all of NCHHSTP's leadership positions currently are filled with permanent staff. NCHHSTP's most recent permanent appointments are Dr. Wayne Duffus (Associate Director for Health Equity) and Mr. Thomas Sukalac (Associate Director for Informatics).

Dr. Fenton emphasized that his role as the CHAC DFO would be one of the duties he would miss the most as the NCHHSTP Director. Over his seven-year tenure, CHAC's advice and support have been immensely helpful and played a critical part in strengthening the efficiency and effectiveness of his leadership role at CDC. CHAC also has given CDC critical and constructive input and valuable guidance on future directions. He thanked both the current and former CHAC members for their diligent efforts and tremendous contributions.

Ms. Dempsey and Dr. Marrazzo moderated CHAC's discussion with Drs. Parham Hopson and Fenton on the HRSA and CDC updates. The discussion topics included:

- the critical need to continue RWP in an ACA era based on outcomes in Massachusetts (e.g., a decrease in the number of new HIV infections and adherence to performance measures by CHCs);
- key priorities, activities and focus areas of the new NCHHSTP Director in the first two years of assuming this position;
- the need for additional investments by HHS agencies other than CDC and HRSA to truly integrate prevention and care/treatment in jurisdictions across the country;
- reasons for the minimal uptake of pre-exposure prophylaxis (PrEP) for HIV prevention despite CDC's evidence-based guidance and approval of PrEP by the Food and Drug Administration (FDA);
- interventions, information and programs (e.g., school-/out-of-school-based activities, social media campaigns and updated messages) to effectively reach children during their transition to youth/adolescents; address HIV prevention in new groups of young persons in a proactive and ongoing manner; and achieve the goal of an HIV-free generation;
- strategies to enhance coordination between state health departments and CHCs to improve testing and linkage to care/treatment for PLWH and newly diagnosed cases in jurisdictions across the country;

- HRSA's plans to allocate funds to rural states that have limited services and significant populations of PLWH not in care, but will opt-out of Medicaid expansion under ACA;
- CDC's engagement of the U.S. Department of Education, particularly for DASH activities and implementation of NHAS in collaboration with other federal agencies; and
- HAB's client-level data on the payer status and income breakdown of RWP clients to determine the future role of RWP and implications of ACA implementation, particularly for the underinsured patient population.

Drs. Parham Hopson and Fenton made several follow-up remarks in response to some of the topics CHAC raised during the discussion. In terms of priority issues for the new NCHHSTP Director in the first two years, attention should be given to three major areas. First, the momentum NCHHSTP has established over the past seven years under Dr. Fenton's leadership should be maintained. The focus should be placed on initiatives that have played a significant role in driving health impact and helping NCHHSTP to become more efficient and effective.

Second, syndemic and holistic approaches (e.g., PCSI, social/structural determinants of health, and a broad sexual health framework) that have been developed and promoted over the past seven years should be sustained over time. The new NCHHSTP Director should ensure that the divisions do not return to the historical approach of operating independently in silos.

In addition to the disease itself, individuals with the disease along with their families and communities also should be considered in all NCHHSTP activities. Moreover, the new CAPUS initiative should be widely promoted to help NCHHSTP advance from considering syndemics and social/structural determinants of health as theories to actually incorporating these issues into prevention programming.

Third, NCHHSTP should continue to leverage opportunities under new and existing policies of the Administration (e.g., ACA and NHAS). NCHHSTP should conduct environmental scans and immediately take action on these initiatives.

In terms of truly integrating prevention and care/treatment, the federal partners have engaged in extensive discussions on the possibility of deploying CDC staff to HRSA and HRSA staff to CDC. This approach would allow CDC and HRSA to share information in a more efficient manner and become more knowledgeable of the organizational culture of the other agency. However, efforts to identify CDC staff with a willingness to relocate to the Washington, DC area and HRSA staff with a willingness to relocate to Atlanta have been difficult. In the interim, CDC and HRSA will continue to participate on joint workgroups and collaborate on other activities, but the agencies welcome input from CHAC on additional ideas to make further progress in this area.

The integration of public health and primary care continues to be an extremely important issue for both CDC and HRSA. However, CHCs increasingly are overwhelmed and overburdened by meeting the diverse needs of their clients: infectious diseases (e.g., HIV, STDs and viral

hepatitis); chronic diseases (e.g., obesity, physical exercise and nutrition); and other needs (e.g., mental health, substance abuse, homelessness and sexual identity).

Due to the competing priorities of CHCs, CDC and HRSA have identified four action steps to emphasize the importance of integrating public health and primary care to achieve a greater impact on infectious diseases. First, specific components in an “integrated relationship” for HIV, STDs and viral hepatitis should be clearly defined and streamlined for CHCs. Second, funding should be allocated to CHCs to replicate best/promising practices and lessons learned in integration.

Third, training resources should be provided for CHCs to learn more about the cultures, business practices and standard operating procedures of both public health and primary care. Fourth, CHCs should be funded to conduct demonstration projects to gather data on public health/primary care integration.

In terms of strategies to more effectively reach youth, NCHHSTP will develop and implement a cross-center strategic plan for youth HIV/STD prevention and sexual health in FY2013 based on recommendations from the External Expert Review that was held in March 2012. In this effort, a “life course” approach will be taken to determine the aging process of the youth cohort over time and the impact of NCHHSTP’s sexual health and HIV/STD prevention activities on youth. Results from the initiative will be used to coordinate activities, fill gaps, and identify opportunities in this area as the youth cohort ages.

CHAC was extremely impressed by the high level of productivity of CDC and HRSA over the past six months, including their individual activities and joint efforts as federal partners. Several members particularly thanked HAB for its tremendous outreach in hosting four regional listening sessions for communities and stakeholders to provide input on RWP reauthorization.

CHAC made a number of comments and suggestions for CDC and HRSA to consider in their ongoing efforts to further advance HIV, viral hepatitis and STD prevention and treatment.

- CDC and HRSA should explore the possibility of including language in FOAs that would require applicants to demonstrate coordination and collaboration between prevention and care/treatment as a condition of funding.
- CDC and HRSA should elevate discussions on the uptake of PrEP from an agency level to a higher departmental level at HHS. If CDC has no funds to support implementation of PrEP, for example, HHS could direct HRSA to conduct a demonstration of project of PrEP based on its mandate to focus on HIV-infected persons through RWP grantees.
- An integrated prevention package that includes PrEP and ART should be developed for specific populations and widely marketed to providers.
- CDC’s recent publication on HIV diagnoses among MSM by metropolitan statistical area (MSA) reported that 10 MSAs account for >50% of all new HIV infections in the country. These data should be used to further promote integration in all jurisdictions and mobilize

resources across the federal government to reach this disproportionately impacted population.

- CHAC and PACHA should issue a joint statement to emphasize that one of the most important areas of focus for the new NCHHSTP Director should be to formally institutionalize SDH in FOAs and other activities to ensure this framework is sustained over time.

## Overview of the Impact of the Affordable Care Act on HRSA/HAB

### Rebecca Slifkin, PhD

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

#### Advice Requested from CHAC by HRSA:

- What are the main issues of concern around ACA implementation that need to be addressed?
- What are the critical lessons learned from states that already have expanded insurance coverage?
- What technical assistance will RWP providers need to be able to participate in both Medicaid expansions and plans on the exchanges? Do all providers have the necessary billing systems established for private insurance? What capacity issues exist? What are the anticipated issues with provider contracting?
- What strategies can be implemented to reach and enroll eligible RWP populations and PLWHA in insurance? What approaches can be applied to specifically reach homeless populations?
- How can HRSA coordinate with CDC to ensure that new cases are directed both to care and insurance coverage?
- How can CHAC members serve as vehicles for delivery of outreach and enrollment activities and materials?
- What resources do CHAC members need in terms of educational/outreach materials and training to facilitate enrollment?

Dr. Slifkin presented an overview of the impact of ACA on RWP and PLWHA. ACA will dramatically increase health insurance coverage for PLWHA due to several changes. Insurers will be prohibited from discriminating against persons with preexisting conditions. States will have an option to expand Medicaid coverage to all U.S. citizens and legal residents who have lived in the United States for at least five years up to 133% of the Federal Poverty Level (FPL).

Medicaid matching funds to states by the federal government will be 100% in years 1-2 of ACA and 90% thereafter. However, states that elect not to expand Medicaid coverage to the full 133% will not be eligible for the 100% federal match. These states will continue to receive their

regular federal matching rate. Decisions on whether and when to implement Medicaid expansions will be at the discretion of each state.

Health Insurance Exchanges (HIEs) will be available for persons with incomes that are too high for Medicaid expansions. These persons will be able to purchase affordable private insurance, but low-income persons can apply for federal assistance for their HIE insurance premiums up to 400% of the FPL and HIE co-payments/deductibles up to 250% of the FPL. This change will affect the extent to which AIDS Drug Assistance Program (ADAP) funds can be used for financial assistance for insurance premiums.

States that plan to independently operate HIEs must submit their applications to CMS by December 14, 2012. States that plan to jointly operate HIEs with the federal government must submit their applications to CMS by mid-February 2013. The federal government will operate HIEs for states that do not submit applications in either of these two categories. HIE coverage will be initiated on January 1, 2014, but HIE enrollment will begin in October 2013.

HRSA is aware that multiple sources must be engaged to address diverse and complex issues related to ACA, including HHS and HRSA bureaus at the federal level, states and external stakeholders. In support of this effort, HAB convened stakeholder meetings with RWP grantees and HRSA is continuing to communicate with state partners to gather and analyze information and identify potentially problematic areas.

HRSA is compiling lessons learned and experiences related to state Medicaid expansions that were implemented by California, Colorado and Massachusetts. HRSA is reviewing CMS's draft ACA regulations and is using these opportunities to propose revisions based on its statutory requirements. Based on its analyses to date, HRSA has identified a number of areas that will need legal decisions or policy guidance to ensure that RWP is closely aligned with ACA. These issues include continuity of care, access to providers with experience in treating PLWHA, and available resources for providers to enroll clients in ACA.

HRSA recognizes that extensive outreach will be needed for RWP clients to understand their eligibility status and options to enroll in ACA and for RWP providers to deliver care and treatment in accordance with HRSA's payer of last resort requirements. CMS recently announced that HHS will collaborate with states and other stakeholders in developing an outreach strategy for consumers. The components of the strategy will include a navigator program and additional assistance through face-to-face sessions, call centers and Internet resources.

CMS will begin disseminating ACA outreach materials by the end of January 2013, but HRSA also will distribute information on ACA specifically for its target populations. HRSA has taken steps to ensure that its future ACA materials will be distributed in concert with CMS materials to avoid dissemination of conflicting information. Most notably, HRSA serves on the HHS-wide

ACA Communication Workgroup and regularly meets with the CMS Office of Communication to discuss communication strategies and the delivery of common messages.

HRSA's key priority at this time is to offer tools, technical assistance, resources and other necessary support to providers to have a strong voice in ACA implementation and develop contracts with Medicaid expansions and HIE providers, and other guidance to encourage providers to develop contracts that will help RWP clients continue care and treatment with their existing providers in local jurisdictions.

HRSA's other major focus area at this time is access to prescription drugs. All Medicaid expansions and HIE plans will be required to cover prescription drugs. This issue has not been fully resolved in ACA to date, but HRSA still will be required to ensure that RWP clients are "medically whole." HRSA is continuing to collaborate with CMS on coordinating ADAP in an ACA environment and addressing potential changes that could occur with Medicaid expansions.

Ms. Dempsey moderated CHAC's discussion with Dr. Slifkin on the impact of ACA on RWP and PLWHA. The discussion topics included:

- the need for HRSA to provide RWP grantees with clear language and guidance on the ACA regulation related to "Essential Community Providers" (ECPs);
- the need for HRSA to review best practices and models to directly engage, educate and empower PLWH in its ACA implementation activities; and
- incomes outside of the ACA regulations: (1) low-income PLWH who still will not be eligible for Medicaid under the expansions and (2) PLWH outside of the Medicaid expansion threshold who will be unable to afford HIE insurance premiums.

CHAC made several comments and suggestions for HRSA to consider in its ongoing efforts to provide guidance to grantees on the impact of ACA on RWP and PLWHA.

- HRSA's plan to provide RWP grantees with experiences and lessons learned from state Medicaid expansions is a sound approach. The following guidance should be provided to RWP clinics and providers based on the California model:
  - complete the process to become a Federally Qualified Health Center (FQHC);
  - complete the process to register with local Medicaid managed programs as a primary care provider (PCP) or specialist;
  - complete the process to register with the 340B Drug Pricing Program at the HRSA Office of Pharmacy Affairs;
  - make efforts to replicate and/or link to chronic disease programs until payment reform with team-based care and patient-centered medical homes (PCMHs) is fully implemented and reimbursed nationally; and
  - responsibly share data with other state programs on HIV-infected patients, including ADAP data, to avoid interruption in treatment.

- HRSA and CMS should allocate funding at this time to build the capacity of academic centers in serving as the national infrastructure to recruit and train the next generation of HIV providers. This initiative would help to assure retention of the PCMH model for HIV care that was established by RWP.
- Efforts by the federal government to disseminate ACA information have been difficult and time-consuming to date due to the complexity, regulatory burden and overall magnitude of this issue. However, the agencies should take advantage of existing social media platforms and other communication systems to rapidly deliver basic information to RWP grantees and PLWH. Although federal agencies can only distribute materials that have undergone the formal clearance and approval process, factual messages in laymen's terms can be delivered in the interim to alleviate the fears of PLWH and the general public. The agencies should engage CHAC members and other stakeholders in a grassroots effort to develop and launch a general information campaign with basic messages that would be easily understood by the public (e.g., "ACA prohibits insurers from discriminating against you if you have a preexisting condition." "Here are 10 reasons why ACA is important to you."). The federal agencies also should establish a toll-free hotline for the public as a companion to the general information campaign. Moreover, journalists should be engaged to convey key ACA messages through the media.

Dr. Slifkin appreciated CHAC's in-depth discussion on the impact of ACA on RWP and PLWHA, but she noted that the comments and suggestions did not directly respond to HRSA's request for advice. She asked the members to review the questions HRSA posed to CHAC and provide more focused feedback, particularly in the context of best practices, lessons learned and experiences that could be applied to ACA implementation. She confirmed that the list of "ACA Frequently Asked Questions" HHS released on the previous day would be circulated to CHAC as a resource in responding to the questions.

Dr. Rima Khabbaz joined the meeting and announced that she would begin serving as the Acting Director of NCHHSTP on January 2, 2013. During her acting role over the next few months, she looked forward to collaborating with NCHHSTP leadership and CHAC to ensure that the solid strategic direction Dr. Fenton established was maintained. She confirmed that NCHHSTP's leadership and participation in national strategies and its momentum of various programs, activities and efforts across CDC would be sustained and advanced.

