

**U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
Health Resources and Services Administration**



**Virtual Meeting of the
CDC/HRSA Advisory Committee on
HIV, Viral Hepatitis, and STD Prevention and Treatment
November 3 and 4, 2021**

Record of the Proceedings

Table of Contents

EXECUTIVE SUMMARY	1
MINUTES OF THE MEETING	3
DFO Opening of the Meeting	3
Conflict of Interest Disclosures	3
Introductions, Welcome, and Adoption of Minutes	5
DFO Welcoming Remarks	5
HRSA Update	6
HRSA HAB Update	7
HRSA BPHC Update	10
CDC Update	11
CHAC Member Discussion with CDC and HRSA on Updates	13
Special Presentation – Engagement in Care among People Living with HIV Using Telemedicine During the COVID-19 Pandemic	15
CHAC Discussion on Special Presentation	16
Panel 1 – Improving STI Screening in People with HIV through the Ryan White HIV/AIDS Program	20
Bacterial STI Testing and Treating Barriers.....	21
CHAC Member Discussion on STI Panel	22
Business Session and Member Discussion – Part 1	24
Recap Day One/Review Day Two Agenda	26
DFO Opening of Meeting and Roll Call: Day 2	27
Recap of Day 1 and Objectives/Process, Day 2	27
Public Comment	27
Work Group and Liaison Reports	29
Ending the HIV Epidemic Community Engagement Workgroup	29
Presidential Advisory Council on HIV/AIDS	29
Discussion on Workgroup and Liaison Reports.....	30
Panel 2 – Providing Housing Services at the Intersection of Substance Use Disorder, Mental Health, and HIV	31
HOPWA Perspective on Providing Housing Services at the Intersection of Substance Use Disorder, Mental Health, and HIV	32
HIV Outbreaks Among People Who Inject Drugs: Recent CDC Experience.....	33
Insights from Boston, Massachusetts	34
Insights from Hennepin County, Minnesota	36
CHAC Member Discussion on Panel 2	38
Additional Public Comment	42
Updated Guidelines for Hepatitis B Screening	43
Panel 3 – Beyond Viral Load. Patient Centered, Integrated Care with Emphasis on Quality of Life and Emotional Wellbeing	44
Using Bundled Interventions to improve HIV Health Outcomes & Quality of Life for Black Women with HIV	45
Early Findings from the Black MSM Initiative	47

CHAC Member Discussion on Hepatitis B Screening Presentation and Panel 3.....	49
Business Session and Suggestions for Future Agenda Items – Part 2	51
Recap Day Two.....	53
Adjournment.....	54
ATTACHMENT A: PARTICIPANT LIST	55
ATTACHMENT B: LIST OF ACRONYMS	58
ATTACHMENT C: WRITTEN PUBLIC COMMENTS	60

Executive Summary

The United States (U.S.) Department of Health and Human Services (HHS); the Centers for Disease Control and Prevention (CDC) National Center for HIV, Viral Hepatitis, Sexually Transmitted Diseases (STDs), and Tuberculosis (TB) Prevention (NCHHSTP); and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) convened a meeting of the CDC/HRSA Advisory Committee on HIV, Hepatitis, and STD Prevention and Treatment (CHAC) virtually on November 3 and 4, 2021.

The Committee received and discussed updates from HRSA HAB, HRSA's Bureau of Primary Health Care (BPHC), and CDC. Members praised updated policy guidance from HAB on client eligibility and recertification in the Ryan White HIV/AIDS Program (RWHAP), inquired about data on the transition to telehealth in health centers and how those innovations will be sustained, asked whether/how CDC and HRSA were tracking provider morale amidst the COVID responses, and praised new impact data from CDC's adolescent and school health program.

Presentations were also made on five key issues related to the nation's responses to HIV, STDs, and viral hepatitis:

Engagement in Care among People Living with HIV Using Telemedicine During the COVID-19 Pandemic

The presenter shared findings from an analysis of patient engagement in telemedicine in a Baltimore HIV clinic which concluded that patients already virally suppressed maintained a high level of engagement in the transition to telemedicine and, promisingly, engagement (defined as completing ≥ 1 visit during the study period) improved significantly among patient populations with historically lower rates of engagement, including younger patients, female patients, and patients who had not yet achieved viral suppression. CHAC members discussed the effects of disparities in access to broadband and/or technological literacy; whether there is an important quality difference in telephone vs. video visits and implications for parity in payment for them; and the need to further assess durability of patient viral suppression outcomes, longer term retention, and other factors disaggregated by type of visit and patient characteristics.

Improving STI Screening in People with HIV through the Ryan White HIV/AIDS Program

Panelists highlighted the relationship between HIV and STIs and presented information about several HAB-supported projects underway to improve STI screening and treatment among people with HIV (PWH), and shared insights into system-level challenges to the implementation of routine bacterial STI screening and treatment that were identified in the demonstration sites for one of those projects. In the discussion that followed, CHAC members discussed issues including concerns about misalignment across various federal STI guidelines (CDC, USPSTF), opportunities to leverage other programs such as family planning and Medicaid to reach additional populations with STI services, cost and other barriers to accessing penicillin G benzathine for STI treatment, and the need to expand the use of and reimbursement for self-swabbed extra-genital tests to improve patient access to these services.

Providing Housing, Behavioral Health, and HIV Services in Response to an HIV Cluster/Outbreak Among Unhoused People Who Use Drugs

The panelists reviewed CDC's insights from supporting more than 10 communities in responding to recent HIV outbreaks among people who inject drugs in which unstable housing was a common issue, highlighted opportunities for collaboration with the Housing Opportunities

for People With AIDS program and other programs administered by the U.S. Department of Housing and Urban Development, and also discussed the experiences of Boston, Massachusetts, and Hennepin County, Minnesota, in responding to HIV outbreaks among people who use drugs also experiencing homelessness. Members discussed approaches to serving this population with complex needs.

Updated CDC Guidelines for Hepatitis B Screening

CDC provided a review of the proposed new hepatitis B screening recommendations which add to existing recommendations for screening among pregnant people and risk-based testing a new recommendation for universal hepatitis B screening at least once in a lifetime for adults >18 years of age with screening to be done with a 3-test panel. Members discussed the need for improving primary care provider training on the hepatitis B screening guidelines and misalignment across CDC and USPSTF guidelines.

Patient-Centered, Integrated Care Emphasizing Quality of Life and Emotional Wellbeing

Panelists explored how treating the whole person, including addressing behavioral health, mental health, and substance use disorder treatment needs with culturally tailored interventions can improve quality of life, highlighting lessons and recommendations from two RWHAP Special Projects of National Significance, one focused on HIV care for Black women and the other focus on Black men who have sex with men. Members discussion included recommendations on roles for peer in such programs and the need for quality of life measures.

CHAC Action

CHAC members voted to establish an informal work group to discuss and draft potential recommendations regarding issues of telemedicine in HIV and sexual and reproductive health before the next meeting.

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

**CDC/HRSA Advisory Committee on
HIV, Viral Hepatitis, and STD Prevention and Treatment
November 3 & 4, 2021**

Minutes of the Meeting

The United States (U.S.) Department of Health and Human Services (HHS); the Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases (STDs), and Tuberculosis (TB) Prevention (NCHHSTP); and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) convened a meeting of the CDC/HRSA Advisory Committee on HIV, Hepatitis, and STD Prevention and Treatment (CHAC). In response to the COVID-19 pandemic, the proceedings were held virtually via Zoom on November 3 and 4, 2021.

The CHAC is a committee chartered under the Federal Advisory Committee Act (FACA) to advise the Secretary of HHS, Director of CDC, and Administrator of HRSA on objectives, strategies, policies, and priorities for HIV, viral hepatitis, and STD prevention and treatment efforts for the nation.

Information for the public to attend the CHAC meeting virtually was published in the Federal Register, in accordance with FACA rules and regulations. All sessions of the meeting were open to the public (see Appendix A for the Participant List).

DFO Opening of the Meeting

Laura Cheever, MD, ScM
Associate Administrator, HIV/AIDS Bureau (HAB)
Health Resources and Services Administration (HRSA)

Dr. Cheever welcomed committee members and viewers to the November 2021 meeting of CHAC. She noted that the committee’s meetings are open to public and all comments made during the meeting are a matter of public record. She then conducted a roll call to determine the CHAC voting members and *ex-officio* members who were in attendance. During the roll call members disclosed whether they had any potential conflicts of interest.

Conflict of Interest Disclosures

CHAC Voting Member (Institution/Organization)	Disclosure of Conflict
Jean R. Anderson, MD (The Johns Hopkins Hospital)	Spouse has stock in AbbVie, BMS, Pfizer, and Merck
Wendy Armstrong, MD (Emory University School of Medicine)	Recipient of funding from HRSA/Ryan White HIV/AIDS Program

CHAC Voting Member (Institution/Organization)	Disclosure of Conflict
Jodie Dionne-Odem, MD (University of Alabama, Birmingham)	Recipient of funding from NIH
Shannon Brown Dowler, MD (North Carolina Medicaid)	
Daniel Driffin, MPH (D3 Consulting)	
Travis Gayles, MD, PhD (Hazel Health)	
Meredith Greene, MD (University of California, San Francisco)	Recipient of funding from NIH, HRSA/Ryan White HIV/AIDS Program, and Gilead
Debra Hauser, MPH (Advocates for Youth)	Recipient of funding from CDC, ViiV, and Gilead
Venton Hill-Jones, MSHCAD, PMP (Southern Black Policy and Advocacy Network)	Recipient of funding from HRSA and Gilead
Shruti Mehta, PhD, MPH (Johns Hopkins Bloomberg School of Public Health)	Recipient of funding from USAID and PCORI
Gregorio A. Millett, MPH (amfAR, Foundation for AIDS Research)	Recipient of funding from ViiV
Johanne Morne, MSED (AIDS Institute, New York State Department of Health)	Recipient of funding from CDC and HRSA/Ryan White HIV/AIDS Program
Kneeshe Parkinson (Washington University/Project ARK)	Recipient of funding from HRSA/Ryan White HIV/AIDS Program
Robert Riestler (Denver Element)	Recipient of funding from CDC and HRSA/Ryan White HIV/AIDS Program
Leandro Rodriguez, MBA (Latino Commission on AIDS)	Recipient of funding from CDC and HRSA/Ryan White HIV/AIDS Program
Samuel So, MB, BS (Asian Liver Center at Stanford University, Stanford University)	Recipient of funding from CDC, NIH

Ex-Officio members in attendance included Dr. Pradip Akolkar of the Food and Drug Administration (FDA), Dr. Paul Gaist of the National Institutes of Health (NIH) Office of AIDS Research, Dr. Neerja Gandotra of the Substance Abuse and Mental Health Services Administration (SAMHSA), Ms. Kaye Hayes of HHS Office of HIV/AIDS and Infections Disease Policy, and Dr. Richard Wild for the Centers for Medicare and Medicaid Services (CMS).

Dr. Cheever confirmed that a quorum was present for CHAC to conduct its business on November 3, 2021.

Introductions, Welcome, and Adoption of Minutes

Jean Anderson, MD

CHAC Co-Chair, HRSA appointee

Travis Gayles, MD, PhD

CHAC Co-Chair, CDC appointee

Dr. Anderson welcomed CHAC members, federal staff, and viewers of the meeting online. She noted that the agenda for the two-day meeting briefly previewed the topics to be discussed. She also offered a warm welcome to newly appointed committee co-chair, Dr. Gayles.

Noting it was his first meeting as co-chair, Dr. Gayles observed that he excited to be in his new role and continuing his work with CHAC. He thanked everyone for their patience with working with the virtual platform for the meeting.

Dr. Anderson reviewed the minutes from the April 12 business meeting and the April 20-21 CHAC meeting. Mr. Riester observed that he was identified throughout the minutes as Dr. Riester and that should be changed to Mr. Riester. No other changes were requested.

CHAC Action

Ms. Hauser made a motion to approve the April 12 meeting minutes, which was seconded by Dr. Armstrong. CHAC members voted to approve the minutes with no changes or further discussion.

Dr. Dionne-Odem made a motion to approve the April 21-22 meeting minutes, which was seconded by Ms. Hauser. CHAC members voted to approve the minutes with no changes or further discussion.

DFO Welcoming Remarks

Laura Cheever, MD, ScM

Associate Administrator, HIV/AIDS Bureau (HAB)
Health Resources and Services Administration (HRSA)

Dr. Cheever welcomed new members to the committee and thanked an outgoing member. She thanked Mr. Devin Hursey, whose term ended, for contributing his expertise to CHAC. She welcomed newly appointed members Mr. Daniel Driffin, Dr. Shannon Dowler, Dr. Vincent Guilamo Ramos, and Dr. Samuel So. In addition, she welcomed Dr. Ada Stewart as the liaison to CHAC from the Presidential Advisory Council on HIV/AIDS (PACHA). She also congratulated CHAC member Dr. Travis Gayles on his new role as the committee's co-chair. Finally, she congratulated CHAC co-chair Dr. Anderson on achieving a professional milestone as an emeritus professor at Johns Hopkins University.

Jonathan Mermin

Director, National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
Centers for Disease Control and Prevention (CDC)

Dr. Mermin welcomed all of the members and thanked them for participating, noting that he was looking forward to the discussions over the next two afternoons.

HRSA Update

Diana Espinosa, MPP

Acting Administrator, Health Resources and Services Administration

Reflecting on HRSA's mission – to improve health outcomes and achieve health equity through access to quality services, a skilled health workforce, and innovative, high-value programs – Ms. Espinosa observed that the CHAC meeting is a reminder that HRSA is supported in that mission by federal partners, state and community partners, and stakeholders from across the country and around the globe. She observed that HRSA benefits in many ways from the discussions that take place in these meetings and remarked that the CHAC members are not just HRSA's partners in the field, but also are a rich source of information as stakeholders work together to end the HIV epidemic in the United States. She underscored that since HRSA is largely grant making agency, everything HRSA does as an agency is done through partnership.

Ms. Espinosa shared a brief update on HRSA activities. She highlighted since the CHAC last met, HRSA had identified several priorities for the months ahead that are consistent with the Department of Health and Human Services' priorities:

- Emergency and public health preparedness, including COVID-19
- Behavioral health
- Health equity
- Maternal and reproductive health

She observed that health equity has been a HRSA priority for many years, and that it remains central to the work done every day by HRSA staff and funding recipients. She remarked that this is especially true in the Ryan White HIV/AIDS Program (RWHAP), noting that the program's comprehensive system of care is a shining example of what HRSA means when they talk about the agency's commitment to health equity. HRSA's RWHAP recipients work every day to provide essential support services to address social determinants of health to help keep people with HIV in care and treatment.

She also highlighted that in recent months, HRSA's programs, including some new ones, have continued address issues magnified by the COVID-19 pandemic. Highlights include:

- Awarding grants to 270 health centers across 26 states, Washington, DC, and Puerto Rico, to expand HIV prevention and treatment services, including pre-exposure prophylaxis (PrEP), testing, outreach, and care coordination.
- Establishing and managing the rural health clinic COVID testing and mitigation program.
- Investing in key programs to strengthen telehealth services in rural communities, to expand telehealth innovation and quality nationwide, and to expand access to pediatric mental health care through telehealth.
- Awarding grants to support and build a community-based workforce to build vaccine confidence and increase vaccinations in underserved communities.
- Providing financial support to small rural hospitals for COVID19 testing and mitigation.
- Creating three new workforce programs promoting resiliency, mental health, and wellness among the health professional workforce.

Ms. Espinosa stated that continued collaboration and partnership is important to her and to HRSA. She thanked the CHAC members and viewers for all the work they have done to support and protect the HIV community during the challenges resulting from the COVID-19 pandemic. She reiterated that ending the HIV epidemic in the United States continues to be and will remain one of HRSA's highest priorities. She concluded by inviting CHAC members to reach out to share their ideas about how HRSA and its partners can continue to work together on shared goals as everyone continues to navigate through these unprecedented times.

HRSA HAB Update

Laura Cheever, MD, ScM

Associate Administrator, HRSA HAB

Dr. Cheever provided an update from HRSA's HIV/AIDS Bureau (HAB). The Bureau recently reviewed and refreshed its vision and mission statements, taking into consideration changes in the healthcare landscape, the Ending the HIV Epidemic in the U.S. (EHE) initiative, and the impending release of the updated National HIV/AIDS Strategy (NHAS). The updated statements are forward-looking and focus on where HAB and the Ryan White HIV/AIDS Program (RWHAP) want to be in 5 years, and what they need to do to get there. She explained that the vision is what HAB would like to accomplish at the highest level over the long term, while the mission is the current organizational focus to work toward that vision.

- The updated vision statement is: Optimal HIV care and treatment for all to end the HIV epidemic in the U.S.
- The updated mission statement is: Provide leadership and resources to advance HIV care and treatment to improve health outcomes and reduce health disparities for people with HIV and affected communities.

She underscored achieving HAB's vision and mission is only possible with the support of recipients and other stakeholders who are carry out the important work in clinics and communities every day.

Dr. Cheever reported that along with the updated vision and mission, HAB has updated their strategic priorities and organizational principles. The four strategic priorities are:

- Lead Progress: Foster Innovative Solutions to Drive Improvements
- Partner for Results: Engage Strategically with Stakeholders to Enhance Outcomes and Achieve Results
- Promote Integration: Integrate HIV Services to Improve Overall Outcomes
- Leverage Data: Use and Disseminate Data to Inform Decision Making and Measure and Evaluate Progress

Dr. Cheever shared that HAB and CDC's Division of HIV Prevention (DHP) released over the summer the *Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026*, which outlines the planning requirements for RWHAP Parts A and B recipients and all DHP-funded state and local health departments. The Integrated Plan Guidance meets all programmatic and legislative requirements associated with both CDC and HRSA HIV funding. Submitting integrated HIV prevention and care plans reduces grant recipient burden and duplicative planning efforts and promotes collaboration and coordination around data analysis.

Dr. Cheever shared that HRSA's National Strategic Plans Implementation workgroup has submitted policy and programmatic activities to support implementation of the new STI and Viral Hepatitis National Strategic Plans. Those activities will become part of the federal implementation plan for each strategic plan. HRSA has also been supporting the White House Office of National AIDS Policy in developing the updated National HIV/AIDS Strategy (NHAS), which is currently in progress. She noted that HRSA takes these sorts of strategic plans very seriously, remarking that much of gains in viral suppression achieved in the last decade were facilitated by the first (2010) NHAS which focused on driving changes in viral suppression.

She also reported that HAB has announced that the 2022 National Ryan White Conference on HIV Care & Treatment will take place August 23-26, and the theme is "The Time Is Now: Harnessing the Power of Innovation, Health Equity, and Community to End the HIV Epidemic." The conference is planned to be a hybrid model with some participants joining onsite in Washington, DC, and others participating virtually. This could change, depending on the status of the COVID-19 pandemic at that time. The conference website is live and the abstract submission period will open in November 2021. Registration for the conference will open in early 2022.

Policy Updates

Dr. Cheever provided several policy updates, spotlighting two recent policy notices that she characterized as some of the most important work recently completed.

- Policy Notice (PN) 21-01, *Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement*, simplifies the process by which RWHAP Part A, B, or C recipients request waivers of the statutory Core Medical Services Expenditure amount requirements, reducing the amount of documentation RWHAP recipients must submit to a one-page attestation form, thereby reducing burden.
- Policy Clarification Notice (PCN) 21-02, *Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program*, outlines the HRSA HAB guidance for RWHAP recipients and subrecipients for determining client eligibility and complying with the payor of last resort requirement, while minimizing administrative burden and enhancing continuity of care and treatment services. Two major policy changes are incorporated in PCN 21-02. First, it eliminates the six-month recertification requirement and allows RWHAP recipients and subrecipients the flexibility to conduct timely eligibility confirmations in accordance with their policies and procedures to assess if there are changes in a client's income and/or residency status. Clients can self-attest. HAB also clarified that clients should not be disenrolled automatically if they didn't recertify, only when a determination of ineligibility is actually made. Second, PCN 21-02 affirmatively states that immigration status is irrelevant for the purposes of eligibility for RWHAP services. HAB anticipates that the successful implementation of this PCN will reduce burden, avoid unnecessary disenrollment, and promote better overall continuity of care for RWHAP clients.

She also noted that HAB clarified that FY 2020 CARES Act funding may be used to incentivize vaccinations for RWHAP clients and family/household members living in the same household as the RWHAP client since many recipients are part of their communities' vaccine efforts. Dr. Cheever also discussed activities underway that reflect HAB's health equity approach to its work, including in the areas of program data and implementation, organizational culture and personnel, service delivery, and community engagement/partnerships.

Program Updates

Next, Dr. Cheever shared some program updates. Among the highlights she shared:

- HRSA recently launched the Ending Stigma through Collaboration and Lifting All to Empowerment (ESCALATE) program, designed to reduce stigma for people with HIV on multiple levels throughout the health care delivery system, including on the individual client, organization, and system levels. The program aims to increase cultural humility in care and treatment settings and focuses on improving organizational readiness and strengthening the capacity of RWHAP recipients and subrecipients to employ people with HIV.
- Applications are open for the Engage Leadership through Employment Validation and Advancing Transformation and Equity (ELEVATE) project. ELEVATE is designed to increase leadership, representation, and engagement of people with HIV in RWHAP planning, development, implementation, and clinical quality management activities by developing skills and supporting knowledge transfer through peer coaching for people with HIV. The program will also support organizational readiness to employ people with HIV in RWHAP recipient and subrecipient organizations.
- HAB recently launched the online RWHAP Best Practices Compilation. It serves as a central location for RWHAP-funded programs to share innovative strategies to bring people into care, keep them engaged in care, and improve their health, while reducing new HIV infections.
- The 2021 HAB/RWHAP biennial report provides an update on RWHAP efforts to improve health outcomes for people with HIV and highlights the innovative models of HIV care and treatment that RWHAP recipients implement in communities across the country. These include implementing a jurisdictional approach to *Ending the HIV Epidemic in the U.S.* initiative planning; linking care to incarcerated people with HIV; utilizing telehealth and telepsychiatry services, housing and employment services, and integrating trauma-informed care into dental practices and services to people with HIV.
- HAB recently co-hosted a webinar with the HHS Administration on Community Living (ACL) to educate RWHAP stakeholders about opportunities to collaborate with ACL-supported state and local aging services. Dr. Cheever noted that as more people with HIV are aging, it is really important that the infrastructure that supports people who are aging understand people with HIV and that RWHAP programs know about aging services/resources in their communities.

