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 1-3, 2022

Record of the Proceedings

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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/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) on November 1-3, 2022

CHAC members heard presentations from HRSA and CDC on key issues including Ryan White HIV/AIDS Program activities; Ending the HIV Epidemic (EHE) activities; initiatives to meeting the HIV workforce challenges; the response to the mpox outbreak; and progress toward integrating whole-person, syndemics, and quality of life indicators.

Three special panels were held to provide CHAC members an overview of:

1. The importance of nontraditional partnerships in EHE activities and challenges and successes from different perspectives.
2. Opportunities for addressing the HIV workforce challenges through AIDS education and training initiatives, including a review of the National AIDS Curriculum, the AIDS Education and Training Centers, and resident training activities with Historically Black Colleges and Universities (HBCUs).
3. The successes, challenges, and potential for expanding the use of community health workers in response to HIV/AIDS and STI services.

CHAC members also heard a federal update on the CDC's response to the mpox outbreak and discussed recommendations for CDC to consider going forward. CHAC members discussed the importance of proactively addressing mpox before the April 2023 CHAC meeting.

The CHAC Self-Testing and Self-Collection Workgroup presented a review of thier evidence. The Workforce Workgroup presented a broad review of the scope of HIV workforce issues and outlined nine draft recommendations for CHAC consideration. CHAC members discussed ways forward for narrowing down the broad topic of workforce challenges into focused efforts to present at the April 2023 CHAC meeting.

Throughout the three-day meeting, CHAC members highlighted three overarching themes: 1) the need top operationalize responses to outbreaks and epidemics before they occur, 2) the need to address perpetual disparities among disproportionately affected populations, and 3) the need to consider the resources necessary to support community engagement and whole-person care to mitigate further workforce burden.

CHAC Action Items

- Accepted the April 2022 minutes with no changes or further discussion.
- Accepted the recommendations put forward by the Self-Testing and Self-Collection Workgroup with no further changes.
- Approved the continuation of the Self-Testing and Self-Collection Workgroup and approved the request to extend time to the Self-Testing and Self-Collection Workgroup to focus on STIs.
- Approved the recommendations to CDC on their response to mpox with the amendment of the language and two additional recommendations that were discussed.

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 1-3, 2022

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) on November 1-3, 2022

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 *Federal Register*, in accordance with FACA rules and regulations. All sessions of the meeting were open to the public. Please see Appendix A for the Membership Attendance.

Day 1: DFO Opening of the Meeting and Roll Call

Theresa Jumento, PhD, MPA
Senior Advisor
HIV/AIDS Bureau
Division of Policy and Data
Health Resources and Services Administration

Ms. Theresa Jumento welcomed participants to the CHAC meeting, called the proceedings to order at 12:30 p.m. Eastern Time (ET), reviewed ground rules, and provided instructions for discussion periods. She indicated that members of the public would have an opportunity to provide oral comments at 12:40 p.m. ET on the third day of the meeting and that public comments would not be accepted at any other point in the meeting.

Laura Cheever, MD, ScM
Designated Federal Officer
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration

Dr. Laura Cheever welcomed participants on behalf of CDC and HRSA. She reminded them that CHAC meetings are open to the public and that all comments made during proceedings are a matter of public record. She asked CHAC members to be mindful of potential conflicts of interest identified by the Committee Management Office and to recuse themselves from voting

or participating in these discussions. Dr. Cheever conducted roll call and gathered conflicts of interest disclosures from voting and *Ex-Officio* members in attendance, which established a quorum for the CHAC to conduct business.

Conflict of Interest Disclosures

CHAC Voting Member (Institution/Organization)	Disclosure of Conflict
Jean Anderson, MD (Co-Chair) Johns Hopkins Medical Institutions	Stock: Merck Honoraria from AIDS Healthcare Foundation and DBKmed
Wendy Armstrong, MD Emory University School of Medicine	Recipient of funding from Ryan White HIV/AIDS Program
Jodie Dionne, MD University of Alabama at Birmingham	Recipient of funding from NIH
Daniel D. Driffin, MPH D3 Consulting	No conflicts
Travis Gayles, MD, PhD (Co-Chair) Hazel Health	No conflicts
Meredith Greene, MD University of California, San Francisco	Recipient of funding from NIH and Gilead; work for Ryan White-funded clinic
Venton Hill-Jones, MSHCAD, PMP Southern Black Policy and Advocacy Network	Recipient of funding from Gilead, HRSA, CDC
Kali Lindsey ETR	No conflicts
Christine Markham, PhD University of Texas Houston	Recipient of funding from NIH, CDC, OMH, ACF
Shruti Mehta, PhD, MPH Johns Hopkins Bloomberg School of Public Health	Recipient of funding from NIH, USAID, Abbott
Johanne Morne, MS-ED 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 CDC; work for Ryan White-funded organization
Robert Riester, PLWH Colorado Health Network	Recipient of funding from CDC, HRSA; work for Ryan White-funded organization
Leandro Rodriguez, MBA Latino Commission on AIDS	Recipient of funding from HRSA Ryan White HIV/AIDS Program, CDC, SAMHSA, Gilead, ViiV
Gloria Searson, MSW Coalition on Positive Health Empowerment	Recipient of funding from Gilead, CDC, NIH

CHAC Voting Member (Institution/Organization)	Disclosure of Conflict
Samuel So, MBBS, FACS Stanford University	Recipient of funding from CDC and NIH

Ex-Officio members in attendance included Dr. Pradip N. Akolkar of the US Food and Drug Administration (FDA), Dr. Neeraj Gandotra of the Substance Abuse and Mental Health Services Administration (SAMHSA), Dr. Maureen Goodenow of the National Institutes of Health (NIH), Ms. Kaye Hayes of the Office of Infectious Disease and HIV/AIDS Policy (OIDP), Mr. Richard Haverkate, Indian Health Service (IHS), Dr. Iris Mabry-Hernandez of the Agency for Healthcare Research and Quality (AHRQ), and Dr. Aditi Mallick of the Centers for Medicare and Medicaid Services (CMS). Also in attendance was liaison representative Dr. Ada Steward of the Presidential Advisory on HIV/AIDS (PACHA).

Introductions, Welcome, and Adoption of Minutes

Jean R. Anderson, MD
CHAC Co-Chair, HRSA appointee

Travis Gayles, MD, PhD
CHAC Co-Chair, CDC appointee

Dr. Jean Anderson reviewed the meeting agenda and Dr. Travis Gayles asked voting members to review and approve the minutes of the April 2022 CHAC meeting.

CHAC Action
Dr. Jodie Dionne called for a motion to accept the minutes. CHAC members unanimously accepted the minutes with no changes or further discussion.

DFO Welcoming Remarks

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

Deron Cornell Burton, MD, JD, MPH
Captain, US Public Health Service
Acting Director
National Center for HIV, Viral Hepatitis, STD, and TB Prevention

Dr. Cheever provided an update on CHAC staff and membership. Ms. Carla Holmes will be transitioning to the Bureau of Primary Health Care. Dr. Aditi Mallick will serve as the new CMS *Ex Officio*, and Dr. Cheever thanked Dr. Richard Wild for his ongoing support as the alternate CMS *Ex Officio*. CAPT Deron Cornell Burton, Acting Director for the NCHHSTP will be the acting CDC DFO while Dr. Jonathan Mermin is deployed to serve the Mpox (Monkeypox) response.

CAPT Deron Burton provided administrative updates, including a farewell to Ms. Gloria Searson and appreciation to Dr. Travis Gayles and Dr. Shruti Mehta for extending their membership as HHS identifies their replacements. In addition, the Telehealth letter was submitted to the HHS Secretary on June 29, 2022 and the LGTBQI+ letter was submitted on August 25, 2022. CHAC is awaiting response from HHS for both letters.

HRSA and CDC Updates

HRSA Update

Carole Johnson, MA
Administrator
Health Resources and Services Administration

Ms. Carole Johnson thanked committee members for their work, which has provided valuable advice to HRSA for the strategic distribution of federal funds and resources. She said that HRSA is particularly grateful for the CHAC's creative and innovative approaches to address the COVID-19 pandemic and the specific needs of the community. However, there continues to be pressing needs going forward. There is a critical need to expand the workforce with people who can deliver culturally competent, community-driven services to support people where they are and to help retain people in care. One challenge in training a new workforce is the space to obtain real world clinical experience. It is known that where a person trains is often an indicator of where a person will practice. There is an opportunity for the CHAC to consider what clinical training sites should look like to create the space and resources needed to support an emerging workforce.

Ms. Johnson said that another key priority at HRSA is addressing mental health care needs. HRSA has requested new funds from Congress to train the full continuum of behavioral health care workers—from community health workers and peer support specialists to licensed clinical social workers and psychiatrists. HRSA also aims to ensure that there is no wrong door for accessing mental health services and has received $60 million from the bipartisan Safer Communities Act to provide training for primary care providers to identify and treat people with lower complexity mental health conditions and retain them in care. HRSA will look to the Ryan White Program as a gold standard for funding programs that provide whole person care, reaches underserved communities, and retains people in services.

HRSA has also received nearly $115 million towards the Ending the HIV Epidemic (EHE) initiative, which HRSA will use to help ensure people with HIV continue to receive support and treatment. HRSA's Bureau of Primary Health Care (BPHC) has received $20 million to expand HIV prevention services and to ensure that people with lived experience can serve as peer navigators and community health workers. Ms. Johnson emphasized the importance of including the voice of people with lived experience in policymaking, the development of meaningful outcome measures, and the identification of gaps to help HRSA focus its efforts. There is also a critical need to support gender-affirming care through efforts such as the Transgender Women of Color Initiative. HRSA is anxious to continue working with the CHAC to provide essential HIV care support to Ryan White recipients and to focus on a public health response to mpox.

HRSA HIV/AIDS Bureau Update

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

Dr. Cheever provided an overview of recent HAB activities. She began by reviewing important federal collaborations. First, HAB is encouraging recipients to take a status neutral approach to ensure that people have access to support and intervention regardless of HIV status. HAB and CDC are developing a joint program letter to outline for their recipients how to support this approach. Second, HRSA continues to engage in a syndemic response to HIV, viral hepatitis, STIs, and homelessness. A syndemics approach helps consolidate activities in support of the National STI and Viral Hepatitis Strategic Plans. Third, the National HIV/AIDS Strategy now includes quality of life indicators to address measures beyond viral status, such as mental health, food insecurity, employment status, and housing status. HAB had received input from stakeholders including women, young people, and aging people with HIV to take a more holistic approach to quality of life. In response, HAB is developing a framework of gaps and opportunities to address a range of quality-of-life indicators.