Dr. Khabbaz emphasized that the national search to identify and officially appoint the new NCHHSTP Director in a timely manner is one of CDC's key priorities. CDC is extremely pleased that Dr. Marrazzo agreed to serve on the search committee to ensure CHAC's voice is heard in these deliberations. Because CDC has fast-tracked the search process, Dr. Khabbaz encouraged the CHAC members to submit names of potential candidates with the necessary skills, expertise and qualities to serve as the next NCHHSTP Director. She noted that CDC expects to post the position announcement in January 2013.

## Overview of Ryan White HIV/AIDS Program Client-Level Data

### **Deborah Isenberg, MPH, CHES**

Chief, Data Management Branch, Division of Science and Policy/HAB  
Health Resources and Services Administration

### **Faye Malitz, MS**

Senior Data Advisor, Division of Science and Policy/HAB  
Health Resources and Services Administration

#### **Advice Requested from CHAC by HAB:**

- What is CHAC's input on analytic priorities for RWP client-level data?

Ms. Isenberg and Ms. Malitz presented an overview of the preliminary 2010 Ryan White Services Report (RSR) client-level data. Outpatient ambulatory medical care (OAMC), medical case management (MCM) and non-medical case management (CM) funded providers were required to report client-level data for the first time in 2009. This requirement was expanded to include all RWP-funded providers in 2010. The Ryan White Data Report (RDR), which collected aggregate data from funded providers, was retired in 2010.

The client-level file should contain one record for each client who received an RWP-funded service during the reporting period. Each client record must include the client's encrypted unique client identifier (eUCI). Each record may include up to 66 data elements that are grouped into three sections: demographic information, RWP-funded services and clinical information.

The RSR data management process is completed within 12-18 months and includes six steps. Step 1 begins with raw data files. In 2010, these files accounted for a total of 802,173 duplicated records. Step 2 is the first data cleaning process to remove records that should not have been reported (e.g., clients who did not receive an RWP-funded service or did not meet other parameters). Step 3 is the de-duplication process. This probabilistic record linking approach is used to identify records that are considered matches (the same client). The approach was vetted and validated by an external panel.

Step 4 is the merging of data into a single record after identifying clients who are matches. Step 5 is the second data cleaning process. Step 6 is the development of analytic files to be used to conduct analysis, create reports and respond to data requests. The data management process results in one merged record per client. The total number of clients receiving at least one Ryan White funded service is considered to be a point estimate with an upper and lower bound. The upper bound requires all demographic variables that are used for matching to be the same to be considered the same client, while the lower bound uses the eUCI only.



In CY 2010, an estimated 546,156 clients received at least one Ryan White funded service. HRSA acknowledges several limitations of the new RSR dataset that need to be considered as the data are being reviewed. The data analyses are preliminary and are not considered to be mature at this time. Data quality issues, such as a high number of missing and unknown rates for several demographic and clinical variables, likely are impacting data. Finally, the RSR dataset captures data reported by grantees, but may not fully reflect the quality of care provided at RWP-funded sites.

### **Demographics**

The first data that were presented were demographics. HRSA noted that different demographic reporting requirements result in different denominators for analyses. For example, all grantees must report the birth year, race, ethnicity and gender of each client regardless of the services received. All grantees also must report the transgender status of each client who self-identifies as “transgender.” The following variables must be reported for clients who receive OAMC, MCM or CM services: the first service date, enrollment status and data of death if applicable, poverty level, geographic unit code, HIV risk factors, HIV/AIDS status, and AIDS diagnosis. Housing status must be reported for clients who receive OAMC, MCM, CM or housing services. Medical insurance must be reported for clients who receive any core medical service or CM service.

The preliminary 2010 RSR data are summarized and exclude missing or unknown data. Of the estimated 546,156 clients who received at least one RWP-funded service in CY 2010, 68.5% of RWP clients were male, 30.7% were female and <1% were transgender. By race/ethnicity, 47.3% of RWP clients were Black non-Hispanic, 27.7% were White non-Hispanic, and 22.3% were Hispanic. Women were represented at higher levels among racial/ ethnic minorities than men (e.g., 40% Black non-Hispanic and 28% Hispanic compared to 18% White non-Hispanic).

By age, 1 in 3 RWP clients were 40-49 years of age, 24% were 50-59 years of age, 19% were 30-39 years of age, and 9% were in the 24 and under age group. Medicaid was the most frequent payer source reported (27.5%) followed by no insurance (25.5%); multiple payer sources can be reported with the exception of no insurance which is reported only for clients who were uninsured for the entire 12-month reporting period. Some, 84.2% of RWP clients were stably housed. Two-thirds of RWP clients reported an annual household income of ≤100% of the federal poverty level (FPL) and 22% reported 101%-200% of the FPL.

## **Services**

RWP Parts A, B and C grantees are required to allocate 75% of their funding to provide core medical services and the remaining 25% to provide support services to clients. Providers must report clients who receive core medical services by number of visits and quarter with the exception of local Pharmacy Assistance Programs and the Health Insurance Program. These programs follow support service reporting rules. Clients are only allowed one visit/per day/per service. Means and medians are shown to identify outliers in the data. Providers must report clients who receive support services by quarter.

For core medical services, 309,642 clients received at least one OAMC visit in 2010 and represented 57% of all clients who received any RWP-funded service. These clients accounted for ~1.8 million visits. The 283,876 clients who received at least one MCM visit in 2010 accounted for ~2.9 million visits. Oral health care (83,333 clients accounting for 291,209 visits) and mental health care (72,756 clients accounting for 477,347 visits) were the third and fourth most frequently provided services.

Home health care (1,617 clients), home/community-based health care (1,698 clients) and hospice care (178 clients) collectively accounted for a small number of clients served, but the 69,135 total visits are indicative of clients with more serious disease or illness. HRSA is providing technical assistance to ensure that grantees report core medical services in the same manner.

For support services, 25.4% of clients received case management services, 13.2% received transportation services, 12.8% received health education and risk reduction services and 11.4% received psychosocial support services. Eleven percent of clients received food bank/home delivered meals, while 9.5% received treatment adherence counseling outside of a medical or medical case management visit.

## **Clinical Information**

In terms of clinical information, HRSA reviews different variables to assess the quality of care delivered by RWP medical care providers and calculate performance measures. The clinical data represent all activities regardless of payer source; however, given high missing/unknown rates for many for these variables, the data reported may not fully reflect the quality of care provided at RWP-funded sites. Providers reported clinical information for all clients who were HIV-positive and received at least one RWP-funded OAMC visit. The total number of clients was 307,562 after excluding those with an HIV indeterminate status from the analysis.

Some 87.8 % of clients had at least two medical care visits in 2010; 33.7% had 5-9 visits and 13.4% had greater than 10 visits. Of clients for whom a viral load was reported, 76.2% received at least 2 viral loads during the reporting period. Missing data from the RSR dataset included medical care visit dates for 16,113 clients, CD4 counts for 48,658 clients and viral loads for 57,218 clients. HRSA will continue to provide technical assistance to grantees to improve reporting of these data to more accurately determine the quality of care provided to clients.

During the 2010 reporting period, 62% of clients received risk screening, 54% of clients received mental health screening, and 54% received substance abuse screening. TB, HBV and HCV screening are collected in two ways in the RSR: whether the client was screened during the reporting period and, among clients for whom no or not medically indicated was reported, whether the client was screened since receiving an HIV diagnosis. During the reporting period, clients received screening for TB (41%), HBV (30%) and HCV (33%); among clients for whom “no” or “not medically indicated” was reported for screening in CY 2010, an additional 47% were screened for TB, 57% for HBV and 62% for HCV. In future report periods, HRSA intends to only collect if the client was ever screened since HIV diagnosis. Nearly 80% of clients received highly active ART and 66% of clients were screened for syphilis at any time during the reporting period.

HRSA's next steps will be to conduct additional analyses with the 2010 RSR data and complete processing of the 2011 RSR data. Data management processes will be refined as needed. Technical assistance will continue to be provided to grantees to improve the quality of data reported for the RSR dataset. Best practices among grantees in reporting RSR data will be compiled and disseminated. The HAB data analysis plan will be revised as needed to distribute multiple RSR data products in the first 3-6 months of 2013.

Dr. Marrazzo moderated CHAC's discussion with Ms. Isenberg and Ms. Malitz on the preliminary 2010 RSR dataset. The discussion topics included:

- HRSA's ability to compare the RSR dataset with data from HIVQUAL and other RWP-funded programs;
- HRSA's plans to address budgets of RWP-funded providers to support more complete entry of data into the RSR dataset;
- HRSA's plans to collect data on racial/ethnic groups other than NHBs, NHWs and Hispanics (e.g., Native Americans and Asian/Pacific Islanders) that receive RWP-funded services;
- HRSA's intention to reanalyze the RSR dataset to determine the insurance status of clients who receive support services;
- the role of gender in utilization of RWP-funded services, particularly since minority women were represented at higher levels than men in the RSR dataset;
- the role of treatment adherence in case management;
- HRSA's ability to analyze RSR data to determine the gap between the number of clients who received medical care and CM;
- time and costs RWP grantees need to devote to data collection for the RSR dataset;
- web-based access to RSR data by RWP grantees and their funded providers; and
- the role of the RSR dataset in addressing the mandate for all HHS-funded HIV programs to develop core measures for the collection of uniform data on adverse outcomes.

CHAC congratulated HRSA on its longstanding efforts to produce the preliminary 2010 RSR dataset. The members emphasized that RWP client-level data are extremely important to grantees in order to improve the quality of care and gain more knowledge of clients served at sites.

CHAC's comments and suggestions for HRSA to consider in refining the preliminary 2010 RSR dataset and completing analyses of the 2011 RSR data are outlined below.

- HRSA should analyze the RSR data to be more granular, useful and informative in an ACA environment. Additional data analysis should include the number and types of services utilized per client and across various age groups and specific RWP-funded services that will not be covered by Medicaid/Medicare. These types of data analyses would be extremely helpful for program planning at the clinic level.
- HRSA should explore methods to develop an accurate proxy measure or an appropriate indicator for "family health" in the RSR dataset. In this effort, HRSA should analyze utilization of specific RWP-funded services (e.g., child care and pediatric development services).
- HRSA should modify the data elements in future RSR datasets to specifically collect data on clients who self-identify as "gay" and clearly delineate and distinguish between "identity" and "risk behaviors." This information will be extremely important in guiding further implementation of NHAS and health disparities initiatives.
- HRSA should attempt to limit the number of RSR data elements to those that are most important and easiest to extract from electronic medical records (EMRs). This approach would improve the quality of data without increasing the data collection burden on RWP grantees.
- HRSA should take steps to enhance the accuracy of RSR data elements related to adverse events or those that are ready for interventions. For example, more emphasis should be directed to the HCV data elements due to important trends. Most notably, a considerable proportion of the HIV-infected population has HCV. MSM are presenting to STD clinics with incident HCV disease. Treatment options for HCV are continuing to increase.
- HRSA should explore the possibility of collecting data on family planning, contraception and other reproductive health services of RWP clients due to the large proportion of women at RWP-funded clinics.

Ms. Isenberg and Ms. Malitz clarified that HRSA has completed or currently is conducting some of the additional analyses suggested by CHAC. These analyses will be distributed after the preliminary 2010 RSR dataset is refined, finalized and cleared for release.

## Panel Presentation: Update on the CDC and HRSA Continuum of Care Activities

### Advice Requested from CHAC by CDC and HRSA:

- What are CHAC's general reflections on CDC's continuum of care data and differences between the CDC and HRSA surveillance systems?
- What programmatic and evaluation strategies should CDC and its federal partners prioritize in terms of implementation of CAPUS?
- What is CHAC's guidance for CDC to respond to recommendations from the Institute of Medicine (IOM) Report in terms of the Medical Monitoring Project (MMP)?
- What is CHAC's guidance regarding HRSA's next steps in addressing the HIV treatment cascade in the future?
- What is CHAC's guidance on improving HRSA's data systems to collect relevant data on the HIV treatment cascade?

### Amy Lansky, PhD

Deputy Director, Surveillance, Epidemiology and Laboratory Science/DHAP  
Centers for Disease Control and Prevention

Dr. Lansky provided an overview of CDC's continuum of HIV prevention and care activities in her portion of the panel presentation. CDC uses the total number of HIV-infected persons in the United States as the denominator for all categories in the continuum of care (e.g., persons with HIV who are diagnosed, linked to care, retained in care, on ART and virally suppressed).

CDC uses two data sources to calculate the continuum of care. The National HIV Surveillance System (NHSS) captures data on HIV prevalence (*i.e.*, the total number of persons infected and diagnosed with HIV) and persons who are linked to care. MMP captures data on persons who are retained in care, prescribed ART and have viral load suppression.

CDC collects HIV diagnosis data from 46 states and AIDS data from the District of Columbia and 4 other states. These data are adjusted to account for delays in reporting new cases and deaths, incomplete reporting of diagnosed cases, and missing data in the HIV transmission category. An extended back-calculation model is used to obtain the total prevalence in the United States. In the dataset, "prevalence" is equal to the cumulative number of HIV infections minus the cumulative number of deaths. "Undiagnosed prevalence" is equal to HIV prevalence minus the number of diagnosed HIV infections in living persons.

The most recent linkage to care data were reported to CDC by 14 jurisdictions that submitted complete laboratory test results to health departments through December 2011. CDC's surveillance definition of "linkage to care" is the percentage of persons with  $\geq 1$  CD4 or viral load test results within three months of their diagnosis. This dataset reflects persons  $\geq 13$  years of age diagnosed with HIV in 2010.

MMP is a complex cross-sectional survey sample that is conducted in three stages. In stage 1, 17 states/territories are sampled from all 50 U.S. states, the District of Columbia and Puerto Rico. The sample represents 76% of all persons diagnosed with HIV in the United States. In stage 2, outpatient HIV care facilities are sampled within the 17 states/territories. In stage 3, a sample is taken from HIV-infected adults who received medical care in the sampled facilities in the time period of January-April.

The MMP data collection process includes medical record abstraction to document clinical care, interviews to obtain self-reported demographic characteristics, and linkages to NHSS. Retention in care is determined by the number of HIV-infected adults who had at least one medical care visit in January-April. Prescription of ART is determined by documentation in the medical record abstraction of any ART prescription in the past 12 months. Viral suppression is determined by documentation in the medical record abstraction of the most recent viral load that is undetectable or  $\leq 200$  copies/mL.

The results of CDC's most recent continuum of care data are summarized as follows. The HIV prevalence in 2009 was ~1.1 million persons. By total population, 82% were diagnosed, 66% were linked to care, 37% were retained in care, 33% were prescribed ART, and 25% were virally suppressed. By gender, females had slightly higher rates in most stages in the continuum of care compared to males, but the rate of viral suppression was basically the same for females (26%) and males (25%).