Data Updates

Dr. Cheever highlighted HAB's new RWHAP Compass Dashboard, a user-friendly, interactive data tool to visualize the reach and impact of the RWHAP and outcomes among clients served. It allows users to view national-, state-, and metropolitan area-level data and to explore RWHAP client characteristics, such as age, housing status, race and ethnicity, and outcomes including viral suppression and retention in care. It also visualizes information about services received through the RWHAP and, in the benchmarking feature, enables users to see how the RWHAP program is performing by state as well as by eligible metropolitan and transitional grant area.

EHE Activities

Dr. Cheever concluded with a discussion of HAB's activities to implement the EHE initiative. She presented Year 1 EHE Client Data, noting that the HAB EHE-funded service providers exceeded the goal of serving 18,000 clients. Between March and December 2020, they served 11,139 new clients and re-engaged 8,282 clients, for a total of 19,421 clients. She discussed how the EHE recipients achieved this outcome by using their EHE funds, and the new flexibilities that come with them, to expand and innovate the delivery of existing RWHAP

services, including AIDS Drug assistance Program (ADAP), early intervention services, emergency financial assistance, housing, medical case management, medical transportation, mental health services, and outpatient substance use services. She also highlighted some of the recipient activities, such as:

- linkage to care and re-engagement activities through low barrier clinics with high-intensity support, incentives, and care coordination; streamlining the client experience for initial contact and referral to services; and establishing rapid re-engagement protocols after missed appointments.
- Rapid ART programs which included a dedicated rapid linkage to care coordinator; new standards for starting treatment within 7 days of diagnosis from at-home/self-testing; and ART starter packs or 30-day supply at conclusion of first medical visit.
- Engaging peer navigators and community health workers to help clients navigate their HIV care and the general health care system, supplementing traditional case management activities.

Finally, Dr. Cheever highlighted HAB's 16 virtual EHE listening sessions held regionally in fiscal year 2021. The sessions engaged state and local health departments, community health centers, community organizations serving people with HIV, primary care offices, AIDS Education and Training Centers, and people with lived experience. The sessions engaged more than 1,900 people. These sessions informed HAB in developing guiding principles for its ongoing community engagement activities, which are vital to HRSA's work.

HRSA BPHC Update

James Macrae

Associate Administrator, Bureau of Primary Health Care (BPHC)

Mr. Macrae began his update with a discussion about the impact of COVID 19 on health centers. He reported that:

- Health centers served 28.6 million patients in 2020, a 4% decrease overall from 2019. He observed that most of the decrease was experienced with children and adolescents.
- Patient visits in 2020 decreased 7% overall compared to 2019, with 114.2 million patient visits in 2020. Despite this overall decline, health centers saw a significant increase in mental health visits, a slight decrease in medical visits and enabling services (patient education, transportation, translation, community health workers), and a significant decrease in vision and dental visits.
- In-person visits decreased by 36.63 million in 2020, or 30%, from 2019 while virtual visits increased by nearly 6,000% – 28.05 million more virtual visits than in 2019. Many health centers had been moving toward increasing the option of virtual visits, he noted, but COVID-19 made that transition happen much more rapidly. In 2020, 99% of health centers offered virtual visits, compared to 43% in 2019.

He reported that BPHC has invested in work with 25 health centers to assess and identify what the right balance of virtual vs. in-person visits may be moving forward. They'll be considering what makes sense from patient, provider, and reimbursement perspectives.

Mr. Macrae also provided updates on BPHC's EHE activities. He discussed the Primary Care HIV Prevention (PCHP) funding available to health centers in the 57 EHE jurisdictions. The funding supports the health centers to expand HIV prevention and treatment services, including testing, PrEP-related services, outreach, and care coordination. In FY 2020, BPHC awarded

\$54 million to support 195 health centers and in late FY 2021 it awarded \$48 million to support an additional 108 health centers. The President's FY 2022 Budget Request contains \$50 million to support up to 140 more health centers. In anticipation of those funds, BPHC has issued a Notice of Funding Opportunity.

Mr. Macrae also discussed calendar year 2020 HIV services data results from all health centers:

- Nearly 2.5 million HIV tests were conducted
 - 1.1 million were conducted by the 195 health centers that received FY 2020 EHE/PCHP funding
- Over 389,000 PrEP patients were seen at 925 health centers
 - Of these PrEP patients, 151,000 (40%) were seen through the 195 health centers that received FY 2020 EHE/PCHP funding
- 81% of patients (6,304) with first HIV diagnosis linked to care within 30 days
 - At the EHE/PCHP-supported health centers, 86% of newly diagnosed patients were linked to care within 30 days
- 190,000 patients with HIV received primary care services at health centers, including many sites co-funded by the Ryan White HIV/AIDS Program

Among the next priority activities for BPHC, he reported, are hearing more from health centers about the transition to tele-PrEP and telehealth, strategies for keeping patients engaged in HIV services, and working with more health centers that aren't yet engaged in HIV services to meet where they are in terms of their ability to provide PrEP and other HIV services, having heard many are interested but not yet fully ready to start.

CDC Update

Jonathan Mermin, MD

Director, NCHHSTP, CDC

Dr. Mermin began his CDC update by introducing Dr. Leandro Mena, the recently appointed director of the Division of STD Prevention within NCHHSTP. Dr. Mena previously ran the STD program in the Mississippi Health Department, was medical director of a local STD clinic, and co-founded a local LGBT clinic. He also served as a professor at the University of Mississippi. Dr. Mermin also shared a brief update on NCHHSTP staffing more broadly, noting that 700 of the Center's employees had been deployed to the CDC's COVID response activities, with most having done multiple deployments. He stated that about 6% of the Center's staff is currently deployed to COVID-response activities.

HIV Update

Dr. Mermin began his HIV update by noting that CDC had published several HIV Surveillance Reports since the last CHAC meeting. Among other things, those reports show that from 2015–2019:

- HIV diagnoses decreased by 9%
- New infections among young gay and bisexual men dropped 33%
- The South continues to be disproportionately affected
- Remained stable among persons who inject drugs

Dr. Mermin observed that the CDC actions begun a decade before, including the focus on high impact prevention and redistribution of resources, resulted first in the leveling off in the number of new infections and then the more recent declines. The most dramatic reduction has been

among young men who have sex with men (YMSM), especially young Black MSM. That outcome, he observed, really was part of a concerted effort to try to do better for this population. He also acknowledged that outbreaks continue among MSM and people who inject drugs in particular, and some of those outbreaks are made harder to tackle when syringe services programs (SSPs) not available in the affected community.

Another of the new reports is the latest from the Medical Monitoring Project (MMP) examining behavioral and clinical characteristics of people with diagnosed HIV between 2019 and 2020. It showed that over 80% of people with diagnosed HIV infection were prescribed ART, and about 60% overall have sustained viral suppression over the prior 12 months. Dr. Mermin noted that the MMP data suggest that last decade's focus on the HIV continuum of care has helped the nation focus on and improve services that are really important for people's health and for prevention and achieve these improved outcomes.

He also highlighted two recent, large HIV funding awards. CDC awarded \$42 million to 96 CBOs to implement program components that follow the EHE pillars. CDC also awarded \$117 million of EHE resources to health departments to help rebuild/ expand HIV prevention & treatment efforts in the 57 EHE jurisdictions.

Viral Hepatitis Update

CDC recently just completed a convening with the Association of Public Health Laboratories (APHL) titled Identifying High-Priority Diagnostics Approaches for Advancing Hepatitis C Elimination in the United States. The experts discussed major changes that need to happen with HCV testing to achieve elimination. Some of those had previously been discussed at CHAC meetings. CDC is also supporting planning for Advancing HIV, STI, and Viral Hepatitis Testing Conference, which will take place in spring 2022. Participants will share data and become familiar with test performance, best practices, implementation of testing algorithms, quality assurance, and the application of newer testing technology in a variety of settings.

Dr. Mermin also re-capped CDC's work on scientific and policy recommendations on updated adult hepatitis B vaccination, a process dating back to 2016. He reported that the very same day as the CHAC meeting, CDC's Advisory Committee on Immunization Practices (ACIP) was meeting to consider whether to expand the adult hepatitis B vaccination recommendation to a larger population of adults.

STI Update

CDC is investing \$1B in American Rescue Plan funds over a five-year period to support 21st century outbreak response needs, with a focus on strengthening the Disease Information Specialist (DIS) workforce. The first year of funding was distributed as a supplement to PS19-1901: STD Prevention and Control for Health Departments. CDC is developing a new structured NOFO for the remaining years of funding. The focus of the initiative is on expanding and enhancing frontline public health staff; conducting DIS workforce training and skills building; building organizational capacity for outbreak response; and evaluating and improving recruitment, training, and outbreak response efforts. The expanded, more diverse, and well-equipped workforce is needed to address STDs, HIV, and emerging infectious diseases like COVID.

Dr. Mermin reported that over the last decade, congenital syphilis has diffused across the nation. By 2019, 43 states and D.C. reported at least one case. Now >1000 cases per year are reported. This increase over time clearly spotlights gaps in our healthcare system, he observed, and we need to interrupt this ongoing transmission.

He also said that CDC had recently published new STI Treatment Guidelines with over a dozen important changes. CDC is now looking at ways to structure future updates that would make it easier and faster, perhaps through modules that would give CDC flexibility to update just sections rather than entire guidelines.

Adolescent and School Health Update

He shared results from a new study showing the positive impact of CDC's adolescent and school health programs. Published in the *Journal of Adolescent and School Health*, the study findings included:

- Students in schools that implemented the program were:
 - 12% < likely to have ever had sex
 - 16% < likely to have more than four lifetime sexual partners, or be currently sexually active
- After two years of implementation students were:
 - 13% less likely to miss school
 - 24% less likely to experience forced sex
 - 11% less likely to ever use marijuana and 23% less likely to currently use marijuana

He noted the reach of the programs is broad – 2 million students in 28 large school districts – and the cost is less than \$10 per student.

Dr. Mermin also highlighted a new National School COVID-19 Prevention Study that is intended to assist schools in ongoing way to effectively respond to changes in COVID epidemiology and interventions.

TB Update

Dr. Mermin announced that CDC had recently awarded funding for a research consortium on tuberculosis epidemiology to help gather the information needed to enable the nation to continue to reduce TB cases, which are now at one of the lowest points ever.

CHAC Member Discussion with CDC and HRSA on Updates

Dr. Gayles thanked the presenters for their updates, observing that it was great to hear about the scientific, clinical, and policy innovations they discussed. He noted that he was pleased to hear about how the new funds becoming available were being used to build up and bolster the public health and healthcare infrastructures. He then opened the session for questions or comments from CHAC members.

Dr. Dowler asked Mr. Macrae whether in the health center telehealth data BPHC was separating out the 3 types of telehealth visits or whether they are they all lumped together. Mr. Macrae noted that the data includes both video and audio visits but does not include remote monitoring visits since one of the changes that occurred during the pandemic was the ability to bill payers for both video and audio visits. He noted BPHC has heard from patients about the importance of continuing both formats, since in some rural areas with broadband access challenges video visits are less feasible.

Dr. Armstrong followed up on that issue asking whether BPHC will separately assess video and telephone visits when they assess outcomes and for whom telehealth is working. Mr. Macrae said that BPHC agrees with the importance of examining those dimensions. They definitely saw more use of telehealth in rural areas, but many in all settings preferred using just a mobile phone for convenience or privacy. HRSA believes that underscores the importance of continuing audio only options

Dr. Anderson thanked Dr. Cheever, Mr. Macrae, and Dr. Mermin for the just amazing work over the course of the last year and a half. She inquired whether any of the programs have data on issues related to the morale of healthcare providers during this time or whether they are trying to track that. Mr. Macrae remarked that BPHC was concerned about the morale of the primary care workforce before COVID and had been developing a related survey of health center staff at all levels. The demands of the COVID pandemic have put a greater spotlight on provider morale concerns. He had spoken to a clinicians group the day prior about how many health center providers are feeling demoralized and burnt out, just as we are seeing in public health. BPHC will conduct the morale survey in next 6 months. Originally, they had thought it establish a baseline, but now given what has transpired over last 18 months it will hopefully provide data on what will be a low point. He hopes the survey will offer some insights on how to bring some sort of joy back to working in health centers.

Dr. Gayles asked Mr. Macrae about what he foresees in terms of sustainability of the additional funding infusions public health has received tied to COVID-19 given that public health covers so much more. Mr. Macrae remarked that the resources the health center program has received as part of the response to COVID have been phenomenal, but that they one-time funding. So BPHC is talking with health centers about how to use those resources to propel them to the next level rather than just using them to fill gaps; thinking strategically in terms of the investments needed in tech and the workforce to sustain the health centers for the future. Many health centers doing that, but others are honestly struggling just to meet their immediate needs. We need to continue to make the case for public health and primary care funding and why those investments make sense. Dr. Mermin praised the dedication among people who work in health centers and public health that has sustained them through work in this challenging time, but he also acknowledged that during this time it has been hard to do this work for many of them. He noted that things have been especially hard on public health directors with many threats and even forced resignations.

Ms. Hauser observed that she was particularly impressed and pleased that CDC's Division of Adolescent and School Health has been able to show its impact in the new evaluation study that Dr. Mermin discussed. She noted that it is a game changer and that she hoped the findings yield additional resources for those programs. She added a reminder that educators are also in the midst of lots of stress, depression, and burnout due not just to COVID-19, but a host of other issues such as CRT, masks, sex ed, and trans bans and other issues at ground zero of the current culture wars. Dr. Gayles remarked that Ms. Hauser's point was a good reminder of the integrated nature of the work that everyone was doing and how so many partners in the work of public health are also being impacted and, unfortunately, politicized.

Special Presentation – Engagement in Care among People Living with HIV Using Telemedicine During the COVID-19 Pandemic

Moderator: Theresa Jumento, HRSA HAB

Ms. Jumento introduced the special presentation on the impact of the transition to telemedicine on people with HIV in a Baltimore clinic.

Engagement in Care among People Living with HIV Using Telemedicine during the COVID-19 Pandemic

Walid EI-Nahal, MD, Johns Hopkins Medicine

Dr. EI-Nahal shared findings from an analysis of patient engagement in telemedicine in a Baltimore HIV clinic. He noted that modeling shows that engagement/retention in care supports HIV treatment, improves health, and prevents transmission. Engagement was defined as completion of a visit with a provider. At the onset of COVID-19 pandemic, the clinic suddenly switched out of necessity from in-person visits to telemedicine. This provided an opportunity to assess how telemedicine affected patient engagement. The specific research questions were:

- What is the association between the transition to telemedicine and engagement with care?
- Was this association the same across subgroups?
- What was the rate of use of video visits and was this uniform across subgroups?

Dr. EI-Nahal assessed differences in the proportion of scheduled patients completing at least one visit in periods pre- and post-transition to telemedicine, including analysis by patient subgroups and by visit modality (telephone vs video). There were approximately 2,000 patients in each group. Most (85%) were virally suppressed and 60% had been patients for more than 10 years. The main findings of the study were:

- Telemedicine is associated with at least maintained visit completion for most patients (91% of patients completed ≥ 1 telemedicine visit)
- Patients already virally suppressed at maintained a high level of engagement in the transition to telemedicine
- Improvement in visit completion among some groups historically at risk for disengagement:
 - Younger patients
 - Female patients
 - Patients who have not yet achieved viral suppression
- But most visit completion was done by telephone – video visits were more likely to be completed by younger patients and women
- Reduced video access disproportionately affects older patients, Black patients, and patients with substance use disorder

Dr. EI-Nahal acknowledged there are remaining questions to be studied, observing that while telemedicine improved visit completion for some groups, we don't yet know the effects of an in-person vs. telephone vs. video visit on the quality of care and outcomes such as viral suppression, comorbidities, or patient satisfaction. He contended, though, that some engagement (even if "just" by phone) is likely better than none for patients who are missing in-person visits altogether. Further questions include if telemedicine continues to have wider

uptake beyond the pandemic, how can it be leveraged to increase engagement with people living with HIV? How does this engagement compare to in-person engagement? How can it be implemented in a way that mitigates disparities?

CHAC Discussion on Special Presentation

Dr. Gayles opened the discussion commending Dr. El-Nahal's work, thanking him for his contribution to helping us better understand impacts of this recent necessary innovation in HIV care delivery. He also underscored the observation about disparities in access to or facility with technology. He asked about difference in telehealth uptake in communities with health literacy challenges and asked if Dr. El-Nahal had any insights on addressing either those challenges or how to address the disparities in technology access and use. Dr. El-Nahal shared that the team attempted many things on the fly as they transitioned to telehealth. For example, he would try with all patients to make good faith effort to have a full video visit, rather than a telephone visit, because he felt it would be a better quality visit. He would try different platforms. But sometimes after various attempts, he would switch over to a telephone visit. He found that some patients were often eager to make that switch to telephone visits since it was just easier than figuring out how to get set up with MyChart [Hopkins' patient portal with a video visit feature] or they had issues with tech literacy. To try to address those patient challenges, clinic staff would try to reach out ahead of scheduled appointment to set up the electronic connection with the patient. He also remarked that he had talked to some other groups that were doing small scale pilots that provided tablets and support to use them to patients. He doesn't know how financially feasible or scalable that approach is. But he stressed that finding out that some patients can't engage in the same online way isn't an excuse, instead it should be a motivator to find ways to work with them.

Dr. So inquired whether the study looked at whether people who used video telemedicine visits had broadband access or not. He also observed that some of the platforms are quite different in terms of ease of use and wondered if simplifying the video application on the phone would improve adoption of the technology. Finally, he remarked that since many older folks are not as tech savvy they may be more likely to have difficulty logging in to a video visit platform. Dr. El-Nahal replied reported that the study did not have data about patient access to broadband, but he suspects that it is a very, very important factor. He also concurred about some of the tech challenges, explaining that a few months into the transition, his clinic switched platforms because of difficulties experienced with first platform. One useful feature of the platform allows the provider to text the patient link to visit, reducing the tech work for patient since they just had to click the link to open the video visit. He recommends platforms that do as much of the heavy lifting for the patient as possible to make the visits easy; but recognizes that clinics and providers have to balance that ease of use with security protections.

Dr. Armstrong asked if the clinic received increased resources for the additional technology and/or staff and also about how patients got labs and medications. Dr. El-Nahal said he didn't know if the resources were increased or just re-purposed. Staffing roles shifted from supporting in-clinic visits with some staff calling to support patients in advance of a telemedicine visit. Regarding meds and labs, the clinic began mailing medications to patients, putting in a lot of work to make sure patients continued getting medications from their on-site pharmacy via mail. From the provider perspective, that seemed to work really well. For labs, he and his colleagues did a follow-on project to look at the time to lab completion after the shift to telemedicine. During the early months because their on-site lab was closed, patients were going longer periods between labs. Later, once the on-site lab re-opened, patients who weren't virally suppressed snapped back to regular lab monitoring while patients who were already suppressed shortened

the time between visits and lab completion, but labs were not done as frequently as before, likely balancing risk of COVID exposure when going to get labs.

Mr. Riester remarked that he was interested in the sizable study population that was older and asked if the study was able to analyze outcomes by years since HIV diagnosis. He also asked about possible benefits of or insights from the geolocation feature in one of the platforms. Dr. El-Nahal noted that more than >60% of the patients had been in care for >10 years, few patients had been diagnosed in the prior year. So age did tend to correlate with how long they had been diagnosed, but the team had not stratified their analysis that way. Regarding geolocation, he said that they may be able to assess whether distance from clinic is a factor in use of telemedicine, but that in his urban clinic many patients live relatively close by in a densely populated area. He agreed that distance from the clinic, generally, is likely an important factor in which patients might use telemedicine.

Dr. Dowler observed that in North Carolina Medicaid there were no telehealth options pre-pandemic, then COVID flipped the switch on suddenly. They did some studies, looking at total cost of care, likelihood of using additional services, and member satisfaction seems equivalent to in-person visits. She expressed concern about payment parity for telephonic care; she feels the quality isn't the same since the provider can't examine the patient, can't look a rash, or assess affect in same way. From a payor perspective, she added, the risk of fraud and abuse or accidental mistreatment is higher for telephone care. She said she hears the argument about telephonic care options and equity for people with differences in access devices or broadband. But if payors pay telephonic care at parity, they're encouraging low value care for populations already experiencing inequities and that could end up exacerbating those inequities. Whether telephonic, video-supported, and in-person are all the same quality has to be part of ongoing conversation. Telehealth definitely has a role. She noted that in North Carolina they saw that, particularly in substance use disorder space, telehealth increased compliance with medications. Dr. El-Nahal noted that her remarks put a fine point on the need for more studies about the downstream effects on viral suppression and treatment of other comorbidities and whether there are differences in outcomes based on types of visits.

Mr. Millett thanked Dr. El-Nahal for the presentation. He noted that his findings were a bit different from some other findings in the literature, observing that a JAMA paper from last year that looked at telemedicine and telehealth during found that Black, Latino, and older patients as well as those covered by a public payer were all less likely to use telemedicine, and that several meta-analyses had found the same. A paper presented at the Conference on Retroviruses and Opportunistic Infections (CROI) last year found that among people with HIV African Americans and patients who were detectable were less likely to use telemedicine. There seems to be a pattern in the telemedicine literature, he remarked, that doesn't seem to bode well for HIV disparities. He asked Dr. El-Nahal why he thinks his research diverges in some parts from those other studies. He also asked if the Hopkins team will continue to do more prospective work with this cohort regarding differences among those vaccinated for COVID or not. Or, perhaps, other planned analyses looking at durability of engagement. Dr. El-Nahal commented that with regard to generalizability of his findings or alignment with other studies, there are several factors at play. One difference may be in implementation details. As a provider, he could call the patient if they weren't online for a scheduled visit five minutes after the scheduled start time. So perhaps the patient and provider each having equal power to start the visit made a difference. Another difference may be the specific point in time. His data is from very early in the pandemic, which is a fairly unique period of time. Additionally, his data is from a cohort already enrolled in clinical care so they may tend to be more engaged than a more general population of people with HIV. So, one must look at this data with those lenses. In the future, he is hoping to look at mixture of

telemedicine and in-person visits, and how outcomes change in that setting when not in throes of COVID. He hadn't consider analyzing by COVID vaccination status and thought that was a good idea to explore given high levels of COVID related anxiety among the cohort early on.