Dr. Cheever highlighted HAB policy activities. One important policy effort is the COVID-19 Public Health Emergency Unwinding, which could result in the interruptions of Medicaid coverage for many people. HRSA is working with recipients on a phased outreach response to educate recipients about this change. In phase one, HRSA will focus on promoting awareness and education to ensure recipients are aware of the Medicaid renewal process and how it will restart during the Unwinding. In phase two, recipients and subrecipients will need to provide support for Medicaid renewal and transitions to alternate coverage when needed. Another important HAB policy activity is the Ryan White Program's reaffirmation that people can use RWHAP funds to provide covered services for gender affirming care, which will help address the large disparities in both access to care and viral suppression among transgender clients.

Next, Dr. Cheever reviewed notable Ryan White Program activities. Health equity has been an integral component of the Ryan White Program since its inception and continues to promote equity in five distinct ways: 1) engagement with community, 2) use of data, 3) continued quality improvement, 4) implementation science, and 5) service delivery. Notably, HAB has partnered with NIH and CDC on implementation science initiatives to help address multiple areas that impact health equity, such as housing, food, and transportation. The Ryan White Program has also made response to the mpox outbreak a very high priority area, helping ensure that Ryan White providers are seen as trusted providers for mpox prevention and care services. In addition, the 2022 National Ryan White Conference was successful, with nearly 9,000 registrants, 350 abstracts, and 160 concurrent breakout sessions. Holding a virtual conference helped increase attendance among people who would not have otherwise been able to attend.

The Ryan White Program hosted a technical expert panel with the Department of Housing and Urban Development (HUD) to look beyond the Housing Opportunities for Persons with AIDS (HOPWA) program, expanding to other HUD programs, and incorporate trauma-informed care approaches to help reduce stigma around housing. The Ryan White Program has also released Special Projects of National Significance (SPNS) initiatives specifically to: 1) consider models to improve telehealth HIV care; 2) ensuring that key populations such as formerly incarcerated individuals and LGBTQI+ populations have improved access to housing; and 3) identifying best models of care to increase the uptake of long-acting injectables. Importantly, the Ryan White

Program has funded a contract to support a community of practice for Part D recipients. This effort will focus on transitioning youth into adult care, expanding trauma-informed care, and enhancing preconception counseling.

Dr. Cheever said that HAB will re-compete the Regional AIDS Education & Training Centers (AETCs) in 2024 and is considering ways enhance how the program can increase the size and diversity of the HIV workforce, design educational programs on current HIV best practices, and increase the integration of HIV care for newly diagnosed individuals. The E2i was a project that funded community-based organizations to evaluate interventions for transgender women, adherence and retention among Black men who have sex with men (MSM) and trauma-informed care. The next iteration of this project, the 2is, will focus on the rapid implementation and evaluation of seven innovative strategies for people with a history of incarceration, LGBTQI+ youth, people with substance use disorder, and telehealth.

Finally, Dr, Cheever provided updates on HAB innovation dissemination and data efforts. The Ryan White Program maintains a dashboard of recipient best practices that can be searched by population, challenge, or care environment. It also maintains the Compass Dashboard, which provides both client-level data on client characteristics and outcomes and public-facing data aggregated across national, state, and metropolitan areas. HAB has published its first qualitative summary of progress for the EHE initiative, which outlines EHE activities, accomplishments, barriers, and challenges.

HRSA Bureau of Primary Health Care Update

Ernia Hughes, MBA
Director
Bureau of Primary Health Care
Health Resources and Services Administration

Ms. Ernia Hughes talked about the important work that the HRSA BPHC does in partnership with community health centers across the nation. In the last 57 years, community health centers have distinguished themselves as cornerstones of primary care delivery to traditionally underserved individuals. Their efforts reduce health disparities, advance health equity, expand access to primary care, and provide a whole person approach to underserved communities. HRSA currently funds nearly 1,400 community health centers operating over 14,000 care sites across the US. Community health centers care for more than 30.2 million people, including one in five people with HIV.

In partnership with the BPHC and HAB, community health centers are able to expand the reach of HIV services across the nation. There are currently 958 community health centers that represent 70 percent of the health care ecosystem that provides HIV prevention services. Of the 958 centers, 302 received a first-time grant from BPHC, and 284 of these with demonstrated competence in the provision of HIV services in a primary care setting received grants intended to decrease the risk of HIV transmission in underserved community. HRSA continues to support community health centers, with $54 million awarded to 195 centers in 2020, $48 million to an addition 64 centers in 2021, and another $20 million to 64 centers in 2022. Data show that these primary care HIV-funded health centers serve more than 9 million individuals, conducted 1.7 million HIV tests, prescribed pre-exposure prophylaxis (PrEP) to more than 53,000 individuals, and linked 86 percent of individuals newly diagnosed with HIV to care within 30 days.

Ms. Hughes talked about notable trends in HIV care within community health centers. HIV screening during a primary care visit within community health centers is becoming a standard practice. There has also been increased access to home test kits and greater access to care through telehealth delivery. Community health centers are leveraging technology to support an integrated workflow that connects all disciplines in the health center to care for people with HIV. Ms. Hughes reiterated the importance of partnerships to achieve the greatest reach to underserved communities.

HRSA Bureau of Health Workforce Update

Luis Padilla, MD, FAAFP
Associate Administrator
Bureau of Health Workforce
Health Resources and Services Administration

Dr. Luis Padilla provided an overview of HRSA's Bureau of Health Workforce (BHW) efforts to address the pressing needs of those who provide care for people with HIV. Prior to the COVID-19 pandemic, there was already a significant shortage of primary care providers, psychiatrists, and addiction counselors. The pandemic further impacted this shortage through two key drivers: early retirement within the workforce and an increasing demand for services. BHW aims to address this challenge across four areas: 1) increasing the workforce supply, 2) ensuring equal distribution of the workforce, 3) advancing health equity by diversifying the workforce, and 4) boosting the resilience of the workforce.

One key program in the BHW is the National Health Service Corps (NHSC), which has received approximately $800 million in American Recovery Act supplemental funding to nearly 20,000 participants over the last two years. Despite this increase in supplemental funding, 2023 is expected to show a decline in awards unless congressional appropriations are increased to maintain the same level of funding. The largest segment of the NHSC is the mental and behavioral health care providers, representing 46 percent of the field. In 2021, Congress provided appropriations for a loan repayment program for registered nurses, psychiatric nurse specialists, and pharmacists—disciplines that had not previously been able to receive NHSC funds in the past but added a boost in the provision of substance use disorder treatment and prevention services.

The American Rescue Plan (ARP) also provided funding to expand the community health worker program with $225 million for training and $40.7 million in public health scholarships. There are currently 83 awardees who receive training and 29 scholarship grantees. Trainees receive specific training in the care and coordination of care for people with HIV and play an important role as trusted advisors. One awardee is developing public health curricula specifically to address the needs of people with HIV. In addition, the ARP provided $103 million, and the Dr. Lorna Breen Act added another $50 million, to promote resilience in the workforce through building a culture of wellness in organizations.

CDC Update

Deron Cornell Burton, MD, JD, MPH
Designated Federal Official
Captain, US Public Health Service
Acting Director
National Center for HIV, Viral Hepatitis, STD, and TB Prevention

CAPT Burton updated the CHAC on the recently released NCHHSTP 2022-2026 Strategic Plan that outlines strategies to reduce the incidence, morbidity, and mortality associated with HIV, viral hepatitis, STIs, and TB; reduce disparities and promote health equity; and achieve organizational excellence. He also discussed CDC Director Rochelle Walensky's initiative to modernize CDC in order to consistently and efficiently deliver expert public health information and guidance that is understandable, accessible, and implementable. Notably, the Center for Surveillance, Epidemiology, and Laboratory Services (CSELS) is providing funding to improve critical health infrastructure by addressing historic underinvestment in marginalized communities, providing cross-cutting support to public health agencies for needs related to workforce and data systems, and funding to national partners that can further support this work. CAPT Burton then provided an overview of activities from the NCHHSTP's five divisions.

The **Division of HIV Prevention (DHP)** had several EHE programmatic achievements: 1) distributed 100,000 free HIV self-test kits to disproportionately affected populations including transgender women and racial/ethnic minority communities, 2) Health departments administered 250,000 HIV tests resulting in 1,000 new diagnoses, 3) provided more than 18,000 PrEP prescriptions, 4) supported 108 Syringe Services Programs in EHE jurisdictions, and 5) used real time data in over 200 instances that allowed CDC grantees to quickly direct resources to communities to address gaps in services DHP also released new HIV surveillance reports in May of 2022, indicating the number of HIV diagnoses in 2020 was 17 percent lower than 2019, likely due to pandemic-related factors such as disruptions to care, patient hesitancy, and shortages in HIV testing materials. In September 2022, DHP released two reports that feature quality of life indicator data such as unmet needs for mental health services, food insecurity, unemployment, housing status, and HIV stigma. DHP released an Issue Brief highlighting the role of status neutral HIV care and service delivery, and also awarded funding to several initiatives including transgender status-neutral community-to-clinic models, mass mailing of HIV self-tests, enhanced surveillance of persons with early and late HIV diagnosis, and integrated HIV programs for health departments to support EHE. Finally, DHP released its 2022-2025 Strategic Plan Supplement that integrates the National HIV/AIDS Strategy and EHE Pillars with four cross-cutting areas: 1) health equity, 2) community engagement, 3) status neutral approach, and 4) syndemic approach.

The **Division of Adolescent and School Health (DASH**) is responding to the mental health crisis among adolescents, which disproportionately affects LGBTQ youth. DASH promotes school activities that promote a safe and supportive learning environment and result in improved outcomes. DASH recently released their School Health Profiles 2020 report, showing that policies and practices to promote connectedness and prohibit harassment have improved mental health outcomes for all youth, and particularly among LGBTQ youth.

The **Division of STD Prevention (DSTDP)** released preliminary 2021 STD data in September 2022, showing an increase of 4.4 percent in STIs from 2020 to 2021, disproportionately affecting Black/African American and American Indian/Alaska Native individuals. DSTDP also published its 2022-2026 Strategic Plan and held a two-day meeting of experts to outline a national research agenda to improve STI prevention and treatment. DSTDP began a pilot project in 2019 to strengthen the infrastructure of STD specialty clinics, which currently supports 26 clinics in 16 states that also support HIV testing and access to PrEP. DSTDP has also funded $9 million across several projects to innovate STI testing and service delivery. Finally, DSTDP is continuing to explore the role of Doxy-PEP to prevent STIs and is working on interim guidance.

The **Division of Viral Hepatitis (DVH)** released its 2020 Viral Hepatitis Surveillance Report and 2022 Viral Hepatitis National Progress report. The data in these reports indicate a decrease in viral hepatitis cases by 47 percent from 2019 to 2020 and 24 of 37 affected states have declared an end to their hepatitis A outbreaks. The data also show a 32 percent decrease in acute hepatitis B cases and a 16 percent increase in hepatitis C cases from 2019 to 2020. CAPT Burton emphasized that these data should be interpreted with caution in the context of the COVID-19 pandemic. DVH leveraged CDC's DCIPER platform in its new, secure HepSEE Dashboard, which began in March 2022 is expected that the full version will be available to pilot in January 2023. In addition, DVH recently funded $7.1 million in two awards to increase access to harm reduction services within syringe services programs. Finally, DVH released a new Vital Signs report on the elimination of hepatitis C treatment eligibility restrictions.