By race/ethnicity, NHBs and Hispanics had lower rates in all stages in the continuum of care compared to NHWs. Compared to NHWs, lower rates of NHBs were linked to care, retained in care, on ART and virally suppressed. The rates of most stages in the continuum of care were relatively comparable between Hispanics and NHWs, but a stark difference was seen in viral suppression (e.g., 26% in Hispanics versus 30% in NHWs).

By transmission category, male injection drug users (IDUs), female IDUs and MSM-IDUs accounted for the largest proportion of HIV diagnoses compared to MSM and heterosexual males and females. Female IDUs (28%), MSM (27%) and MSM-IDUs (26%) accounted for the top three highest rates of viral suppression compared to the other transmission groups.

By age, the younger age groups had lower rates of HIV diagnosis and linkages to care. The rate of viral suppression was highest in the 55-64 age group (36%) and lowest in the 25-34 age group (15%). Rates of HIV diagnoses and linkages to care were highest in and comparable among the 45-54, 55-64 and  $\geq 65$  age groups. Because MMP only captures data from adults  $\geq 18$  years of age, the continuum of care data in the 13-24 age group are limited to persons who are diagnosed with HIV and linked to care.

CDC acknowledges several limitations with its continuum of care data. The dataset represents linkage to care data from only 14 states. Retention in care may be underestimated because the

data are based on visits from January to April only. Experiences in care most likely are different for persons in the younger age group of  $\leq 18$  years. The samples are too small to capture data on racial/ethnic groups other than NHBs, NHWs and Hispanics. Implementation of treatment guidelines in the future is expected to result in changes in the continuum of care.

Overall, CDC's continuum of care data showed that 75% of persons diagnosed with HIV do not have a suppressed viral load. HIV diagnosis and care are critical for all age groups. Additional efforts are needed to provide all PLWH with optimal HIV care, reduce disparities and ultimately decrease HIV transmission.

In terms of prevention activities related to the continuum of care, CDC currently is funding the HIV Surveillance CoAg, Health Department HIV Prevention CoAg, and CAPUS demonstration project. CDC also has drafted prevention recommendations for adults and adolescents with HIV in the United States, in collaboration with HRSA and other partners.

CDC is the lead federal agency for CAPUS, but the demonstration project is being conducted in close collaboration with HHS and HRSA operating divisions and SAMHSA. Of 18 jurisdictions that were eligible for CAPUS funding based on burden of disease, disparities and level of SDH, awards were made to health departments in 8 states: Georgia, Illinois, Louisiana, Mississippi, Missouri, North Carolina, Tennessee and Virginia.

CAPUS was designed to achieve two major goals. First, the proportion of racial/ethnic minorities with a diagnosed HIV infection will be increased by expanding and improving testing capacity. Second, linkage to and retention in care will be optimized and newly/previously diagnosed racial/ethnic minorities with HIV will be reengaged in prevention and care services. To achieve these goals, social, economic and structural barriers to HIV testing, linkage to and retention in care, and reengagement in prevention and care services will be addressed in racial/ethnic minorities.

All 8 CAPUS grantees are required to create work plans with four mandatory components and allocate 25% of their funds to CBOs to support the development of human capital, partnerships, skills and infrastructure. The four mandatory components of the CAPUS framework are:

- use of surveillance data and data systems to improve care and prevention;
- provision of HIV testing, linkage to, retention in, and reengagement in prevention, care and treatment;
- provision of navigation services; and
- strategies to address social and structural factors that directly affect HIV testing, linkage to, retention in, and reengagement in prevention, care and treatment.

CAPUS grantees also are allowed to include supplemental and optional components or other approaches in their work plans. The combined activities will be designed to have the greatest

potential to address social/structural determinants that impede the identification of unknown HIV-positive racial/ethnic minorities and link, retain and reengage these persons in care.

The CAPUS project will complement CDC's prevention portfolio by specifically focusing on the continuum of care and improving the health of racial/ethnic minorities living with HIV in disproportionately affected jurisdictions. During the three-year demonstration project, the 8 CAPUS grantees will identify practical and workable solutions to minimize the impact of broader problems on HIV testing and care. These lessons learned will be broadly shared with other jurisdictions.

CDC reviewed findings and recommendations from two recent IOM reports that focused on the continuum of care and will have implications for MMP. For the first report, the IOM Committee was charged with (1) identifying core indicators and data elements for HIV care and supportive services to monitor the impact of NHAS and ACA on HIV care; (2) identifying the best sources of public and private data to assess core indicators; (3) identifying potential barriers to data collection; (4) discussing the role of HIT; and (5) addressing the analysis and dissemination of data.

For the second report, the IOM Committee was charged with exploring strategies to obtain nationally representative estimates that will characterize and monitor the impact of ACA on coverage and utilization of health care among PLWH in both public and private settings. The committee addressed three major questions to fulfill its charge.

1. What approaches can be taken to collect data from a nationally representative sample of PLWH in the United States to establish a baseline for health insurance and healthcare access prior to 2014?
2. If obtaining a nationally representative sample is not possible, do other alternatives exist (e.g., using multiple existing data sources or requiring a complete accounting of all HIV-positive persons in care) to collect data on care and utilization beyond clients enrolled in RWP?
3. What strategies can be implemented to continue to regularly obtain data from a large nationally representative or other sample of HIV-positive persons after 2014 to monitor the impact of ACA on health insurance and healthcare access?

The second report 2 contained the following recommendations that will impact MMP.

The White House Office of National AIDS Policy (ONAP) should use multiple existing data sources to establish a baseline for healthcare coverage and utilization prior to 2014. These data sources should include NHSS and MMP (CDC), RWP (HRSA), Medicaid/ Medicare (CMS), and datasets of other federal agencies, academic networks and private insurers.

CDC should improve MMP by 2015 to ensure higher response rates and increase the ability of samples to be nationally representative. ONAP and HHS should use the improved version of



MMP to obtain nationally representative data on the coverage and utilization of health care among PLWH.

HHS should convene a multidisciplinary task force to design improvements in MMP and ensure that this data source remains responsive to changes in the HIV epidemic and healthcare environment. ONAP and HHS should use data from Medicaid/Medicare, RWP and private insurers to monitor the impact of ACA on the coverage and utilization of health care at state and program levels.

The IOM Committee acknowledged that three major factors will impact the implementation of these recommendations. First, eligibility of healthcare coverage and access to care will vary among states because ACA provisions will not be uniformly implemented by all states. Second, MMP cannot be used for state-level analyses because persons in every state are not included in this nationally representative sample. Third, data from Medicaid/Medicare, RWP and private insurers will provide information on the effect of ACA at state and program levels, but not at the national level.

Overall, CDC's continuum of care data showed that an overwhelming 75% of ~1.1 million PLWH in the United States do not have a suppressed viral load. CDC is continuing to target its HIV prevention activities to testing and linkage to care, retention in care, treatment adherence, and enhanced use of surveillance data to measure progress along the continuum of care. However, significant disparities in HIV by race/ethnicity and age persist. CDC's next steps will be to respond to the IOM recommendation of using MMP to obtain national estimates to monitor the NHAS goal of improving health outcomes of PLWH.

**Rupali Doshi, MD, MS**

Medical Officer, Office of the Associate Administrator/HAB  
Health Resources and Services Administration

**Laura Cheever, MD, MS**

Deputy Associate Administrator, HIV/AIDS Bureau  
Health Resources and Services Administration

Drs. Doshi and Cheever provided an overview of HRSA's activities to address the HIV care continuum in their portion of the panel presentation. The 2007 Cheever publication, *HRSA Continuum of Engagement in HIV Care*, has been an instrumental resource for RWP clinics to focus on the full spectrum of PLWH, including persons who are not engaged, intermittently engaged or fully engaged in HIV primary medical care. The 2011 Mugavero, *et al.* framework provided additional guidance to enhance understanding of healthcare service delivery for PLWH.

HRSA's direct funding to RWP Parts A, B, C, D and F grantees addresses all areas of the HIV care and treatment continuum. HRSA also is continuing to fund SPNS Initiatives and research-

oriented demonstration projects to fill gaps in knowledge, identify cost-effective evidence-based interventions, and compile best practices in this area.

HRSA will award \$1 million annually over the project period of the “System Linkages” SPNS Initiative for state-level grantees to improve HIV diagnosis and linkage to care. Grantees will take a public health approach in this effort by using their surveillance data to engage diverse partners in identifying and linking persons to HIV to care. Most notably, grantees will implement a quality improvement “plan/do/study/act” model for rapid dissemination and testing of promising practices across the network.

HRSA’s SPNS Initiative for correctional settings was successful in reaching stationary PLWH in state prisons, but the ability to reach PLWH in local/county jails has been much more difficult due to the transient nature of this population. As a result, HRSA closely collaborated with CDC to develop a SPNS Initiative for HIV testing and reengagement of HIV-positive persons in care specifically for jail settings.

HRSA is funding a SPNS Initiative focusing on various uses of data to improve care for HIV patients. For example, the Louisiana grantee has been successful in engaging all parts of the hospital system in the state to flag and report data on PLWH who need to be reengaged in care. HRSA is allocating MAI funds from the HHS Secretary to replicate the Louisiana model in other jurisdictions. HRSA is funding an initiative to determine whether opiate replacement therapy can help PLWH to stabilize their lives and engage in care through primary care settings.

Despite these initiatives, HRSA recognizes that more data are needed to effectively reach special populations with a disproportionate impact of HIV and improve their quality of care. For young MSM of color, for example, HRSA is partnering with the Adolescent Treatment Network (ATN) to rapidly distribute their best practices to RWP grantees and provide ATN with access to RWP clients.

Quality management is a key component of the RWP legislation that addresses all aspects of the care continuum. Most notably, HRSA awarded a five-year cooperative agreement to the New York State AIDS Institute to provide quality management training and technical assistance to RWP grantees through NQC. This initiative focuses on retention in care through the In+Care Campaign and has engaged >500 providers who deliver care to >400,000 patients. The cooperative agreement represents a successful collaborative model among HRSA, NQC and providers in identifying best practices of retention in care and testing new quality measures.

The HHS Secretary recently publicized 7 measures for HHS-funded HIV activities that should be aligned and coordinated among federal agencies. These measures are consistent with the NHAS and National Quality Strategy goals. At this time, NQC is considering whether to endorse 4 of HRSA’s 7 proposed measures. HRSA also is collaborating with CMS on implementation of the measures in EMRs through the Meaningful Use Program.

HRSA is continuing to conduct activities to address its mandate to develop quality measures. Several of HRSA's performance measures directly focus on the HIV care continuum. Most notably, efforts are underway at HRSA and CDC to obtain national endorsement from NQF on a number of HIV care measures, including indicators for retention in care, ART and viral load suppression.

HRSA has analyzed RWP data to better understand the continuum of care. HRSA's sources for primary and secondary client-level data and aggregate data include the RSR dataset, ADAP report, HAB performance measures, and In+Care Campaign database. RSR data showed that 546,156 clients received RWP-funded services in 2010. HRSA's denominator in these analyses was based on CDC's estimate of 940,000 persons with a known HIV-positive diagnosis in the United States at the end of 2009. Of these persons, ~58% received an RWP-funded service in 2010. However, the numerator includes persons with an unknown HIV status and persons who might be HIV-negative, but are eligible for RWP-funded services.

The RSR dataset only captures the HIV status of clients who received OAMC, MCM and CM services. The number of HIV-positive clients who had a medical care visit or CM visit was 429,000. This figure accounted for 79% of clients who accessed RWP-funded services in 2010. The number of clients who had at least one medical care visit was ~307,000. This figure accounted for 72% of clients who were known to be HIV-positive. "Retention in care" was defined by the HAB performance measure of clients who had two visits separated by at least 90 days. The percentage of HIV-positive RWP clients who were retained in care was 72%. The remaining 28% of clients had at least one medical care visit, but were not retained in care.

Of uninsured HIV-positive RWP clients, 85,000 (or 83%) had at least one medical care visit and 17% had no medical care visits. The number of RWP clients who had at least one visit and received an ART prescription at any point during the reporting period was 208,000 (or 68%). The number of RWP clients with viral load suppression who had at least one medical care visit was 174,000 (or 57%). The number of RWP clients who received ART and had viral load suppression was 145,000 (or 69%). In the larger population of HIV-positive RWP clients who had a medical care or CM visit, 41% had an undetectable viral load.

Ms. Dempsey moderated CHAC's discussion with Drs. Lansky, Cheever and Doshi on the CDC and HRSA continuum of care activities. The discussion topics included:

- potential errors or underestimates in the CDC and HRSA datasets on the percentage of persons in care due to the migration of patients from RWP clinics to private practices or care systems in other states;
- geographic variations in the treatment cascade and the impact on population health in states with the best treatment cascade; and
- persistent problems in the treatment cascade with specific subgroups, particularly ongoing increases in HIV among gay/bisexual men and minorities.

CHAC made several comments and suggestions for CDC and HRSA to consider in enhancing their continuum of care datasets.

- Most of the continuum of care projects focus on HIV testing and linkage to care, but additional resources should be allocated to retention in care to dramatically improve outcomes.
- CDC and HRSA should make efforts to collect continuum of care data by region to better understand geographic differences in the treatment cascade and more effectively target interventions.
- CDC and HRSA should place stronger emphasis on targeting prevention services to HIV-uninfected persons.
- HRSA should conduct intensive case management to determine reasons for diagnosing HIV cases with CD4 counts <50 copies/mL. The diagnosis of HIV-infected persons with CD4 counts <200 copies/mL should be viewed as a sentinel event. A major goal of RWP clinics should be to increase the CD4 counts at which persons are diagnosed with HIV.
- The IOM committee recommended that HHS convene a multidisciplinary task force to design improvements in MMP. The HHS Office of HIV/AIDS and Infectious Disease Policy is developing indicators across the HIV system at this time and should be extensively engaged in the task force.
- CDC and HRSA should explore the possibility of releasing a joint FOA for the development of a new and innovative treatment cascade to achieve a greater impact on retaining hard-to-reach populations in care (e.g., African American MSM). The treatment cascade should be designed with multiple medical services and social services that are attractive to and needed by these subgroups, including job training and education. Grantees of the joint CDC/HRSA FOA could pilot the innovative treatment cascade in select communities across the country.
- CDC and HRSA should track the actual experiences of PLWH, particularly their barriers to care (e.g., income, transportation needs, employment status, availability of health care and psychological issues). This type of information would help to enrich the CDC and HRSA continuum of care datasets.
- CDC and HRSA should place more emphasis on providing education and accurate information to PLWH regarding the benefits of remaining in care. PLWH often are informed of the negative aspects of care and are fearful of remaining in care.