Dr. Stewart commended the presentation and remarked that she had seen similar results in her practice. She thinks of telemedicine – both the video visits and audio-only options – as another tool to use in getting people into care and retaining them in care, not as a complete alternative to in-person care. She concurred with others who had raised the issue of reimbursement for telemedicine since that will impact providers looking at offering this modality of care. Dr. El-Nahal said that, moving forward, he, too, hoped that both telemedicine options would be used as a complement not a replacement for in-person visits to improve engagement. How to implement it is the tricky part to be worked through since offering a telephone option is important for access for some patients, but that might incentivize delivery of care that's not of the best quality.

Dr. Greene echoed concerns made about the quality of phone-only visits, she saw that in her clinic, too. She commented that it is important to assess not just the patient experience, but also the provider access to and experience with telehealth. She also raised issue of equipment to support telemedicine. One of the two clinics she works in didn't have a video platform option at the start of COVID. As clinics move more toward a hybrid approach using both in-person and telemedicine, she is still hearing that some providers are having to bring their own laptops to make this possible because exam rooms don't have webcams or monitors to enable video visits. She added that, based on her own experience working with older adults, telemedicine may be a way to improve access to healthcare for an aging population, people with mobility limitations, or people with disabilities. Finally, she remarked that it is important to be mindful of the clinic staff resources required to support telemedicine, sharing that in her experience it sometimes takes an in-person visit to show a patient how to use the telemedicine interface. Dr. El-Nahal agreed on the importance of provider satisfaction, noting that provider buy-in is important for a quality visit. He's proposing as a next step some qualitative work on barriers and facilitators to quality visits. He also agreed that an in-person visit to help a patient get set up for subsequent telemedicine visits can be very useful. Dr. Gayles encouraged such further studies.

Dr. Mehta followed up on the discussion about the differences between these findings and what has been reported in the literature and inquired whether the study had found any disparities when they further stratified the data by combinations of factors, such as older African American women. Regarding further analysis in the ongoing study, she shared that she would be curious about whether those patients whose engagement improved the switch to telemedicine maintained engagement and suppression over time, noting that would help provide information on the quality of care received through the telemedicine visits. Dr. El-Nahal replied that they had not looked the intersection of different patient characteristics and how that impacted engagement. Perhaps such multi-variate analysis could possibly further explain some of the discrepancies seen. There's a lot that needs to be done to better understand engagement and outcomes beyond engagement, and the durability of the intervention. Engagement for the first 6 months during pandemic is one thing, but what is the effect of using telehealth for 5-6 years on engagement and health outcomes. He and his team would like to look at that over a longer period.

Dr. Anderson asked whether the type of visit was assessed. She was interested since Dr. El-Nahal had mentioned there was a 40% prevalence of depression. She wondered if, especially in the early days of pandemic, whether some of the telemedicine visits were acute visits for anxiety or depression? She commented that telemedicine may be particularly helpful for some women

being able to maintain contact with care since the burden of childcare falls disproportionately on them. She also observed that [pandemic-driven temporary changes in] state laws really enabled the transition to telemedicine, particularly in areas like the mid-Atlantic, with parity of licensure across state lines. But she is concerned that there some of those laws are expiring, which could be a barrier to continuing to offer telemedicine. Finally, she observed that patients experiencing intimate partner violence (IPV) may not be able to be screened effectively for IPV via telemedicine, since they may be in the same space as the abuser during a telemedicine visit, and unable to speak freely. Dr. El-Nahal agreed that there had been some reversion in terms of licensure and regulation, noting that is why it is important to study telemedicine while those allowances were in effect so that providers can lobby for permanent policy changes. He responded that their analysis did not stratify by visit type. He agreed with Dr. Anderson that there are some types of issues for which in person visits are more appropriate, such as mental health and IPV. He also observed that he and his team had hypothesized childcare being among the reasons for the engagement improvement among some women.

Dr. Mermin thanked Dr. El-Nahal for his presentation and the discussion. He observed that this is an example of heterogeneity mattering since this data differed from what others have found and that learning why would be very useful as conversations about the future of telemedicine continue. He asked if Dr. El-Nahal would consider bringing together others who have published on the topic of telemedicine outcomes during COVID for a dialogue about the data, the differences observed, and any conclusions that can be made about what aspects of telemedicine work for which populations. Those conclusions would help inform CDC and HRSA's ongoing conversations with the Centers for Medicare and Medicaid Services about continuing telemedicine. Dr. El-Nahal noted that it isn't just a matter of heterogeneity in study designs but also in how telemedicine was delivered in unusual circumstances which can result in different findings.

Dr. Cheever noted that the study population was a really established patient population and thinks that the strong, existing provider-patient relationships could be a significant factor in the reported outcomes, especially with telephone consultations. She suggested that it may be worth stratifying data by length of relationship/length of time in care. Dr. El-Nahal agreed that would be important when assessing outcomes and visit satisfaction, on both the patient and provider sides.

Dr. So suggested that patient satisfaction with video telemedicine vs. audio only is very different and something to examine. He believes that both the provider and the patient prefer to see each other since it makes it easier to bond and improves confidence. Another benefit to telemedicine, he suggested, is that the doctor is almost always on time, so the patient avoids having to wait in a doctor's office. Dr. El-Nahal agreed that he's heard that many patients found it very convenient since it reduced the time required to travel to a visit.

Dr. Mermin added that there may be ways to do video visits well, observing that one of the major complaints from patients and physicians is that majority of time a doctor is seeing a patient in an office visit they are looking at a computer screen to document things for reimbursement and liability. But everyone hates that. So, the question becomes if we could structure the video visit where you can see the patient's face while also typing in information on the side of the screen, might that make for a better connection? We don't know this, but maybe the screen-based telemedicine option might be valuable since it allows provider to do both. Dr. El-Nahal agreed, stating that if the provider is already looking at a screen, there might as well be a patient's face there.

Dr. Anderson remarked that she had found video visits to be surprisingly more intimate. Dr. El-Nahal agreed. He believes telemedicine definitely has potential to reach patients not well reached before. But providers have to be careful about how it is implemented because some patients may not get enough out of a telemedicine visit and providers also need to monitor downstream effects use of telemedicine as a complement to in-person visits on physiologic outcomes like viral suppression or patient satisfaction with it. He also observed that the video visits also often provide information about the patient's living or working environment that he wouldn't otherwise necessarily get to learn about.

Mr. Riester endorsed Dr. Mermin's suggestion of gathering a group of people who have studied this, observing that early in the AIDS crisis things weren't always studied well. So, it's very important to take advantage of this opportunity to learn from the past about what wasn't known.

Dr. Gayles thanked Dr. El-Nahal and stated that he was looking forward findings from his further studies. He also thanked the CHAC members for their good questions and discussion.

Panel 1 – Improving STI Screening in People with HIV through the Ryan

Moderator: Marlene Matosky, MPH, RN, HRSA HAB

Ms. Matosky introduced the panel presentation, observing that the topic was very important to both HRSA and CDC.

She set the stage for the discussion by providing an overview of the national scope of STIs in the United States. Per CDC data, in 2018 there were 68 million cases of sexually transmitted infections with 26 million new cases, resulting in 1 in 5 people in the U.S. having an STI. That turns into \$16 billion in lifetime medical costs.

She emphasized the relationship between STIs and HIV stating that people who have STIs are more likely to get HIV, when compared to people who do not have STIs. In addition, STIs can increase the risk of spreading HIV.

Ms. Matosky provided a brief overview of the HRSA HIV/AIDS Bureau's investments in several recent STI projects:

- *Chart Abstraction of the Ryan White HIV/AIDS Program (RWHAP) Recipient Clinical Data* – The project aim is to provide HRSA with relevant, complete, and accurate data to inform assessments and plan for future work within RWHAP program by collecting 3 types of data: provider level, facility level, and client level data. This will include a deep dive into data on testing for syphilis, gonorrhea, and chlamydia. The first round of data collection is now underway with 50 clinics.
- *Enhancing Linkage of STI and HIV Surveillance Data in the Ryan White HIV/AIDS Program* – HRSA HAB is supporting technical assistance to 4 health departments (AL, DC, FL & LA) to enhance the integration of HIV and STI surveillance data with RWHAP data in order to improve linkage, re-engagement in care, and health outcomes for people with HIV Funding a technical assistance provider for 3 years to provide support 4 jurisdictions.
- *AIDS Education and Training Centers* – Included among the broad array of AETC activities are a number of STI-focused ones, including an STI module in HIV curriculum, preceptorships for clinical personnel to demonstrate integration of STI screening into

primary care, and technical assistance on developing protocols to integrate or routinize STI screening into HIV care.

- *Performance measures* – As part of HRSA HAB’s ongoing HIV Electronic Clinical Quality Measures (eCQM) Modernization work, the Bureau is working to develop, specify, and test two eCQMs: an annual retention measure and a syphilis testing and treatment measure and present those to the National Quality Forum for endorsement. Then HRSA will seek to have that eCQM adopted by CMS adopt them for its Merit-based Incentive Payment System (MIPS) Program. HRSA is also assessing changes to an STI composite measure in the MIPS program.

Bacterial STI Testing and Treating Barriers

John A. Nelson, Rutgers School of Nursing

Jennifer Janelle, University of Florida, Department of Medicine in the College of Medicine

Christine S. Brennan, Louisiana State University Health Sciences Center, New Orleans

The presenters shared insights from a HRSA HAB-supported Special Project of National Significance (SPNS), *Improving STI Screening and Treatment among People with or at Risk for HIV*. The 3-year (2018-2021) project was led by Rutgers University’s School of Nursing and sought to evaluate evidence-based interventions to increase routine STI screening, testing, and treatment of bacterial STIs at 9 RWHAP clinics in 3 jurisdictions (DC, FL, and LA). Three of the 9 clinics were in rural settings. The 3 jurisdictions have higher than national average incidence rates for HIV, chlamydia, gonorrhea, and syphilis. Four interventions were selected for implementation at each of the clinics: sexual history taking, patient self-collection of urine and extragenital specimens for chlamydia and gonorrhea testing, provider training on the latest STI screening and treatment guidelines, and sexual and gender minority welcoming measures to better serve and engage some populations at higher risk of STIs.

The presenters then discussed the major systems-level challenges in the implementation of routine bacterial STI screening, testing, and treatment experienced by the 9 sites, which included:

- *Decreased Disease Intervention Specialist (DIS) contact tracing for chlamydia, gonorrhea, and syphilis due to re-direction of DIS workforce COVID-19 contact tracing:* Implementation of the interventions at the 9 clinics began just as the COVID-19 pandemic began. This resulted in decreased partner notifications, partner testing, and treatment as well as increased risk of patient with STI being lost to care.
- *High cost of penicillin G benzathine:* The cost difference between wholesale (and 340B-supported) and retail is substantial (\$0.20 per dose vs. up to \$1,200 per dose, 2019 figures) for this syphilis treatment, which means that many small pharmacies, especially in rural areas, do not carry penicillin G benzathine. This is not only because of the per dose cost but also because they are required to purchase a box of 10 doses which they may not be able to use before expiration. If there is no 340B-eligible health department or clinic in the area, the treatment may not be available. There is no FDA-approved generic form.
- *AIDS Drug Assistance Program (ADAP) formularies:* Each state or jurisdiction develops its own ADAP formulary. A 2021 assessment by NASTAD found that 50% (27/54) of ADAP formularies DO NOT include penicillin G benzathine for the treatment of syphilis, including most of the states in the South. Instead, second line regimen (doxycycline) is often prescribed, but not only is its effectiveness not well studied among people with

HIV, it requires taking a pill twice a day for at least 14 days which can pose an adherence challenge for some patients.

- *Limited Coverage of STI Screening and Testing by Medicare and Some Private Insurance:* Coverage limitations pose financial barriers to appropriate screening since Medicare and some private insurances doesn't cover the testing frequency recommended by CDC for some populations at higher risk of STIs, covering it only once per year and often charging a co-pay for repeat tests which can discourage patients from seeking testing.
- *Misalignment of CDC STI Screening Recommendations and USPSTF Recommendations:* Since USPSTF recommendations affect coverage of screening by insurers and public payors, the impact of the misalignment is that in those at risk of STIs—particularly men who have sex with men and pregnant persons in the third trimester—getting screened as recommended by CDC guidelines may result in insurance not paying for the screening and testing.
- *Extragenital Testing Recommendations:* Recommendations for extragenital site screening for STIs (in throat and rectal area via a swab) are sometimes not routinely followed by many healthcare providers. Extragenital site screening is essential for curbing spread of STIs as well as increases in antimicrobial resistance. Some studies find substantial proportion of asymptomatic STIs diagnosed only through routine extragenital site testing. Currently the recommendation for extragenital screening is based on risk assessment, which requires successful screening (accurate sexual history to identify those at risk) to start with.
- *Laboratories Not Offering NAAT Specimen Self-Collection:* A reliable mechanism for processing extragenital site testing exists, but the sample collection is the challenge. The Rutgers study demonstrated high acceptability of extragenital site collection by both providers and patients, streamlining the process for providers and reducing potential embarrassment for some patients. Unfortunately, the assays that test the samples are not yet indicated for testing of self-collected swabs. So, the self-collected swabs can't be processed, causing barriers to self-collection. Labs need to individually do a validation study of patient-collected compared to provider-collected specimens before routinely testing patient-collected specimens. Initial FDA approval of extragenital chlamydia and gonorrhea nucleic-acid amplification tests (NAAT) used provider-collected specimens for validation study, not patient self-collected specimens. As a result, labs cite a lack of FDA approval of such NAAT testing kits for patient "self-collection." The resulting limitations on use of self-collection of samples also increases to cost because patients are required to visit a clinic so a provider can collect the sample. Greater use of specimen self-collection would increase screening, decrease cost, and reduce risk of resistance developing. Most large commercial labs have not done validation studies, and therefore do not allow patients to do self-collection of extragenital site NAATs at community-based laboratory patient service centers.

Final project results are being evaluated. All of the interventions were satisfactory to both providers and patients.

CHAC Member Discussion on STI Panel

Dr. Anderson opened floor to member discussion and questions.

Dr. Dowler shared that in her own work in two different settings she sees firsthand the lack of standardization of funding for what is covered for STI screening and testing. We wondered whether there are opportunities to make better use of the Medicaid program to facilitate more

STI testing, including Medicaid family planning programs which might be leveraged to get more men tested. Ms. Matosky shared that the project's analysis phase is underway with a robust dissemination phase to follow and that the suggestions may be helpful in tailoring messages for health departments and providers to think about. Dr. Nelson agreed, noting that the coverage rules for STI screening and testing change in every state and jurisdiction, even in ADAP formularies as well as Medicaid managed care, which may limit the number of asymptomatic screenings. The limitations on routine screening and testing for those at continued risk is what needs to be changed. In the project's first year (baseline) evaluation, most of the RWHAP clinics were doing the annual syphilis and gonorrhea tests and the symptomatic testing, but most were not routinely conducting asymptomatic testing on those at continued risk. He wondered if Dr. Dowler's framing of the service as part of broader sexual and reproductive health services could be useful in influencing payers.

Dr. Dionne-Odem shared that she and her colleagues do a lot of STI work in Birmingham and the presentation supports what they see and what a decade's worth of data has shown: STIs are asymptomatic; extra-genital infections, especially in men who have sex with men and people with HIV, are more common than urine or urethral infections but everyone tests the urine; and self-swabbing is preferred by patients and increases STI testing rates across the board. So, it's surprising that these things aren't in place, especially since latest STD Guidelines recommends them, like having penicillin G benzathine available in rural pharmacies or doing third trimester syphilis tests. She said would like to see CHAC do whatever they can do follow up on the data and findings from this SPNS project. She said work needs to be done to get the payment issues resolved by educating the payers on the need for extragenital screening for a third trimester pregnancy and for PrEP patients. Dr. Janelle added that work needs to be done to get the self-collected swab validated and approved for use in the NAAT. Dr. Nelson added that since May 2019 there have been 2 FDA-approved assays for extragenital testing. Requiring every lab do a validation study doesn't seem cost-effective. Especially in the era of telehealth, providers need to be able to send their patients to LabCorp or Quest to get it done. But those community-based sites won't allow patients to self-collect.

Dr. Mermin praised the detail and practical advice shared. He indicated that the validation issue is an FDA matter, and the agency has said they are interested in changing rules for self-collected samples both outside and within facilities. He stressed that this is a really important issue but noted that reclassification of HIV and HCV testing had taken many years of work, some of which was still in process. He asked FDA's liaison to CHAC, Dr. Pradip Akolkar, whether there is a way CHAC, CDC, and HRSA can better engage with FDA on these issues because all of them want accurate tests and realize there is a public health good and healthcare good of having tests moved to where people are instead of asking people to come to the test. Dr. Akolkar shared that FDA is in discussion with CDC and APHL about how to streamline different self-collection devices that can be used with the diagnostic assays for STIs. They are trying to leverage existing studies as to how this will be useful. COVID has delayed some of the work. He also explained that FDA is reviewing the data from CDC and other investigators on how the different types of home-collected samples, such as dried blood spots or microcontainers, work with various assays. This will allow the sponsors to come up with new sample matrices that can be used with the assays.

Dr. Anderson stated that the misalignment between STI guidelines from different parts of federal government is a little disturbing. She noted that on the perinatal guidelines for HIV there is great effort to coordinate and link across the federal guidelines and recommendations to make sure the various agencies aren't saying different things. She asked if there is any thought of doing that across CDC and USPSTF so they aren't contradictory on STI guidelines. Dr. Mermin said

that CDC has had a long history of working with USPSTF, noting though that USPSTF is an independent body that follows a standard process to assess each question. CDC and USPSTF often share analyses. Usually, he said, CDC is a little bit ahead of the Task Force with recommendations because the agency is in the midst of the frenzy of public health. With regard to STI testing for PrEP, he noted that is included as a part of the PrEP services covered under the ACA's preventive services provisions, as was clarified over the summer by an FAQ from CMS. However, CDC recognizes that this is not yet being implemented as widely as it should be. He continued, that the USPSTF has to be independent of the agencies. He pointed out that the public can make suggestions to the Task Force about what should be examined. Dr. Mermin also highlighted that CDC also manages another source of guidance, the Community Preventive Services Task Force, though its recommendations are not tied into ACA provisions like USPSTF's are.

Dr. Dionne Odem shared that she knows that the USPSTF does a deep dive into the literature; if there aren't studies demonstrating both effectiveness and cost-effectiveness of periodicity of testing they can't recommend it. So she urged fellow members to publish their data about the importance of frequent STI screening so that cost-effectiveness analysis can be done, published, and considered by the USPSTF.

Business Session and Member Discussion – Part 1

Dr. Gayles opened the floor for members to discuss business items or issues of concern. Dr. Anderson reminded members that this is an opportunity to raise questions that the council wasn't able to discuss earlier, raise issues of concern, or highlight things that they believe the CHAC should discuss or pursue regarding recommendations.

Ms. Parkinson observed that she felt that sharing more of the "behind-the-scenes work" such as what the CHAC had heard that day would be helpful to grantees/recipients, health departments, and planning councils, and others in communities to inform their work. She said she planning to share some of what she had heard in her work at the state level and for Fast Track Cities.

Mr. Driffin suggested that blogs on HIV.gov would be helpful to raise broader awareness about important things like changes in HRSA HAB's recent policy clarification notice on recertification would be helpful to the community. He also suggested a blog around World AIDS Day on the Bureau's recommitment to community engagement, especially of people with HIV. He added that as a trainer for the BLOC program, he thought hearing such a strong recommitment to people with HIV continues an important equity conversation, especially welcome after the previous administration.

Dr. Gayles concurred and added that it is also important to remind community about the ongoing commitment to innovate, make best use of resources, and enhance the work, coming up with new solutions and strategies to meet needs of community.

Dr. Anderson remarked that there were a number of positive innovations and outcomes during the COVID pandemic around how providing care for the infections that are the charge of this committee. She suggested that those may be a worthwhile focus of the committee, looking at how to amplify them or identifying whether there are other opportunities that should be taken advantage of to move that agenda forward. Dr. Gayles agreed, noting this is an especially timely right now as funds shifts around to reinforce the public health infrastructure and people start thinking about a post-pandemic world.

Dr. Dowler added that the opportunity to take advantage of the growth in telehealth is so important for sexual health, since many people are more comfortable talking about sexual health, access testing, via the relative anonymity that telehealth services offers. She observed as much as she'd prefer people access these services via their medical homes, she realizes not everyone will. So, the option for telehealth and self-sample collection will reach some folks who were previously less comfortable, which in the end is good.

Dr. Greene echoed Dr. Dowler's observation and shared that she was struck by whole committee's engagement in telehealth conversation. She indicated an interest in discussing more about how to ensure that telehealth is equitable. She is also interested in others' ideas about how to tackle all the issues raised regarding coverage for penicillin and use of self-swabs.

Dr. Gayles asked if others had thoughts about how the CHAC could play a role in the lessons from pandemic or other ideas about what the CHAC should do.

Dr. So said that as a provider over last 2 years, during the pandemic, video telemedicine has been a great alternative and he hopes that in the future providers can still get reimbursed by providing care through telemedicine or video telemedicine. It should be an option, he stated. Most of his patients now prefer video telemedicine since they don't have to take off from work, pay for parking, and they enjoy more private time with provider than before because the provider is not interrupted as often as happens at a clinic. He said it should be an alternative for patients who prefer it.

Dr. Anderson asked Dr. Cheever and Dr. Mermin whether there is a role for CHAC to make a recommendation regarding telemedicine reimbursement and state laws facilitating telemedicine in the context of managing HIV and STIs. Dr. Cheever said yes, noting that there is a federal office for the advancement of telehealth, administered by HRSA, to which CHAC could write a letter about why telehealth is important and how HHS could support its continuation, including thoughts on resources, policies, and what CMS should decide gets paid for. Dr. Mermin added that a formal letter might be useful. But he also noted that all the verbal advice observations shared during the meeting so far had been really helpful. He said that he and his colleagues make note of CHAC members' ideas and observations and also review the and sometimes are reminded of what they haven't yet followed up on.

Mr. Riester noted that earlier conversations had addressed both vaccine incentives and workforce burden and burnout. He wondered whether CHAC could think about incentives to retain the HIV workforce. He said that it is difficult to retain the workforce at the pay they get. So, he suggested that the incentive to start with is pay. To address concern about burnout, he said that there needs to be some sort of mental health support for the workforce. He also remarked that he really appreciates the new RWHAP PCN, observing that it will positively impact many people with HIV.