Last, the **Division of Tuberculosis Elimination (DTBE)** launched its national Think. Test. Treat TB campaign in March 2022 to raise awareness about latent TB infection and to encourage Asian American individuals to talk to their health care providers about risk, testing, and treatment. There have been indications that the campaign has been successful among people born in the Philippines and Vietnam. DTBE recently awarded nearly $8 million in supplemental funding for the screening, evaluation, and treatment of latent TB infection and disease among Ukrainians arriving in the US through the United for Ukraine program and anticipates awarding a second supplement in fiscal year 2023. Finally, DTBE is developing an online toolkit of resources for health departments to support Ukrainian arrivals, their sponsors, and their health care providers.

CHAC Member Discussion with CDC and HRSA

- Dr. Ada Stewart commented on the administrative burden that community health workers face. These providers are required to juggle multiple tasks and see large numbers of patients each day. Some of the early retirement in the workforce is related to this burden and it has been difficult to recruit people into the community health center field. Dr. Steward asked Dr. Padilla to address this burden and the added task of HIV care provision. Dr. Padilla clarified that the funding targeted to assist organizations develop a culture of wellness was specifically focused on identifying the organizational factors that contribute to compassion fatigue, workforce resiliency, and providers leaving the workforce. While there are evidence-based interventions at the individual level, there is less evidence supporting organizational level interventions. BHW will continue this effort if it receives the additional funding from Congress and will take the lessons learned from awardees to identify evidence-based practices at the organizational level that could be expanded to other organizations.
- Dr. Meredith Greene commented on how some of the effective training programs that HRSA oversees have seemed to be under threat of ending in the past and asked if the climate had shifted toward more legislative support for these training programs now. Dr. Padilla answered that there has been an acceleration of interest in training from advocacy stakeholders. The President's 2023 budget requested an additional 240 million for behavioral health services that would allow HRSA to significantly increase behavioral health workforce programs. Unfortunately, it does not seem that Congress will be supporting that number. Similarly, the President's budget requested $50 million for resiliency and Congress seems to be proposing half of that. It is not that there is no interest, but rather that there are competing priorities in the budget.
- Ms. Gloria Searson talked about the need for greater focus on the people at the ground level and their retention. People in care rely on trusted relationships with these providers

to remain in care. There is a need for motivational incentives, such as training to increase skills, or increased awareness of and access to these training programs. Health care workers in rural areas are particularly burned out and some have not been supporting people in this area for very long. There could be significant change with increased levels of education in prevention and with relationship building. Dr. Padilla responded that part of the expansion of the community health care workforce with 13,000 newly trained individuals is to assist current members of the support team with new providers who can carry some of the burden. There is some work that only licensed professionals can provide, but there is an enormous number of activities that can be supported by other professionals who are integrated into the team. This is another way to provide support for compassion fatigue and workforce resiliency.

- Dr. Samuel So said that 5 to 10 percent of people HIV are co-infected with hepatitis B and 10 to 20 percent have co-infected with hepatitis C. He asked if HRSA and CDC are monitoring the screening and testing for hepatitis B and C and whether or not those who are co-infected are receiving hepatitis B and C treatment. Dr. Cheever said within HIV care, including the RWHAP, hepatitis B identification and treatment is happening as a part of HIV care. Part of this success is that tenofovir and emtricitabine treatment for hepatitis B are also commonly used drugs for HIV. There is less data on treatment for hepatitis C. There have been several efforts to encourage people in Ryan White HIV/AIDS Programs to screen for chronic hepatitis C but there are few clinical data available to assess these efforts. HAB has set up a chart abstraction mechanism to obtain better data, which they believe will show high initial screening for hepatitis C and lower follow-up among people with positive antibodies. Unfortunately, the contract for this work was delayed by the pandemic and there are not enough data yet to determine whether they are receiving treatment or not. Data from several large medical centers demonstrate patients who are actively engaged in HIV care and tend to also be cured of hepatitis C. But those who are not well-engaged in HIV care are likely not being reached for hepatitis C treatment. HAB has funded a number of SPNS initiatives to identify different strategies to address this challenge and one lesson they have learned is that providers need to start with a list of their patients with HIV/HCV coinfection in order to assess who has been treated and cured. CAPT Burton echoed the vital importance of data in determining which communities have progress or not in terms of linkage and treatment.
- Dr. Stewart asked CAPT Burton to comment on the racial and ethnic disparities in PrEP that were reported in the Vital Signs report and that continue to exist, despite overall increases in PrEP uptake. She asked what could be done at the federal level, since many of the barriers exist at the state level. CAPT Burton said that the Vital Signs report highlighted the need to remove eligibility restrictions. Part of the work at the federal level is identifying the impact of restrictions and emphasizing the importance of removing them. Expanding the number of providers and locations where treatment is offered is another approach. He agreed that local action is vital for addressing disparities in PrEP coverage.

Panel 1: Nontraditional Partnerships to Address Out-of-Care People with HIV

Presenters:
Tamika Martin, MPH, CHES, EHE Advisor, HIV/AIDS Bureau, HRSA
Yemisi Odusanya, MPH, Senior EHE Advisor, Office of the Associate Administrator
Tanya Khalfan Mendez, MPH, Director, University Health, San Antonio
Audrey South Regan, PhD, Director, Sexual Health Promotion, Columbus Public Health

Ending the AIDS Epidemic: Nontraditional Partnerships

Tamika Martin, MPH, CHES, EHE Advisor, HIV/AIDS Bureau, HRSA
Yemisi Odusanya, MPH, Senior EHE Advisor, Office of the Associate Administrator

Ms. Tamika Martin introduced the EHE initiative within HAB HRSA, which aligns its activities with the EHE four pillars to Diagnose, Treat, Prevent, and Respond. HRSA's efforts include promoting the rapid uptake of HIV care and treatment, increasing workforce capacity, and providing technical assistance through funding for its Health Center and Ryan White Programs. Each HRSA recipient must aim to identify people who are newly diagnosed, not engaged in care, or who have yet to reach suppression in order to engage and retain them in the care process. The Ryan White Program is fundamentally a health equity program that focuses on community engagement to ensure that HIV care and treatment strategies are responsive and readily available to those who need it. HRSA encourages recipients to collaborate with community members and people with lived experience and by investing in programs such as Building Leader of Color 2.0 and ELEVATE for All People with HIV. These programs support leadership development, organizational readiness, and stigma reduction across the individual, organizational, and systems levels.

Ms. Yemisi Odusanya talked about the importance of non-traditional partnerships. In the context of community engagement, a partnership is a formal arrangement with an outside entity with the intent to work together towards a common goal. Non-traditional partnerships are those that are new or less common and include organizations such as small businesses, religious groups, social groups, and individuals who interact with or that are visited by people with HIV. There are some challenges in engaging with non-traditional partnerships. For instance, EHE participants may be reluctant to reach out to new organizations, prefer to maximize their current relationships, or have difficulty building trust with new entities. Organizations want to know that recipients have an open mind about meeting the needs of the community, are committed to building and sustaining a relationship, and intend to create a transformational rather than transactional relationship. Ms. Odusanya emphasized the benefits of non-traditional partnerships and said that HRSA HAB continually encourages its EHE recipients to establish them.

Operation BRAVE

Tanya Khalfan Mendez, MPH, Director, University Health, San Antonio

Ms. Tanya Mendez provided an overview of Operation BRAVE, which is a program within the Bear County Hospital District in San Antonio, Texas. Bear County serves 94 percent of the region's population of people with HIV, which is primary Hispanic, male, and first diagnosed between the ages of 25 and 34. In 2019, Operation BRAVE met with leaders from CDC and HRSA to discuss innovative ideas to continue making progress towards EHE goals. During this meeting, they also received feedback from their priority population, community health workers, and patient navigators. There was a strong desire to develop leaders in the community to focus on social justice, HIV treatment, and decolonization through education initiatives. As a result of these conversations, Operation BRAVE developed a youth program of 18–29-year-old individuals who lived in Bear County and were passionate about EHE. They also held two events to promote advocacy and share lived experiences, maintain a wide social media presence, and conduct train the trainer events for young people to help others navigate services. Ms. Mendez talked about their non-traditional partnerships with universities, colleges, art galleries, addiction recovery programs, and other state and local programs that serve people with HIV. They have been successful in connecting people to services both within and outside of

Bear County and have received positive feedback from their partners. Some of their challenges included the loss of a key stakeholder with strong connections to community groups and the need to diversity their peer programs to include people with lived experience.

Central Ohio's Approach to HIV Prevention among Incarcerated Communities

Audrey South Regan, PhD, Director, Sexual Health Promotion, Columbus Public Health

Dr. Audrey South talked about central Ohio's approach to HIV prevention among incarcerated communities. Columbus Public Health is the largest health department in Ohio and supports a robust sexual health program that is responsible for STI infection control. In rural areas outside of Columbus, most of the HIV and syphilis diagnoses occur in the jails and prisons. Almost 70 percent of new HIV diagnoses occur among men and disproportionately affect Black/African American men. Columbus Public Health maintains one disease intervention specialist to provide outreach and linkage to services, as well as a partnership to provide screening services to select affinity groups in one of the correctional facilities. Later this month, disease intervention specialists from Columbus Public Health will provide education and screening services within the correctional facilities and will link those with positive results to follow-up appointments coordinated through the facility's medical clinic. Additionally, Columbus Public Health created an educational video for individuals being release from correctional facilities on HIV testing and resources through the state of Ohio. To re-engage people who are known to be HIV positive or not virally suppressed, Columbus Public Health uses their electronic HIV/AIDS reporting system to identify individuals and work to link them back into care. These individuals are often incarcerated, and special arrangements are made through the correctional facility to allow the team to talk to the individual over the phone and enroll them in care.