### **Panel Presentation: Update on National Viral Hepatitis Activities**

#### **Ronald Valdiserri, MD, MPH**

Deputy Assistant Secretary for Health, Infectious Diseases Director  
Office of HIV/AIDS and Infectious Disease Policy  
U.S. Department of Health and Human Services

**Advice Requested from CHAC by HRSA:**

- How should HRSA and CDC coordinate messaging for HIV and HCV testing in light of the USPSTF draft guidelines?
- What is CHAC's guidance regarding ideal audiences and modes of dissemination of the SPNS findings?
- What are CHAC's suggestions regarding sustainability of telemedicine systems for ongoing technical assistance and clinical capacity building in RWP-funded clinics?
- What is CHAC's feedback on the applicability of clinic delivery models in an HCV mono-infected population?

Dr. Valdiserri covered the VHAP implementation plan in his portion of the panel presentation. IOM issued the 2010 *Hepatitis and Liver Cancer* report that characterized viral hepatitis (VH) as a “silent epidemic” in the United States. The report further concluded that healthcare providers, patients and consumers have limited knowledge of VH, its diagnosis and available treatment options. In response to the IOM report, Dr. Howard Koh, the HHS Assistant Secretary for Health, convened an interagency workgroup to develop VHAP as the first comprehensive strategic VH action plan for the nation.

The HHS workgroup compiled key findings of the IOM report to outline specific action steps and recommendations for VHAP based on six priority areas:

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

The HHS workgroup proposed four major VHAP goals to specifically focus on the U.S. population of ~3-5 million persons with chronic HBV and/or HCV infection. By 2020, increase the proportion of persons who are aware of their HBV infection from 33% to 66%. By 2020, increase the proportion of persons who are aware of their HCV infection from 45% to 66%. By 2020, reduce the number of new HCV infections by 25%. By 2020, eliminate mother-to-child HBV transmission.

HHS's position is that the VHAP goals are achievable with full implementation and meaningful support at the national level, but new funding was not allocated for program activities. However, HHS is leveraging existing resources across its federal agencies to the extent possible to achieve the VHAP goals.

VHAP has led to several important changes to date. Most notably, the national conversation and profile of VH were raised to educate providers, consumers and the private sector about the magnitude and scope of this epidemic in the United States. Clear priorities were established and a strong rationale was provided to improve and stimulate cross-agency coordination and collaboration. A measure of accountability was provided and opportunities were identified to highlight unmet needs in VH.

Following the release of VHAP, Dr. Koh directed the HHS agencies and relevant offices to designate subject-matter experts to serve on the Viral Hepatitis Implementation Group (VHIG). However, federal partners and entities outside of HHS also are represented on VHIG: Federal Bureau of Prisons, Department of Veterans Affairs (VA), and White House Initiative on Asian Americans and Pacific Islanders. The overarching role of VHIG is to identify opportunities to leverage existing resources, establish priorities and advance policy.

HHS awarded a contract to Battelle to evaluate the impact of VHAP to date at state, local and community levels. At the federal level, several of the 142 VHAP action steps for 2011-2012 have been completed or are underway in the six priority areas, but some initiatives have not been initiated due to the lack of resources. Key examples of coordination across the HHS agencies are highlighted below.

An inventory was created with both federal and non-federal educational materials to maintain and distribute VH information from multiple sources through the CDC National Prevention Information Network. For Hepatitis Awareness Month in May, 10 blogs were hosted; the VH risk assessment tool was launched; the first “National Viral Hepatitis Testing Day” was held on May 19, 2012; and FDA issued safety guidance on blunt-tip suture needles.

USPSTF issued draft HCV testing guidelines with a deadline of December 24, 2012 to submit public comments. Because VHAP calls for the alignment of HCV screening guidelines to the degree possible, VHIG is continuing to explore strategies to address differences between USPSTF’s draft guidelines and CDC’s final recommendations on HCV testing to minimize confusion in the field. VHIG is aware that data will be needed from multiple sources (e.g., CHAC, academic researchers, community advocates and CBOs) to inform this effort. Steps have been taken to achieve the VHAP goal of eliminating mother-to-child HBV transmission.

Articles recently were published in the *MMWR* and the *American Journal of Public Health* discussing the reemergence of new HCV infections among younger IDUs that is linked to the epidemic of prescription opioid use in the United States. To increase recognition of this issue, HHS hosted a meeting in the summer of 2012 for CDC to make presentations to researchers in the National Institute on Drug Abuse.

HHS will compile key outcomes from the meeting to convene a cross-agency, cross-disciplinary and multi-sectoral technical consultation in Washington, DC in the first quarter of 2013. Federal agency representatives, researchers, state/local health departments and community advocates

will be invited to the consultation to describe the current epidemiology of HCV among IDUs; characterize younger IDUs who are at increased risk for HCV; explore prevention strategies that can be implemented; and highlight critical gaps in epidemiology data, surveillance data and prevention research.

The key challenges and opportunities for VH in FY2013 and beyond include the need to prepare providers to take advantage of the rapidly evolving science base of new HCV therapies and increase health literacy among persons with chronic HCV. Gaps in funding need to be filled to expand, share and improve VH surveillance data for both public health and clinical settings and establish a baseline. ACA might provide opportunities for improved diagnosis, prevention and treatment of HBV and HCV.

Because the existing VHAP action steps are intended to be completed in 2013, additional VH efforts will need to be identified beyond 2013. Full implementation of VHAP will be limited if reliance is solely placed on the ability of federal agencies to leverage resources. Overall, VHAP has been an extremely positive initiative to date due to close coordination and collaboration among the federal partners. VHAP is available on both the CDC.gov and AIDS.gov websites. The *VHAP Year 1 Interagency Implementation Progress Report* was distributed to CHAC in the meeting packets.

**Seiji Hayashi, MD, MPH, FAAFP**

Chief Medical Officer, Bureau of Primary Health Care  
Health Resources and Services Administration

Dr. Hayashi covered ongoing activities by the Bureau of Primary Health Care (BPHC) in his portion of the panel presentation. The mission of BPHC 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.

Of 20.2 million patients served by HRSA funded health centers in CY2011, 93% were below 200% of the FPL, 62% were racial/ethnic minorities, 36% were uninsured, ~1 million were homeless, 863,000 were migrants or seasonal farmworkers, and 188,000 were residents of public housing. FQHCs represent 1,128 grantees at >8,500 service sites. The health center workforce of >138,000 staff includes 9,937 physicians and 6,934 nurse practitioners, physician assistants and certified nurse-midwives.

The HRSA Uniform Data System (UDS) showed that HIV testing in health centers increased from 691,208 persons in 2009 to 883,548 persons in 2011. However, the number of HIV patients and HIV care visits has remained relatively stable over this time. FQHCs provide care to only 0.5% of the HIV-positive patient population. Moreover, the 12 Cities in the "Enhanced Comprehensive HIV Prevention Planning and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS" (ECHPP) Program account for 40%-50% of all HIV testing

performed by FQHCs. BPHC is aware of the need to promote more testing in rural or less populated areas.

HBV testing in FQHCs decreased from 256,133 persons in 2010 to 228,050 persons in 2011. The number of HBV patients and HBV care visits also decreased over this time. HCV testing in FQHCs increased from 162,320 persons in 2010 to 197,987 persons in 2011. An increase was seen in the number of HCV patients, while a decrease was observed in the number of HCV care visits over this time.

BPHC informally asked ~30-40 health centers and networks on their HIV testing. The data showed that on average, health centers provided HIV testing at least once to ~15% of all patients 13-64 years of age and HCV testing to ~15% of all patients in the 1945-1965 birth cohort. However, these data were extracted from EMRs and were available for the past few years only, and therefore, the numbers would be grossly under-reported.

BPHC created a quality strategy with three overarching aims of better care, improved population health and affordable care. Emphasis will be placed on four key action steps and milestones to achieve these goals. "Access" to testing and care will require partnerships with existing community infrastructures and organizations and utilization of electronic platforms, tele-health and other technologies. "Comprehensive services" beyond testing will need to be provided.

"Integrated care" (e.g., enabling services, primary care, HIV/STD/VH services, and sexual health/reproductive health services) will need to be packaged in a coherent, simplified and streamlined manner to improve the ability of PCPs to more efficiently and effectively deliver care to patients. An "integrated health system" will need to be established with FQHCs playing an integral role along with hospitals, specialists and diagnostic services.

Over the past year, BPHC has conducted a number of activities and offered several incentives in five major categories to assist FQHCs in responding to the overarching aims, key action steps and milestones of the quality strategy. For "policies and programs," BPHC engaged Primary Care Associations (PCAs) to disseminate CDC's testing and treatment guidelines.

For "funding," BPHC awarded a \$10 million supplement to dually-funded RWP grantees and health centers to increase delivery of care. A \$44 million supplement was awarded to support a PCMH initiative with a strong and explicit focus on HIV/AIDS. Funding was allocated to support the Community Health Applied Research Network that includes an HIV/AIDS research node. The Center for Integrated Health Solutions was funded in partnership with SAMHSA to integrate primary care and behavioral health services with specific activities on HIV/AIDS and VH. A \$20 million award will be made to 30 Health Center Control Network Program grantees in the near future

For "technical assistance," BPHC formed an internal partnership with HAB to provide guidance to health centers on the tele-health initiative. Additional technical assistance was provided to



FQHCs through collaborations with SAMHSA and national organizations (e.g., National Health Care for the Homeless Council, National Association of Community Health Centers (NACHC), Fenway Institute, and Association of Asian Pacific Community Health Organizations). Some of these initiatives will focus on HIV and HBV, including perinatal transmission of HBV.

For “data collection and dissemination,” BPHC intends to adopt HIV positivity and linkage to care as new UDS measures that will be reported by all HRSA funded health centers. A survey will be administered to obtain information on 4,000-5,000 FQHC patients. The survey will include questions on HBV and HCV testing. For “partnerships and collaborations,” BPHC has enhanced its relationships with internal bureaus, federal partners and national organizations (e.g., HAB, CDC, NACHC, PACs and the National Alliance of State and Territorial AIDS Directors (NASTAD)).

Health centers have made tremendous progress to date on addressing the priorities of the BPHC quality strategy. BPHC will continue to focus on the implementation of quality assurance/quality improvement (QA/QI) systems, adoption of EMRs for the Meaningful Use Program, PCMH recognition, improvement in clinical outcomes, and development of team-based care.

Despite this progress, health centers continue to be challenged by several issues. In terms of national guidelines, discrepancies between the CDC and USPSTF HCV testing recommendations are causing uncertainty and confusion at the clinic level. In terms of HIT and data collection issues, not all FQHCs have EMRs in each clinic that are used by each provider at this time. In terms of workforce shortages, the limited number of PCPs and HIV/AIDS specialists hinders the ability of FQHCs to recruit new staff. In terms of financial constraints, FQHCs have insufficient resources to meet the diverse needs of their patients.

**Todd Wills, MD**

Associate Professor of Internal Medicine & Fellowship Program Director  
Division of Infectious Disease and International Medicine  
University of South Florida, Morsani College of Medicine

Dr. Wills covered the SPNS HCV Treatment Expansion Initiative in his portion of the panel presentation. Over the 2010-2014 project period, 29 demonstration sites in RWP-funded HIV clinics will implement an HCV treatment program with annual funding of \$80,000 for two project years. The grantees will use their awards to implement and expand identification and treatment of HCV patients within their comprehensive HIV clinics.

The project was designed with an initial 15-clinic cohort in years 1-2 (September 2010-August 2012) and a second 14-clinic cohort in years 2-3 (September 2011-August 2013). Analysis and data dissemination will be conducted in 2014. Many of the demonstration sites are located in urban settings with the highest prevalence of HCV, but efforts are underway to implement the project in rural settings as well.

HRSA funded the project based on several factors. Most RWP-funded clinics have extensive experience with an array of complex social and medical issues that are common to both HIV and HCV. Most RWP clinics have programs or access to programs for substance abuse counseling and treatment. To establish a model care system for managing HCV in co-infected persons, emphasis on substance abuse will play a critical role. Primary care relationships and services provided in RWP-funded clinics provide an optimal environment to integrate HCV management.

In designing the project, HRSA and the grantees identified numerous elements at both provider and patient levels that would predict a successful HIV/HCV program:

- a medical director dedicated to treating HCV patients;
- an overarching goal to address an unmet need in the treatment of patients;
- a key medical provider with responsibility for treating and monitoring HCV patients;
- ongoing evaluation of candidates for HCV treatment;
- a system to identify all persons with HCV co-infection;
- rigorous treatment protocols;
- client support groups;
- patient education;
- access to psychiatry and mental health services;
- access to chemical drug dependency counseling and treatment;
- medication access and payment coverage;
- availability of in-clinic interferon injections; and
- access to liver biopsies.

The next step for HRSA and the grantees was to examine three potential models of care delivery to implement the project. Model 1 is primary care delivery with expert backup. This collaborative management model involves a primary care HIV provider with no/limited expertise in HCV and a specialist with expertise in HCV management. The specialist would perform the initial patient evaluation, approve treatment initiation and decide on the specific regimen for the patient. The PCP would monitor the patient for treatment response and adverse effects. Clinics that do not have a formal HCV treatment program and have a relatively low volume of patients who receive HCV therapy typically would implement model 1.

Model 2 is integrated care without a designated HCV clinic. This model typically involves an established HCV treatment program and a formal HCV co-infection treatment program. The medical provider and team at the HIV clinic would be responsible for initially evaluating the patient, initiating treatment if indicated, evaluating the patient's response to therapy, and monitoring the patient for adverse reactions. An expert would be consulted only if the patient presented with major complications related to underlying liver disease.

Model 3 is integrated care with a designated HCV clinic. This model involves a team of providers with experience, interest and training in the management of HCV co-infected persons. The co-infection clinic would be held in the comprehensive HIV care clinic at a designated time. A nurse, nurse practitioner, pharmacist or other team member with frequent interaction with a physician typically would be responsible for monitoring the treatment of patients.

The grantees recently completed year 2 of the project and identified several major barriers to implementation. At the patient level, personal experiences of the patient or anecdotal experiences of other patients either helped or hindered the clinic's ability to link patients to HCV treatment. Unstable housing, employment status and social issues also significantly affected implementation of the project. To address these barriers, some grantees provided HCV treatment in a "Healthcare for the Homeless" model. Other patient barriers included adherence requirements, the distance to clinics and transportation needs.

At the provider level, barriers to implementation included lack of training and experience; staff turnover; and expectations of adverse events, time or resource demands of the clinic, and better treatment options in the future. At the system level, benefits for patients from ADAP, Medicaid and private insurance have been inconsistent across states. Support from specialty services (e.g., gastroenterology, psychiatry, mental health and substance abuse services) has been insufficient and unreliable. The ability of clinics to coordinate services across multiple agencies has been difficult.