Mr. Driffin agreed that attention to the workforce is warranted, recommending that any such discussions of the HIV workforce be as broad and as open as possible, not limited only to clinicians and people who can bill for services, and include workforce members with MPHs, MSWs, DrPHs, and others who can play a crucial role. He encouraged consideration of loan repayment programs for the broadly defined HIV workforce. Ms. Hauser agreed that loan repayment is a great motivator. Dr. Dionne Odem recommended that CHAC confer with Dr. Armstrong about incentives when she returns to the meeting the next day since it is an issue she knows a lot about.

Dr. Gayles summarized the topics raised during the business session:

- A role for CHAC in leveraging telemedicine in HIV and STI services and care
- Looking at how to support the HIV workforce, broadly defined, with morale and short-term support, as well as strategies to recruit and retain them in the long term, and make sure they are successful in the long run.

Dr. Dowler added the issue of best practices for Medicaid coverage of STI screening and testing. Since states set the minimum coverage, she wondered if there could be a recommendation that the standard of care is X, Y, and Z, including asymptomatic screening, etc. She said she was aware of a paper coming out soon that CDC was working on about syphilis screening in Medicaid states, and another on STI testing and PrEP in Medicaid states. If anyone should cover these services, she said, our public payers should.

Recap Day One/Review Day Two Agenda

CHAC Co-Chairs: Jean Anderson and Travis Gayles

Dr. Anderson summarized some of topics that had stood out to her from the afternoon's discussion:

- She commended CDC and HRSA for the work they had done over last year and a half in the midst of this pandemic.
- RWHAP providers are very excited about the policy changes, both reducing burden on providers for re-determining client eligibility and the simplified core medical services waiver
- The 2 RWHAP SPNS projects – ESCALATE and ELEVATE – are important for leadership development and organizational capacity development
- The telemedicine discussion was very rich and robust, it was clear that providers and clinics have gained lots of experience in a short time.
- CDC data on reduction in new diagnoses among MSM; successes with HIV self-testing; need to improve awareness of and referral to PrEP
- Congenital syphilis is now a concern in all states
- Incredible impact DASH has had in critical outcomes for youth
- Role of telemedicine continues to evolve; some real strengths, some unanticipated; need for further study on impact and thinking how we can use telemedicine to further improve services
- Discussion about challenges and barriers to STIs, concerned about shortage of penicillin G benzathine; need more support for extragenital testing and overcoming lab barriers to self-collection

Dr. Gayles observed that Dr. Anderson's highlights summary was very thorough. He acknowledged that he now works in the telehealth industry, so he had remained quiet during that discussion. He views telehealth as another tool to augment and complement services that are already there. He remarked that one of the things that caught his attention was Dr. El-Nahal's report of increased engagement in care among patients who hadn't been virally suppressed. He also said that the discussion of provider fatigue and resilience resonated with him. He remarked that while people like him so often champion resilience in places where work is hard, he feels it is also necessary to sometimes pause to acknowledge that the work is just hard and to continue to find ways to support personnel in those challenging positions. He said it

was encouraging to hear about an infusion of additional resources into DIS and novel service delivery strategies. At the same time, he said it was somewhat disheartening to hear some of the same old issues persist, like social determinants of health and congenital syphilis. So, there is a need to develop innovative new strategies that can move us past that.

Dr. Cheever thanked the members for their thoughtful reflections and announced that the meeting would be in recess until 12:30 the following afternoon.

DFO Opening of Meeting and Roll Call: Day 2

Laura Cheever
Associate Administration, HRSA HAB

Dr. Cheever welcomed participants to the second day of the CHAC meeting. She then conducted roll call and asked members to disclose any changes to conflict of interest. She confirmed that a quorum was present for CHAC to conduct its business on November 4, 2021.

Recap of Day 1 and Objectives/Process, Day 2

CHAC Co-Chair: Jean Anderson

Dr. Anderson shared a brief re-cap of the prior day's robust discussion of several issues and looked ahead to that afternoon's agenda. She highlighted:

- The discussion about how telemedicine may be becoming a more permanent part of the healthcare landscape and the possibility that it could help improve engagement in care for people with HIV, especially for certain subgroups, which could make real contributions to ending the HIV epidemic.
- The conversation about continuing barriers to screening, testing, and treatment for bacterial STIs, which highlighted limited access to penicillin G benzathine, the limited coverage of STI screening and testing in Medicare and some private insurance, and the lack of a recommendation from USPSTF for screening gonorrhea and chlamydia for people with HIV or persons on PrEP.

For the afternoon's business session, she encouraged members to be thinking of action items to move these issues identified during the discussions forward. She also invited them to identify agenda items for future meetings.

Public Comment

Dr. Cheever introduced the public comment segment of the agenda, inviting the speakers to introduce themselves and share their comments in the order that they had registered. Each commenter was allotted three minutes.

Keith Hughes
Detroit Health Department

Mr. Hughes indicated an interest in getting more info about national HIV workforce. He also spoke about his conversations with colleagues regarding their desire for innovations in how PrEP navigation is being done in their area. He shared that he would like to get feedback on

some of the more innovative practices from around the country and around the world that could help improve HIV prevention efforts in his community.

Jose Rodriguez

Senior Policy and Advocacy Manager, HIV Medicine Association

On behalf of HIVMA, Mr. Rodriguez commended HRSA on the recently issued updated policy guidance on conducting Ryan White HIV/AIDS Program eligibility determinations, noting the positive benefits of this change. He also highlighted recommendations submitted by HIVMA and its Ryan White Medical Providers Coalition to the White House Office of National AIDS Policy to inform the development of the 2022 National HIV/AIDS Strategy (NHAS) and the accompanying implementation plan, encouraging the CHAC members to read those in full in his written comments. First, he highlighted recommendations related building a robust, diverse, and culturally competent workforce, observing that a workforce that reflects the communities most impacted by HIV is foundational but attention to the workforce had not previously been a core part of the NHAS. He also highlighted that the Bolstering Infectious Outbreaks Preparedness Workforce Act (BIO Act) currently being considered by Congress would create a new loan repayment program that would address infectious diseases workforce shortage in two critical areas by offering loan repayment to bio-preparedness health care professionals and health care professionals providing infectious disease care. Second, he expressed HIVMA's concern about the rise in sexually transmitted infections and appreciation that the committee would be discussing the role of the RWHAP in improving STI screening among people with HIV later in the meeting. HIVMA urges HAB and the CDC to continue to collaborate on this issue and take a comprehensive approach to preventing, identifying, and treating STIs.

HIVMA's full recommendations were provided in writing and are included in Attachment C.

Heather O'Connor

Woman living with HIV; and Program Director, International Community of Women Living with HIV, North America; and Member, People Living with HIV Caucus

Ms. O'Connor shared that in July, the U.S. People Living with HIV Caucus released *Demanding Better*, a policy agenda to guide the current administration in developing the new NHAS. One of the points of the strategy is meaningful involvement of people with AIDS, and specifically how that relates to women living with HIV who chose to breast feed. She is a mother of two children who breastfed, and who are both happy, healthy, and HIV-negative. She observed that she is not alone in her experience. She shared that she founded the Milky Moovement+, a network of mothers living with HIV who are interested in breastfeeding. She stated that these women face many challenges, including lack of lactation support due to stigma, lack of provider support due CDC guidelines, and HIV criminalization due to lack of provider support due to CDC guidelines. She said that she had been informed that CDC guidelines on breastfeeding will be changed and requested the meaningful involvement of people with HIV in the process of drafting new guidelines. She believes women living with HIV who have breastfed their children have lived experience that would be valuable in updating the guidelines.

Mr. Christopher Hall, MD, MS, AAHIVM

Clinical Medical Director, Molecular Testing Labs

Mr. Hall submitted written comments, provided in Attachment C.

Briana Diaz, JD

Policy Director, Positive Women's Network-USA

Ms. Diaz, on behalf of the Positive Women's Network-USA (PWN), spoke about what she characterized as the urgent need to explicitly include and integrate quality of life for people living with HIV systematically throughout the federal response to the HIV epidemic, with measurable indicators for success. As a member of the U.S. People Living with HIV Caucus, PWN recently helped develop and release *Demanding Better: An HIV Federal Policy Agenda By People Living with HIV (Demanding Better)*, which highlighted the need for quality of life for people living with HIV to be centered in the federal HIV response. She urged HRSA, given its purview over services for people living with HIV to affirmatively commit to patient-centered, integrated care that includes improving the quality of life of people living with HIV. She said that HRSA must set a minimum standard for quality of care for people living with HIV, and that the patient-centered care model must include an emphasis on quality of life for people living with HIV. To ensure that the model does so, she shared several recommendations for HRSA, CDC, and the Department of Health and Human Services.

PWN's full recommendations were provided in writing and are included in Attachment C.

Work Group and Liaison Reports

Ending the HIV Epidemic Community Engagement Workgroup **Venton Hill-Jones, Workgroup Chair**

Mr. Hill-Jones shared that the workgroup's current focus was trying to get a grasp on any additional guidance that will be issued by CDC and HRSA about any next steps for the EHE planning work in the 57 priority jurisdictions. He suggested that revisions to those EHE plans may be needed as a result of the impacts of COVID-19 before implementation of the plans can be started. He also shared that he is concerned that in a number of the jurisdictional EHE plans key populations seem to be mentioned only in the section about local HIV epidemiological data, without detailing corresponding strategies and activities to serve those populations in the rest of the plan. He also noted he believes that there is a need to continue conversations about this as well as about strategies to meaningfully engage people with HIV in ongoing planning and implementation, rather than jurisdictions just reporting back to them on what is being done.

Presidential Advisory Council on HIV/AIDS **Ada Stewart, MD, Liaison**

Dr. Stewart thanked the CHAC members for their work and remarked that she was honored to join the meeting for the first time as the liaison from PACHA. She provided highlights from the August 3-4 PACHA meeting. The Council heard remarks from ADM Rachel Levine, MD, Assistant Secretary for Health, which stressed the commitment of the Biden administration to work to end the HIV epidemic. ADM Levine also swore in eight new PACHA members, including a new co-chair, Ms. Marlene McNeese of the Houston Health Department. Dr. Stewart observed that the Council is now comprised of a very diverse group of individuals with a wealth of experience and expertise. Continuing the highlights of the most recent PACHA meeting, she shared that they had also heard from Mr. Harold Phillips, Director of the White House Office of National AIDS Policy, about work underway to develop an updated National HIV/AIDS Strategy. The Council also discussed ideas and issues raised by a panel on strategies to improve access

to PrEP. The next PACHA meeting is November 15 and 17. On the first day, three panels will examine the role of molecular HIV surveillance/outbreak detection and responses in ending the HIV epidemic. She shared that the Council has also established a workgroup to look at the role of molecular surveillance, best practices, possible risks, benefits, and the future of its role in the EHE initiative. On the second day, the Council will hear from a panel focused on opportunities to engage and collaborate with the private sector on ending the HIV epidemic. The meeting will conclude with a panel reflecting on lessons resulting from the COVID-19 pandemic and how those can help move HIV work forward.

Discussion of Workgroup and Liaison Reports

Following the two reports, the CHAC members engaged in discussion with the presenters.

Dr. Anderson asked Mr. Hill-Jones whether he was requesting answers from CDC and HRSA at this time so the working group can move forward and, if so, if he could clarify his specific questions. He replied with two questions:

1. Have there been additional conversations about how the integrated prevention and care planning process will intersect with the EHE planning process so there is not only guidance on how to build an integrated plan, but also about how the creation of those integrated plans overlaps with EHE work?
2. What, if any, guidance will be provided with regard to next steps for updating jurisdictional EHE plans, particularly in communities where non-concurrence was provided on plans submitted in December 2020?

He continued by remarking that workgroup members know that community engagement continues to be a challenge in some areas and that some health departments, whether intentionally or not, are not moving with enough information that they can adapt their plans. He summarized the inquiries as: How do we not create plans that just sit on shelf? They're living documents that can and should be updated as all stakeholders push forward with implementing them.

Dr. Mermin invited Dr. Demetre Daskalakis, Director of CDC's Division of HIV Prevention, to respond. Regarding the first question about harmonizing the process of developing integrated HIV prevention and care plans with EHE jurisdictional plans in jurisdictions that will have both, Dr. Daskalakis observed that CDC and HRSA share the hope that they will be harmonized at the state and local levels. They are providing intensive technical assistance to the jurisdictions on integrated plan development to support the many opportunities to identify areas of efficiency, as well as opportunities to weave in the status neutral approach to HIV services. Regarding the second question about continued iteration of the jurisdictional EHE plans, he concurred that those plans are not static and are intended to be living documents. He shared that as CDC works with the EHE jurisdictions, the project officers engage them in continual evaluations of those plans and their progress. As a result of those conversations, the plans and interventions will evolve. He observed that community engagement is expected to continue as the plans evolve over time. Mr. Hill-Jones followed up by inquiring if there is going to be a formalized process for health departments to formally submit updated EHE plans and, if so, how community stakeholders will learn about the process to develop those plans and receive any resulting updated plan. Dr. Daskalakis replied that there is no formal process or deadline for jurisdictions to submit updated EHE plans. The work of continuous quality improvement of how the plans are both written and implemented is being done jurisdiction-by-jurisdiction through conversations with CDC's program officers. He acknowledged that some jurisdictions' EHE

efforts have been significantly affected by COVID-19 and that CDC is sensitive to those so is pursuing a process of improvement, rather than a new deadline for revised plans.

Mr. Driffin stated that he was looking forward to the conversation about HIV molecular surveillance at the next PACHA meeting mentioned by Dr. Stewart. He suggested that perhaps PACHA consider recommending creation of additional reports by state and local health departments regarding their use of molecular surveillance. Perhaps through EHE plans, EHE community advisory boards, planning councils, or as part of integrated HIV prevention and care plans, jurisdictions could be required to discuss how they are using the information and whether/how it is impacting efforts to end the epidemic. He shared that he believes that the information is being used in locked rooms, and the community has no idea of whether it is impacting outcomes. He concluded by observing that as a person with HIV in the deep South, he still has serious concerns about the use of molecular surveillance.

Dr. Anderson asked Mr. Hill-Jones whether there was there anything else the CHAC could assist him with to help move the working group forward. Mr. Hill-Jones replied that the meeting's questions and discussion can help move them forward as would having a better understanding and standard expectations around what happens next regarding updating EHE plans. He noted that the process is made more complex in some local jurisdictions whose EHE plans are rolled up into a larger state EHE plan that covers multiple jurisdictions; as a result, there are sometimes different understandings of CDC or HRSA requirements and next steps. He added that both the lack of understanding about what comes next, and that the layered plans creates concerns in communities, especially in southern states where, he remarked, there is often resistance to critical conversations about things that need to be done to end the HIV epidemic, like having critical conversations about racial equity and how that overlaps that with efforts to end the epidemic among key populations, including populations of color. He concluded by strongly recommending that CDC and HRSA set a deadline for state and local health departments to submit updated EHE plans that reflect, in part, how they are addressing the impacts of COVID-19 on the original EHE plan.

Ms. Antigone Dempsey, Director of HAB's Division of Policy and Data, shared that the Bureau is working on an internal evaluation and qualitative analysis of all the EHE reports being submitted by the jurisdictions. Once it is completed a couple of months, HAB will be happy to share it and discuss it with the workgroup and/or the CHAC. It will include information about the number and type of community engagement activities that have been conducted.

Panel 2 – Providing Housing Services at the Intersection of Substance Use

Moderator: Susan Robilotto, HRSA HAB

Dr. Robilotto introduced the panel and began with an overview of the intersection of HIV, substance use disorder, and homelessness. She observed that the confluence of these issues continues to complicate HIV care and calls for innovative solutions. She shared 2019 data on viral suppression among RWHAP clients with HIV attributed to injection drug use. Overall, the rate of viral suppression among this group was consistent with the national RWHAP average (87.1% vs. 88.1%). However, further disaggregating the data by age, health coverage type, and housing status reveals that those with unstable housing have the lowest viral suppression rates (71.6%). Examining data on viral suppression among RWHAP clients by housing status reveals that housing stability is a significant predictor of viral suppression. Among RHWAP clients with

unstable housing, viral suppression rates are lower (74.5%) compared to RWHAP clients overall (88.1%) and especially low for transgender clients (67.9%), youth ages 13-24 (69.3%), and people who inject drugs (71.6).

In recognition of the viral suppression disparities by housing status, HRSA HAB convened a technical expert panel in November 2019 to understand the breadth of housing resources, identify barriers and supports to leveraging these resources across programs, and assess strategies that address the housing needs of people with HIV while engaging them in care and treatment. The panel identified multifactorial and overlapping issues affecting housing status among RWHAP clients, including:

- Incarceration history
- Inconsistent case management as clients move through different systems
- Lack of documents needed to secure housing
- Healthcare systems unable to meet the needs of the unstably housed
- Increasing housing expenses
- Economic insecurity
- Criminalization of homelessness
- Limited availability of housing support services

Dr. Robilotto also discussed HRSA's roles in responding to HIV clusters and outbreaks. She stated that when clusters or outbreaks are identified, HAB's role is to help get newly diagnosed individuals into care quickly and maintain them in care. HRSA works with stakeholders to understand the system of care, assists in identifying gaps in services necessary to quickly link newly diagnosed people with HIV to care and treatment, and works with RWHAP recipients to assess resources and address barriers to care for impacted populations. The RWHAP's AIDS Education and Training Centers also provide training to build systems capacity in the community when needed. Lessons from HRSA's outbreak responses include the importance of focusing the response to address the specifically affected community, new partnerships and collaborations often are needed to respond with stakeholders including food pantries and faith communities, and there is a need for new/different models of care in impacted communities such as low barrier clinics, drop-in hours, etc. She then turned over the presentation to Ms. Harcrow and Dr. McClung to begin the panel presentation with discussions of the roles of HUD and CDC roles in responding to HIV outbreaks.

HOPWA Perspective on Providing Housing Services at the Intersection of Substance Use Disorder, Mental Health, and HIV

Rita Harcrow, Director, Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development

Ms. Harcrow began with an overview of the Department of Housing and Urban Development's (HUD) Housing Opportunities for People With AIDS (HOPWA) program, noting that it was established in the 1990s to provide support to state and local governments with resources to support housing services for low income people with HIV and their families. The program's goal is to help eligible households overcome key barriers to housing: affordability and discrimination. Under HOPWA, HUD makes grants to eligible cities, states, and nonprofit organizations to provide housing assistance and supportive services to over 100,000 households annually (55,000 receive rental assistance or direct housing, another 45,000 receive supportive services). Based on local need, grantees chose from a menu of eligible activities/services that HOPWA can provide, including: facility-based and scattered-site permanent supportive housing; emergency/transitional/short-term facilities; short-term rent, mortgage, and utility assistance; housing search and placement; and supportive services.

Ms. Harcrow continued by explaining that HOPWA is one of the several programs within HUD's Office of Community Planning and Development which include housing assistance programs and housing development programs for people experiencing homelessness or housing instability which can also assist eligible individuals with HIV and their families. At the local level, these programs all have required planning processes with significant input expected from stakeholders including people with lived experience of housing instability or homelessness. Of note, these programs have recently received two rounds of substantial supplemental funding (\$17B combined) through the CARES Act (2021) and the American Recovery Plan (2021) with authorization to use resources on some activities not normally authorized. The activities must primarily benefit individuals and families who are homeless, at risk of homelessness, or in other vulnerable populations. As a result, many communities now have some new resources to address housing services and are making plans about what to do with it. Finally, she discussed recent collaboration at the federal level in which her office, the Office of HIV Housing (OHH) which administers HOPWA, has been working with CDC to better understand role of housing in local responses to HIV outbreaks. Through this collaboration, OHH recently deployed disaster technical assistance providers to HIV outbreaks in Minnesota and are now working to glean lessons from their experience to identify some best practices that could be used to better serve communities that experience an HIV outbreak.

HIV Outbreaks Among People Who Inject Drugs: Recent CDC Experience **LCDR R. Paul McClung, MD, Division of HIV Prevention, NCHHSTP, CDC**

Dr. McClung discussed CDC's recent experience with HIV outbreaks among people who inject drugs. He began by observing that responding to HIV clusters or outbreaks is one of four pillars of the *Ending the HIV Epidemic in the U.S.* initiative. He noted that successful outbreak response requires expanding delivery of services from other three pillars – testing, treatment, and prevention, especially PrEP and syringe services programs (SSPs). Outbreaks, however, often shine a spotlight on other needs and challenges making it clear that HIV services alone are not enough, he observed. This was evident in multiple outbreaks in recent years that have occurred in communities of various sizes and in most regions of country in which both substance use disorder and injection drug use played roles. But, he noted, a number of other challenges – homelessness and mental health – have also been especially prominent.

Dr. McClung said that in these outbreaks CDC has consistently seen that HIV is just one of many challenges the individuals experiencing, underscoring the complex medical and social service needs of people who inject drugs. He highlighted two. First was unstable housing, which is problematic in itself but which can exacerbate or confound other issues such as mental conditions, incarceration, employment, or trauma. Second, many of the challenges these individuals experience bring with them their own layer of stigma that is beyond the HIV stigma we usually think about and that can further complicate the individuals' seeking of the care they need. He said that these other needs must be addressed alongside or even before the HIV needs.

He then shared insights from CDC's recent HIV outbreak response experiences, including:

- Health departments: outbreaks can outpace limited staff capacity, have to find new ways to work together, but funding and services are often siloed.
- Community engagement essential for planning and implementation, it has to be ongoing but can be difficult to maintain
- Must address services for people with HIV and those at risk also need dedicated services, which sometimes requires separate funding and additional partners

- Policy barriers can limit the reach of needed services, such as laws that prohibit or limit SSPs
- Need to “bend” our existing services as quickly as possible to meet people where they are instead of asking them to change to accommodate our systems

Dr. McClung discussed the support that CDC provides for outbreak response, explaining that all health departments that receive CDC HIV funding received funding to plan and conduct detection and response activities. Those jurisdictions can request capacity building assistance on program development and implementation and CDC staff is available to provide remote technical assistance or onsite surge support. CDC also facilitates coordination with other federal agencies whose programs or services are needed as part of the outbreak response. He concluded by highlighting some areas where improvements are needed with regard to HIV outbreak response and housing including improved partnerships at the federal, state, and local level; uses of data to better understand impact of housing on HIV outcomes and improvements in integration of those data promote stronger local responses; and more creative approaches to delivering integrated services during, before, and after an outbreak occurs. Dr. McClung concluded by observing that the hard work that goes into these improvements has the potential to make profound and lasting differences for the prevention and care experiences for people far beyond the period of the outbreak response.