CHAC Member Discussion on Panel 1

- Dr. Gayles asked Ms. Mendez what best practices they learned from their youth peer program. Ms. Mendez answered that youth peers speak the same language as the population they are trying to reach, which helps make the information they are providing more relatable.
- Mr. Daniel Driffin expressed appreciation for the efforts by Columbus Public Health to engage those lost to care. He also asked Ms. Mendez if the youth in their peer program were compensated. Ms. Mendez said that they had received feedback that the youth wanted to be compensated for their time and effort. In response, the program created a tiered payment system based on the amount of effort they put in monthly.
- Dr. Anderson asked Dr. South what happens when incarcerated individuals who access treatment through the correctional facility program are released. Dr. South said that, in addition to their educational video, released individuals still have a relationship with the disease intervention specialists. There is also a specialist in the Ohio Department of Health who does similar work because released individuals may move outside of the Columbus area.
- Mr. Kali Lindsey asked if the youth peer program was developed using previous science-based frameworks or human-centered design concepts. Ms. Mendez answered that the program was primarily developed through listening sessions with the youth cohort to identify what they were most interested in so that they could tailor the program to the community.
- Dr. Greene commented on the potential for using non-traditional partnerships to address clinical workforce issues and to support older people with HIV. She asked whether Columbus Public Health had an existing relationship with the local correctional facilities

that helped facilitate this partnership. Dr. South said that there had not been a specific existing program or partnership. They leveraged a relationship with advocates in the administrative offices of the jails who recognized the value of the programs and the opportunity to provide needed services. In addition, Franklin County has a CATCH court program that offers reproductive and sexual health services to trafficking victims and sex workers that is somewhat related to the partnership with the jails.

- Ms. Mendez addressed Dr. Greene's comment on peer programs for older aged populations. She said that the listening group indicated that there was already an older presence in their community and that the younger adults felt they did not have the same support. Mr. Robert Riester lauded what Operation BRAVE was doing and talked about a symposium he was involved in that included an intergenerational discussion group. He suggested that an advocacy-promoting event that included a mix of generations would highlight different HIV experiences from different aged groups.
- Dr. Gayles asked the panelists to highlight a few best practices for successful community engagement. Dr. South said focusing on relationship-building to show the value of the work was important. They also found that working incrementally and building off the success of smaller projects in the beginning helped to build stronger programs and partnerships. Ms. Mendez answered that persistence was also key to their program, particularly during the COVID-19 pandemic, when colleges and universities had shifted their focus. In addition, it is important to understand that youth want to see immediate results. For instance, when the youth group suggested TikTok as an educational tool, the program had to quickly create their TikTok platform to show the youth that their feedback was being heard.
- Ms. Kneeshe Parkinson commented on the success of social media marketing with the youth and suggested that social media could also have an impact on the older HIV population.

Business Session Part 1

Dr. Gayles and Dr. Anderson asked CHAC members to reflect on the topics that had been addressed and to identify action items or areas that require more discussion.

- Mr. Driffin suggested further discussion on nontraditional partnerships and the disproportionate impact of mpox on the Black community.
- Ms. Parkinson said that the uptick in funding should be reviewed to ensure that it is being well-utilized among organizations.
- Dr. Anderson talked about the unwinding of operations after COVID-19 and how that might impact the workforce. For instance, the pandemic increased the use of telehealth and extended licensure to surrounding states, which could be impacted as the pandemic response unwinds.
- Dr. Gayles added that CHAC members should consider how to leverage telehealth to extend services being provided. The payer and provider communities consider telehealth as a provider of a clinical transaction rather than a proactive tool for social determinants of health and the whole person perspective. It would be important to consider the payer perspective in supporting the telehealth platform and how people receive reimbursement.
- Ms. Parkinson commented on the health workforce burnout issues and the need to consider their quality of health and what they need to continue their work.

- Mr. Lindsey said that it would be important to ensure that the lessons learned during the COVID-19 pandemic are not lost when considering EHE efforts. For instance, COVID-19 highlighted that telehealth did extend services but the hand off did not always work well because infrastructure and capacity were not fortified. Rural areas and communities of color were last to have access to interventions and services. It will be important to address these limitations in EHE now so that there is readiness for when the next epidemic or pandemic strikes.
- Mr. Driffin said that it was important to remember the workforce that is closest to the ground, such as peer navigators and those with HIV. These individuals are often the front line for testing and engagement to care. The definition of workforce has not always highlighted these providers and it is important to include them in the conversation.
- Dr. Greene expressed concern about what will happen to the workforce as provisions that were extended during the COVID-19 pandemic end. It would help reduce the administrative burden of health care workers if they did not have to spend time on discontinued insurance enrollment. Too often, the burden is being placed on primary care providers. There needs to be more focus on nontraditional partnerships and building up people with lived experience toward hiring them into the workforce. To that end, hybrid training sessions could greatly extend the number of people who are able to participate.
- Dr. Christine Markham talked about the disparities among Black/African American and American Indian/Alaska Native people in new cases of HIV and in rates of chlamydia, gonorrhea, and syphilis. She emphasized that it was important to ensure that all communities were at the table and had access to funding.
- Dr. Stewart stressed that, despite upticks in measures such as PrEP use, there are still racial and ethnic disparities that need to be addressed. It is also important to ensure that any innovations or advances that came from the pandemic are not implemented without the input of the community. She talked about how her clinic created a telemedicine practice to overcome workforce challenges but then learned that patients did not welcome it.
- Dr. Gayles added that the disparities often occur in settings of significant improvement for other communities. There may be best practices that are scaled across the country, but they do not work for everybody. There is a need to understand what is missing in these practices that continues to perpetuate gaps and disparities. Anytime there is something new, whether COVID-19 or mpox, the disparities again emerge.
- Dr. Cheever talked about understanding patient preferences in terms of telehealth to help determine the right balance of in person care and telemedicine that is based on patient preferences and optimizing engagement and outcomes.
- Dr. Anderson suggested further discussion on the large proportion of individuals with hepatitis C who are not getting treated.
- Mr. Driffin said that he had heard from states and clinical teams that access to long acting injectables is being closed off to people with HIV. He questioned how to continue a conversation about newer technologies that are met with rejection from the onset.

Day 1 Recap

Jean R. Anderson, MD
CHAC Co-Chair, HRSA appointee

Travis Gayles, MD, PhD
CHAC Co-Chair, CDC appointee

Dr. Anderson expressed gratitude to HRSA and CDC for their efforts to move beyond a primary focus on medical approaches through their commitment to holistic, status-neutral approaches that incorporate syndemics, quality of life indicators, and non-traditional partnerships. HRSA and CDC data presentations on data accessibility and communities of practice highlighted continuing gaps and needs, which can help advance how providers are supported. The focus on implementation science will help the field translate what should work based on traditional research into what actually works in practice. She talked about the robust discussion on the COVID-19 unwinding and how it will impact access to care, health care coverage, and the workforce. CHAC members highlighted the importance of learning from the innovations during the pandemic and extending those lessons into other public health emergencies, such as the mpox outbreak. CHAC members also discussed workforce challenges and the need to address burnout, particularly in duplicative administrative requirements. She added that the presentations on nontraditional partnerships as a way to extend the workforce was an exciting prospect. CHAC members emphasized the need to include all communities in the conversation and expressed continued concern about the ongoing racial and ethnic disparities.

Dr. Gayles emphasized the importance of the whole person approach as a standard practice rather than an exception. He added that the work of whole person care, identifying social determinants of health, and creating nontraditional partnerships takes a lot of energy and there is a need to address how to train the next generation of leaders and providers to continue this work. He talked about the challenges of grant funding and the need to sustain best practices so that they are not dependent on a grant cycle. Finally, he talked about the 40 years of sustained disparities and the challenge of addressing disparities when the gaps have become expected.

Adjourn

Dr. Cheever adjourned Day 1 of the November 2022 meeting and CHAC stood in recess until 12:30 p.m. on November 2, 2022.

Day 2: DFO Opening of the Meeting and Roll Call

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

Dr. Cheever welcomed participants to the second day of the CHAC meeting and conducted roll call, which established a quorum for the CHAC to conduct business.

Recap of Day 1

Jean R. Anderson, MD
CHAC Co-Chair, HRSA appointee

Travis Gayles, MD, PhD
CHAC Co-Chair, CDC appointee

Dr. Anderson reflected on two overarching themes from Day 1: workforce challenges and continued disparities in the prevalence and incidence of infection. She expressed hope that Day 2 discussions will progress these themes into CHAC recommendations for HRSA and CDC. Dr. Gayles welcomed participants and introduced Panel 2.

Panel 2: What's Next for the AIDS Education and Training Center Program?

Moderator:
Ronald Wilcox, MD, Chief Medical Officer, Health Resources and Services Administration, HIV/AIDS Bureau

Presenters:
Ricardo Rivero, MD, MPH, University of Illinois Chicago
David Spach, MD, University of Washington
Goulda Downer, PhD, FAND, CNS, LN, RD, Howard University
Philip Bolduc, MD, University of Massachusetts

Dr. Ronald Wilcox provided an overview of the AETC Program, which is funded by Part F of the Ryan White Program and has provided HIV care and treatment training for medical professionals for the past 35 years. The AETC network has two national centers (the National Clinician Consultation Center and the National Coordinating Resource Center), eight regional centers across the US and its territories, and an online National HIV Curriculum into Health Professions Training program.

Regional AETCs offer multiple training modalities: didactic and interactive presentations (i.e., panel discussions, webinars, train-the-trainer), communities of practice (i.e., organizations working collaboratively to improve operations), clinical preceptorships (i.e., clinical observation with patients or "mini residencies"), clinical consultation (i.e., case-based discussions), and coaching for capacity building (i.e., technical assistance). Across these training modalities, the AETC program provides core training (i.e., HIV treatment, service delivery, and organizational development); training for minority providers (i.e., increasing capacity to provide HIV care);

practice transformation (i.e., coaching and assistance at individual clinics); and interprofessional education (i.e., partnerships with accredited schools and educational programs to provide HIV training to students).

Developing the HIV Workforce: The MATEC Clinician Scholars Program

Ricardo Rivero, MD, MPH, Midwest AIDS Education and Training Center

Dr. Ricardo Rivero talked about the Midwest AETC's (MAETC) Clinician Scholars Program (CSP), which is a 12-month training program designed to strengthen the HIV clinical workforce by increasing the capacity of participating clinicians to provide high-quality HIV care along the continuum. The program is open to physicians, physician assistants, advanced practice nurses, nurses, and clinical pharmacists who provide care to a patient population with greater than 50 percent representation from racial and ethnic minority individuals. The program builds skills and knowledge through mentorship, standardized learning components, and regular engagement with MAETC staff. Graduates of the program complete at least 40 hours of multimodal and multidisciplinary training, participate in a two-day Immersion Institute, attend at least five sessions of a Collaborative Learning Series, complete at least 12 hours of clinical preceptorship, and present a case for discussion.

Between 18 and 25 applicants are accepted into CSP each year, and 214 have graduated from the program since its inception in 2010. Approximately 77 percent of participants have been female clinicians, 40 percent identify as being a member of a racial minority, and 5 percent identify as Hispanic. The majority of participants work in community health centers and others work in settings such as infectious disease clinics, pharmacies, correctional facilities, hospitals, and private practice.