Despite these challenges, the grantees have achieved early successes in the project. Several clinics serve as medical homes and are able to provide supportive resources to patients who are on HCV treatment (e.g., optimal nutrition, support groups and familiar nurses). Patients who have completed HCV treatment serve as peer counselors for patients who are initiating therapy. Some clinic staff members serve as dedicated "patient trackers" to ensure patients present for their appointments and laboratory tests. Clinic-based injections have been beneficial for patients, particularly for those with an IDU history.

The tele-medicine teacher/learner/treater community model has been extremely successful in decreasing fear among providers with various levels of expertise in initiating HCV treatment. Monthly video conference calls are held for clinic staff to share lessons learned, best practices and preliminary successes in HCV treatment on an ongoing basis. The iterative learning model played a significant role in dramatically increasing the number of patients who were enrolled in HCV treatment from ~50-60 patients in year 1 of the project to 250 patients in year 2.

Dr. Marrazzo moderated CHAC's discussion with Drs. Valdiserri, Hayashi and Wills on the national VH activities that are underway. The discussion topics included:

- efforts by the SPNS HCV Treatment grantees in enrolling patients with active alcohol/substance abuse behavior; and

- potential incentives to increase participation by gastroenterologists in HCV treatment of patients.

CHAC made several comments and suggestions for the federal agencies to consider in further implementation of national VH activities.

- The federal agencies should formalize plans at this time to provide necessary training and skills to the healthcare workforce to cure the serious infection of VH in the large U.S. population of ~3-5 million persons. For example, the agencies should fund initiatives to build on and scale up successes of the AIDS Education Training Center (AETC) model and other innovative programs to increase engagement and capacity of PCPs across the healthcare workforce in VH treatment.
- The grantees of the SPNS HCV Treatment Expansion Initiative should review important lessons learned from the VA care delivery model. The VA currently delivers care to >120,000 veterans with chronic HCV infection using a team approach that includes mid-level providers. The VA model could assist the grantees in addressing barriers at both provider and system levels.
- Substance abuse care and treatment should be characterized as a mandatory element or one of the most critical components in developing expert models of care for HCV. Substance abuse serves as the major barrier to patients engaging in and adhering to HCV treatment until cured. Moreover, many providers exclude patients with active substance abuse behavior from HCV treatment.
- Consumer education should be considered at the same level of importance as provider education to achieve system-level changes in VH. Knowledge and understanding of the benefits of diagnosis, care and treatment are extremely limited in the large U.S. population of ~3-5 million persons with chronic HBV and/or HCV infection.

Dr. John Ward, Director of DVH, announced some upcoming events in follow-up to CHAC's suggestions on increasing knowledge of VH throughout the healthcare workforce. CDC will convene a stakeholder panel on January 11, 2013 with professional medical associations and mid-level providers to increase awareness of VH and identify collaborative opportunities to utilize educational channels for dissemination of quality VH information.

CDC intends to convene a follow-up stakeholder panel with HRSA, industry partners and continuing education providers to specifically focus on education of the workforce. CDC is continuing to consult with professional education programs of its industry partners to assist in these efforts.

## Overview of Promising Practices in PEPFAR

**Philippe Chiliade, MD, MHA**

**Advice Requested from CHAC by HRSA:**

- What is CHAC's feedback on HRSA's proposed approach to identify a few innovations and best practices from PEPFAR that could be adapted, piloted and rapidly implemented into the U.S. HIV program?

Dr. Chiliade presented an overview of PEPFAR promising practices and innovations that potentially could be applied to domestic HIV/AIDS programs and describe a framework to translate selected best practices to the domestic HIV response. In 2003, PEPFAR was launched to provide emergency access to ART to millions of persons in resource-limited settings. With its reauthorization in 2009, PEPFAR increased its focus on sustainability, country ownership and scale-up of ART to >6 million of persons. In recent years, the demand increased for dissemination of PEPFAR innovations, promising practices and lessons learned.

HAB conducted a peer-reviewed literature of published PEPFAR and other global HIV services. HAB used a combination of peer review search methods and non-traditional search techniques to extract PEPFAR gray papers and identify best practices. Most of PEPFAR/Global innovations and promising practices are not published in peer-reviewed journals, but through gray papers, conference abstracts, social media and networks. U.S. government agencies, universities and organizations are expected to expand the peer-reviewed literature on PEPFAR over the next few years. Moreover, emerging publications are expected to analyze, test or systematically review some evidence-based data on PEPFAR innovations.

HAB conducted a literature review with an overarching goal of identifying PEPFAR promising practices that have the potential to help close gaps in the continuum of domestic HIV/AIDS care and focus on care and treatment. Continuum of care data show that of HIV-positive persons, around 20% are unaware of their infection, 62% are linked to care, 41% are retained in care, 36% are prescribed ART, and <28% are virally suppressed.

The literature review resulted in HAB organizing PEPFAR promising practices and innovations into six major categories and three classes. The "task-shifting" category is for PEPFAR practices/innovations that redefine roles in order for other types of practitioners to provide HIV/AIDS care and treatment to patients. Examples include shifting tasks from physicians to nurses (e.g., monitoring and dispensing medications to stable patients); from nurses to skilled practitioners (e.g., providing basic care and treatment, testing and counseling); and from skilled practitioners to lay workers (e.g., providing testing, counseling and education).

The "peer-based solution" category is for PEPFAR practices/innovations that use workers or support systems with the same experiences of a target group. Local residents, PLWH, or persons of the same origin, gender, religion, sexual orientation or workgroup as the HIV/AIDS patient can be trained to facilitate treatment adherence, encourage retention in care, and

overcome personal barriers to social/structural determinants. Examples of peers include sex workers, MSM, HIV-positive mothers and prisoners.

The “community support” category is for PEPAR practices/innovations that strengthen the investment and interaction of the community and fully utilize community resources. Examples of community support include involvement of the community in the care and education of orphaned children with HIV; engagement of celebrities or well-known/well-regarded community actors; and integration of local government into the HIV/AIDS response. Many aspects of the community support category overlap with those in the peer-based solution category.

The “location” category is for PEPAR practices/innovations that specifically focus on physical and temporal aspects to address barriers to HIV care, including access, stigma and knowledge. Examples of location-based activities include the placement of HIV services inside integrated care centers to improve privacy and reduce stigma; creation of mobile centers for hard-to-reach areas; increased access to HIV care for stigmatized populations to present to clinics during night or weekend hours of operation; and home visits.

The “communication” category is for PEPAR practices/innovations that improve communication between a variety of stakeholders, including patients-medical providers, service providers-communities, communities-PLWH, and families-PLWH. Examples of communication include technology to facilitate service delivery (e.g., short messaging services (SMS) to remind patients of appointments and drug regimens or to transmit laboratory results to facilities) and programs that empower serodiscordant couples to openly discuss their HIV status to prevent transmission of infection.

The “policy” category is for PEPAR practices/innovations that guide the implementation of care and treatment practices at the structural level. Examples of policies include dissemination and determination of the type, regimen and characterization of drugs; harm reduction policies rather than criminalization of high-risk groups; and changes in training curricula and the scope of practice to allow for task shifting among healthcare workers.

The six major categories of PEPFAR innovations fall into the programmatic and technological classes, but a third class is solely devoted to technology. Examples of technology include SMS, physical hardware, mobile diagnostics, point-of-care testing, and crowd sourcing/crowd mapping. The technology class can span the entire gradient of classes or serve as a standalone category.

PEPFAR and the broader global HIV/AIDS response have produced a number of innovations and promising practices. Efforts should be made at this time to gather, analyze and prioritize practices that have the most promise for successful application and translation to domestic HIV/AIDS programs. However, the most significant and relevant domestic needs should be first evaluated to narrow the search and focus the identification and translation of global best practices. Both domestic and international HIV/AIDS experts should be engaged to identify

priority initiatives. The SPNS Program or other existing infrastructures should be utilized to adapt, pilot and monitor the quality and outcomes of PEPFAR promising practices in U.S.-based settings prior to scale-up.

CHAC supported HRSA's proposed approach of organizing PEPFAR promising practices and innovations for translation to U.S. HIV/AIDS programs, selecting those more likely to have a cost-effective impact on the domestic continuum of response, adapting a few selected, one for pilot and if successful for scale up. The members made several comments and suggestions for HRSA to consider in its next steps to advance this initiative.

- HRSA should explore the possibility of encouraging RWP grantees to replicate country operating plans in which countries are directed to scale-up treatment based on the local epidemic and treatment coverage of the community. For the U.S. model, RWP grantees should aim to achieve population-level impact through solid public health and clinical outcomes in jurisdictions with the highest prevalence of HIV/AIDS.
- PEPFAR's global successes in linkage to and retention in care, viral suppression, and task shifting for both prevention and treatment/care should be prioritized and piloted as the first three initiatives in the international-to-domestic translation of HIV/AIDS activities. However, the input and expertise of PLWH should be key components in all phases of identifying, adapting, piloting and broadly implementing PEPFAR promising practices in domestic settings.
- Community health workers/*promotores* increasingly are being integrated into the U.S. healthcare system with more training, research and medical assistance. These workers, particularly those who are HIV-positive or HIV-affected, should be an integral part of the task-shifting category to reach underserved or linguistically-isolated populations.
- Emphasis should be placed on PEPFAR and other international models that allow patients to access HIV/AIDS care in an easier and more convenient manner outside of provider practices. For example, task shifting could include pharmacists who manage patients via telephone calls or online follow-up. The Vancouver, Canada model involves the submission of HIV/AIDS test results to a centralized source and a standardized protocol to address treatment failure. Other models have been tremendously successful in reaching PLWH and engaging their friends and families for support to assure retention in care.

## 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 announced that the business session would include CHAC's formal votes on draft recommendations proposed by the Sexual Health Workgroup, Viral Hepatitis Workgroup, and PACHA/CHAC Disclosure Workgroup. CHAC's discussion of other items that also would need to be addressed during the business session resulted in the members suggesting ~9 topics. To make the business session as productive and efficient as possible, CHAC agreed to group these issues into four major categories.

Category 1: Impact of ACA on RWP and PLWHA

Champions: Dr. Kathleen Clanon; Mr. Ernest Hopkins

Category 2: Data issues

Champion: Dr. Carlos del Rio; Dr. Jennifer Kates

- Treatment cascade
- Linkage to and retention in care
- Late diagnosis of HIV
- Additional feedback on the 2010 RSR dataset

Category 3: Models of care and support for HIV and HCV

Champions: Ms. Regan Hofmann; Dr. Britt Rios-Ellis

- Substance abuse treatment for HCV patients
- Patient education and peer-based solutions for HIV, HCV and sexual health
- Application of PEPFAR promising practices and innovations (e.g., viral suppression, task shifting and peer-based solutions) to domestic HIV/AIDS programs
- Workforce issues for HIV and HCV prevention and treatment

Category 4: Characteristics and priorities of the new NCHHSTP Director

Champions: Dr. Jeanne Marrazzo and Mr. Douglas Brooks

With no further discussion or business brought before CHAC, Dr. Marrazzo recessed the meeting at 5:18 p.m. on December 11, 2012.

### Opening Session: December 12, 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 December 12, 2012. He reconvened the proceedings at 8:39 a.m. and welcomed the participants to day 2 of the CHAC meeting.

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.

**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 announced that the presentations on the previous day covered several important areas: implementation of VHAP; the impact of ACA on RWP reauthorization; appropriate use of new data (e.g., HRSA's RSR dataset and CDC's MMP data); training and support to the workforce to assure continued quality care to patients; retention in care and other aspects of the treatment cascade; and application of PEPFAR promising practices to domestic HIV/AIDS programs.

Dr. Marrazzo emphasized that draft recommendations/resolutions proposed by CHAC members during the business session would address a number of these key themes. She concluded her opening remarks by briefly reviewing the agenda for day 2 of the CHAC meeting.

**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  
Workgroup Chair

**John Douglas, Jr., MD**

Chief Medical Officer, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention  
Centers for Disease Control and Prevention

**Advice Requested from CHAC by the Sexual Health Workgroup:**

- Does CHAC formally approve a one-year extension for the workgroup to complete its activities?

Ms. Dempsey and Dr. Douglas covered the following topics in their update on the workgroup's recent activities. After CHAC's formal adoption of the workgroup's proposed definition of "sexual health" during the May 2012 meeting, a CHAC letter and a joint CHAC/PACHA letter were sent to the HHS Secretary on this issue. The HHS Secretary currently is drafting a response to CHAC and PACHA on the sexual health recommendations.

The workgroup was established in 2010 with a two-year time frame to fulfill its charge, but several outstanding issues still need to be addressed. Most notably, strategies are needed to broadly address sexual health. Strong collaboration is needed with BPHC, providers and health departments to translate the sexual health concept into actual practice. A white paper needs to be developed to raise the visibility of sexual health in the field. The original two-year time frame has ended, but the workgroup is now seeking CHAC's approval to continue its activities for an additional one-year period.

In response to the workgroup's request, Dr. Fenton explained that workgroups are established to complete specific tasks and generate outputs and outcomes over a defined period of time (typically 18 to 24 months). The workgroup is dissolved after fulfilling its charge. If CHAC votes to approve a one-year extension, he urged the workgroup to clearly define its additional goals and actually deliver these outputs.

In follow-up to Dr. Fenton's comments, Dr. Clanon raised the possibility of renaming the "Sexual Health Workgroup" to reflect a more targeted focus on specific tasks during the workgroup's one-year extension. She noted that the concept of sexual health is broad and is an integral part of all aspects of CHAC's charter to provide guidance on HIV, VH and STD prevention and treatment.

## Public Comment Session

### **Lindsey Dawson**

Public Policy Associate, The AIDS Institute (TAI)

Ms. Dawson made the following comments for CHAC's consideration. TAI is highly supportive of the USPSTF Grade A recommendation for routine HIV screening of adolescents and adults 15-65 years of age, other persons at increased risk of HIV, and pregnant women. This positive grade change will help make HIV screening a routine component of preventive care. Most notably, high USPSTF grades inform clinical practice and grade changes positively impact reimbursement across many payers. However, progress will be possible only if providers offer HIV tests, patients give their consent, and new reimbursement pathways are utilized.

The grade change will facilitate improvement in coverage of HIV screening through Medicaid, Medicare and private insurance. The field can benefit from leadership by the federal government in terms of challenging implementation efforts. TAI emphasizes the need for assistance from CDC to aid in the implementation of the USPSTF recommendations after being finalized. Providers need education on the importance of routine screening and its reimbursable status, but facilities, providers and administrators also will need technical assistance related to billing and reimbursement practices.

TAI has observed a patchwork of capabilities, infrastructures and knowledge related to current HIV testing reimbursement across the United States. TAI requests that CDC develop a toolkit for implementing these practices. The toolkit should include case studies, detailed information on training, accreditation and coding, and strategies to overcome barriers to reimbursement. NASTAD, providers and other parts of the healthcare sector have concluded that the absence of the toolkit will serve as a barrier to implementation.