Insights from Boston, Massachusetts

H. Dawn Fukuda, ScM, Director, Office of HIV/AIDS, Bureau of Infectious Disease and Laboratory Sciences, Massachusetts Department of Public Health

Jennifer K. Brody, MD, MPH, AAHIVS, Director, HIV Services Boston Healthcare for the Homeless Program and Instructor of Medicine, Harvard Medical School

Ms. Fukuda, Dr. Brody, and Mr. Hanft shared RWHAP recipients’ perspectives on addressing HIV outbreaks among unstably housed individuals with substance use and mental health disorders.

Ms. Fukuda and Dr. Brody presented about how the Boston Health Care for the Homeless program collaborates with the Massachusetts Department of Public Health to provide HIV care at the intersections of homelessness, substance use disorder and mental illness. Ms. Fukuda began by observing that as a state health department, her agency relies on the expertise, credibility, creativity, and effectiveness of their clinical and community-based partners more than anything. She then discussed the health department’s roles in this partnership, highlighting some health department responsibility that are foundational to serving this population:

- Monitor and share surveillance data in real time – She noted that sometimes health departments have information from their surveillance systems that other partners do not have and the health departments can sometimes hold it too close to the vest. She argues that health departments need to share that data in as real time as possible. It may not be perfect or complete, but it is important information to share to address populations experiencing an acute crisis. Her health department has convened stakeholder meetings quickly when they’ve gotten a signal of a cluster or outbreak so timely responses can be implemented.
- Practice frequent bi-directional communication – She noted that sometimes their partners alert them before the state’s HIV surveillance system detects a cluster or outbreak. So bi-directional communication is essential. Though that’s not hard, it takes time and commitment to share and be open to hearing things from people working in the community.

- Engage stakeholders – She added that there also must be spaces for stakeholder convening, and support and flexibility for providers to engage in those conversations about what interventions make sense (and which ones don't) given the available data, which aren't necessarily quick conversations. This is support and flexibility that federal funders should provide.
- Fund innovative creative responses – Working alongside community and advocates and provider partners for the right mix of services and abilities to engage affected populations. She observed that sometimes that means the funding for the interventions isn't perfectly aligned with their funding scopes and that they need flexibility to braid funding from federal funders with state, county, and city funding. She believes there needs to be more conversations about how to do so responsibly, quickly, and effectively.
- Care for the workforce – She concluded by observing that health departments also have a responsibility to care for the workforce engaged in this work, she sees it as a core part of their obligation to respond to a crisis alongside serving the people and families who are struggling.

Dr. Brody explained that Boston has experienced a sustained uptick in HIV amongst unsheltered people who use drugs, most of whom also have major mental illness. Her health center has focused efforts on the region's epicenter of the addiction and overdose crises in Boston, which includes a large encampment of people who inject drugs who are unsheltered. The severity of the vulnerabilities have become more profound. They apply a "design for the margins" framework in which they build a stronger system for everyone by designing it to serve the most vulnerable patient, not for the most stable patient or even an "average" patient. So, they redesigned their HIV program thinking of the street homeless patient, with severe substance use disorder, mental illness and trauma, recurrent incarceration, as well as considering the needs of patients of color, patients who did not speak English and who were undocumented. Principles of building their HIV program for the margins included: centering health equity and racial justice; a non-judgmental, non-contingent approach that demonstrates and upholds care, dignity, and respect for the patient regardless of whether they engage in any particular type of care and no services are contingent on others; centering survival needs and patient choice and autonomy; and delivering services where the people need them and promoting harm reduction and social (re)connection.

She explained that the resulting model includes a multidisciplinary HIV team outside the walls of a clinic that provides low threshold HIV care (ART, PrEP, nPEP), primary care, sometimes provided on the street, and mental health care. It also includes outreach nurses/navigators/social workers who offer HIV directly observed therapy for those who won't come into clinic for ART or PrEP, medical case management, housing advocacy, harm reduction services including overdose prevention, and other support services to assist patients with transportation, food, and phones to enable and incentivize telehealth or clinic visits and just to meet survival needs. All this builds patient trust and engagement over time since they feel they have a whole team helping them navigate the complex crises they are experiencing. They have an embedded housing advocate on the team and they collaborate closely with housing providers, but she noted that in a place like Boston with very limited available housing units, this advocacy can only go so far.

Dr. Brody shared key program outcomes for the 81 unsheltered people who inject drugs who were newly diagnosed with HIV and who have been seen at least once by the Boston Healthcare for the Homeless program in the past 2 years, noting that 84% were linked to care, 93% of those were retained in care, and 57% achieved viral suppression. Among the patients

on directly observed therapy, 79% were virally suppressed. However, 17 of the patients (21%) obtained housing since diagnosis, underscoring that challenge.

She explained that the major barrier to accessing housing for these patients in Boston is the inadequate supply of low-income housing with the appropriate supportive services. Other barriers are patient involvement criminal legal system and criminal records that prohibit access to some housing services, poor/no credit history, difficulty in documenting homelessness for those not using shelters, difficulty in obtaining vital documents (IDs, birth certificates), systems that are too siloed (housing, mental health, medical, addiction) that don't effectively communicate and collaborate with one another. Too often, she observed, patients give up in despair and stop trying, which can lead to worsening substance use disorder and mental and physical health.

Dr. Brody shared some lessons from her program's experience. She underscored the key role of bi-directional data sharing with the health department and the need for dynamic/flexible funding streams to support a rapid, tailored response to the needs of patients. She also stressed the importance of collaborating across institutions and disciplines, including housing partners, and the role of individual patient accompaniment and advocacy for negotiating highly stigmatizing systems and (re)building trust. She also highlighted the need to fund engagement tools that address basic survival needs (phones, food, and transportation). She added that, as their program demonstrated, HIV viral suppression for unsheltered people can be achieved but alone is insufficient in supporting the more holistic wellbeing and long-term health that the patients deserve. The patients need housing to achieve that. Finally, she observed that the work is labor/resource intensive and may not be durable.

Dr. Brody concluded by discussing remaining challenges and some suggested policy solutions. She cited:

- Insufficient housing opportunities across a flexible spectrum of service needs, noting that funding is needed for both housing AND support services. Specifically, congregate and scattered site housing are needed, with high intensity services including harm reduction and intensive case management.
- NIMBYism (often built on racialized stigma) must be addressed with proactive community/stakeholder engagement which should be funded and supported.
- All forms of medication for opioid use disorder, including methadone, should be offered in low threshold venues. But to make this possible, Federal methadone regulations must be adjusted to improve access via primary care/pharmacies.
- Overdose prevention centers are a core (but missing) evidence-based intervention that could be implemented since they support engagement and trust building and reduce forward transmission of HIV for both housed and unsheltered people who inject drugs.
- Reduce overdose, HIV/HCV transmission, improve engagement in medical/behavioral health care, as well as recovery and social services.
- Workforce trauma/burnout must be addressed through funded programs.

Insights from Hennepin County, Minnesota

Jonathan Hanft, Ryan White Program Manager, Hennepin County Public Health

Mr. Hanft presented on how Hennepin County, Minnesota, centered housing in response to an HIV outbreak among people who inject drugs, many of whom were experiencing unsheltered homelessness. Hennepin County had already been responding to an outbreak of hepatitis A among people who inject drugs, many of whom were experiencing homelessness, when in January 2020 the state health department notified the county health department that an HIV

outbreak had been detected in the county among persons who inject drugs. The incident command structures for the hepatitis A and HIV outbreaks were merged, creating a Drug-Related Infectious Disease response. Subsequently, in April 2021, the outbreak case definition was expanded to include MSM/IDU, which doubled the number of cases associated with the cluster. As of late October 2021, there were 81 cases associated with the outbreak. American Indians and African Americans were disproportionately represented among outbreak cases with over a quarter of cases are among indigenous people and 14% among African Americans. Among the outbreak cases, the greatest risk factors were injection drug use alone, injection drug use combined with male-to-male sex, and unsheltered homelessness and living in tent encampments. An additional 49 “outbreak adjacent” cases have been identified by DIS and healthcare for the homeless staff.

Mr. Hanft explained that lack of housing is a primary driver of this HIV outbreak. Cluster detection analysis conducted in collaboration with CDC found that the beginning of the outbreak closely correlated with the establishment of the first large homeless tent encampment in Minneapolis in the summer of 2018 with about 200 people residing there. The number of encampments has since grown in Minneapolis with a few also in adjacent St. Paul. Since the beginning of the COVID pandemic, many of the encampments have been closed by the city and state, making it challenging for healthcare for the homeless outreach staff and community-based harm reduction outreach front-line workers to sustain contact with many outbreak cases. Over 60% of the HIV outbreak cases had at least one encounter recorded in the county’s Homeless Management Information System database; however, only a small minority of cases have been placed in shelters through the county’s coordinated entry system.

He shared that the state’s client-level RWHAP data demonstrates that advancement along the housing continuum empowers people in the RWHAP system to achieve viral suppression. Although there is little difference in care retention among those who are stably, temporarily, or unstably housed, viral suppression rates are consistently 16-25% lower for those who are unstably housed compared to those who are stably housed, he reported. Further, the data for the Minneapolis TGA reveals that there are significant racial and ethnic housing disparities among the RWHAP clients, with American Indians, people who have multiple racial identities, and transgender people having the highest rates of being unstably housed. African Americans are more likely to be unstably and temporarily housed and Latinx are more likely to be temporarily housed compared to whites. A prior analysis of the TGA’s data found that no RWHAP services were positively correlated with viral suppression for unstably housed clients. However, among people with HIV who were temporarily housed, receipt of ADAP, medical case management, and being insured had high to very high positive associations with viral suppression. The TGA has concluded that without safe, stable, desirable housing, it is unlikely any other public health intervention (service) will improve viral suppression among people who are unstably housed. As a result of that analysis of the impact of RWHAP services on viral suppression, in collaboration with the Minnesota Council for HIV/AIDS Care and Prevention and Minnesota’s Part B recipient, over the last four years Hennepin County has significantly increased RWHAP resources for transitional housing assistance including rental subsidies and housing navigation and coordination services, serving almost 8 times as many clients in 2021 than they did in 2016.

Mr. Hanft provided an overview of the 5 teams that comprise Hennepin County’s structured response to the drug-related infectious disease outbreak:

- Prevention-focused Homeless Screening and Harm Reduction includes community early intervention (RWHAP funded) and syringe services/harm reduction providers as well as

outreach staff from Hennepin County's Health Care for the Homeless (HCH) program and the county's Red Door HIV and STI clinic.

- Homeless Clinical Treatment is staffed by HCH nurses and their social services staff who together provide medical care coordination, PrEP, PEP, ART, and HCV treatment, and treatment for co-occurring conditions including substance use disorder and mental health services.
- Person-centered Housing Coordination is provided by HCH staff including a specialist medical case manager that is Ryan White funded, who focuses on medical care access and retention, and linkage to housing resources.
- System Level Housing and Outreach Coordination is led by staff in the county's housing stability area who work to overcome system barriers and provide housing navigation.
- Epidemiology and Data is comprised of HCH's public health epidemiology staff, RWHAP data outcomes coordinator, and public health clinic data analyst compiles. They integrate and analyze data from multiple sources to inform individual level HCH and disease intervention, assess the needs of the outbreak and outbreak adjacent population, and evaluate progress in the response.

Mr. Hanft highlighted two initiatives underway in Hennepin County to improve its response to the HIV outbreak that hopefully will have impact on broader work to engage people with HIV in optimal care. First is an effort with the epi team and public health clinic staff to integrate cross-sector data to inform both client-level HIV care engagement and population-level HIV health improvement. Second, the county is convening a housing technical working group to develop and implement lower-barrier housing models that will lead to more successful services that result in more rapid housing of people with HIV in safe and desirable settings.

Mr. Hanft concluded by observing that movement along the HIV care continuum to sustained viral suppression is unlikely without rapid movement along a housing continuum. He remarked that with current housing services systems with their complex funding streams, varying eligibility, sobriety requirements, and criminal background check policies, there are too many steps and barriers to securing safe and desirable stable housing for people with HIV who inject drugs and who are experiencing homelessness. He believes that implementing successful rapid models of housing service delivery that remove these barriers is as critical as providing rapid ART start in achieving viral suppression. In other words, housing is treatment as prevention.

He added that Hennepin County is grateful to both CDC and HUD for the assistance they have provided during their outbreak response.

CHAC Member Discussion on Panel 2

Dr. Anderson opened the floor to discussion and questions.

Dr. Mermin thanked the panelists for their presentations and for all the work they are doing that was reflected in them. He said that he thought this is a moment in time for appreciating the important role of housing. Previously, CDC collaborated with HUD on a study that found that if individuals with HIV were housed they were more likely to be virally suppressed, housing made a difference. Other studies at CDC, like the Medical Monitoring Project, look at the correlation of unstable housing and negative health outcomes. But he thinks there's a gap. We would all like to do more, he said. He asked the panel whether there is space within EHE and/or jurisdictional integrated HIV plans where housing can be prioritized and where that might manifest itself. He also asked if there were new or expanded resources for housing in communities specifically for

HIV what would the panelists do with those resources for greatest effect; what programs would they make sure to implement to yield results in 2 years?

Ms. Fukuda responded that one of the hardest issues from a funder's [state health department] perspective is that this is a complex population to house, and an unpopular population to house because of the many challenges they are experiencing. The individuals need a variety of supports to manage the many struggles they have experienced. So, it can be difficult to find housing for them. In response to Dr. Mermin's second question, she suggested that the ability to buy buildings that could house these individuals would be important and then communities could staff it with resources from CDC, HRSA, SAMHSA, and HUD. She drew a parallel to the early days of responding to HIV when advocates, organizations, and agencies could buy buildings that they then owned and could staff so they didn't have to worry about being "unpopular."

Mr. Hanft responded to the question about the best place to direct the resources by observing that in his area there are a number of open units of housing now, likely the result of additional COVID and ARP funds. What they really need, though, is the intensive housing coordination and case management, someone who is really well connected to the client, to go hand-in-hand with them to navigate these complex housing and other systems and help them when things fall through. He suggested that resources for that kind of staffing where are most needed. He also stated that resources are needed for more supportive types of housing models with onsite staffing.

Dr. Brody agreed with both her fellow panelists that there is a need for buildings and units, remarking that it shouldn't take 12 years to get someone housed as it had for one of her own patients for one of her patients with complex needs. She cautioned that once the client is in the door there is a whole plethora of new challenges for which these individuals with complex needs require intensive support and accompaniment. Housing, she stated, is essential, but insufficient. The need for buildings is especially great in high-cost jurisdictions. She believes that individuals are so capable of getting better and needing less over time and feels it would be wonderful to have housing options that they could move through, graduate from an SRO with intensive services and move to another place where they can have more independence flourish with fewer supports.

Mr. Hanft shared that one thing they are learning in Minneapolis is how people want to live. For example, they are learning from encampments that people want to live with people they know, who are their friends. But the available housing isn't structured that way. In his community, they are now looking at a pilot that would allow 4 people to live together in a unit. Single adult housing has often not worked, for a variety of reasons including sometimes cultural or social implications of that format.

Mr. Driffin posed 3 questions. First, do CDC or HUD have a SPNS-like mechanism that would be able to investigate employment, housing, and PrEP options for vulnerable populations like MSM or transgender women across the South? Second, are there any current modeling efforts in place that could show the impact if there were a HOPWA-like program for people vulnerable to HIV to provide them prevention options paired with supportive services? Is such modeling available anywhere, like across EHE jurisdictions? Third, are there any efforts or ongoing assistance at HUD for many of the southern jurisdictions to collect, monitor, and report important HIV health outcomes like viral suppression among persons receiving services in their programs?

Dr. McClung said he was not aware of a specific SPNS-like mechanism at CDC to study this further. But, he observed, there are conversations between CDC and HUD looking specifically at evidence gaps in housing as HIV prevention from either a modeling standpoint or using existing or new data. He observed that housing, as Mr. Driffin had pointed out, extends across prevention, testing, and care efforts to end the epidemic.

Dr. Mermin added that yes, there is lots of interest in investigating the issue further and lots of thoughts about doing so not just for HIV, but for preventing poor outcomes for other health issues, too. He added that there are lots of large-scale mechanism to help people get housing across the country, particularly those supported through HUD. So, it may not be a matter of CDC needing to support housing but identifying ways to leverage those existing systems. He suggested that a question that could be asked of HRSA is whether HAB itself, mindful of legislative limitations, might be interested in exploring offering PrEP and housing services in places already providing HIV care since those places would also be welcoming to those at risk for HIV; but he recognized that such offerings are not possible right now.

Dr. Daskalakis added that one of the important ongoing conversations between HUD and CDC is about modeling and doing work around what he's calling status-neutral housing approaches. He thanked Ms. Harcrow for engaging with CDC in that work. He also shared that CDC is looking at its data to better understand the impact of housing on some behaviors and what stability of housing does for both people with HIV and people who can benefit from HIV prevention services. So, he encouraged CHAC members to "watch this space." He explained that CDC is also thinking of innovative ways to weave together resources to better serve people who could benefit from prevention. In that area, CDC is talking to a few jurisdictions that have created innovative approaches to addressing housing needs of people at risk of HIV and will learn from those as they get deeper into the experience.

Ms. Harcow added in response to Mr. Driffin's questions that there are some limitations about what HOPWA can and can't do because of statutory requirements limiting use of funds to people with HIV. But, within that, she added, HOPWA funds are really flexible and can be maximized for things like employment programs in ways that RWHAP can't. So, she that HOPWA has partnered with RWHAP on a couple of SPNS projects to look at employment programs. Regarding the question about southern jurisdictions and data collection – she acknowledged that there are limited program reporting requirements for the bulk of the HOPWA funding disseminated via formula grants; but for the 10% of funds that are competitively funded more and better data can be collected. Soon HOPWA will be announcing 20 new grantees under the competitive program. Built into that NOFO were requirements for data collection and participation in a technical assistance cohort looking at viral suppression outcomes. She said that HUD had received some great, innovative proposals serving different populations including LGBTQ people and seniors. So she is hopeful about the data these projects will yield.

Ms. Fukuda noted that while she appreciated the discussion about the need for innovative housing solutions for people with HIV generally, the focus of the panel is the intersection of behavioral health, substance use disorder, and HIV clusters/outbreaks among unstably housed or homeless individuals, which is a very niche, very specific issue requiring housing solutions for very high need people in physical, medical, and psychosocial crisis. They may be in need of short-term models of housing and care. She emphasized the need to think about meeting the needs of this population differently than housing for people with HIV in general.

Dr. Brody added housing-first support services to serve this population do look different. She suggested that they include intensive case management, but also harm reduction services so

they don't die of overdose since they are alone in new housing and away from their network who could intervene with Narcan. She said that SSPs are also needed along with overdose prevention plans and checks from staff. She noted that there is lots of potential for creative peer programming for overdose prevention and community care on preventing overdoses and practicing harm reduction. But, echoing Ms. Fukuda, she stated that the support services needed to respond to the very specific, unique needs of this population living with HIV and experiencing homelessness would look different than for other people with HIV in need of housing services.

Dr. Greene reflected that across the presentations there had been references to the siloing that exists in systems that complicates effective service delivery, but she thinks that integrating medical and housing services is going to be really critical. She remarked that, as the panel had highlighted, housing is healthcare, thus stakeholders need to find ways to bring medical services to housing. She added that another layer to consider is anticipating future needs of an aging of population with HIV. Older individuals in need of housing and substance use and mental health services may also need support for activities of basic daily living that often come as people age and the housing and other services will need to be able to accommodate. She suggested that this may require a similar intensity of support services in a multi-pronged approach with case management, as Dr. Brody and Ms. Fukuda highlighted for the individuals. Finally, Dr. Greene remarked that we need to think of all those service providers and navigators as important parts of our workforce, not just the medical providers, to make sure that all of them receive the necessary support for this intensive work.

Dr. Anderson observed that the intersection of these 4 very complex issues makes for a complex topic. She asked the panelists several questions. First, she inquired what they know about how the intensity of the services needed and provided in the Boston and Minnesota programs plays out in more rural settings, especially in the South. Second, she asked about the whether either site had experience with using peer navigators and, if so, are they effective? Third, she asked HUD about how well developed access to HIV testing, preventive services, and treatment in HUD-supporting programs is.

Dr. Brody replied to the question about peer navigators sharing that in an earlier iteration of one of their navigation programs, they had been funded to use peers, which was an exciting opportunity. But they found that the setting, intensity of the work, stresses of the role, and exposure to active substance use and related circumstances made it very challenging for many of the peer navigators who were in recovery. She said they needed a much more robust system of supervision and peer support to safely integrate peers. She added that she knows it would be an effective addition, but more support services are needed for the navigators to be able to engage them safely.

Ms. Harcrow replied to the question about HIV services in HUD programs saying that while she'd like to say there is a solid program now that encourages collaborations in testing and other HIV services in HUD-supporting housing settings, that it is really newer, fledgling work that isn't yet widespread. She added that in the new administration there has been new engagement at the highest levels of HUD around the National HIV/AIDS Strategy that she had not seen before. She shared that there is better recognition that HIV housing needs are greater than what HOPWA can address. That's leading to more collaborations in the Department, particularly with Public Housing which touches more individuals than any other HUD program. Better collaboration on the ground with those programs could make a real difference, she said.

Dr. McClung responded to the question about housing and rural outbreaks, observing that most of what CDC has seen has been in metropolitan areas, with the exception of Scott County, Indiana. Even in West Virginia, the outbreaks have been in major population centers. In CDC's experience working with health departments and local partners, housing needs identified in an outbreak response can quickly outpace local capacity for case management and follow up; this capacity can be even more quickly overwhelmed in less urban areas where fewer staff and financial resources are available. He added that there are also some very unique challenges with availability of housing units in rural areas.

Ms. Harcrow remarked that she is a child of the rural south and has worked in both RWHAP and HOPWA for years in the south, so she recognizes that there is a difference from town to town or community, with the work often relying on a single individual. She added that there is also a real variety of programs and types of housing available, including some types of housing that HUD can't support. She referred back to the idea raised earlier about needing more structures, acknowledging that this need exists in the south, too.

Mr. Hanft remarked that the question about better integration of healthcare and prevention services with housing is a good one. He said that one thing he and his colleagues have learned from the homeless encampments in Minneapolis is that they need to change that environment to prevent infectious diseases. He explained that having a housing system that can meet the needs of this population would enable them to eliminate a variable – encampments – that is raising the risk of infectious disease transmission and outbreaks.