Dr. Rivero reviewed short-term outcomes from data collected at exit interviews. The most frequent change resulting from the program was a change in knowledge (88 percent), followed by change in practices (70 percent) and change in attitudes (60 percent). Further analysis of these data revealed three interconnected outcome domains: increases in clinical capability, forming a professional identity, and establishing a place within an HIV clinician network. Participation in the program showed critical gains in these areas, emphasizing the importance of mentorship and networking to form relationships that enhance capacity and build professional identity. Dr Rivero also reviewed long-term outcomes from two- to four-year post-graduation interviews. Over 90 percent of graduates were still providing direct HIV services and over 50 percent reported an increase in the percentage of HIV patients served. The results also indicated that graduates expanded their HIV services and educated other clinicians in their clinics to increase capacity for HIV care.

Dr. Rivero summarized by saying that CSP is a promising model for filling critical gaps in the HIV workforce within underserved communities.

AETC National HIV Curriculum

David Spach, MD, Editor in Chief, National HIV Curriculum

Dr. David Spach introduced the National HIV Curriculum, which is an AETC program developed at the University of Washington and supports the integration of its e-Learning Platform into health care professional programs. The National HIV Curriculum has two functions: an informational resource platform that provides up-to-date materials on different topics and a learning portal with sequential self-study modules that provides continuing education credits.

Dr. Spach talked about the potential for the National HIV Curriculum to build the HIV workforce. It is free, provides unlimited access to education and resources, includes a formal tracking system and certificate program, and content can be downloaded by instructors to provide training to others. In addition, it features a learning group function that allows a group lead to assign individuals with specific modules and track their group's strengths and weaknesses to help direct where one-on-one learning or small group learning might be helpful.

The National HIV Curriculum currently has more than 55,000 registered learners and many more who access the information resources. The distribution of learners is aligned with areas that have higher prevalence of HIV and approximately half of learners identify with a racial or ethnic minority group. The curriculum is involved with every regional AETC, integration programs, and residency pathway programs. Dr. Spach highlighted that the National HIV Curriculum is part of the University of Washington's Infectious Diseases Education and Assessment (IDEA) program that has developed similar curricula for STD, hepatitis C, and hepatitis B.

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

Goulda Downer, PhD, FAND, CNS, LN, RD, Project Director, Capital Region AETC Telehealth Training Center, Center of Excellence

Dr. Goulda Downer began by providing context about the 100 Historically Black Colleges and Universities (HBCUs) that primarily serve Black/African America, Hispanic, and lower income students. Despite representing only 3 percent of all higher education institutions, HBCU graduates represent a large proportion of the Black/African American clinical workforce. The National HIV Curriculum Integration Project partnered with HBCUs to help strengthen and expand this clinical workforce in regions of high disease burden.

Dr. Downer talked about challenges during the development of the program. There was a lack of HIV knowledge across HCBU faculty and a lack of awareness about the importance of HIV care among students. There was also a sense that a course on HIV would not be used again or would involve inadequate compensation. To overcome these challenges. Dr. Downer and her team worked to ensure adequate compensation opportunities, such as federally qualified health centers for students to use their skills. The team also cultivated relationships with HBCU leadership to identify champions. These partnerships were critical for moving past hurdles such as accreditation and integration of HIV education into the curriculum. Then, the team conducted an analysis of current curriculum to identify deficiencies related to HIV.

Before the program, only 24 percent of students were interested in HIV education and 25 percent indicated that they were not interested in the field of HIV at all. After the program, 58 percent indicated that they were interested in a career in clinical HIV and were confident in their ability to deliver clinical HIV care. Nearly 11,000 clinicians have been enrolled in the program, with nurses accounting for the majority of students.

Dr. Downer summarized that their HBCU program helped develop a community that is better informed and able to provide quality HIV care. The innovative strategies they used for success included buy-in from leadership, ensuring there was a functional learning management system and dedicated faculty, and a responsive communication channel. Eleven of their partners now have embedded the program into their curriculum.

National HIV Residency Pathway Community of Practice

Philip Bolduc, MD, New England AETC

Dr. Philip Bolduc talked about the National HIV Residency Pathway Working Group, which is a small group seeking to create a community of practice for HIV training in medical residencies. There is a very large pool of primary care residency trainees who have primary care skills that would match existing needs of people with HIV; HIV residency programs would add specialty HIV skills to their experience. There are currently 25 HIV residency pathways, which provide substantial time with patients and opportunities for connections to the HIV community and helps to develop their sense of identity as an HIV care provider. The development of the National HIV Curriculum has created an opportunity to expand the network of HIV residency pathway programs because it lowers the barriers involved in startup.

Dr. Bolduc said that the community of practice that the working group seeks to develop would provide guidance and mentorship to new faculty looking to create these programs and raise awareness of the social justice aspects of HIV to leverage the passion for diversity, equity, and inclusion that young trainees have. The 25 HIV residency pathway programs currently in place are primarily located in the west and northeast, which are mostly outside if EHE areas. The working group therefore aims to expand HIV residency pathway programs into EHE areas in the south through incentives such as mentorship and career development.

The National HIV Residency Pathway Working Group has developed a toolkit to help overcome the complexities of starting a new program. The toolkit includes standards for HIV education, clinical requirements, and competencies in supervision and evaluation. In addition, the community of practice would offer monthly case conferences, a forum to connect with others, and linkages to HIV employment and mentoring.

Dr. Bolduc summarized that a community of practice for HIV residencies would provide a solution to the HIV workforce problem by tapping into primary care residency programs and focusing on EHE areas of need.

CHAC Member Discussion on Panel 2

- Dr. Gayles asked Dr. Downer how her team engaged with HBCU leadership to create buy-in of their training program. Dr. Downer answered that they were already part of a trusted cohort that had previously worked with the HBCUs. Her team had worked with many of their partners from the National Minority Education Training Centers for years and leadership in those organizations would champion the training program to the presidents and provosts. Without those connections, obtaining buy-in would have been very challenging.
- Mr. Driffin commented to Dr. Downer that it was important to consider how to engage both the smaller HBCUs and LGBTQ HBCU students who have experience in seroconversion. He asked Dr. Rivero if there were any qualitative data to explain the high rates of nurses and nurse practitioners in the program. Dr. Rivero answered that he was not surprised at the numbers because of the necessary movement away from specialty care into primary care. He expects that this trend will continue in the future.
- Dr. Stewart said that despite AETC programs and other efforts to increase the workforce, there are still workforce challenges. She asked how AETC programs could be promoted to reach more people. Dr. Wilcox said that they are developing a communications plan for their stakeholders and are also utilizing the National

Coordinating Resource Center as a means of marketing the AETC program. Dr. Rivero added that there has been a solid infrastructure in place for 34 years to promote AETCs through the regional and local partners, as well as through relationships with community health centers.

- Dr. Stewart asked Dr. Bolduc how forthcoming changes in residency programs might impact HIV residency programs as a means to increasing the HIV workforce. Dr. Bolduc answered that their approach is to bring strength in numbers. Every residency program has a different set of challenges and there is not a one size fits all approach. The more the community grows with different programs, the more solutions they will be able to share with others. The challenges are not insignificant. Everyone wants residents during their training and there has to be a call to inspire people to HIV residencies. The working group has conducted a soft launch of their toolkit and mentorship with a few programs, and they are currently seeking funding to expand. Dr. Spach added that HIV residency pathway programs are not the only pathway. There are also global health pathways and there is precedent for these types of pathways to benefit a program. Having an HIV pathway acts as a recruitment tool because it provides extra education and opportunity. The incoming class at Yale had 50 applicants specifically interested in the HIV pathway, for example.
- Dr. Gayles commented that although there has been progress in training a more diverse group of people, there is still a lack of representation. He asked the panel to address how they would ensure that diverse groups are linked to and serve in areas that are underserved and underrepresented.
- Dr. Wendy Armstrong commended Dr. Downer for her team's work because data show that people develop an interest in HIV care before medical school or earlier. It is critical to spark interest early; it is also critical to remind people that HIV is not over. She reiterated Dr. Gayles question about placing people into areas of need. Her team has a training program in Atlanta, but people want to stay in Atlanta rather than move to rural areas that are desperately in need. It is challenging to support residents on a shoestring budget in a program that does not produce revenue. Dr. Spach responded that there are two ways of relocating people. One is a large move from one geographic location to another. The other is more regional relocation to programs near their current community. The challenge with a regional move is the need for innovative solutions, such as developing satellite clinics in rural areas. For example, University of Washington has several satellite clinics within an hour or so from the university, where providers can have ongoing weekly visits to integrate into the community. One solution for large geographic moves is the development of a job board linked with AETCs to help connect people to areas in need.
- Dr. Dionne said that HIV is often the most straightforward infection to manage. She asked if there was a way to change training requirements for family practitioners to include basic competencies for HIV. Primary care doctors who are not working within a Ryan White-funded clinic will not have access to all of the resources that patients typically need, such as housing support, substance abuse management, or social work. Dr. Spach agreed that there were substantial challenges. The larger urban-based areas where there is high need tend not to be affiliated with Ryan White clinics. Some of the residency programs that the working group has been looking at are smaller and more community-based and often have good infrastructure from federal qualified health care centers. These are systems-level challenges and cannot likely be addressed with residency programs. The working group is looking to broaden the experience people have by linking HIV pathways with other training such as substance use or gender diverse populations. PrEP will also be a high priority for these trainings. Dr. Cheever

agreed that it required a systems perspective. She talked about previous efforts to determine what health centers need to provide HIV care, which found that the clinics did not need to have all ancillary services but rather an understanding of who to partner with or where to find a Ryan White-funded services such as case management. One provider cannot successfully provide HIV care alone, wherever they are located. If there are such individual medical care providers, then they will need to be connected with broader resources within their community to successfully meet the needs of low income people with HIV.

- Dr. Downer said that an ongoing issue is the stigma that is associated with HIV. She added that when her team started their program, only one in four students knew what the AETCs do. There is a need to communicate deliberately and intentionally about how to find the right resources and where to send a patient because their students did not know.
- Dr. Anderson spoke from an OB-GYN perspective. The obstetrics and gynecology field is an interesting hybrid of primary care and specialty care and HIV education is foundational to OB-GYN residents. She wondered if there had been any collaboration with OB-GYN societies such as the American College of Obstetricians and Gynecologists (ACOG). She also expressed concern about the Dobbs v. Jackson decision and the potential for care deserts for reproductive care because of the challenges in maintaining accreditation or attracting residents. She emphasized that women's health is primary care and that every HIV provider should understand the basics of mother-to-child transmission, which is part of EHE. Dr. Spach answered that the National HIV Curriculum is comprehensive and includes a section on perinatal transmission, as well as a section on women and HIV and guidelines about women's health screening. Although they have had several national experts who provided input into the curriculum, they have not had formal involvement with ACOG and would be eager to have a connection with them. He agreed that there are major challenges in women's health that will need attention in the coming years. Dr. Wilcox added that regional AETCs are expected to offer training in both HIV care for women and on the prevention of perinatal transmission.
- Dr. Greene commented on the need to address training on age-related concerns for older individuals with HIV, such as cognitive issues. She asked about AETC training for the nontraditional workforce. Dr. Wilcox answered that although AETC targets clinical professionals, there is an emphasis on training the entire health care team. For instance, there is a focus on ensuring the front desk personnel have training in cultural competency with LGTBQ communities and ensuring that the team is trained on working with community health workers.
- Ms. Parkinson asked if AETC programs offer mental health or opioid use training in their curriculum and if any of those trainings were targeted to older adolescents and young adults. Dr. Wilcox said that regional AETCs conduct needs assessments to determine the topics for curriculum and that many to provide training on opioid use, other substance use, and behavioral health. To his knowledge, none of those programs are specifically targeted to younger individuals. Dr. Rivero said that this age group has not traditionally been a target population and that their AETC primarily focuses on the care team. He noted that their AETC has an ongoing partnership with the Opioid Response Network, which helps them target physicians who need more training on opioid use and for opioid use experts who do not work with HIV care. Dr. Spach added that all of the regional AETCs do a good job with training on these issues, particularly in individualized trainings in communities that are more regionally focused.