CDC grantees are accustomed to receiving testing grants and will require assistance in the transition to become adept at billing. CDC testing funds will remain critical due to the challenging budgetary climate and increased importance on leveraging limited dollars. HRSA also will need to reach out to its grantees. Most notably, BPHC will be instrumental in reaching out to and advising CHCs on implementing routine screening and billing infrastructures.

The provision of guidance to RWP grantees on billing and reimbursement practices also will help in identifying unknown HIV-positive persons. This guidance will be integral for CDC and HRSA grantees to take advantage of reimbursement changes that will be associated with the USPSTF grade change after being finalized. After the USPSTF Grade A recommendation is finalized, routine HIV screening will need to undergo the Medicare coverage determination process in order to become a Medicare covered service.

TAI urges the HHS Secretary to address this issue as soon as the grade is finalized to ensure that beneficiaries have access. Moreover, encouraging state Medicaid programs to cover routine screening will be instrumental because HIV disproportionately impacts low-income communities. The grade change is greatly needed and will more closely align the USPSTF recommendations with the CDC guidelines, NHAS goals and available science. Support from CDC and HRSA will be critical for implementation.

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

Principal Investigator & Director

Mountain Plains AIDS Education and Training Center

Dr. Bradley-Springer made the following comments for CHAC's consideration. AETCs are positioned at this time to help CHAC advance its agenda for HIV, VH and STD prevention and treatment in the upcoming environment of ACA and RWP reauthorization. AETCs are aware that clinicians, prescribers and specialty practitioners are overburdened in meeting the diverse

needs of their HIV patients. As a result, nurses should play a stronger role in these efforts due to their medical knowledge and psychosocial communication skills in developing, managing and evaluating behavioral health programs in HIV settings.

Because brief interventions for behavioral problems have not been effective to date, registered nurses and other non-clinician professionals should be assigned to address important and time-consuming issues (e.g., engagement and retention of patients in HIV care, adherence to HIV treatment regimens, smoking cessation, health literacy and patient education). At this time, the healthcare sector has a surplus of experienced and trained registered nurses who could be utilized in HIV settings. Overall, nurses are the largest group of healthcare providers in the world, but representation of nurses on CHAC is limited to Dr. Parham Hopson.

**Kimberly Miller**

Policy Officer, HIV Medicine Association (HIVMA)

Ms. Miller made the following comments for CHAC's consideration. HIVMA and its four partner organizations sent a joint letter to the HHS Secretary dated September 25, 2012. The purpose of the letter was to urge the HHS Secretary to reinstate the Ryan White Clinical Conference. Over the past 14 years, this event has served as an important forum for physicians, nurses and other members of care teams at RWP-funded clinics to remain informed of the latest developments in HIV care and treatment to further advance the field.

HIVMA and its four partner organizations are requesting CHAC's support in encouraging the HHS Secretary to reinstate the Ryan White Clinical Conference. The letter was distributed to CHAC to guide its decision-making on this issue.

**Daniel Raymond**

Policy Director, Harm Reduction Coalition (HRC)

Mr. Raymond made the following comments for CHAC's consideration. HRC recognizes that the current standard of HCV care is based on interferon and has been a major challenge in expanding the capacity of providers to deliver HCV treatment. Experts have predicted that interferon-free HCV treatment will not be available for at least 1-2 years. However, HRC is requesting CHAC's input at this time on a robust system-level approach with the necessary practices, supportive payment systems and incentives to enhance the skills and knowledge of the workforce in preparation of this change.

HRC has identified several areas that need to be addressed to prepare for an era of interferon-free HCV treatment. A system-level approach should be institutionalized across the healthcare system in order for PCPs, internists and infectious disease doctors to take ownership of the management and care of HCV patients. Process and quality measures should be developed to benchmark and establish targets for HCV treatment. Existing models should be reviewed and

replicated to the extent possible, such as American Medical Association activities and HIV/HCV co-infection efforts.

Solid registries should be developed with robust cohorts to evaluate innovations in HCV care and monitor advancements in clinical practice to improve patient outcomes. The federal government should develop and disseminate rigorous and credible HCV treatment guidelines to expand capacity beyond the specialty field and also to navigate and manage patients through the pipeline of drugs that will be submitted for FDA approval.

Strong efforts should be made to bridge the gap in HCV diagnosis. For example, USPSTF has given a Grade C recommendation to CDC's HCV screening guidelines for the 1945-1965 birth cohort, but these persons are at the highest risk for HCV morbidity and mortality and account for the majority of cases in the United States. As a group of experts, CHAC should provide input to USPSTF on the critical need to diagnose and monitor HCV on an ongoing basis.

**Michael Shankle, MPH**

Director of Prevention and Policy, HealthHIV

Mr. Shankle made the following comments for CHAC's consideration. HRSA awarded a CoAg to HealthHIV to establish the National Center for HIV Care in Minority Communities. The overarching goal of this initiative is to build and expand the clinical and organizational capacity of CHCs that primarily serve racial/ethnic minority populations and are not directly funded by RWP. This funding will help CHCs to sustain the provision of HIV care to clients.

HealthHIV has recruited >100 organizations to participate in this initiative and will award funds to up to 30 sub-grantees each year through a competitive process. The 62 CHCs selected to date represent >300 providers nationally with an annual patient population of ~1 million persons, including 3,000 PLWH. This initiative has allowed CHCs to increase their provision of HIV care. For example, a CHC in New York has doubled its HIV-positive patient population due to 6-10 new patients per month.

CHCs will serve as a major source of primary medical care for a large proportion of newly insured persons in the United States who will have access to health insurance after ACA implementation. As a result, clinical training and organizational capacity building will be even more important to fully integrate quality HIV care into primary care settings. CHC providers in high-incidence HIV jurisdictions have expressed a strong interest in delivering HIV care.

HealthHIV welcomes the opportunity to engage CHAC in dialogue on its data, experiences, challenges and successes in HIV primary care integration, CHC capacity building and workforce development. HealthHIV's lessons learned are based on its AETC activities and National Workforce Capacity Building Initiative that addresses the HIV workforce shortage by providing mentoring and training to HIV care providers.

Dr. Fenton and the CHAC members made several remarks in follow-up to the public comments. CDC has made a strong commitment to collaborate with the health sector to mobilize providers and scale-up HIV testing. CHAC should identify the strongest drivers to help CDC promote change within the provider community in implementing routine HIV screening guidelines (e.g., direct funding of HIV treatment and care by HRSA and funding by private insurance and other clinical sectors).

CHAC should provide leadership in extensively engaging professional societies to train their members in HIV testing, identify linkage-to-care resources in communities, and offer incentives to PCPs at the local level. CHAC's outreach efforts also should include AETCs as a primary mechanism in rapidly increasing HIV screening after the USPSTF Grade A recommendation is finalized.

Workforce issues have been a recurring theme in CHAC's discussions and comments by the public, but sufficient attention has not been given to this topic to date due to its overwhelming scope and magnitude. To advance this effort, CHAC/PACHA could conduct a joint evaluation of ongoing activities at state, local and community levels to advance workforce development. CHAC could discuss whether any of the proposed task-shifting options to various practitioners could be endorsed as a "safe" or promising practice in U.S.-based settings. CHAC could draft recommendations to engage PLWH with an interest in returning to work without discrimination or stigma.

The co-Chairs and DFOs are aware of the need to develop the 2013 agendas with much more time for CHAC to discuss workforce issues. To assist in this effort, a few CHAC members should participate in pre-planning discussions with CDC and HRSA to identify specific workforce issues that should be addressed in 2013 and each year thereafter. For example, CHAC's discussions on workforce issues in 2013 could be limited to reaching goals for HIV screening, retention in HIV care, and management of antibiotic-resistant gonorrhea.

### Update by the PACHA/CHAC Disclosure Workgroup

#### **Kaye Hayes, CHAC Ex-Officio Member**

Executive Director, Presidential Advisory Council on HIV/AIDS  
Office of HIV/AIDS and Infectious Disease Policy  
U.S. Department of Health and Human Services

#### **Douglas Brooks, MSW**

Senior Vice President, Community, Health and Public Policy  
Justice Resource Center  
CHAC Liaison Representative, Presidential Advisory Council on HIV/AIDS

**Antigone Dempsey MEd, CHAC co-Chair**

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

**Ernest Hopkins, CHAC Member**

Director of Federal Affairs  
San Francisco AIDS Foundation

**Britt Rios-Ellis, PhD, CHAC Member**

Professor and Director, National Council of La Raza  
Center for Latino Community Health, Evaluation and Leadership Training  
California State University, Long Beach

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

- Does CHAC endorse the guiding principles and policy recommendations for HIV disclosure proposed by the workgroup?

The workgroup members covered the following topics in their update on the workgroup's recent activities. The NHAS Federal Implementation Plan outlined specific tasks for PACHA and CHAC. PACHA was tasked with developing recommendations 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 to normalize and promote safe and voluntary disclosure of the HIV status of individuals. HRSA would be responsible for publishing the recommendations.

PACHA/CHAC initially raised several concerns that would need to be addressed to fulfill their charge. Most notably, language in NHAS appeared to have a bias in favor of disclosure. Potentially negative consequences and ramifications for individuals who disclose their status and the opposite bias from a civil rights perspective also would be important issues to address.

The next steps for PACHA/CHAC in this process were to gather information to determine the overarching goal of the disclosure recommendations, necessary competencies, legal context, target audiences, and HIV criminalization issues. PACHA/CHAC then co-chaired a Disclosure Summit in June 2012 to ground the disclosure activities in theory, expertise and experience; create a framework of guiding principles and policy recommendations that would foster an environment allowing for safe and voluntary disclosure; and synthesize and build consensus.

The summit participants represented multiple disciplines, cross-cutting partners and diverse thought leaders in both public and private sectors, including PLWHA, community advocates, social scientists, medical ethicists, researchers, health providers, education leaders, lawyers and policymakers. The summit resulted in the development of two major outputs: (1) a set of guiding principles for recommendations on safe and voluntary disclosure of HIV status and (2) a

set of short-/long-term policy recommendations to promote safe and voluntary disclosure of HIV status in the United States.

The summit participants agreed on a number of key themes to develop the guiding principles and policy recommendations. HIV disclosure impacts the entire life and various networks of individuals, including their family, social, professional, service and sexual networks. Disclosure is not a single discrete event, but rather is an ongoing process that spans a lifetime. Disclosure is associated with both benefits and risk.

The personal benefits of disclosure include social support, mental health services, access to care, treatment adherence, and the ability to obtain benefits and secure legal protections. The group benefits of disclosure include opportunities for dialogue, increased visibility and empowerment, connections and group cohesiveness, and reduction in discrimination and stigma.

The risks of disclosure include negative reactions, adverse decision-making, potential re-disclosure, loss of privacy, and possible criminal prosecution. Overall, the most important element is for individuals to make an informed decision on disclosure that is best for their personal situation in a particular context.

The organizational structure of the summit allowed the participants to achieve the expected outcomes. On day 1, the full group of participants created the guiding principles. On day 2, the participants divided into teams to craft policy recommendations in three areas: criminalization/legal issues, health systems issues, and family/societal issues. The full group reached consensus on the guiding principles and policy recommendations.

The workgroup presented the HIV disclosure guiding principles and policy recommendations that would be placed on the floor for CHAC's formal vote during the business session. The workgroup noted that this language replaces the October 26, 2012 draft report that was previously distributed to CHAC.

### **PREAMBLE**

We are committed to ending the HIV/AIDS epidemic. We are committed to honoring the strength and resilience of people living with HIV/AIDS and their invaluable role in the nation's ongoing fight against the epidemic. We are committed to ensuring and protecting the right and ability of all people to live full, healthy lives.

With these commitments firmly in mind, we recognize and respect:

- the ultimate autonomy of each individual faced with the opportunities and challenges of disclosing her or his HIV status;
- that disclosure of HIV status is not a single, discrete event, but rather an ongoing process spanning a lifetime and myriad contexts; and
- that the disclosure process necessarily involves multiple parties.



These commitments and the recognition of the characteristics of the disclosure process informed the development of the guiding principles for our discussions and our ultimate recommendations. While this document is focused on the NHAS directives on HIV disclosure, the group also acknowledges that disclosure of all STIs promotes greater communication and sexual health.

***GUIDING PRINCIPLE 1: Society has an obligation to create a safe environment for HIV disclosure.***

There is an obligation and a responsibility for society to create a safe environment for people to voluntarily disclose their HIV status as well as other sexually transmissible infections. Accordingly, any laws and policies that create disincentives to an individual's safe and voluntary disclosure of her or his HIV status, e.g., by increasing HIV stigma and discrimination, should be eliminated. All relevant Federal, state and local laws and policies should incorporate the current state of medical science, best-practices in public health, and evidence-based strategies and priorities for effectively addressing the HIV epidemic and should strive to create and maintain resources and environments conducive to safe and voluntary disclosure.

***GUIDING PRINCIPLE 2: Discussion of HIV and STI status is important.***

Confidential and ongoing communication about HIV status and other relevant sexual health conditions (both for those living with HIV and those whose current status is negative or unknown) is essential for individual, family, and community health. An environment that allows for safe, voluntary disclosure empowers persons living with HIV to: 1) access support and care without fear of stigma or persecution; and 2) participate in the organizations and mechanisms of policy, to which they bring invaluable lived-experience. Ultimately, an environment that protects the ability to engage in safe and voluntary disclosure enables all community members to make informed decisions in regard to their own health and conduct.

***GUIDING PRINCIPLE 3: The circumstances and context of disclosure must be respected.***

A complex constellation of cultural and social factors influences every individual's ability to safely disclose her or his HIV status. These factors must be respected in order to create environments that facilitate safe and voluntary disclosure. Only if we understand and appreciate the external pressures militating against safe, voluntary disclosure, can we create solutions that allow for all people to access the support, treatment and education resources that they need and deserve.

***SHORT-TERM POLICY RECOMMENDATIONS***

1. HHS and other federal funders should devote a portion of currently funded programs to facilitate campaigns and education on safe and voluntary disclosure that encourages an understanding of HIV in the context of a range of sexually-transmissible diseases that can have a profound impact on health and life. Issues of disclosure should be infused in prevention campaigns. Federal funders should be encouraged to conduct research on what is already known related to effective programs and how to apply their research

findings.

2. Federal funders should develop and/or disseminate quantitative and qualitative research agenda and fund studies on the benefits and challenges of disclosure.
3. The Surgeon General should write a letter to the American People containing up-to-date information about HIV/AIDS and the importance of frank discussions about maintaining sexual health. Much has changed since Surgeon General Koop's 1988 letter; a new letter will help correct many persistent misconceptions about HIV, its transmission, and the prognosis for those whose infection is detected early and are provided with appropriate access to HIV-related healthcare.
4. The Secretary of Health and Human Services should appoint an HHS representative to work with the associate attorney general to create a working group to examine laws and policies that discriminate against people with HIV and formulate recommendations for the elimination of those laws, and develop recommendations for laws and policies that would support and protect people living with and vulnerable to HIV.
5. A dedicated position should be established within the Office of the Associate Attorney General for HIV Law and Policy.