Ms. Parkinson thanked the HOPWA supporting essential housing services for people in the HIV community. She reiterated the importance of peer support from people with lived experience in connecting individuals to these services. She also remarked that there is also often lots of red tape involved, which can deter some people from pursuing these housing services, which is another area where a navigator can be helpful.

Additional Public Comment

Dr. Cheever introduced one more public comment that that didn't make it in during the earlier period.

Steven Bryson, JD

Sero Legal Fellow, AIDS Law Project of Pennsylvania

Mr. Bryson commented on HIV criminalization, stating that in response to the Ryan White CARE Act of 1990, states were required to enact statutes targeting people living with HIV because of stigma, fear, and misinformation. After 40 years, he observed, we have a far better understanding of HIV and, therefore, our laws should reflect that knowledge. He recounted that in 2010 when the CARE Act was reauthorized, the requirements for states to have a legal mechanism to prosecute people who intentionally expose people to the virus were removed, which prompted the start of the movement to modernize and eradicate HIV criminalization. He expressed concern that although those state laws were enacted to receive funding from the government, the government hasn't issued any guidance to states regarding the need to repeal or modernize those HIV specific criminalization laws. The quality of life of people with HIV cannot be adequately addressed when HIV criminalization laws infringe on their human rights and perpetuate stigma, he argued. He pointed to recent guidance from the United Nations Development Program that urges prosecutors around the world to shift from criminalization to a

more public health approach to ending the epidemic. It outlined many avenues through which cases could be resolved through alternative means and urged prosecutors to only use criminalization only as very last resort. Mr. Bryson explained that when HIV is criminalized, people with HIV face more than just the direct consequences of criminal convictions; they also face legal sanctions and restrictions imposed by statutes on people because of their criminal record. While many states may have passed these laws to reduce transmission, there is zero evidence that criminalization curbs infections rates. In fact, he continued, evidence shows that criminalization does the opposite because it discourages individuals from testing because ignorance is the only defense to these statutes. Criminalization undermines efforts to encourage HIV testing and retain people in care and creates distrust between people with HIV and public health officials. Furthermore, fear of prosecution discourages people with HIV from cooperating with traditional STI prevention measures like partner notification or treatment adherence programs. HIV criminalization undercuts important public health initiatives by ignoring actual transmission risk, exacerbating stigma, and devaluing the importance of personal responsibility in HIV prevention, he explained. He concluded with a demand that the federal government must address criminalization in its efforts to end the HIV epidemic.

Updated Guidelines for Hepatitis B Screening

Presenter: Erin Conners, Division of Viral Hepatitis, NCHHSTP, CDC

Dr. Erin Conners of CDC's Division of Viral Hepatitis provided information about CDC's *Updated Guidelines for Hepatitis B Screening and Testing*. She began by reviewing the latest estimates on the 880,000 people living with hepatitis B virus (HBV) infection in the United States, though modeled estimates put that figure even higher (1.4M-2.4M). She explained that a large proportion of these individuals were born outside of the U.S. and have been chronically infected since childhood. But there is also a segment of people who acquired HBV infection as a result of behavioral risk factors (i.e., injection drug use, unprotected sex) and who were unvaccinated for hepatitis B. Justifications for hepatitis B screening include the fact that chronic infection can be detected before the onset of symptoms of liver disease using reliable and inexpensive screening tests and treatment for chronic HBV infection has been shown to reduce morbidity and mortality. Dr. Conners also noted that universal screening may help reduce stigma by not singling out some populations that are already often marginalized, such as non-U.S. -born individuals, and also since patients wouldn't have to reveal potentially stigmatizing risk factors in order to get screened. In addition, universal screening simplifies a complicated process that has fallen short: under current screening guidelines, only about a 1/3 of persons with HBV are aware of their infection. Finally, she remarked that universal hepatitis B screening complements existing hepatitis C and HIV screening guidelines.

She then discussed analyses conducted to inform the new proposed hepatitis B screening recommendations. A cost-effectiveness analysis of universal screening conducted by modelers compared the current practice to the current practice plus a one-time adult screening test. They found that screening all adults ages 18-80 at least once with a hepatitis B surface antigen (HBsAg) test is cost saving compared to current practice. She also discussed a finding from the systematic review of universal screening that sought to determine the prevalence of chronic HBV infection in the United States. It concluded that the median prevalence of chronic HBV infection in the general population was 0.4%.

As a result of all these factors, the revised hepatitis B screening recommendations add new recommendations to the existing risk-based testing guidelines. The first added recommendation

is for universal hepatitis B screening at least once in a lifetime for adults ≥ 18 years of age. The second recommendation is to use a 3-test panel that includes tests for hepatitis B surface antigen (HBsAg), antibody to hepatitis B surface antigen (anti-HBs), and total [IgG and IgM] antibody to hepatitis B core antigen (total anti-HBc) rather than HBsAg only. Finally, the update adds to the list activities, exposures, or conditions associated with an increased risk of HBV infection which would prompt risk-based testing among:

- People currently or formerly incarcerated in a jail, prison, or other detention setting
- People with a history of sexually transmitted infections or multiple sex partners
- People with a history of hepatitis C virus infection
- Anyone who requests hepatitis B testing

Dr. Conners then reviewed a flow chart translating the recommendation into how a provider might implement the new hepatitis B screening recommendation.

Before she concluded, Dr. Conners also noted that CDC's own Advisory Committee for Immunization Practices (ACIP) had also just voted unanimously to recommend universal hepatitis B vaccination for all adults 19 through 59 years of age.

Panel 3 – Beyond Viral Load. Patient Centered, Integrated Care with

Moderator: Shalonda Collins, HRSA HAB

Ms. Collins opened the panel presentation by explaining that the panel would explore how providing patient-centered, integrated care for people with HIV (i.e., treating the whole person, including addressing behavioral health, mental health, and substance use disorder treatment needs) can improve quality of life. We know, she continued, that many people with HIV experience numerous challenges like stigma, poverty, mental health and/or substance use disorders that affect quality of life or overall sense of well-being. While it remains unclear how to measure quality of life in the HIV care continuum, it is clear that these things greatly affect both remaining in care and care outcomes. So, the presentations will describe how providing integrated, whole-person care can improve quality of life.

She provided an overview of three recent Technical Expert Panels (TEP) convened by HRSA HAB that were especially relevant to this panel's subject. She explained that TEPs consist of RWHAP recipients, providers, subject matter experts, representatives of public health organizations, stakeholders with lived experience, and staff from across HHS and other federal agencies who all share their experience and perspective on the specific topic. TEPs provide HRSA HAB insight into key issues of interest to the agency and participants' input is considered when developing strategies relating to specific populations, policies, or programs. The three TEPs and their purposes were:

- Addressing the HIV Care Needs of People With HIV in State Prisons and Local Jails (March 2020)
Purpose: To identify supports and barriers to HIV care and treatment in correctional facilities, as well as community re-entry and current approaches
- Dimensions of HIV Prevention and Treatment for Black Women (October 2020)
Purpose: To examine the research, clinical, and patient landscapes related to HIV prevention and treatment for cisgender Black women

- Addressing the Health Care and Social Support Needs of People Aging with HIV (November 2020)
Purpose: To explore the health care and social support needs of RWHAP's aging population, with a focus on the barriers to and strategies for providing services

Ms. Collins explained that each TEP offered significant insights on the value of integrated care and the need for patient-centered care to address SDOH. She said that key themes from across the three TEPs included:

- Address Stigma – when coupled with other negative perceptions, stigma can make receiving certain services difficult
- Treat the Whole Person – person-centered and whole-person care gives patients more control of their care and goes beyond HIV treatment to provide clients with social, economic, and other forms of support associated with their condition with an integrated care team that includes primary care, psycho-social services, and case managers.
- Social Determinants of Health
- Create Multidisciplinary Care Teams
- Access to Care (Impact of COVID) – Access can be improved by creating welcoming environments, low-barrier clinics, providing transportation; recognizing that COVID has interrupted care or created barriers to accessing care.
- Provide social support
- Value Lived Experience – Engage people with HIV as navigators, community health workers, or coaches to enhance quality of care and make sure key linkages happen. TEP panelists stressed professionalizing these roles, providing training, and compensating them fairly.
- Encourage patient health literacy and advocacy
- Partner with Communities – An important principle at HRSA is partnering with communities in the planning, development, and implementation of HIV care strategies, which was supported by the TEP panels as well.

Executive summaries of each of the three TEPs are available on HAB's website.

She introduced the panel members who represent two HRSA SPNS Initiatives, Improving Care and Treatment Coordination for Black women with HIV and the Black MSM Initiative.

Using Bundled Interventions to improve HIV Health Outcomes & Quality of Life for Black Women with HIV

Serena Rajabuini, PhD, MPH, Assistant Professor, Department of Public Health, Zuckerman College of Health Sciences, University of Massachusetts, Lowell
Alicia Downes, Senior Program Manager, AIDS United

Dr. Rajabuini and Ms. Downes provided an overview of the HRSA SPNS Initiative focused on improving care and treatment coordination for Black women with HIV, which their organizations are managing and evaluating. The 4-year initiative (2020-2024) is funded by the Minority HIV/AIDS Fund (MHAF) through the SPNS program and has been titled Black Women First. It is supporting 12 demonstration sites and a single organization to serve as an Evaluation and Technical Assistance Provider (ETAP) to lead the multi-site evaluation and provide technical assistance to demonstration sites. The initiative is designing, implementing, and evaluating bundled interventions – a group of evidence-informed practices put together into a package that when implemented together produces better health outcomes (i.e., improved engagement,

higher retention, and improved viral suppression) than when the practices are delivered separately – for cisgender and transgender women with HIV who identify as Black or African American and are age 18 and older.

Dr. Rajabiun explained that there are both system-level and client-level outcomes being assessed. At the system level the two primary outcomes are improved ability to address the socio-cultural determinants specific to Black women and implementing care coordination models that are culturally relevant for and by Black women. Client-level outcomes are centered on improving health outcomes including linkage to care within 30 days of diagnosis, improved retention in care, and increased rates of viral suppression.

Ms. Downes reviewed the 6 domains from which the demonstration sites have chosen their evidence-informed interventions:

- Enhanced patient navigation, enhanced case management, peer engagement
- Red carpet care experience
- Stigma reduction
- Trauma-informed care (organizational capacity building & individual care)
- Intimate Partner Violence (IPV) organizational training, screening & assessments
- Self-efficacy, health literacy

She explained that most sites have chosen at least 3 interventions. She then discussed several examples of specific interventions.

The presenters also discussed their approach to meaningful involvement of site partners and Black women with HIV. This includes an ETAP Advisory Council comprised of Black women who are living with HIV, a medical provider and supervisor of Community Health Workers. In addition, the Positive Women's Network is providing each of the project's demonstration sites with technical assistance on developing community advisory boards and the initiative is using a community-engaged evaluation approach, all of which help ensure meaningful involvement of women from the focus population throughout the initiative.

As part of the evaluation, Dr. Rajabiun explained that they are examining quality of life measures focused on physical and mental health functioning, multidimensional social support, HIV stigma, and resiliency and coping.

Ms. Downes and Dr. Rajabiun concluded by sharing some recommendations on enhancing the quality of life of Black women with HIV based on the early stages of project implementation. These included:

- The need for meaningful involvement of women to focus on their priorities
- Greater community support and investment in structural factors that influence quality of life such as representation in the workforce, housing, childcare, career development, and equal wages
- Develop and implement intervention approaches that are culturally relevant to Black women with HIV, address medical mistrust and misinformation, are trauma-informed, and address the inequities such as housing, employment, income equality, and education
- Incorporate measures in addition to clinical outcomes such as family and social systems, economic and social stability, satisfaction with life, and physical and mental health functioning

Early Findings from the Black MSM Initiative

Sarah Hodge, MPH, Research Scientist, Public Health Department, NORC
Chandria Jones, PhD, MPH, Senior Research Scientist, Public Health Department, NORC
Sara Legrand, Associate Research Professor, Duke Global Health Institute and the
Center for Health Policy and Inequalities Research, Duke University

Ms. Hodge and Dr. Jones provided an overview of another SPNS project known as the Black MSM Initiative that was funded from 2018-2021. The goal of the Black MSM Initiative is to implement, evaluate and support replication of four evidence-informed behavioral health models, in order to improve HIV health outcomes for Black men who have sex with men. The focus population is uniquely vulnerable – living at the intersection of stigma around race, sexual orientation, HIV status, mental health status. As a result, many men have had a hard time accessing and engaging in traditional models of HIV care. The initiative supports 8 demonstration sites and an evaluation and technical assistance provider (ETAP). The demonstration sites are implementing four different evidence-informed models of care that are being adapted to integrate behavioral health and HIV clinical care specifically for Black men with HIV who have sex with men:

- Strength Through Youth Livin' Empowered (STYLE), which uses social marketing and virtual support
- Project Silk, a recreation-based drop-in space to support artistic expression
- Brothers United/the Damien Center's one-stop shop model
- Youth-focused Case Management offering intensive case management support

A total of 805 participants have been recruited across the 8 demonstration sites and data collection will conclude at the end of this year.

Based on preliminary findings from an incomplete data set, the 535 clients who reached the 6-month mark experienced improvements in all three key Initiative outcomes, with significant improvement in retention in HIV care and receipt of ART. While viral suppression rates increased, the change was not statistically significant.

Regarding quality of life, the multi-site evaluation doesn't have a single quality of life measure but does include several measures related to quality of life. For example, it looks at behavioral health as an element of quality of life. Preliminary data based on about 250 clients found statistically significant increases in 3 behavioral health measures at six months: referral to behavioral health services, receipt of behavioral health services, and engagement in behavioral health care.

Dr. Jones and Ms. Hodge shared lessons from the initiative, including:

- The value of social and community support services – It is difficult to engage fully in health care services when people are struggling with basic life needs. They may be more willing to work with a program that can offer higher-priority services, including social support.
- The need to professionalize peer navigators – Peer navigators are crucially important and should be treated as professionals (e.g. credentialed) and compensated for their expertise. Peers provide “low-barrier” behavioral health support that meets clients where they are. It is also hard to retain people in navigator roles if they don't see it as a path to a career. It is also important to recognize that serving as a navigator often involves asking peers to relive difficult times/experiences in their lives, so there is a need to provide qualified supervisory support for them.

- The desire for a diverse, non-stigmatizing, trauma-informed workforce – People want to engage in services where all their identities are welcomed by professionals with similar lived experiences. Creating non-judgmental environments helps build trust in services.
- Accessibility of virtual services and telehealth increased use of services – Increased access to virtual services meets clients where they are. Increased flexibility in service provision ensures people can engage when and where they are ready. A lot of clients reported that virtual services made it easier to engage with the program. Adding assessment of tech literacy would be helpful.

Dr. LeGrand provided an overview of one of the four interventions, Style 2.0, as it was implemented in the demonstration site in the Triangle region of North Carolina and in Columbia, South Carolina. The intervention focuses on young Black MSM between the ages of 18-35 who are new to HIV care, at risk of falling out of care, or in care but not virally suppressed. Elements of the intervention included:

- Navigation – A health care educator/coach facilitated linkages to HIV care system and other services. This was a professional role defined as a health care educator/coach as opposed to medical provider. Two positions were filled by young Black men, which created a dynamic in which participants felt more comfortable opening up and sharing their concerns. Navigators could advocate for participants with medical staff. Informal check ins via text or phone by the navigators were also an important part of the behavioral health care and support.
- Mental Health/Substance Use Intervention – Participants received referrals to a Behavioral Health Provider, known as “the Stylist,” for 4 motivational interviewing sessions and, as needed, referrals additional behavioral health services. Virtual “warm hand-offs” from the navigator to the behavioral health provider were part of the protocol.
- STYLE 2.0 App (from HealthMpowerment) – provides users with information and resources in a fun and engaging way, fosters social support by creating online community, and includes game-based motivational elements. Updates were posted weekly.
- Virtual Support Groups -- Weekly virtual support groups were open to all STYLE 2.0 participants were the most popular of all the STYLE components. The virtual community of participants functioned as a support group, an especially welcome, comfortable, and safe space during COVID-19. Participants worked through stressors together, discussed resources, and engaged in bonding activities. Dr. LeGrand said that offering the group virtually provided greater opportunity to participate, especially for those participants who didn’t previously want to or couldn’t because of transportation issues.

She reported that a total of 66 participants were enrolled, half in North Carolina and half in South Carolina.

Dr. LeGrand concluded by sharing some of the lessons learned so far, including:

- A hybrid approach to services should be available as needed. Due to COVID, all services were provided online, though they had envisioned a hybrid model which they believe could be useful/necessary for some participants to succeed since some participants at least need in-person interaction, however brief, prior to engagement in telehealth.
- A more flexible behavioral health model is needed for this population; the traditional 1 hour, in-person session with a therapist may not be optimal. Similar findings reported from other BMSM Initiative demonstration sites that also transitioned from the traditional mental health model to a more flexible model of utilizing behavioral health providers and

health care navigators to address various treatment goals and utilizing telehealth for these interactions.

- Representation Matters—the two young, Black male navigators have been key to success.

Dr. Jones concluded the presentation by observing that the value of this Initiative has been to be able to center Black MSM – a high-need population in terms of both HIV health outcomes and behavioral health needs – for whom existing models of both HIV and behavioral health care have not been sufficient. She added that they are continuing to learn more about how to best serve these clients and help them achieve overall well-being. She stated that our job is not complete if we're only getting a client in to see his HIV care provider, and that to treat the whole person it is important to recognize their culture, their lived experience, the context in which they are interacting with the world, including their providers' office. She concluded that we need to think about how physical and mental health are deeply intertwined and you can't really have one without the other.

CHAC Member Discussion on Hepatitis B Screening Presentation and

Dr. Stewart thanked the panelists for their presentations and their work to look at the special needs of black women with HIV and black MSM. On the topic of hepatitis B screening she raised concerns from a clinician's perspective about covering the cost of the lab tests and vaccination for individuals found to not have immunity as well as questions about how to treat individuals found to have acute or chronic hepatitis B virus infection. She remarked that primary care clinicians need more clarity on how to care for individuals who test positive. She felt that without that many clinicians may not want to follow the recommendations.

Dr. Conners replied that in parallel to the updated HBV screening guidelines, CDC is also doing cost effectiveness analyses of vaccination, specifically looking at whether in some settings screening might help reduce the cost of vaccination by identifying patients who had already been vaccinated or had signs of previous infection. Regarding the issue of how to treat patients diagnosed with hepatitis B, she stated that this was the next big step to consider around implementing the new screening guidelines since CDC wants providers to have the tools they need to adopt the screening guidelines. CDC will continue to work to reduce the burden on providers to implement both the new hepatitis B screening guidelines as well as the hepatitis B vaccination guidelines announced the day prior.

Dr. So added that for the last 25 years he has been raising hepatitis B awareness and advocating for a comprehensive strategy for the elimination of hepatitis B transmission, death, and stigma. He stated that CDC's new universal adult hepatitis B screening recommendation is very important and will also make it much easier for providers since the universal recommendation can be implemented in electronic medical records as a provider prompt for any patient >18 years old without a record of a hepatitis B test indicating that they should be tested. The 3-test panel costs only \$38 for Medicare, he noted, so it is a very inexpensive one-time test to evaluate someone for treatment or vaccination. Since ACIP recommended universal adult hepatitis B vaccination the prior day, he observed it will now be covered by virtually all public and private forms of health coverage. He continued by remarking that what many people don't understand about hepatitis B is that it is called a silent killer because 15-20% people with HBV will die from liver cancer. There are major HBV-related disparities: Asians are 8 times more likely to die and Black Americans are 2.5 times more likely to die of hepatitis B than non-

Hispanic white Americans. He stated that the CDC's new recommendation is a major, very important development that will help streamline screening and address a major health disparity. He added that it will also save tens of thousands of lives and potentially save hundreds of millions of healthcare dollars on liver transplant and liver cancer, as well as also help to meet the HHS and global targets of diagnosing 90% of people with hepatitis B by 2030. He believes that treatment of hepatitis B is actually very simple, but that it's the hepatologists who make it very complicated. He shared that there's an application that can help primary care providers with hepatitis B treatment in which the provider answers 4 questions to help determine if a patient needs to be on treatment or just seen for follow up. He posed a question for CHAC: In order to have the new CDC recommendations covered by all health plans, can CHAC ask USPSTF to consider updating their hepatitis B screening recommendation to match CDC's?

Ms. Parkinson thanked all the panelists for great presentations. She said she was pleased to see attention on the needs of Black women with HIV so that disparities can be eliminated. She asked how to go about requesting that CDC and HRSA provide more funding for PrEP services for Black women in ways that more meaningfully support awareness and uptake reaching both HIV-negative Black women and also Black women with HIV whose partners may wish to consider PrEP. She also asked what could be done to better integrate models of care addressing SDOH and women aging with HIV that recognize that, with U=U, some are finding love again and want to thrive.

Antigone Dempsey, Director of HRSA HAB's Division of Policy and Data, responded by noting that this wasn't the first SPNS initiative to focus on Black women with HIV and that HRSA has developed a better understanding of the important role of trauma-informed care through various initiatives. She added that the implementation science approach being used in the Black Women First SPNS project will help HRSA and RWHAP recipients understand what works and how, to see if there were differences between sites that used a particular intervention compared to sites that didn't use it and then disseminating those findings so all programs can benefit. She also remarked that insights from this SPNS project could help inform expansion of PrEP services for Black women since the women in need of PrEP share many characteristics of the women seeking HIV care in the demonstration sites, they just need a different HIV service.

Dr. Rajabiun concurred with Ms. Dempsey, sharing that some of her colleagues had observed that some of the strategies being used in Black Women First to get women into care could be adapted for PrEP navigators, peers, or community health workers. She suggested this might require a more standard training around the whole status-neutral continuum of HIV services – prevention and care services – to build the capacity in the service delivery system of a network of community peers who can engage specific populations.

Ms. Parkinson agreed that robust implementation of a peer program can ultimately improve viral load suppression, linkage to HIV care, and other HIV services. She noted that since some people can be intimidated by healthcare providers, peers can help meet a client where they are and navigate healthcare and other support services with sensitivity to other dimensions of the client's life.

Dr. Greene observed that improving the quality of life of people with HIV will be influenced largely by how we measure it and how we ask clients about it, especially as we assess programs for impact. She asked the presenters how or why they chose the ways they assessed quality of life and whether they had other insights on core aspects of the assessment of quality of life among people with HIV. Dr. Rajabiun responded that they had found in the Black Women First initiative that there was a connection between quality of life and unmet service needs for

housing, food, substance use disorder treatment, etc. She said that dimensions of social support and social support networks, particularly with regard to connections with family and friends, also influenced clients' perception of quality of life. She added that physical and mental health functioning and well-being are also clearly part of quality of life. Ms. Downes added that they had asked about stigma because that impacts how clients think and feel about themselves and impacts decisions about coming into care. Dr. Jones stated that they didn't have a single quality of life measurement in the BMSM initiative, but something that was impactful was asking the population being centered how they interpret quality of life, then building the measures to assess that.