- Ms. Johanne Morne said that there is an opportunity in developing these education frameworks to help residents understand the impact and barriers of inequities. She encouraged the use of honest and upfront language about the barriers that patients have in adherence as follow-up as a result of racism and other inequities. In particular, she encouraged building in space for trainees to feel awkward early in their career as they learn about these topics and begin to understand the impact on the community.

Special Presentation: Federal Update on Monkeypox

CDC Mpox Response

Jonathan Mermin, MD, MPH, Rear Admiral, US Public Health Service

Dr. Jonathan Mermin provided an overview of the mpox virus, an orthopoxvirus that can spread through skin contact and some degree of other bodily fluid. There have been increasing numbers of mpox outbreaks over the last few decades, which may be attributed to the loss of immunity resulting from the end of smallpox vaccinations, as well as increased intersections of humans and animals in certain parts of the world. The current outbreak has a slightly shorter incubation period than other mpox outbreaks, and the prodromal symptoms that are common in other outbreaks are sometimes absent or follow rash onset. Although severe cases are not as common as in other outbreaks, cases that are severe can cause persistent lesions and multisystem organ involvement. Most severe cases occur in immunocompromised individuals and most of those individuals are people who live with HIV. The average age of infection is 34 and approximately 96 percent of cases are cisgender men, among which the majority of those reported were gay, bisexual, and other men who have sex with men (MSM). Approximately one-third of cases were Black/African American, one-third Hispanic, and one-third White. Approximately 40 percent of cases had HIV infection and 40 percent had a diagnosed STI in the prior 12 months.

There was a 50 percent reduction in sexual risk behavior among MSM as information about risk and prevention was disseminated during vaccination rollout. Two doses of the vaccine are recommended for immunity. CDC currently recommends intradermal administration. More than 650,000 people have been vaccinated, however CDC estimates that nearly two million people could benefit from the vaccine, indicating that CDC is approximately halfway to their goal. The vaccine was approved by FDA with established safety but not effectiveness data. Therefore, CDC is conducting preliminary analyses and their initial findings suggest that the vaccine is effective. Absolute number of cases peaked in mid-August 2022, with a subsequent steady decline. However, there are local outbreaks that continue to be a concern.

As incidence has decreased, disparities increased. Black/African American individuals comprised 12 to 15 percent of cases at the beginning of the outbreak, but 45 percent of cases as incidence decreased overall. CDC established an Equity Office to promote equity from both the LGTBQ and race/ethnicity perspectives and special vaccine equity initiatives. Disparities persisted despite these efforts, emphasizing the importance of constant vigilance. CDC has also conducted community engagement through digital media, messaging on dating apps, and vaccination programs within event venues. White House Mpox Response Coordinator Demetre Daskalakis has promoted ongoing dialogue with communities, which aids with fast response times.

Going forward, ongoing challenges include decreased vaccine uptake, blame placed on the LGBTQ community, intersectionality obstacles, and criticism of CDC on messaging approaches.

Dr. Mermin asked CHAC members to consider how to disseminate messages and interventions to a specific population without increasing stigma and discrimination. He highlighted that mpox landed in an environment in which STIs have increased in the past several years and the infrastructure to rapidly respond isreduced. Additionally, systemic homophobia, racism, and economic policies are associated with the increase in STIs and its major racial and ethnic disparities. U=U and PrEP uptake have also changed the prevention landscape and sexual risk, particularly among gay, bisexual, and other MSM.

Dr. Mermin reviewed the key issues of the public health response to mpox, including routine vaccination in clinics that provide HIV and STI services, continued event-based vaccine equity initiatives, continued community engagement and collaborations with health departments, and ongoing mpox and vaccine research and surveillance. He also highlighted lessons learned going forward, including anticipating the future and acting fast, focusing on equity, bring services to people, and increasing public health action as societal concern decreases. He asked CHAC members to consider when the current mpox outbreak would be considered over; the policies, systems, and resources needed to be in place for future outbreaks; and what CDC and HRSA have done well and what should be stopped.

HRSA Response to Monkeypox Outbreak

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

Dr. Susan Robilotto provided an update of HRSA's response to mpox. HRSA has been working closely with HHS and, in particular, CDC to monitor cases in the US and to provide resources to help health care providers who are treating people with mpox or may be at risk. HRSA recognized early on that their Ryan White recipients were trusted providers in the communities most impacted by mpox. Therefore, HRSA focused its efforts on providing up-to-date information and resources to help Ryan White providers address mpox in their communities.

HRSA provides updated information in various ways. For instance, they released mpox updates in their Have You Heard webinars. They also created an information webpage with resources and guidance for Ryan White recipients, subrecipients, and stakeholders. HRSA released a letter to recipients outlining the allowability of Ryan White funds to provide for diagnosis, treatment, and vaccination of mpox. HRSA was identified as a distribution point due to the health care services it provides for people with HIV and a large number of uninsured and underinsured patients. In August 2022, HRSA received an allotment of the JYNNEOS vaccine to distribute to Ryan White recipients. HRSA has since distributed vaccines to 50 Ryan White Part C dually funded Health Center Program providers who care for a significant number of MSM and transgender persons. HRSA notified these providers to offer PrEP to people who may be exposed to mpox, based on CDC guidance.

Dr. Robilotto invited CHAC members to review the technical assistance resources that HRSA provides on its website and said that the resources will continue to evolve as new information becomes available.

CHAC Member Discussion on the Federal Update on Monkeypox

- Dr. Mehta asked if there were data to better understand whether there was a relationship between the disparities in mpox and those who have not yet been vaccinated. She also wondered if there were challenges such as risk perception, access, or vaccine

hesitancy. Dr. Mermin answered that there were data indicating a disproportionate under-vaccination of Black/African American and, to a lesser extent, Hispanic individuals. The under-vaccination and the increasing disparities in mpox are likely related, but not necessarily causal. Dr. Mermin emphasized that the burden of getting vaccinated should not be on the individual, but rather the system. Of the estimated two million people who would benefit from the vaccine, approximately 600,000 are people with HIV and many of those are seen in Ryan White-funded clinics. It should be routine during a clinical visit to talk about and offer the vaccine. This should also be routine in PrEP and STI clinics, as well as community outreach venues. This approach would overcome the hurdle of self-identifying. There are some concerns about misinformation about the vaccine and there is less concern about mpox in general because rates are decreasing in some areas. The availability of vaccines was likely different across different communities. Looking at these components together, the cause of the increasing disparity is more systems-based. The outreach did not happen in an ideal way and there is a need to counteract concern about the vaccine with appropriate information, such as awareness of the subcutaneous vaccination for those concerned about the potential effects of an intradermal vaccination. However, this type of response will rely on an ample supply of vaccine.

- Mr. Driffin talked about how severe mistrust about vaccination was created in the rollout. White gay men received the subcutaneous route at first, and then when the vaccine was being encouraged among Black and Hispanic men, the route and amount of vaccine was changed as a result of inventory. There has to be a deeper conversation about mistrust, including for PrEP, HIV treatment, and the long rollout of injectable therapy. Mr. Driffin also talked about the missed opportunity to hold an equity event during HCBU homecoming season. For instance, Atlanta University Center just hosted homecoming with more than 65,000 Black and Hispanic men in one place, but mpox was minimally discussed. There is a need to have infrastructure already in place, such as a long-acting strike team that is ready to respond, because there will be future outbreaks.
- Mr. Lindsey talked about how he participated in a workgroup of global funders to talk about the bright spots and innovations at the community and systems levels during the COVID-19 pandemic. Many of the same bright spots and innovations are being talked about again for mpox. There could not be a better time to recognize that the system cannot continue to leap from outbreak to outbreak without a continuous level of community engagement and systems innovation. The lessons learned from these outbreaks need to become standard, everyday response. Atlanta did excellent work setting up community clinics, but the system was not already in place. It was created just for mpox. In addition to HCBU homecoming events, there have been other large regional gatherings, such as Pride events, that offer an opportunity to talk about a systemic response and a sharing of lessons as events move from one region to another. HRSA and CDC are talking about the right things: diffusion of innovation, health equity, syndemic approaches, and intersectionality. These conversations should not be episodic but a part of standard operating procedures. There is a need to invest in infrastructure and prioritize the communities that repeatedly get left behind.
- Dr. So asked if the antiviral to treat mpox is effective and available. Dr. Mermin remarked that there is currently no drug proven to be effective for mpox in humans because there haven’t been enough cases. Tecovirimat is the most commonly available antiviral and CDC holds the Expanded Access Investigational New Drug application. NIH is conducting a clinical study of tecovirimat called the STOMP trial, which will provide some information about effectiveness. There will likely need to be a non-randomized examination to determine effectiveness. There is some experience of tecovirimat

causing resistance over time in people with severe disease. There are also two other drugs, including brincidofovir that is available through FDA. Although it is not clear if these treatments are effective, there is a priority to help people with immunosuppression avoid severe disease.

- Dr. Steward echoed the need to use lessons learned from the COVID-19 pandemic toward readiness for the next epidemic or pandemic. During the COVID-19 pandemic, vaccines were put in places that people of color could not access, and primary care offices were put on the backburner, even though they were ready to vaccinate their patients. The same thing is happening with mpox vaccinations. The vaccines were not initially available in primary care or in clinics where people receive HIV care, and they are still difficult to obtain in those offices.
- Ms. Parkinson asked about research on cisgender and transgender women and mpox. Women were left out of the HIV response 40 years ago and women in marginalized communities were left out of the COVID-19 response. She wondered how there could be infrastructure or due diligence to ensure that there is intentionality in providing access to vaccination. Dr. Robilotto said that HRSA's messaging to Ryan White providers on vaccination was about risk and was not gender specific. The messaging will continue to evolve once HRSA has access to more vaccines.
- Dr. Dionne asked about the transmissibility of mpox as an STI. She also talked about a presentation from Bavarian Nordic on data showing that a subcutaneous single booster dose of the vaccine repeated two years later results in high neutralizing antibody levels. CAPT Burton responded that there have been discussions about mpox as an STI but there he has not seen the latest data and will follow-up as he learns more.