### **LONG-TERM POLICY RECOMMENDATIONS**

1. HHS and medical providers should prioritize disclosure support as a component of mental health services within clinical settings. Disclosure education, training and support should be included under the definition of "peer navigator/support." Recognizing that disclosure is a continuous and voluntary process, we need to fund supportive work around disclosure in the clinical setting over a person's lifespan. In addition, the following approaches should be supported:
  - Part of the clinical care model should include a comprehensive discussion of HIV and STI disclosure outcomes with a trauma-informed approach to care. Approaches to disclosure in the clinical setting which merely involve informing the newly-diagnosed of the existence of a law mandating disclosure and/or advising and admonishing the person to disclose to all sexual partners should be discouraged.
  - To support this, AETCs should be allowed to train peers and count peer training. In addition, medical professionals need to be trained. Accordingly, nursing and medical education should include skills building on supporting and facilitating disclosure.
2. HHS should develop sex-positive prevention messages rooted in evidence-based research but also reflecting and tailored to people's real lives; create culturally relevant messages developed by people living with HIV.
3. HHS should develop ways to encourage and incentivize states to address state and local laws that create barriers to disclosure of HIV status and access to care. To further support this, we recommend that HHS conduct an objective analysis on the impact of these laws on access to testing and care.

The workgroup's next steps will be to collaborate with HHS on devising strategies to implement the HIV disclosure recommendations. The focus initially will be placed on the updated Surgeon

General letter and guidance directed to the Department of Justice. The workgroup will then prioritize the remaining recommendations for implementation.

CHAC applauded the workgroup for its outstanding efforts in addressing the extremely complex issue of HIV disclosure and formulating well-articulated, actionable and pragmatic guidance to HHS. The CHAC members made three key suggestions for the workgroup to consider in finalizing the recommendations.

- The research recommendation should be expanded to encourage HHS to compile examples of state HIV criminalization laws that hinder persons from receiving HIV testing. Solid data in this area will be necessary to empower states to change their existing laws.
- The term “sex-positive” should be clarified to ensure that HHS is given clear guidance in order to implement the recommendation.
- New language should be included in the recommendations for HHS to explore strategies for persons to disclose their HIV status through the Internet and social media platforms. Most notably, Ms. Dempsey and Mr. Brooks will co-host a Twitter chat (#HIVdisclosure) on December 14, 2012 at 11:00 a.m. EST.

Dr. William Grace, *ex-officio* member for NIH, responded to one of CHAC’s suggestions. NIH currently is funding 77 research grants related to HIV disclosure both domestically and internationally. Some of the domestic grantees are analyzing state laws to determine the impact of disclosure on HIV testing.

### Update by the CHAC Ryan White Reauthorization Workgroup

**Kathleen Clanon, MD**  
Director, Division of HIV Services  
Alameda County Medical Center  
CHAC Member

**Ernest Hopkins**  
Director of Federal Affairs  
San Francisco AIDS Foundation  
CHAC Member

#### Advice Requested from CHAC by the Ryan White Reauthorization Workgroup:

- What is CHAC’s input on the reauthorization issues articulated by the workgroup?
- What is CHAC’s guidance on the workgroup’s most useful role in advising HRSA/HAB in light of its role in reauthorization discussions?

Dr. Clanon and Mr. Hopkins covered the following topics in their update on the workgroup's recent activities. The workgroup was established during the May 2012 meeting with a formal charge of developing recommendations on RWP reauthorization for CHAC's consideration and potential adoption. The workgroup's guidance would be designed to reflect evolving care needs in the context of ACA implementation.

Following the May 2012 CHAC meeting, the workgroup held one face-to-face meeting and three teleconferences to identify potential issues to cover in its recommendations:

- potential new care models (e.g., primary care and specialist co-management);
- definition of the "HIV specialty medical home;"
- strategies to share best practices in successful care linkage;
- meaningful use of local epidemiological and laboratory data; and
- expansion of the prevention mandate in treatment and other care settings.

HAB staff has actively participated in the workgroup's activities and provided technical guidance in three key areas: (1) the intersection between RWP and ACA, (2) advice and requests to HRSA on strategies to keep CHAC and RWP grantees informed, and (3) updates on the status and availability of data and information to RWP grantees.

HRSA opened a public comment period in July 2012 to obtain input on RWP reauthorization issues that potentially could be impacted by ACA. Based on this feedback, the workgroup developed a list of issues the HHS Secretary should consider in any discussions on RWP reauthorization.

Because workgroups have no mechanism for their parent committees to formally approve recommendations in between public meetings, two CHAC members (Drs. Kathleen Clanon and Steven Johnson) submitted the list of issues in a letter to HRSA as independent RWP medical providers in order to maintain momentum of this effort. The July 31, 2012 letter to Dr. Mary Wakefield, Administrator of HRSA, was distributed to CHAC for review. The workgroup's list of issues covers five key recommendations on RWP reauthorization

1. Reevaluate the definition and application of the "payer of last resort."
2. Ensure that prioritization of "core medical services" (*i.e.*, the 75/25 rule) promotes access to a comprehensive program of HIV care and services.
3. Invest in the commitment to reach an "AIDS-Free Generation" by expanding access to the RWP model.
4. Improve the allocation of resources to better target funds to locations where PLWH receive HIV care. Use client-level data to determine inputs to this formula.
5. Re-envision the Planning Council to monitor service gaps, service utilization and HIV-related disparities rather than funding allocations.

The workgroup cited language in the 1990 RWP authorization legislation to support the payer of last resort recommendation: "CARE Act grant funds cannot be used to make payments for any

item or service if payment has been made or can reasonably be expected to be made with respect to that item or service under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or by any entity that provides prepaid health care.”

The workgroup’s next steps will be to address various options for RWP reauthorization (e.g., no reauthorization, technical revisions or full reauthorization); explore strategies to facilitate integration of RWP with new insurance options; and develop a large-scale vision for the future.

CHAC made several comments and suggestions for the workgroup to consider in refining its draft recommendations on RWP reauthorization.

- The workgroup should expand the payer of last resort recommendation to specifically address payment to the Indian Health Service to meet the unique HIV/AIDS care and treatment needs of Native Americans. Most notably, Native Americans currently are eligible to access both RWP clinics and ADAP programs to obtain medications.
- The workgroup should ensure that its recommendations on RWP reauthorization to HHS and HRSA are aligned with those of other organizations and constituencies to the extent possible. A cohesive approach will be needed to promote similar legislative agendas and convey the same messages in terms of ACA implementation for PLWHA.
- The workgroup should revise its recommendations to more strongly focus on integration of prevention into care. For example, the existing structure for direct care, provision of PrEP by RWP providers, and implementation of other strategies would be excellent drivers for HIV testing in CHCs.
- Lessons learned and emerging practices from interagency grassroots initiatives (e.g., ECHPP, the 12 Cities Project and CAPUS) should be compiled to inform the language, policies and new directions of RWP reauthorization.

At the conclusion of the discussion, the workgroup confirmed that CHAC’s suggestions and comments to finalize the draft recommendations on RWP reauthorization would be considered. The workgroup also would take responsibility for responding to the questions Dr. Slifkin posed on the previous day regarding the impact of ACA on RWP and PLWHA.

### **Update by the CHAC Viral Hepatitis 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 Viral Hepatitis Workgroup:**

- What are CHAC’s potential next steps to address the new USPSTF HCV testing

## recommendations?

Ms. Dempsey covered the following topics in her update on the workgroup's recent activities. The workgroup was established during the May 2012 meeting and formally charged with three major tasks. First, opportunities will be identified within CDC and HRSA to improve and coordinate prevention, screening, linkage to care, and treatment for persons with chronic HBV and HCV infection.

Second, the current state and adequacy of surveillance measures will be assessed 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 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. Third, the implications of ACA on VHAP will be evaluated.

To fulfill its broad charge, the workgroup identified and engaged ~10 expert consultants, policymakers, medical providers and community members/advocates with a strong interest in HBV and HCV. CDC, HRSA and HHS are represented on the workgroup as well. The workgroup held its first two meetings in November and early December 2012 to prepare for the current CHAC meeting and determine priority issues for the next six months.

During its November 2012 meeting, the workgroup agreed to prioritize five key activities over the next six months:

- focus on the HCV testing recommendations;
- identify opportunities within CDC and HRSA to improve and coordinate prevention, screening, linkage to care, and treatment for persons with chronic HBV and HCV with an emphasis on identifying locations where individuals receive treatment;
- support basic messaging related to enrolling persons into care;
- focus on hepatitis testing recommendations in the context of ACA; and
- focus on workforce issues.

During its December 2012 meeting, the workgroup noted that the public comment period for the draft USPSTF HCV testing recommendations would close on December 24, 2012. Based on CHAC's formal approval during the business session, the workgroup would submit the following language as CHAC's public comment to USPSTF.

Both CDC and the USPSTF conclude with moderate certainty that HCV testing is of benefit to HCV-infected persons. While both sets of recommendations agree on the rationale for and value of HCV screening, the USPSTF distinction of a Grade C for birth cohort screening does not reflect the supportive data and will limit the extent to which this recommendation is implemented in actual practice. HCV testing with linkages to appropriate care and treatment can benefit HCV-infected persons regardless of the approach to testing. Accordingly, both birth cohort and risk-based strategies warrant a

Grade B recommendation. We are concerned that the “suggestion for practice” corresponding to the grade C designation will not allow for the recommendation to be applied routinely during care of this large population of persons infected with HCV in the distant past and now at greatest risk for HCV morbidity and mortality. Many of these persons either lack the ability to cover the cost of this screening themselves, who are uninsured, or whose insurance coverage will not pay for the screening test. Many of these persons will not be reached by risk based testing alone. As stated by USPSTF, “Many individuals with chronic HCV infection are unaware of their condition. A risk-based approach may miss detection of a substantial proportion of HCV in the birth cohort.” This will undermine the opportunity presented by the CDC’s strong recommendation to make screening routine for this birth cohort to identify, for the first time, the large proportion of undiagnosed HCV infection in U.S. adults, and to intervene with effective care and treatment. We call on the USPSTF to reconsider this grade and elevate the recommendation for routine birth cohort screening to grade B.

### 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**

Dr. Marrazzo entertained a motion for CHAC to approve the previous meeting minutes. A motion was properly placed on the floor and seconded by Drs. Marjorie Hill and Kenneth Mayer, respectively, for CHAC to approve the previous meeting minutes.

**CHAC unanimously adopted the Draft May 8-9, 2012 Meeting Minutes with no changes or further discussion.**

#### **Topic 2: CHAC Sexual Health Workgroup Champions: Workgroup Members**

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

CHAC recommends an extension of the Sexual Health Workgroup's original two-year time frame for one additional year. During the one-year extension, the workgroup will focus on providing advice to CDC and HRSA in two key areas: (1) implementation of a sexual health framework approach and (2) development of strategies to disseminate information about sexual health.

**CHAC unanimously approved the resolution.**

**Topic 3: PACHA/CHAC Disclosure Workgroup**  
**Champions: Workgroup Members**

The following motion was properly placed on the floor and seconded by Ms. Antigone Dempsey and Mr. Tommy Chesbro, respectively.

CHAC recommends formal adoption of the workgroup's report that outlines guiding principles and policy recommendations for HIV disclosure and submission of the report to the HHS Secretary.

**CHAC unanimously approved the resolution.**

**Topic 4: Viral Hepatitis Workgroup**  
**Champions: Workgroup Members**

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

CHAC recommends formal adoption of the workgroup's draft language on the USPSTF Grade C recommendation for HCV screening of the birth cohort and submission of this language to USPSTF as a public comment from CHAC.

**CHAC unanimously approved the resolution.**

**Topic 5: New NCHHSTP Director**  
**Champions: Jeanne Marrasso, MD, MPH; Douglas Brooks, MSW**

The CHAC members discussed and offered several suggestions to refine the resolution Dr. Marrasso and Mr. Brooks drafted regarding the new NCHHSTP Director. At the conclusion of the discussion, the following motion was properly placed on the floor and seconded by Drs. Carlos del Rio and Marjorie Hill, respectively, for CHAC to formally adopt and submit the following resolution to the CDC Director.

CHAC applauds the vision, intellect, commitment and care that Dr. Kevin Fenton has brought to his leadership of the CDC National Center for HIV/AIDS, Viral Hepatitis, STD



and TB Prevention. A hallmark of Dr. Fenton's tenure was his tireless effort to address issues of overarching importance for prevention and treatment of HIV/AIDS, viral hepatitis and STD, including Health Equity and Social Determinants of Health, Prevention through Healthcare, and Sexual Health.

As the search commences for a new Director of the Center, we encourage the CDC Director and search committee to select a candidate who will continue to prioritize a public health approach that is holistic and who understands the need to consider the interrelated and interdependent systems that impact peoples' lives, particularly those most affected by these preventable and treatable diseases. This focus on health equity and prioritization of resources where they are most needed and have the most impact is especially critical as we transition into the era of the Affordable Care Act, which we hope will result in increased access to health care and ultimately improve population health. For this transition to be successful, we believe that both CDC and HRSA need to recognize the success of Dr. Fenton's efforts to institutionalize these priorities, and that his successor build on them. An important part of the work of this position is to align public health and primary care priorities, and to continue the momentum for addressing these issues in the context of CDC's and HRSA's scientific and programmatic work.

**CHAC unanimously approved the resolution.**

**Topic 6: Late Diagnosis of HIV**  
**Champion: Carlos del Rio, MD**

The CHAC members discussed and offered several suggestions to refine the resolution Dr. del Rio drafted regarding late diagnosis of HIV. At the conclusion of the discussion, the following motion was properly placed on the floor and seconded by Dr. Carlos del Rio and Mr. Ernest Hopkins, respectively, for CHAC to formally adopt and submit the following resolution to the HHS Secretary.

The U.S. Department of Health and Human Services' (HHS) recent Antiretroviral Therapy (ART) Treatment Guidelines (March 2012) now recommend ART treatment regardless of CD4 count both for benefit to the individual as well as to prevent HIV transmission. CHAC expresses its concern about the challenge that late diagnosis of HIV continues to have on long-term outcomes of persons with HIV in the United States as well as ongoing transmission. CHAC recommends that the Secretary of HHS convene a group to examine the causes of late diagnosis of HIV, and proactively examine these cases as "sentinel events" or "failures of early detection" that highlight failures of the health system that need to be addressed.