Dr. Gayles thanked the panelists for their presentation and their work, saying he looked forward to continued work that will inform efforts of everyone serving these populations.

Business Session and Suggestions for Future Agenda Items – Part 2

Dr. Gayles began by saying that he and Dr. Anderson had conferred about the CHAC's obvious enthusiasm around the previous day's discussion of telemedicine. As such, they proposed a vote on setting up an opportunity for a small group of members to draft a letter about the value that telemedicine could continue to add to service delivery. He also highlighted concerns raised by the STI panel regarding the lack of penicillin G benzathine in some pharmacies amidst the rising number of congenital syphilis infections. He then opened the floor to members to raise opportunities that may have arisen from the day's presentations and discussions.

Dr. So asked whether CHAC can reach out to HHS or others to request that the USPSTF reconsider updating its hepatitis B screening recommendations in light of the CDC's updated recommendations. He explained that the USPSTF last reviewed those guidelines two years ago but made no changes. He reminded the members that without a USPSTF [grade A or B] recommendation, most health plans won't cover the cost of the screening test. Dr. Gayles observed that it was less a question of can the CHAC do it than of how they can best do that.

Ms. Morne shared appreciation for the significant work that had gone into the several presentations and the tremendous work the presenters are doing across the nation. She had several recommendations for possible follow up by the CHAC on issues raised by those presentations. First, she recommended following up on lessons from COVID response, with a particular focus on the DIS staff who were the foundation of the COVID response. The conversation needs to continue about DIS workforce development, she said, noting that more can be done regarding certification, wages, opportunities for advancement, training, and the ability to transfer skills to other public health areas. Second, she highlighted growing concerns among community-based providers about the ability to offer competitive wages in the current economy in which many sectors have hiked wages. Most often, she said, CBOs now are offering lower wages than even retail. Third, she said she would welcome an update from HRSA on the impact of the changes to the RWHAP eligibility and recertification requirements, for which she and others are grateful. Finally, she observed that much of that day's conversation had centered around SDOH, suggesting that there needs to be additional dialogue about how to better enable work across programs at the local, state, and federal levels to address SDOH in less siloed ways. Rather than identifying short-term interventions, she asked how stakeholders can work for longer term supports addressing SDOH needs that can be maintained.

Dr. Gayles concurred, emphasizing the importance of recruiting, retaining, supporting, and developing DIS staff.

Ms. Parkinson suggested that at a future meeting the CHAC revisit roles for peer health coaches who provide patient education, support, navigation, and other services. She believes that peer coaches offer services that most providers need, are a critical part of the care team, and peer support programs need to be ramped up in order to end the epidemic by 2030.

Dr. Dowler remarked that she had enjoyed learning about what's happening on the ground, how different the pain points are in different parts of the country, and also how different the resources are. Among the topics explored that she felt merited further consideration were telehealth, but even more specifically access to sexual health services via telehealth. She also cited the increase in congenital syphilis as a topic for further discussion, particularly the lack of coverage by commercial payers as a barrier for extragenital STI testing. Finally, she expressed interest in more information on hook-up culture via apps increasing HIV/STI risk and how those apps can be used to connect people to services.

Mr. Millett thanked all of the federal partners for the incredible work they had been doing over very difficult prior 18 months. He shared suggestions for topics he felt would be important to address at the next CHAC meeting. First, he noted that the updated National HIV/AIDS Strategy (NHAS) will have been released by that meeting, so it would be important for the CHAC to look at it, find out what federal and nonfederal partners are doing to work toward its goals, and also consider what the CHAC can do to support those efforts. Second, he suggested that the discussion should continue about the impacts of COVID on HIV. He noted that agencies are continuing to gather and assess data on the outcomes and impacts of the COVID-related lockdown and disruptions to health services to determine and whether and where programs have recovered or may now be lagging as a result and how they can be supported. Finally, regarding the continuing conversation about telehealth, he recommended that the focus should be less about how many people opted in to using telehealth or continued using it, but more on outcomes -- whether people with HIV are remaining virally suppressed when using telehealth. Some recent studies have been showing that isn't necessarily the case. He said he would like to see additional data on whether people are remaining suppressed, and if so, whether there are associations with methods of telehealth or other factors. Dr. Gayles thanked Mr. Millett for the reminder about the upcoming release of the NHAS and agreed that should be placed on the next meeting agenda.

Dr. Anderson thanked all of the CHAC members for their very active participation over the two days. Observing that one of the opportunities they have as a committee is giving advice to CDC and HRSA, she revisited an earlier discussion about the idea of having a small informal internal group meet to draw up a draft list of recommendations on telemedicine that could be brought back to committee the next meeting for consideration.

CHAC Action

Dr. Anderson made a motion that an informal group to discuss and draft potential recommendations regarding issues of telemedicine in HIV and sexual and reproductive health before the next meeting. Ms. Hauser seconded the motion. CHAC members unanimously approved the motion.

Dr. Gayles and Dr. Anderson invited members interested in contributing to the draft recommendations to email the co-chairs.

Ms. Hauser counseled that the telehealth recommendations should consider the needs of young people ages 16-24 years and seek clarity around what can and can't be done to help them access such services. Dr. Gayles concurred, observing that considerations of young people are often left out of these conversations and that the needs of even younger people should be considered.

Ms. Hauser also shared that she and her organization had heard concerns from many young people about how they will access PrEP after Gilead's Advancing Access Patient Assistance program ends in the new year. She suggested that CHAC should consider, perhaps as a future agenda item, the implications of the announced end that program since it has funded lots of things that were getting people to services, noting that it's an important piece of the safety net to be repaired.

Ms. Parkinson proposed as another topic for a future CHAC agenda the issue of federal guidelines on breastfeeding by women living with HIV, which had been raised during one of the public comments. She remarked that with U=U many people with HIV are finding love again, so it fits that there also would be attention on having and nursing children.

Mr. Riester suggested other issues the CHAC may wish to explore are related to the workforce. He wondered whether any unused administrative funds that normally would have been expended for travel, going to meetings, etc. during the past 18 months could be re-directed to provide support to staff. He also recommended that CHAC discuss the programs and proposed legislation, mentioned in a public comment, for a student loan forgiveness for individuals in all parts of the HIV workforce.

Dr. Armstrong observed that the issue of breastfeeding has been a discussion among several groups recently since there is some discordance between the HHS HIV treatment guidelines with a nuanced, evidence-based, harm reduction discussion of breastfeeding vs. CDC's website that says women should not breastfeed without similar nuance. She recommended that there should be concordance across the federal guidelines to prevent the possibility of weaponizing those strong [CDC] statements against women who chose to breastfeed. Regarding loan repayment programs, she shared that there has been a bill before Congress for loan repayment for people engaged in HIV care, but there has not been much of enthusiasm for a disease-specific loan repayment program. So, the idea has now been folded into the broader BIO Act, which Mr. Rodriguez of HIVMA had discussed in his public comment.

Dr. Dionne-Odom observed that the recommended move away from risk-based screening for hepatitis B should be a model for changes in STI screening because too many infections are being missed using current risk-based guidelines.

Recap Day Two

CHAC Co-Chairs: Jean Anderson and Travis Gayles

Dr. Gayles thanked the committee members for their participation, patience with navigating the technology for the virtual meeting, and endurance over the two meeting days.

Dr. Anderson also thanked all the members. She observed that a big theme of the second day's presentations and discussions had been the role of social determinants of health and the increasing emphasis on holistic and integrated care for people with HIV which, she remarked, is

really welcomed. Another theme was related to the workforce, including the involvement of persons with lived experience, which is something she believes the CHAC will continue to discuss. Finally, she re-capped that the CHAC had approved a motion to have a group of members develop recommendations about telemedicine for the committee's consideration. She turned the meeting over to Dr. Cheever to close.

Dr. Cheever thanked the members for the wonderful discussion. She also thanked the HAB staff who worked hard to develop the panel presentations. She said she looks forward to seeing the Committee members again in the spring of 2022 for the next CHAC meeting that will be hosted by CDC. She also noted that the meeting after that is scheduled for November 1-2, 2022, and will, hopefully, be in person if it is safe to do so.

Dr. Cheever then adjourned the meeting.

Adjournment

CHAC Co-Chairs' Certification

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

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

Travis Gayles, Co-Chair CDC/HRSA Advisory Committee on HIV, Viral Hepatitis, and STD Prevention and Treatment	Date
--	------

Attachment A: Participant List

CHAC Members Present

Dr. Jean Anderson (Co-chair)
Dr. Travis Gayles (Co-chair)
Dr. Wendy Armstrong
Dr. Shannon Brown Dowler
Dr. Jodie Dionne-Odom
Mr. Daniel Driffin
Dr. Meredith Greene
Ms. Debra Hauser
Mr. Venton Hill-Jones
Dr. Shruti Mehta
Mr. Greg Millett
Ms. Johanne Morne
Ms. Kneeshe Parkinson
Mr. Robert Riestler
Mr. Leandro Rodriguez
Dr. Samuel So

CHAC Members Absent

Dr. Vincent Guilamo-Ramos
Ms. Gloria Seanson

CHAC Ex-Officio Members Present

Dr. Pradip Akolkar
Food and Drug Administration

Mr. Richard Haverkate
Indian Health Service

Ms. Kaye Hayes
Office of Infectious Disease and HIV/AIDS
Policy, HHS

Dr. Paul Gaist
Office of AIDS Research, NIH

Dr. Neeraj Gandotra
Substance Abuse and Mental Health
Services Administration

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

CHAC Ex-Officio Members Absent

Dr. Iris Mabry Hernandez
Agency for Healthcare Research and
Quality

Dr. Douglas Olsen
Centers for Medicaid and Medicare
Services

CHAC Liaison Representative from PACHA

Dr. Ada Stewart
Lead Provider and HIV Specialist
Cooperative Health

CHAC Designated Federal Officers

Dr. Laura Cheever, Associate Administrator
HIV/AIDS Bureau
Health Resources & Services Administration

Dr. Jonathan Mermin, Director
National Center for HIV, Viral Hepatitis, STD
and TB Prevention
Centers for Disease Control and Prevention

Federal Agency Attendees

Dr. Demetre Daskalakis, Director
Division of HIV Prevention
National Center for HIV, Viral Hepatitis, STD
and TB Prevention
Centers for Disease Control and Prevention

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

Diana Espinosa, Acting Administrator
Health Resources and Services
Administration

Dr. Kathleen Ethier, Director
Division of Adolescent and School Health
National Center for HIV, Viral Hepatitis, STD
and TB Prevention
Centers for Disease Control and Prevention

Theresa Jumento
Division of Policy and Data
HIV/AIDS Bureau
Health Resources & Services Administration

Jim Macrae, Associate Administrator
Bureau of Primary Health Care
Health Resources and Services
Administration

Dr. Carolyn Wester, Director
Division of Viral Hepatitis
National Center for HIV, Viral Hepatitis, STD
and TB Prevention
Centers for Disease Control and Prevention

Guest Presenters

Christine Brennan, PhD, APRN
Associate Professor
Health Policy & Systems Management
Louisiana State University

Jennifer K. Brody, MD, MPH, AAHIVS
Director, HIV Services
Boston Healthcare for the Homeless
Program
Instructor of Medicine, Harvard Medical
School

Shalonda Collins, MPH, CHES
Public Health Analyst
Policy Development Branch
Division of Policy and Data
HIV/AIDS Bureau
Health Resources and Services
Administration

Erin Conners, PhD, MPH
Epidemiologist
Division of Viral Hepatitis
National Center for HIV, Viral Hepatitis, STD
and TB Prevention
Centers for Disease Control and Prevention

Alicia Downes
Senior Program Manager
AIDS United

Walid El-Nahal, MD, MHS
Fellow, Infectious Diseases
Johns Hopkins Medicine

H. Dawn Fukuda, ScM
Director, Office of HIV/AIDS
Bureau of Infectious Disease and
Laboratory Sciences
Massachusetts Department of Public Health

Jonathan Hanft
Ryan White Program Manager
Hennepin County Public Health

Rita Harcrow, Director
Office of HIV/AIDS Housing
U.S. Department of Housing and Urban
Development

Sarah Hodge, MPH
Research Scientist
Public Health Department
NORC

Jennifer Janelle, MD
Associate Professor of Medicine
University of Florida

Chandria Jones, PhD, MPH
Senior Research Scientist
Public Health Department
NORC

Sara LeGrand, PhD
Associate Research Professor
Duke Global Health Institute and the Center
for Health Policy and Inequalities Research
Duke University

Marlene Matosky, MPH, RN
Chief, Clinical and Quality Branch
Division of Policy and Data
HIV/AIDS Bureau
Health Resources and Services
Administration

LCDR R. Paul McClung, MD
Lead, HIV Outbreak Coordination Unit
Division of HIV Prevention
National Center for HIV, Viral Hepatitis, STD
and TB Prevention
Centers for Disease Control and Prevention

John Nelson, PhD, APRN
Program Director, AIDS Education and
Training Center National Coordinating
Resource Center
Rutgers School of Nursing

Serena Rajabiun, PhD, MPH
Assistant Professor
Department of Public Health
Zuckerberg College of Health Sciences
University of Massachusetts, Lowell

Susan Robilotto, DO
Director, Division of State HIV/AIDS
Programs
Health Resources and Services
Administration

Attachment B: List of Acronyms

ACA	Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center Acquired
AIDS	Acquired Immunodeficiency Syndrome
APHL	Association of Public Health Laboratories
BMSM	Black men who have sex with men
BPHC	Bureau of Primary Health Care
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CHAC	CDC/HRSA Advisory Committee on HIV, Hepatitis, and STD Prevention and Treatment
CMS	Centers for Medicare and Medicaid Service
COVID-19	Corona Virus Disease 2019
DFO	Designated Federal Officer CDC
DHP	Division of HIV Prevention
DIS	Disease Intervention Specialist
EHE	Ending the HIV Epidemic in the U.S. initiative
ETAP	Evaluation and technical assistance provider
FACA	Federal Advisory Committee Act
FDA	Food and Drug Administration
HAB	HIV/AIDS Bureau
HBV	Hepatitis B Virus
HCH	Health Care for the Homeless
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IPV	Intimate Partner Violence
MSM	Men Who Have Sex with Men
NAAT	Nucleic Acid Amplification Test
NASTAD	National Alliance of State and Territorial AIDS Directors
NCHHSTP	National Center for HIV, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention
NHAS	National HIV/AIDS Strategy
NIH	National Institutes of Health
NOFO	Notice of Funding Opportunity
OHH	Office of HIV Housing (HUD)
PACHA	Presidential Advisory Council on HIV/AIDS
PrEP	Pre-exposure Prophylaxis
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SPNS	Special Projects of National Significance Program
SRO	Single Room Occupancy

SSP	Syringe Services Program
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TEP	Technical Expert Panel
TGA	Transitional Grant Area
U=U	Undetectable = Untransmittable
USPSTF	United States Preventive Services Task Force

Attachment C: Written Public Comments

Written Public Comment from J. Rodriguez, HIVMA



November 3, 2021

CDC/HRSA Advisory Committee (CHAC) on HIV,
Viral Hepatitis, and STD Prevention and Treatment
c/o Laura Cheever Designated Federal Officer
Associate Administrator, Health Resources and
Services Administration (HRSA), HIV/AIDS Bureau (HAB)
5600 Fishers Lane
Rockville, MD 20857

Dear Members of the CHAC:

On behalf of the HIV Medicine Association (HIVMA), thank you for the opportunity to submit testimony for consideration by the committee. HIVMA is a professional community of more than 5,000 HIV clinicians and researchers working on the front lines of the HIV epidemic in communities across the country. In our testimony, we will comment on the HRSA's HIV/AIDS Bureau recent release of updated guidance for conducting Ryan White HIV/AIDS Program eligibility determinations and share recommendations from HIVMA members for the 2022 National HIV/AIDS Strategy relevant to the committee's work and meeting agenda.

Streamlining Eligibility for the RWHAP

We commend HRSA's HIV/AIDS Bureau for issuing the updated guidance [Determining Client Eligibility and Payor of Last Resort in the Ryan White HIV/AIDS Program \(RWHAP\)](#). The new guidance makes significant improvements to the eligibility determination process, including eliminating the six-month recertification requirement, which will facilitate rapid initiation of treatment and help reduce disruptions in HIV services and treatment while also ensuring the RWHAP remains the payor of last resort. We anticipate some jurisdictions and clinics may need assistance with developing and implementing the new processes and urge HAB and the CHAC, in its advisory role, to monitor and develop tools to support implementation.

We also appreciate that the new guidance affirmatively states that immigration status is not relevant for the purposes of eligibility for RWHAP services. The inclusion of this language will clarify and affirm for providers and people with HIV that lifesaving HIV care and treatment can be accessed regardless of their immigration status.

Recommendations for Strengthening the 2022 NHAS

In September, HIVMA and its Ryan White Medical Providers Coalition submitted the [attached](#) recommendations to the White House Office of National AIDS Policy to inform the development of the 2022 National HIV/AIDS Strategy and the accompanying implementation plan. The recommendations

2

were solicited from a diverse group of HIVMA and RWMPC member volunteers providing clinical care or conducting HIV-related research. I hope committee members will review the recommendations in their entirety, but in my testimony, I will highlight key recommendations that may be of particular interest to the committee.

Building a Robust, Diverse and Culturally Competent Workforce

An adequate workforce that reflects the populations most heavily impacted by HIV is foundational to making meaningful progress towards the goals of the National HIV/AIDS Strategy and, yet, building workforce capacity has not previously been recognized as a primary goal of the National HIV/AIDS Strategy or the federal Ending the HIV Epidemic initiative.

HIVMA offered recommendations for strengthening the 2022 NHAS to improve diversity, recruitment, and retention across the HIV care team. In our testimony, we will focus on addressing clinical workforce shortages because there is an important legislative opportunity of which we wanted to make you aware that would support clinicians in pursuing careers in infectious diseases, including HIV clinical care.

HIV workforce studies have long documented shortages of experienced HIV clinicians, including studies conducted by the Centers for Disease Control and Prevention and commissioned by the HRSA's HIV/AIDS Bureau. More recently, a [study published](#) in Oct. 2020 found that nearly 80% of counties in the U.S. lacked infectious diseases expertise, and a [separate study](#) published in May 2021 which examined access to experienced HIV clinicians in 14 Southern states estimated that more than 80% of the counties in those states lacked an experienced HIV clinician, with disparities being greatest in rural areas. Offering loan repayment for service in these communities is important to encourage and support clinicians in pursuing HIV medicine and to draw them to communities where ID and HIV expertise is most needed.

The bi-partisan Bolstering Infectious Outbreaks (BIO) Preparedness Workforce Act ([H.R. 5602](#)) was introduced in the U.S. House of Representatives by Reps. Lori Trahan (D-MA) and David McKinley (R-WV) on Oct. 15 and was included in an Oct. 26 Energy and Commerce Health Subcommittee [legislative hearing](#). The bill would create a new loan repayment program that would address infectious diseases workforce shortage in two critical areas by offering loan repayment to bio-preparedness health care professionals and health care professionals providing infectious disease care as described below.

- **Infectious Diseases Care HCP:** Health care professionals, including physicians, nurse practitioners, physician assistants, pharmacists, and dentists, who spend at least 50 percent of their time providing infectious diseases care in underserved areas or federally funded clinics, including RWHAP clinics, would be eligible for up to \$50,000 in loan repayment per year of service for three years.
- **Bio-Preparedness HCP:** Health care professionals, including physicians, pharmacists, physician assistants, advanced practice registered nurses, and clinical laboratory professionals, who spend at least 50% of their time conducting bio-preparedness activities in facilities across the country would be eligible for up to \$50,000 in loan repayment per year for three years of service.

Importantly, the bill would help to diversify the ID and HIV workforce by allowing HHS to award loan repayment contracts in a manner that increases the diversity of the infectious diseases' workforce with a focus on populations under-represented in medicine.

3

Improving STI screenings in People with HIV

We have been alarmed by the rise in sexually transmitted infections and appreciate that the committee will be discussing the role of the RWHAP in improving STI screening among people with HIV. We urge HAB and the CDC to continue to collaborate on this issue and take a comprehensive approach to preventing, identifying, and treating STIs. Below are topline recommendations generated by HIVMA members to improve STI and HIV prevention.

- Develop mechanisms to track and release publicly real-time local surveillance (HIV, STI, and HCV) and demographic data to improve the ability of programs, providers, and public health officials to develop and implement effective programming responsive to their current local epidemic rather than the epidemic of two to three years prior.
- Normalize conversations about sexual health and health education through provider training and leveraging peer specialists to significantly increase and improve the sexual health counseling provided by clinicians and other health care professionals.
- Focus on identifying and implementing prevention strategies for populations most vulnerable to experiencing HIV-related disparities, including transgender youth and young gay men of color.
- In addition to RWHAP, expand access to STI prevention and treatment services through community health centers, Title X Family Planning Clinics, substance use treatment providers, and other community-based service providers.
- Set a higher national minimum standard for comprehensive sex education and for discussing sexual health that is not heteronormative and reflects the needs of LGBTQJ individuals.

Thank you for considering HIVMA's recommendations. Please consider us a resource as the committee evaluates ways to strengthen CDC and HRSA's response to the HIV, HCV, and STI epidemics. Please contact HIVMA's Senior Policy & Advocacy Manager, Jose A. Rodriguez, at JRodriguez@hivma.org if you have any questions or need additional information.

Sincerely,



Marwan Haddad MD, MPH
Chair, Board of Directors



Recommendations for Strengthening the 2022 National HIV/AIDS Strategy

Version: 9/14/21

PROCESS

The following recommendations for strengthening the next iteration of the National HIV/AIDS Strategy and/or its accompanying implementation plan were developed based on input from the HIV Medicine Association's Board of Directors, Ryan White Medical Providers Coalition, Ending the HIV Epidemic Working Group and HIV Workforce Working Group. The recommendations were generated during two virtual forums held Aug. 26 and Aug. 30, 2021, to solicit HIVMA member input. The recommendations are organized according to the four overarching goals of the 2021 HIV National Strategic Plan with the addition of two new sections – **Leverage Cross-Cutting Interventions** and **Build a Diverse, Culturally Competent Workforce Team** – to address topic areas that generated significant discussion.