Workgroup and Liaison Reports

The Evidence of HIV Self-Testing and Self-Collection

Johanne Morne, MS-ED, Chair

Ms. Morne said that the Self-Testing and Self-Collection Workgroup reviewed available information. Dr. Morne discussed the growing evidence, gained particularly from the COVID-19 pandemic, that self-testing promotes autonomy, increases confidentiality, and provides convenience. Self-testing also supports EHE goals, improves testing access, reduces cost, modernizes testing practices, and increases accessibility. The CHAC discussed three recommendations:

1. Encourage the FDA to downgrade the regulatory classification of HIV self-testing from Class III to Class II diagnostics.
2. Expand the availability of HIV self-collection and self-testing.
3. Modernize the current FDA approach specific to HIV self-testing and self-collection.

Dr. Mehta provided more detail about the evidence review, which focused primarily on two articles. One was a recent literature review that supported the acceptability, feasibility, and validity of HIV self-testing. The other was a randomized trial among MSM that showed that individuals tested more frequently in the self-testing arm and that the impact extended to social networks.

Dr. Markham added that self-testing for HIV has been working well in Native American communities, which is encouraging for remote and rural communities that have concerns about confidentiality.

Dr. Dionne reiterated that the Workgroup was united in their recommendations and felt that CHAC could facilitate access to all patients and to help identify the last 10 to 15 percent of people with HIV who are not aware of their infection.

The CHAC discussed these data in the following recommendation:

The CHAC recommends expanding the availability of self-testing and self-collection and working to resolve any regulatory or legal barriers that exist, including modernizing the current FDA approach specific to HIV self-testing and self-collecting. CHAC specifically encourages the CDC to advance public health efforts by encouraging the FDA to downgrade the regulatory classification of HIV self-testing from Class III to Class II diagnostics. We strongly recommend the CDC share the essential need to expand self-testing and self-collection access through increased affordability of testing technology with the FDA.

Workforce

Jean R. Anderson, MD on behalf of **Vincent Guilamo-Ramos PhD, MPH,** Chair

Dr. Anderson reviewed the Workforce Workgroup's analysis of the issues and facts. The National HIV/AIDS Strategy Implementation Plan outlines key action areas in support of EHE, including increasing workforce diversity, holistic care and treatment provision, culturally and linguistically appropriate services, team-based care delivery, and community recruitment and engagement. The challenges in meeting these action areas for workforce include the scale, reach, and effectiveness of HIV prevention and treatment.

Rather than continuing a traditional approach to HIV workforce development, the Workgroup discussed reimagining the HIV workforce and adopting new models of workforce development. Specifically, the Workgroup identified five strategies for a reimagined HIV workforce:

1. Broadening the definitions of the workforce.
2. Adopting a decentralized and differentiated model for service delivery.
3. Enabling HIV provider practice to the highest level of training and licensure.
4. Increasing the capability to mitigate social determinants of health.
5. Adopting multidisciplinary team-based models for HIV prevention and care.

The CHAC then developed nine recommendations to translate these strategies into action:

1. Remove regulatory barriers that place restrictions on practice at the highest level of training and licensure.
2. Ensure CMS offers appropriate reimbursement for decentralized, differentiated, and team-based whole person, contextualized HIV prevention and care services.
3. Support a shift toward education and training for the future health workforce, emphasizing key competencies of team-based, whole person, contextualized HIV care.
4. Invest in infrastructure development for delivery of decentralized, differentiated HIV prevention and care.
5. Allocate funding to HIV-specific demonstration projects designed to mitigate the specific mechanisms of social determinants of health.

6. Better integrate all team members into the HIV workforce in partnership with other care providers and address appropriate training standards, compensation, and paths for promotion.
7. Develop a standing workgroup or committee within the health system to provide guidance and to monitor and address workforce issues.
8. Develop and disseminate effective, targeted, multilevel interventions to mitigate social determinants of health.
9. Identify and support viable HIV career workforce trajectories through adequate compensation and advancement opportunities and in alignment with emerging workforce needs and challenges.

Presidential Advisory Council on HIV/AIDS

Ada Stewart, MD, Chair

Dr. Stewart provided an overview of PACHA's activities since the last CHAC meeting. After PACHA's November 2021 Full Council meeting, in which PACHA heard from many groups about molecular HIV surveillance and cluster detection and response, PACHA's Stigma and Disparities Subcommittee formed a workgroup to evaluate the impact of this activity. PACHA then convened a two-day workgroup to approve final recommendations on molecular HIV surveillance, which were finalized at the 75th Full Council meeting in October 2022.

PACHA's 74th Full Council meeting was held in Los Angeles County, which is one of the 57 prioritized jurisdictions in the HIV epidemic. PACHA heard from individuals involved in the EHE and other HIV-related issues in Los Angeles County. In addition, PACHA members and other federal partners visited three community-based organizations involved in EHE.

PACHA has also focused on HIV and aging and the need for a comprehensive model of care for people aging with HIV and other comorbidities and social challenges. In addition, PACHA's Full Council approved a recommendation statement on blood donor referral policy for MSM.

CHAC Discussion on Workgroup and Liaison Reports

- Mr. Riester expressed appreciation for PACHA's listening sessions on HIV and aging.
- Mr. Lindsey commented on the need to extend the definition of HIV workforce to include those who work in state and federal government. Many of these individuals have experience working in community-based organizations and Ryan White clinics and provide complementary perspectives to the work of traditional HIV service providers. Including them in the definition of the HIV workforce helps to close the gaps between government, community, and private providers and helps promote collaboration.
- Dr. Cheever thanked the CHAC Workgroups for the tremendous work they do that helps move recommendation forward.
- Dr. Greene asked for clarification on the CHAC's recommendation to continue the Workforce discussion. Ms. Morne said that the Self-Testing and Self-Collection Workgroup also had more work to discuss. Dr. Anderson clarified that the recommendation was not necessarily to have a standing committee within CHAC, but rather at another level of government. Mr. Lindsey added that the workforce challenge was not only about *who* the nontraditional providers were, but also *how* to move them into multidisciplinary teams. The idea was to have an external committee to better address the *how*.

- Dr. Dionne said that the CHAC's recommendation on Self-Testing and Self-Collection was focused on HIV, but there is a need to continue work on the STI side. She asked what the protocol was to extend the to STIs. Dr. Jumento said that CHAC members need to first vote on the current recommendation letter. Once the Workgroup is closed out, CHAC members can then vote to create another small Workgroup to work on that topic.

CHAC Actions

Dr. Armstrong called for a motion to accept the recommendations put forward by the CHAC on the topic of Self-Testing and Self-Collection. CHAC members unanimously accepted the recommendations with no further discussion.

Dr. Anderson called for a motion to approve a continuation for Self-Testing and Self-Collection Workgroup to work on additional self-testing issues. CHAC members unanimously approved the continuation of the Self-Testing and Self-Collection Workgroup.

Business Session Part 2

Dr. Gayles and Dr. Anderson asked CHAC members to reflect on the topics that had been addressed and to identify action items or areas that require more discussion.

- Dr. Anderson said that the CHAC recommendations on workforce were relatively broad and suggested developing a letter of recommendations in coordination with PACHA to identify focus areas for CHAC.
- Mr. Driffin highlighted the importance of the discussions on HCBUs as a platform not only for culture and community, but also to consider STEAM professions. The inclusion of art is important as a platform for ending stigma, reducing discrimination, and increasing access to care.
- Mr. Lindsey emphasized the importance of not losing the thread of discussion on innovations for the HIV workforce.
- Mr. Riester said that aging and HIV be included in the conversation about the HIV workforce, including gerontology.
- Ms. Parkinson recommended continuing an intentional discussion on innovations to address administrative burnout and suggested promoting these programs to a higher level to raise awareness on the who and how of driving these initiatives.
- Dr. So said that the need to engage primary care workers in HIV care is clear, but primary care workers might not see many people with HIV. Rather than asking them to attend several hours of training, there could be a simple algorithm or app that makes it easier for them to engage.
- Dr. Dionne talked about the need for CHAC to do more about mpox, such as a recommendation letter on communication, feedback to CDC, or formation of a workgroup. Dr. Jumento said that the two options would be to form a workgroup to research and bring data to CHAC in April 2023 or to hold an interim business meeting. Mr. Lindsey talked about a report on COVID-19 that provided a snapshot of what was happening in the moment. He suggested that something similar could be done with mpox, in which an external contractor could be hired to conduct qualitative interviews and focus groups with different jurisdictions. This could be a faster solution than forming a workgroup.

- Dr. Stewart emphasized the need to talk about the care of older individuals with HIV in conversations about workforce. There is a need to ensure that their care is not just about viral suppression but rather looks at the whole person and includes social determinants of health. There needs to be a distinction for aging and HIV when talking about the HIV workforce.
- Mr. Driffin said that there was an opportunity to tap into disruptive innovation toward a differentiated model of care for people with HIV. There could be a one or two year program under the leadership of infectious disease primary care or a non-traditional curriculum to address this issue differently. Ms. Parkinson agreed that this model would work very well and suggested that there could be a pilot program for a course in late 2023, which would work best in an HBCU or a college in the Midwest.
- Dr. Dionne asked about the CHAC recommendation on workforce for people to perform at the top of their ability. She suggested that this would have great impact but could also be a heavy lift. Dr. Anderson agreed that it is aspirational and may not be something that CDC or HRSA can do. However, appropriate people at the state level or in professional societies could put together a letter. Dr. Armstrong said that the challenge is that the landscape is different from state-to-state. Recommending it as a best practice would be a good start.
- Dr. Armstrong addressed the idea of an algorithm for primary care providers and suggested that good HIV care is not algorithmic, nor about decreasing discomfort around care provision. Rather, it is about providing holistic care, such as talking about sexual health or having the cultural competence to address the people who come into the clinic. Care can be provided by a number of practitioners, but it needs to be the same approach and that is what the training should focus on.
- Dr. Anderson suggested that there should be a modular approach to build foundational knowledge and a set of skills for any provider. There are things that all providers should know about in the setting of HIV, and a modular approach would provide consistency and standardization. She added that the presentation on the National HIV Curriculum was impressive and that she would review it.
- Mr. Riester said that it was important to not lose track of social workers and medical case managers in the discussion about workforce. Those workers are feeling the challenges in the workforce just as much as clinical providers.
- Dr. So clarified his idea about an algorithm. It would not be about treatment but for all principles of managing HIV care. There are primary care providers who are interested in caring for people with HIV but need simple guidance that is all encompassing to increase their comfort levels.

Day 2 Recap

Jean R. Anderson, MD
CHAC Co-Chair, HRSA appointee

Travis Gayles, MD, PhD
CHAC Co-Chair, CDC appointee

Dr. Anderson said that there had been two CHAC votes to approve the recommendations on Self-Testing and Self-Collection and for the continuation of the Workgroup to be extended into STI self-testing. There was also general consensus to proactively address mpox before the April 2023 meeting and to continue discussion on the HIV workforce.