**CHAC unanimously approved the resolution.**

**Topic 7: CDC's Response to the IOM Report**

**Champion: Jennifer Kates, PhD**

The CHAC members discussed and offered several suggestions to refine the resolution Dr. Kates drafted regarding CDC's response to the IOM report. At the conclusion of the discussion, the following motion was properly placed on the floor and seconded by Drs. Jennifer Kates and Steven Johnson, respectively, for CHAC to formally adopt and submit the following resolution to the CDC Director.

CHAC endorses the recent Institute of Medicine Report, *Monitoring HIV Care in the United States: A Strategy for Generating National Estimates of HIV Care and Coverage* (October 2012). The report was commissioned by the White House Office of National AIDS Policy to provide an enhanced means of assessing the effect of the National HIV/AIDS Strategy and the Affordable Care Act on care received by persons with HIV. In addition, CHAC also requests that CDC report back to the CHAC by its next meeting with input on recommendations in the IOM report specific to CDC, particularly the recommendations related to the CDC Medical Monitoring Project.

**CHAC unanimously approved the resolution.**

**Topic 8: New Data Workgroup  
Champion: Jennifer Kates, PhD**

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

CHAC recommends the formation of a new workgroup to work with HRSA and CDC on assessing emerging data that should directly inform the implementation of the Affordable Care Act, especially as it relates to prevention interventions and the delivery of care in clinics receiving Ryan White funds and in Community Health Centers.

**CHAC unanimously approved the resolution.**

Ms. Dempsey urged the new Data Workgroup to prioritize two key tasks in its initial discussions: (1) clarify and refine its formal charge and (2) engage HAB in discussions on additional data runs to perform with the RSR dataset. The following CHAC members volunteered to serve on the workgroup:

- Co-Chairs: Jennifer Kates, PhD; Jeanne Marrazzo, MD, MPH
- Members: Kathleen Clanon, MD; Angelique Croasdale, MA; Carlos del Rio, MD; Steven Johnson, MD

**Topic 9: Ongoing Support of In-Person CHAC Meetings  
Champion: Kathleen Clanon, MD**

Drs. Fenton and Parham Hopson made two announcements that are likely to impact the function of future CHAC meetings. First, the White House issued a mandate for all federal agencies to reduce the number of face-to-face meetings of their Federal Advisory Committees (FACs) by increasing the use of webinars and other virtual technologies. Second, HRSA's ability to continue to support travel for all HRSA-appointed CHAC members and key HRSA staff to attend CDC-centric meetings in Atlanta is in jeopardy due to severe budget cuts.

In response to these announcements, the following motion was properly placed on the floor and seconded by Drs. Kathleen Clanon and Britt Rios-Ellis, respectively, for CHAC to formally adopt and submit the following resolution to the CDC Director and HRSA Administrator.

Because CHAC advises two federal agencies instead of one, CHAC strongly feels that continuation of two face-to-face meetings per year is necessary. Due to the strong intersection and integration of CDC and HRSA as expressly recommended in the National HIV/AIDS Strategy, CHAC further believes that its HRSA-appointed members must continue to be given travel support to attend CDC-centric meetings in Atlanta.

**CHAC unanimously approved the spirit, concept and intent of the resolution.**

Dr. Clanon would refine the resolution with background information on CHAC's unique role of advising two federal agencies. The revised resolution would be circulated to CHAC for review before submission to the CDC Director and HRSA Administrator. Dr. Parham Hopson and the new NCHHSTP Director would use the final resolution to justify continued travel support for two face-to-face CHAC meetings per year.

**Topic 10: Future Agenda Items**

CHAC proposed the following presentations, overviews or updates to place on future meeting agendas.

- **CDC:** "Meet-and-greet" session with the new NCHHSTP Director
- **CMS:** Overview of CMS's role in the current care model and CMS's efforts to include prevention in the model
- **Guest Presenters:** Presentation by Dr. Michael Mugavero or other experts who are conducting research to determine specific reasons for PLWH disengaging from care (e.g., physical barriers or provider-related issues)
- **Panel Presentation on Workforce Issues:**
  - Ongoing activities with AETCs, Prevention Training Centers, ancillary providers and specialty medical groups (e.g., National Hispanic Medical Association and National Medical Association)

- Preliminary results of the HIV Workforce Study (HAB) and complex workforce issues (Mr. Edward Salsberg, Director, National Center for Health Workforce Analysis, HRSA Bureau of Health Professions)
- Status report on activities conducted by the 12 Cities Project and CAPUS grantees
- Existing capacity and skills of the workforce (e.g., current training approaches and disease-specific issues)
- Field trip to the Ryan White HIV Clinic in Atlanta if time permits

CHAC agreed that due to the overwhelming scope and magnitude of workforce issues, the meeting format would need to be restructured to accommodate this agenda item. For the first meeting in 2013, the morning session would be devoted to key updates from CDC and the entire afternoon session would be devoted to CHAC's in-depth discussion of workforce issues with an emphasis on prevention. The same format would be repeated for the second meeting in 2013, but HRSA would present key updates during the morning session and CHAC's in-depth discussion of workforce issues during the afternoon session would focus on care and treatment.

**Topic 11: Action Items**

CHAC reviewed the action items that were raised over the course of the meeting.

- Dr. Britt Rios-Ellis agreed to co-chair the Sexual Health Workgroup with Ms. Antigone Dempsey.
- The HRSA and CDC Committee Management Specialists (Ms. Shelley Gordon and Ms. Margie Scott-Cseh) will obtain links to the two recent IOM reports from Drs. Jennifer Kates and/or Carlos del Rio for distribution to the entire CHAC membership.
- Dr. Carlos del Rio will organize a field trip to the Ryan White HIV Clinic in Atlanta during the next CHAC meeting if time permits. He also offered the facilities at the Emory University Rollins School of Public Health for persons who are unable to attend the next CHAC meeting to participate in the proceedings remotely.

**Topic 12: Ongoing Assessment of the CHAC Meeting Format**

Dr. Marrazzo solicited additional feedback from CHAC to aid the co-Chairs and DFOs in their ongoing assessment of the meeting format. CHAC's insights and perspectives on the current meeting fell into three major categories.

**Category 1: Preparation for the Business Session**

CHAC made tremendous progress with the new format during the May 2012 meeting in terms of being more efficient and productive and providing HHS, CDC and HRSA with clearer and more substantive guidance. However, day 1 of the current meeting appeared to regress to the old format of a dense agenda with numerous and lengthy presentations and limited time for CHAC's discussion. This structure did not allow the CHAC members to engage in meaningful dialogue and express their thoughts on specific topics during the meeting.

After day 1 of the meeting has been recessed, the new format allows the champions and their CHAC colleagues to meet in small groups in the evening to draft resolutions/recommendations. However, the timeline of this process is problematic. Most notably, the productivity of the members has decreased by this time and their memories are not as sharp after listening to a full day of presentations. The co-Chairs and DFOs should consider two potential options to improve the timeline for CHAC members to prepare for the business session.

- Option 1: The CHAC members should divide into small groups for 15-30 minutes after each series of presentations has been made on a particular issue or theme to discuss the information and begin drafting resolutions or recommendations in “real time” during meetings.
- Option 2: Future agendas should be structured with less and shorter presentations on day 1 of the meeting. By 3:30 or 4:00 at the latest, CHAC should begin preparing for the business session by agreeing on topics that need formal resolutions/recommendations and identifying champions and other members to take responsibility for each issue.

### **Category 2: Meeting Materials**

Stronger efforts should be made for CHAC to become a “greener” committee by reducing the volume of printed meeting materials. For example, CD-ROMs, e-mail attachments and web links should be used to provide CHAC members with documents in the meeting binders (e.g., PowerPoint slide sets, meeting minutes, background information and recent publications). However, “late-breaking” slide sets that are circulated in print during meetings should be formatted with 2 rather than 3 slides per page for easier reading.

Speakers should format their PowerPoint slide sets with two key bullet points at the beginning of their presentations: (1) the purpose, intent or rationale for placing the topic on the agenda and (2) clear guidance requested from CHAC if a formal resolution or recommendation needs to be drafted or specific action needs to be taken.

### **Category 3: Retention of the Membership**

Each CHAC member must make a strong commitment to remain present for the entire length of each meeting. Most notably, FACs are prohibited from formally voting on issues without a quorum. To assist in this effort, CDC and HRSA will finalize and inform the CHAC members of the next meeting date with as much advance notice as possible and also will attempt to adjourn future meetings by 12:00 p.m. on day 2.

## **Topic 13: Parting Remarks to Dr. Kevin Fenton**

*Editor's note:* The quotes outlined below were made over the course of the 1.5-day meeting, but are compiled in one section to honor Dr. Fenton's seven-year tenure as the NCHHSTP Director and the CHAC DFO for CDC.

- Dr. Kenneth Mayer: *“Kevin, I want to salute you on your superb leadership and really thank you for your service. Working with you and your staff has been unparalleled in terms of the level of cooperation.”*
- Ms. Regan Hofmann: *“Kevin, thank you for your superb leadership. We will miss you very much.”*
- Dr. Marjorie Hill: *“We will miss you, Dr. Fenton. There’s a long list of your accomplishments, but I think the transfer of Adolescent Health into the Center was a significant change and is making headway in terms of some of the issues we are talking about.”*
- Dr. Jennifer Kates: *“I’m sad that you’re not going to be here at my future meetings. We really thank you for everything you’ve done.”*
- Mr. Douglas Brooks: *“Dr. Fenton, we all appreciate you for various reasons and one of mine is for your unyielding leadership on including the social determinants of health as we examine the lives of people. As a social worker, I greatly appreciate that and your social worker’s doctorate.”*
- Dr. Rima Khabbaz: *“I suspect you all share my mixed feelings heading into this transition. I’m very excited for Kevin for his opportunity and new position in the U.K. He’s going back home in some ways and he will shape a new agency there. At the same time, we’re going to miss him; that’s an understatement. He’s been a great leader and a great colleague. I have learned from him. I’m really sad to see him go back across the pond.”*
- Dr. Jonathan Mermin: *“Thank you, Kevin, for your leadership.”*
- Dr. Jeanne Marrazzo: *“Kevin, I think I speak for everybody when I say we’ll miss you as we welcome John. We’ll miss you more than our words can express, which I think has been coming across pretty sincerely and intensely.”*

## Overview of Social Media Opportunities for CHAC

### **Jeanne Marrazzo, MD, MPH, CHAC co-Chair**

Professor of Medicine, Harborview Medical Center  
University of Washington

### **Antigone Dempsey MEd, CHAC co-Chair**

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

Dr. Marrazzo and Ms. Dempsey presented an overview of strategic and innovative social media opportunities for CHAC to broadly communicate and widely engage the public in its activities. Social media are web-based and mobile tools and activities that shift communication to interactive dialogue and integrate technology and social interaction.

Each day, Facebook users “like” and “comment” on items 3.2 billion times per day and watch 500 years of YouTube videos. Each minute, Facebook receives 208,000 uploaded images and YouTube receives 60 hours of uploaded videos. Each second, 11 new Twitter profiles are created. The number of wireless devices that are used in the United States at this time is greater than the number of persons in the U.S. population.

Social media are used to complement traditional communication platforms, share information in new spaces, connect with new audiences, encourage engagement and interaction with the content, and empower individuals to make more informed decisions. For example, the CDC iPad application provides outstanding access to *MMWR* articles, Vital signs Reports and other important prevention data.

Social media planning should be strategic in order to achieve communication planning inputs, such as reaching and engaging primary/secondary audiences and determining communication objectives (e.g., raising awareness, increasing knowledge or influencing/persuading). For example, the PACHA website has served as a primary influencer by increasing the visibility of national HIV/AIDS-related efforts. Communication objectives should be designed to lead to effective strategies and tactics for:

1. community building;
2. calls to action;
3. creation of interest and excitement
4. listening and monitoring
5. audience engagement;
6. increased reach; and
7. general awareness and promotion of the issue in the news.

A small group of CHAC members had offline discussions with CDC and agreed that a focus on communication objectives 5-7 would be most relevant and feasible for CHAC’s mission. Agreement was reached that CHAC’s cross-media strategies should include Facebook, Twitter and video conferencing/webinars. However, CHAC’s use of these social media platforms should be designed to deliver consistent messages across multiple channels, promote synergy across media and target efficiencies. A number of CDC resources are available to assist CHAC in increasing its reach to the public through social media:

- *Health Communicator’s Social Media Toolkit* ([www.cdc.gov/socialmedia](http://www.cdc.gov/socialmedia))
- *Guide to Writing for Social Media* ([www.cdc.gov/socialmedia](http://www.cdc.gov/socialmedia))
- *Social Media Guidelines* ([www.cdc.gov/SocialMedia/Tools/guidelines](http://www.cdc.gov/SocialMedia/Tools/guidelines))

Dr. Marrazzo and Ms. Dempsey confirmed that an update would be placed on a future agenda in order for CHAC to propose potential approaches to apply social media tools and strategies to broaden its outreach to the public.

On the one hand, some members noted that CHAC should replicate the PACHA website as a solid model for the public to obtain accurate and up-to-date information on the activities of a FAC from one credible source. For example, a Google search of “CHAC” will result in an outdated roster of the membership and discrepancies between the CDC and HRSA websites.

On the other hand, other members pointed out that CHAC’s ability to replicate the PACHA website as a “one-stop” resource would be extremely challenging due to major differences between the two FACs. For example, PACHA is chartered to advise the HHS Secretary only, while CHAC is chartered to advise both the CDC Director and HRSA Administrator in addition to the HHS Secretary. As a result, both CDC and HRSA maintain separate CHAC websites.

Moreover, PACHA’s base of constituents and stakeholders is limited to HIV/AIDS only, while CHAC’s broader base of constituents and stakeholders includes HIV, VH and STD. To resolve this dilemma, CDC and HRSA should establish a common interagency website to post CHAC’s formal resolutions, recommendations and action items.

**Closing Session**

Dr. Fenton thanked the participants for their kind remarks to him over the course of the meeting. He reiterated that he was honored to serve as the CHAC DFO over the past seven years. He was excited about CHAC’s future directions and extended warm wishes to the members in their new endeavors. However, he urged CHAC to build on and scale up the best and promising practices that have been established over the past seven years. Dr. Fenton confirmed that he would always remain in touch with CHAC from London.

The CHAC co-Chairs and CDC/HRSA leadership thanked the CHAC members for continuing to dedicate their valuable time and expertise while attending meetings and participating in the workgroup activities offline.

The next CHAC meeting would be held on either June 12-13, 2013 or June 18-19, 2013 in Atlanta, Georgia. The CHAC Committee Management Officers would poll the members via e-mail to confirm the exact date and location.

With no further discussion or business brought before CHAC, Dr. Marrazzo adjourned the meeting at 12:30 p.m. on December 12, 2012.

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

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Date

Antigone Hodgins Dempsey, MEd, Co-Chair  
CDC/HRSA Advisory Committee on HIV,  
Viral Hepatitis and STD Prevention and  
Treatment

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Date

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