RECOMMENDATIONS

I. Leverage Cross-Cutting Interventions

- 1 Address the root causes of health inequities and HIV-related disparities, including, structural and systemic racism, discrimination and poor access to education, housing and employment for Black, Indigenous and other People of Color (BIPOC), Latinx, and LGBTQJ populations in addition to the health and socio-economic disparities experienced by rural populations.
- 2 Reduce the "slippage" between policies and recommendations at the federal level and the state and local level. The federal government should set high minimum standards and ensure their implementation by incentivizing and holding states accountable for performance. However, implementation of these standards cannot put at risk the health of people with HIV or destabilize their engagement in HIV care and treatment by instituting restrictive funding or program requirements.
- 3 Maintain the [policy innovations](#) brought about by the COVID-19 pandemic that have facilitated access to health care services and treatment, e.g., ensuring that telephonic visits remain reimbursable, requiring or incentivizing multi-month refills, and streamlining Ryan White AIDS Drug Assistance Program certification and recertification requirements to prevent treatment disruptions.
- 4 Develop national indicators that go beyond linkage to care and viral suppression to incentivize programs, public health officials, and providers to think and do things differently. As examples, collect data and monitor: 1) engagement of people who are not in care in the community; 2) workforce capacity; and 3) the integration of programs and services.

5

- 5 Allow greater flexibility under Centers for Disease Control and Prevention (CDC) and HIV/AIDS Bureau (HAB) funding to facilitate and incentivize collaboration at the local and state level to improve prevention and care coordination, support innovation, meet local needs, and reduce redundancy. Consider expanding the flexibilities that are allowed with the Ending the HIV Epidemic (EHE) initiative funds and were allowed with the CARES Act grants more broadly to CDC and HAB grants.
- 6 Under the EHE, create a flexible fund that would be available in real-time to jurisdictions not currently eligible for EHE funding but that are at increased risk for or experiencing emerging HIV outbreaks. This flexible EHE fund should receive resources in parity to other currently funded EHE funding "buckets."
- 7 Develop mechanisms to track and release publicly real-time local surveillance (HIV, sexually transmitted infections, and viral hepatitis) and demographic data to improve the ability of programs, providers, and public health officials to develop and implement effective programming responsive to their current local epidemic rather than the epidemic of two to three years prior.
- 8 Engage the Centers for Medicare and Medicaid Services (CMS) and federal grant programs to finance innovative models for delivering services outside of traditional clinics, such as leveraging pharmacies and mobile clinics, to provide comprehensive infectious diseases and substance use disorder prevention, screening, and treatment at easily accessible points in the community.

II. Build a Diverse, Culturally Competent Workforce Team

- 1 Add a fifth foundational, overarching goal to build a robust, diverse, and culturally competent HIV workforce that includes increased and more equitable representation of the communities and populations disproportionately impacted by HIV. Achieving the four primary goals articulated in the HIV National Strategic Plan and the EHE initiative will require a diverse and culturally competent HIV public health, clinical, and social services workforce that reflects the populations disproportionately affected by HIV. The impact of the COVID-19 pandemic on the infectious diseases and HIV public and clinical workforce, including administrative staff, makes this even more imperative.
- 2 Address stress and burnout within the current HIV workforce by supporting innovative strategies to reduce clinic staffing shortages, including among administrative staff, promoting best practices for managing clinics and community-based organizations, and engaging HAB and CMS to reduce the administrative burden and to preserve more time for direct patient care.
- 3 Incentivize ID, primary care, and advanced practice providers to provide PrEP and HIV care in underserved areas through loan repayment and enhanced reimbursement opportunities.
- 4 Leverage pharmacists to expand access to screening and prevention services through pharmacies and pharmacists as allowable under state law.
- 5 Recruit a diverse workforce and ensure that cultural competence goes beyond offering multilingual and translation services. To improve access to prevention, care, and treatment and reduce stigma and discrimination, it is important to have staff across the prevention and care continuum that are sensitive to cultural issues and barriers that people are facing. Language and cultural barriers put an already vulnerable population at even greater risk of going without health care and other critical services.

6

- 6 Support and increase access to community health workers and peer outreach specialists to connect with people in the community. Address recruitment and retention challenges for community health workers and outreach staff by increasing base salary levels and developing a pathway for professional support, job placement, and advancement. Direct resources to recruiting populations heavily impacted by HIV, including BIPOC and trans young adults.
- 7 Develop networks of support and accountability for private practice providers who are providing HIV prevention and treatment services outside of the Ryan White HIV/AIDS Program to educate and engage them in the National HIV/AIDS Strategy and the EHE initiative.
- 8 Partner with the Accreditation Council for Graduate Medical Education (ACGME), Accreditation Commission for Education in Nursing (ACEN), the Commission on Collegiate Nursing Education (CCNE), and the Accreditation Review Commission on Education for the Physician Assistant to incorporate basic HIV screening, prevention, and treatment education into training curricula.
- 9 Strengthen HIV curriculum in nursing and advanced practice providers programs with a focus on programs in the South, Historically Black Colleges and Universities, Hispanic-Serving Institutions, and institutions that focus on training rural health providers to develop a diverse clinician pipeline.
- 10 Support and promote locally driven knowledge sharing and information dissemination, such as teleconsults, ECHO models, and mentorship programs. While national ECHO-type programs, consult services such as AETC mentorship programs, and national hotline/warm lines exist, many practicing clinicians prefer to consult those with whom they have established relationships and who are readily available, knowledgeable about local clinical issues and resources, and nonjudgmental. Clinician consultation and mentorship programs are most effective when developed locally, and efforts to launch and sustain programs can be supported with funding and administrative support.
- 11 Engage medical and other health care professional students early in their training to build interest and excitement about the field and the role of HIV providers and programs in addressing health equity.

III. Reduce HIV-Related Disparities & Health Inequities

Stigma & Discrimination

- 1 Work with states to rescind or modernize any HIV criminalization laws or regulations.
- 2 Revise all policies barring people with HIV or restricting their service based on their HIV status, including from service in the military or Peace Corps.
- 3 Engage primary care and other health and medical profession associations in a campaign to educate providers on the stigma and discrimination experienced by people with HIV within the health care system and how it impacts their health and quality of life. See, as an example, [Your Guide to Creating a Stigma-Free Health Care Zone](#), developed by the San Antonio Alliance.
- 4 Partner with provider organizations to incorporate and educate trainees and fellows on their role in reducing stigma and addressing health equity issues.
- 5 Increase training and funding for gender-affirming programming with primary care and HIV providers.

7

Social Determinants of Health

- 1 The COVID-19 pandemic has exacerbated the challenges that many people with HIV face accessing basic services, including food, housing, and transportation. Addressing housing needs, including temporary, permanent, and supportive housing, must be a priority. Without stable housing and food security, it is very difficult to access and engage in other services, including HIV care and treatment.
- 2 Significantly increase access to both mental health services and treatment of substance use disorders to reduce new HIV transmissions as well as improve clinical outcomes through engagement in care and treatment.
- 3 Expand training at all staff levels in trauma-informed care throughout Ryan White Programs and other safety-net clinics.
- 4 Embrace the harm reduction model for improving access to substance use prevention and treatment services, such as pilot testing novel strategies and payment models for reducing barriers to accessing syringes, naloxone, and medication for substance use disorder treatment through clinical care sites.
- 5 Increase support for services that facilitate access to health care and maintain other basic needs, including health care coverage, transportation, broadband Internet, and phones or other electronic and communication devices.

IV. Prevent New Infections

PrEP Scale Up

- 1 Develop trainings and clinical tools to educate providers on the CDC's updated PrEP guidelines and STI screening and treatment recommendations. In addition, educate providers on tools and best practices for simplifying PrEP access from the user's perspective, e.g., telemedicine, flexible prescription refills, and the use of at-home HIV and STI testing.
- 2 Use the Ryan White HIV/AIDS Program as a model and support the development of a new program to deliver PrEP services by safety-net providers and to assist PrEP users with out-of-pocket costs. A major barrier to expanding PrEP use is that many individuals in non-Medicaid expansion states who would benefit from PrEP do not have health insurance or have limited insurance coverage. With a new funding source, the Ryan White HIV/AIDS Program, Title X Family Planning Clinics, Substance Abuse and Mental Health Services programs, the Indian Health Services programs, and other safety-net clinics can provide the infrastructure and expertise for working with underserved populations.
- 3 Expand access to PrEP for high school and college students, including by ensuring options that protect their privacy if they are on their parents' health insurance and educating high school and college health centers on options for accessing PrEP without using their health insurance, if necessary.
- 4 Ensure that as novel modalities, such as long-acting injectables for prevention and treatment, are approved, they are available to those who could benefit the most by working with pharmaceutical companies, in addition to CMS, private insurers, and state Medicaid programs, on drug pricing and access.

Comprehensive Sex & Sexual Health Education

- 1 Set a higher national minimum standard for comprehensive sex education and for discussing sexual health that is not heteronormative and reflects the needs of LGBTQJ individuals.
- 2 Normalize conversations about sexual health and health education through provider training and leveraging peer specialists to significantly increase and improve the sexual health counseling provided by clinicians and other health care professionals.
- 3 Focus on identifying and implementing prevention strategies for populations most vulnerable to experiencing HIV-related disparities, including transgender youth and young gay men of color.
- 4 Expand access to STI prevention and treatment services through community health centers, Title X Family Planning Clinics, substance use treatment providers, and other community-based service providers.

V. Improve HIV-Related Health Outcomes of People with HIV

- 1 Reduce barriers to medication access, including by setting a higher national standard for conducting Ryan White AIDS Drug Assistance Program certification processes that focus on lowering barriers to medication access and mitigating treatment interruptions.
- 2 Identify and support best practices and provider education on transitioning from pediatric to adult sexual health and HIV care.
- 3 Develop best practices for engaging and caring for people as they age with HIV, e.g., focus on cancer screening, preventive medicine, and managing co-morbidities.
- 4 Incentivize universal testing in the emergency departments located in the counties at risk for increases in HIV or viral hepatitis, such as the [220 counties identified by CDC](#) vulnerable to outbreaks due to injection drug use.

VI. Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Stakeholders

- 1 Improve the coordination and integration of programs and service delivery across disease silos and across federal/state/local organizations by addressing policy and resource barriers to doing so.
- 2 Define and incentivize the availability and financing of a minimum set of health care and support services for effective prevention and treatment for HIV, STIs, viral hepatitis, and substance use disorders.
- 3 Develop and fund strategies for integrating HIV, HCV, STI, and substance use disorder prevention and care into sexual health and primary care clinics.
- 4 Incentivize collaborations across specialties and settings to provide screening and treatment where people are engaging in care, e.g., build on successful HIV screening programs in emergency departments to also offer STI screening in ERs with follow up for treatment from the HIV team.



PUBLIC COMMENT
Christopher Hall, MD, MS, AAHIVM
Clinical Medical Director – 11/2/2021

*for HRSA Advisory Committee on
HIV, Viral Hepatitis & STD Prevention & Treatment*

**Self-collect Specimen Collection: Supporting Remote HIV / STI / HCV Care
while Meeting Existing U.S. Regulatory Standards and Requirements**

At-home, self-collected specimen collection addresses several barriers to care, including: limited accessibility, stigma inhibiting access, as well as safety concerns as the COVID-19 pandemic continues. Remote diagnostics are lab-run tests, not rapid-result tests, and are 98-100% as accurate as traditionally collected test specimens, exceeding CLIA regulatory standards for assay performance. Unlike traditional clinical specimen collection, the patient can collect the sample on their own, where they are, & when most convenient – while medically unsupervised. Like over 75% of lab tests in commercial use, Laboratory Developed Tests do not require FDA approval, but are instead primarily regulated by a complex set of guidelines associated with their design and approval. While FDA has ultimate regulatory authority over LDTs in the U.S., other state and Federal agencies provide day-to-day oversight – in particular, CLIA and CAP. Self-collect tests run by Molecular are clinician-ordered with results returned to the clinician responsible for acting on the results, ensuring appropriate linkage to care for all patients, with results reported to local health authorities in accordance with prevailing regulation.

Public Health Opportunities Met by Remote Diagnostics

- Timely and convenient laboratory testing is key to an individual's ability to continuously stay on PrEP, and at home self-collect testing has supported 15-20% PrEP initiation in the U.S. since 2018.¹
- In a recently published study of at-home STI testing conducted by the Washington, DC, Department of Public Health (and supported by Molecular), 81.25% of chlamydial and gonorrheal infections would have been missed without extra-genital testing that was facilitated by at-home self-collection testing kits.²
- Testing performed on at-home, self-collected specimens has been identified by the CDC as a safe and effective way to test for HIV, particularly to support quarterly testing as required for PrEP users.¹ CDC has held up Molecular as a model for this type of testing in select [national guidance](#).³

What is Needed to Fulfill the Potential of Remote Diagnostics for HIV / STI/ HCV Care

- 1) Expansion of clinical guidelines for deploying remote diagnostics to optimize outreach to patients who are: geographically remote, inhibited by stigma, or otherwise best reached by remote care
- 2) Further collaboration with HRSA and CDC to facilitate incorporation of remote diagnostics as a testing alternative supporting HIV PrEP, remote longitudinal HIV care, and hepatitis C diagnosis and testing
- 3) Cross-governmental agency consensus on the value of remote diagnostics, including cultivation of a regulatory framework that promotes continued innovation and adherence to prevailing quality standards
- 4) Progressive billing codes and modifiers supporting the actual cost of delivery of remote diagnostic tests – including kitting, fulfillment, bi-directional shipping, which are inherent costs of non-clinic-based testing approaches

¹ Internal data, Molecular Testing Labs

² Fistonich et al "A Pilot of Mail-out HIV and Sexually Transmitted Infection Testing in Washington, District of Columbia During the COVID-19 Pandemic," AJPM Vol. 61, Issue 3, Supplement 1, S16-25, November 1, 2021.

³ https://www.cdc.gov/nchhstp/dear_colleague/2020/dcl-051320-PrEP-during-COVID-19.html



POSITIVE WOMEN'S NETWORK

Positive Women's Network - USA
436 14th Street, Suite
425
Oakland, CA 94612
510.681.1169 phone
www.pwn-usa.org
@uspwn
www.facebook.com/pwnusa

October 29, 2021

Re: PWN Comment to the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment

Dear Members of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment,

Positive Women's Network- USA (PWN) appreciates the opportunity to submit a comment to the Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC).

PWN is a national organization led by and for women and people of transgender experience living with HIV and allies. We have over 3,000 members through the U.S., chapters in seven states, and a mobilizable network in 20 states. PWN's work is grounded in social justice and human rights, and we explicitly apply a racial justice and gender justice lens to address the many barriers people living with HIV face in all aspects of our lives, including economic insecurity, barriers in access to health care, stigma, and more. We are constituency-led, with Black women, women of color, and working class women living with HIV in all major leadership roles throughout the organization.

We are here today to talk about the urgent need to explicitly include and integrate quality of life for people living with HIV systematically throughout the federal response to the HIV epidemic, with measurable indicators for success.

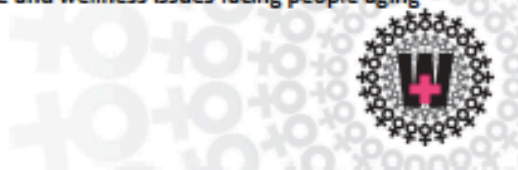
All human beings are born with an inalienable right to life, liberty and the pursuit of happiness regardless of income, gender identity, race, orientation and country of origin. We define this as an inalienable right to a good quality of life. Quality of life is a multifaceted concept which involves a person's own perception of their well-being and level of functioning in important areas of their life. Quality of life goes beyond just analyzing a person's physical health or reducing them to their viral load. When considering quality of life, status of mental, emotional, spiritual and physical health, social support, employment, housing, nutrition, safety, education, geographic location, cultural and linguistic needs, and ability to get their basic survival needs met should all be taken into account. Unfortunately, quality of life for people living with HIV has become an afterthought in the biomedicalized HIV response, leaving the well-being of more than 1.2 million people living with HIV mostly ignored while our viral loads are measured. Our quality of life is even more compromised when looking at societal and structural factors such as racism, poverty, homophobia, transphobia, intersectional stigma, language access, laws that criminalize us, and genomic sequence data that is taken from us, shared, and stored without our consent.

As a member of the U.S. People Living with HIV Caucus, PWN recently helped develop and release *Demanding Better: An HIV Federal Policy Agenda By People Living with HIV* (Demanding Better), highlighting the need for quality of life for people living with HIV to be centered in the federal HIV response. *Demanding Better* brings a unique perspective, informed by people living with HIV's lived experiences, to help develop policies ensuring better care, treatment, and quality of life for people living with HIV.

A key aspect of assuring quality of life for people living with HIV, as described in the *Demanding Better* policy agenda, is ensuring a favorable and safe human rights environment for people living with HIV - one where basic dignity, humanity, and safety are upheld. In the US context, this includes the policies that proactively affirm the rights of communities most vulnerable to HIV - such as transgender and gender nonconforming people, sex workers, Black and Latinx people, and all people living with HIV. It also requires that federal agencies and the administration proactively commit to dismantling laws and policies that increase vulnerability to human rights violations for people living with HIV - such as laws criminalizing HIV positive status. The *Demanding Better* agenda spells out in detail some opportunities to do this through Ending the HIV Epidemic efforts, for example, by tying jurisdictional funding to demonstrated efforts by those jurisdictions to eliminate or update laws that criminalize people living with HIV and bring them in line with current science. A second aspect of assuring quality of life for people living with HIV is protecting a strong safety net. It is no secret that the majority of people living with HIV in the U.S. are low-income, often not by choice, but as the result of a system that has forced us into poverty in order to access expensive medications that we depend on, housing, and more.

We applaud the recent steps taken by HRSA HAB to eliminate onerous recertification requirements and to ensure that immigrants living with HIV have access to Ryan White services. These are important steps in the right direction to improve quality of life for people living with HIV.

To move further in advancing quality of life for people living with HIV (PLHIV) we must begin by ensuring networks of people living with HIV are meaningfully involved in defining what quality of life and success in addressing the domestic epidemic look like and strategies to get there through structured engagement by PLHIV networks in CHAC, PACHA, and throughout the federal HIV response. Next, it is critical to recognize that our rights are seminal to our quality of life. CDC and HRSA must commit to protect and advance human rights for people living with HIV, racial and gender justice throughout the federal HIV response, including specific attention to addressing HIV criminalization, concerns by people living with HIV about molecular HIV surveillance, and the needs of transgender people, immigrants, Black people, Latinx people, and sex workers impacted by HIV. Thirdly, our safety and security are key components of our quality of life. CDC and HRSA should promote a strong safety net for all people living with HIV to ensure food, housing, healthcare access, and economic security, so that basic safety and survival needs are addressed. Finally, the federal response on HIV must measure and be accountable to measures of quality of life for people living with HIV, including our mental health and emotional wellbeing, our financial, housing, and food security, our morbidity and mortality, preventable illnesses, social support, quality of care we receive, and concerns throughout our lifespans, especially healthcare and wellness issues facing people aging with HIV.



Although each of these are important aspects of assuring quality of life for people living with HIV, the majority of this comment will focus on this last recommendation: we ask that CHAC members urge federal agencies to commit to measure and to be accountable to measures of quality of life for people living with HIV in their NHAS implementation plans, in the Ending the HIV Epidemic Effort, and in the soon to be released National HIV/AIDS Strategy.

To do this, we recommend an ongoing cross-agency workgroup dedicated to developing and monitoring quality of life indicators for people living with HIV in the federal response. This workgroup should include seats for at least two designated representatives from the U.S. People Living with HIV Caucus. The Caucus includes national networks of people living with HIV and has mechanisms to directly engage with tens of thousands of people living with HIV throughout the U.S. in a short timeframe. This workgroup should also include participation from civil society clinicians who have a demonstrated track record of commitment to address quality of life and holistic, anti-racist, trans-inclusive quality of care concerns for people living with HIV.

We urge HRSA, given its purview over services for people living with HIV to affirmatively commit to patient-centered, integrated care that includes improving the quality of life of people living with HIV. HRSA must set a minimum standard for quality of care for people living with HIV..

The patient-centered care model must include an emphasis on quality of life for people living with HIV. To ensure the model does so, we recommend HRSA, CDC, and the Department of Health and Human Services do the following:

1. Establish a cross-agency working group on quality of life indicators for people living with HIV, including structured partnership with PLHIV networks.
2. Make an affirmative commitment to improving the quality of life for people living with HIV with an emphasis on customized care for people living with HIV.
3. Require that clinicians, healthcare staff, and other providers funded to deliver HIV-related services are adequately trained on matters of cultural competency, sexual and reproductive care for people living with HIV, behavioral health and gender-affirming well person care.
4. Improve the ability to link people living with HIV to supportive services such as the Supplemental Nutritional Assistance Program (SNAP), Housing Opportunities for People with AIDS (HOPWA), violence and trauma intervention services, and employment services.
5. Collaborate with PLHIV networks to evaluate program policies for people living with HIV and to identify updates needed to policies designed to reduce barriers and disincentives to working and optimize health and well-being.
6. HRSA should allow direct service responses to employment needs of people living with HIV within the Ryan White Program.
7. Establish ongoing training in the AIDS Education and Training Centers of HRSA/HAB for HIV service providers on employment service delivery, linking and partnering with the workforce development and vocational rehabilitation systems, and interactions between work earnings and health care/treatment coverage, financial, and housing benefits.



Written Public Comment from B. Diaz/PWN-US (cont'd)

8. Resource PLHIV networks to identify how stigma and discrimination impact access to care and quality of life and to develop and implement stigma-reduction strategies.
9. Employ or fund PLHIV networks to develop and implement stigma-reduction activities.
10. Require that all Ryan White providers are trained in understanding the needs of transgender people including an emphasis on respect for their pronouns and name changes and how to provide gender affirming care. The training should focus on increasing knowledge, skills and attitudes of providers on gender affirming care, implicit bias and cultural humility.
11. Place a moratorium on the practice of molecular HIV surveillance until informed consent, HIV data sharing and storage concerns are addressed.
12. Proactively incentivize modernizing and repealing laws that criminalize HIV positive status.

Thank you for the opportunity to submit a comment. Please do not hesitate to contact Breanna Diaz, Policy Director, to provide further information.

Sincerely,

Breanna Diaz, J.D.
Policy Director
Positive Women's Network-USA