CHAC members heard about innovative programs in curriculum program in HCBUs and residency tracks.

Dr. Gayles said that a major take home theme was that none of the challenges of today are new, but rather reminders and replays of previous issues and conditions. The goal should therefore be to operationalize responses in ways that do not continue to perpetuate the same challenges.

Adjourn

Dr. Cheever adjourned Day 2 of the November 2022 meeting and CHAC stood in recess until 12:30 p.m. on November 3, 2022.

Day 3: DFO Opening of Meeting and Roll Call

Laura Cheever, MD, ScM
Designated Federal Officer
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration

Dr. Cheever welcomed participants to the third day of the CHAC meeting and conducted roll call, which established a quorum for the CHAC to conduct business.

Public Comment

Mark Misrok is a long-term HIV survivor, member of the US People Living with HIV Caucus, and Executive Director of the National Working Positive Coalition. He expressed disappointment in the current status of CDC and HRSA response to the 40 percent unemployment rate among people with HIV. Unless CDC and HRSA take the lead in advancing initiatives to address employment needs through collaboration with the Department of Labor, Department of Education, and HUD, the high unemployment rate will continue indefinitely, negatively impacting quality of life, economic status, self-esteem, and health outcomes. He looked forward to discussion on how to initiate change.

Richard MacKinnon is Executive Director of the Music City PrEP Clinic in Nashville Tennessee. He said that although Ryan White programs have a high standard of care on the treatment side, there is not a high standard on the prevention side. One major component of the National HIV Strategy is the spread pricing in what HIV clinics pay for medications and what they are reimbursed by pharmacies. It seems that this spread is unsupervised and that the pharmaceuticals can make unilateral decisions that drastically affect the funds available to EHE clinical operations. In addition, he talked about Nashville Tennessee's program to improve PrEP uptake, which has moved the numbers in Tennessee from the bottom rank to the top five. This success is in part due to their utilization of the spread to its maximum capacity. They are adding up to 600 new patients to the STD clinic each month, of which 35 percent are Black/African American.

Mariah Wilberg is Senior Director of the US Strategy & Ending the Epidemic. She expressed appreciation for the federal government's effort to use plain language to describe U=U and asked CHAC to help continue the momentum by advocating for 1) meaningful inclusion of U=U in future Notices of Funding Opportunities from HRSA and CDC, 2) a new Dear Colleague letter from HAB that uses updated language on U=U, 3) an applicable plan for future policy clarifications, and 4) efforts to ensure the workforce is supported with adequate capacity building and technical assistance specifically related to U=U. She said that her organization is available to provide feedback on draft language.

Late Breaking CDC National Center for HIV, Viral Hepatitis, STD, and TB Prevention Updates

Deron Cornell Burton, MD, JD, MPH
Designated Federal Official
Captain, US Public Health Service
Acting Director
National Center for HIV, Viral Hepatitis, STD, and TB Prevention

CAPT Burton provided two new updates from the CDC NCHHSTP. First, NCHHSTP just published a new funding opportunity, Advancing Policy as a Public Health Intervention to Reduce Morbidity, Morality, and Disparities in HIV, Viral Hepatitis, STDs, and Tuberculosis. The program has two components: 1.) developing longitudinal law and policy surveillance data and assessment, and 2.) conducting policy technical assistance among decision-making leadership. It is a five-year program that will be funded at a minimum of $1,500,000 each year.

The other update was the passing of Dr. Dawn Smith, who served in the NCHHSTP DHP and was a dedicated supporter of health equity and an influential researcher and public health practitioner. CAPT Burton invited CHAC members to take part in a moment of silence to remember Dr. Smith.

Panel 3: More Effectively Using Community Health Workers in HIV and STI Prevention, Care, and Treatment

Moderator:
Brian Fitzsimmons, MSW,
Health Resources and Services Administration.
HIV/AIDS Bureau

Presenters:
Caroline Brazeel, MPH, Association of State and Territorial Health Officials
Naomi Seiler, JD, George Washington University
Karen Guillory, Unity Health
Tara Spencer, MS, RN, Health Resources and Services Administration.

Mr. Brian Fitzsimmons provided an overview of two HRSA-funded community health worker projects than ended in February 2020. The first was focused on using community health care workers to improve access to HIV care through the use of implementation tools. The project funded 10 sites that had low viral suppression among racial and ethnic minority populations and a commitment to sustaining the community health worker component in their program. The project sites received technical assistance and training on the successful implementation of community health care workers. One of their key findings was that they had underestimated the time and commitment needed to train and supervise community health workers. Additionally, there were few community health workers and therefore little opportunity for peer support, indicating a need for a mechanism that would allow them to engage with each other.

The other HRSA program provided technical assistance and service delivery funding to one sub-recipient in each of the four Part A jurisdictions to increase capacity in serving minority populations. There were four stages of the implementation model used: 1) exploration (i.e.,

identifying sites), 2) preparation (i.e., establishing systems and processes, 3) implementation (i.e., collecting and reviewing data for continuous improvement, and 4) sustainability (i.e., aligning the community health worker model with a core strategy to improve HIV outcomes). One key finding was that providing a welcoming culture and having a staff structure that reflected priority populations were both important to success. They also found that staff needed to be trained in cultural humility to sustain a judgment-free setting. Established relationships with the priority population and support from senior leadership also impacted the success of the program. Mr. Fitzsimmons pointed out that clients in the south tended not to want to engage with people from their social circles, which was an important consideration for people with lived experience as community health workers.

Pre- and Post-COVID-19: Supporting the State Health Agency CHW Workforce

Caroline Brazeel, MPH, Senior Director, Population Health and Innovation, Association of State and Territorial Health Officials

The Association of State and Territorial Health Officials (ASTHO) works with health departments to sustain a strong public health community health worker (CHW) workforce, especially as recent public health crises like the COVID-19 pandemic and Ending the HIV Epidemic initiative highlighted the need for strong, honest community engagement to reduce health disparities. CHWs are defined by their trusting relationship or unusually close understanding of the community served. In order to better formalize the CHW workforce, states have both taken policy actions and directed significant federal grant funding create systems and infrastructure that support CHWs.

In recent years, states have focused primarily on establishing CHW certification programs and financing mechanisms (primarily through Medicaid) as a means of sustaining the CHW workforce. However, recruitment and hiring policies within governmental public health systems are a complimentary component of sustainability. This includes defining and understanding the necessary competencies for someone in this role to be successful. ASTHO's members have identified certain core competencies, such as cultural mediation, coaching, social support, and outreach, which were important to the success of CHWs.

Preliminary ASTHO data indicates that state health departments typically either hire CHWs directly, subcontract through a community-based organization, or both. ASTHO will continue to engage its members in identifying the hiring and operational practices that allow health departments to rapidly identify, recruit and hire CHWs in a public health emergency, as well as to sustain employment and create career ladders long-term. This includes identifying how to draft job descriptions that allow CHWs to practice in community settings, conduct interview that assess for CHW core competencies, and provide onboarding practices that CHWs into the governmental public health workforce in a meaningful way.

As this learning continues, ASTHO has identified a need to reduce siloes and create visibility across a state health department around existing CHW programs and positions. For example, a Ryan White program director or HIV director may have developed a CHW job description that can be adopted by another public health division. Similarly, existing CHW initiatives may have the potential to share critical community insights to other public health programs. Finally, ASTHO noted that its partnership with the National Association of Community Health Workers is critical and would be an important component of any CHAC effort.

STIs and Community Health Workers: Preliminary Findings and Considerations

Naomi Seiler, JD, George Washington University, School of Public Health

Ms. Naomi Seiler reviewed an ongoing CDC-funded study that generally aimed to understand how the Medicaid program could better address STI care. As one component of the study, the research team conducted a literature review and interviews with key experts to better understand the role of community health workers for STI services. The three main takeaways from their study were that 1) community health care workers have the skills and attributes needed to contribute to the STI response, 2) Medicaid payment could help support a sustainable community health worker workforce, and 3) community health care worker skills and expertise would be complementary to disease intervention specialists.

The literature review established that community health workers can be integrated into health care teams and are particularly effective for improving health outcomes among low-income and minority populations across a range of health issues. They can provide a range of services across care coordination, linkage, education, and communication. The literature also indicated that community health care workers seek training, and that training helps them become particularly effective. Qualitative studies also showed that trust in community health workers is important for providing sexual health information and that patients are more likely to follow recommendations when they are working with a community health worker.

The interviews with key experts highlighted three main themes. First, the experts talked about several common themes related to the role of community health workers, such as being a trusted resource for information about sexual health; their ability to spend more time with patients, link them to providers, and improve clinical workflow; and the need for flexibility from employers to do their job well. Second, the experts also talked about the role of Medicaid in the community health worker workforce. For instance, they indicated that Medicaid covered a large portion of the population that are often marginalized or have health inequities, which is the population that community health workers are most effective in serving. However, Medicaid reimbursement could create a shift in community health workers only serving people with Medicaid, potentially excluding a large number of uninsured people. Third, the experts talked about the limited interaction between community health workers and disease intervention specialists.

Ms. Seiler provided several considerations from their research findings for CHAC members to discuss. STI prevention programs should identify if there were already community health workers in sexual health within the community. Community health workers should also be considered partners for substance use programs as a syndemics approach for STIs. CDC and other partners could consider developing an STI or sexual health training module for community health workers that states could integrate into their certification programs. Community health workers in the sexual health field should identify how their reimburses services. Finally, disease intervention specialists' teams should convene with community health workers in their community to engage in cross training opportunities.

Community Health Workers in HIV and STI Prevention, CARE, and Treatment

Karen Guillory, LICSW, Director of Social Services, Unity Health

Ms. Karen Guillory provided a review of the recruitment, training, and retention of community health workers at Unity Health. Unity has actively employed community health workers for over a decade and consider them an integral part of the team. Unity received a PrEP grant right before the COVID-19 pandemic, which was the greatest barrier to community health worker

recruitment. Another major barrier was the mix of experience and knowledge within their applicant pool. Ideally, a community health worker had both community experience and knowledge of HIV and PrEP. However, approximately 80 percent of their application pool had neither. Other applicants had salary expectations that exceeded the grant funding. As a result, Unity staff had to determine what mix of knowledge and experience was most important to the role. They ultimately hired a team with a mix of experience and knowledge, which created challenges in training.

Unity provides onboarding training in social services, PrEP and HIV, working with special and vulnerable populations, and implicit bias. They also provided focused training on how to engage the community and home visiting. Although Unity has historically had excellent retention of their community health workers, during the pandemic they did have some challenges and attrition. For instance, the new hires felt they needed more supervision and understanding of their role than was anticipated. They also expressed not feeling a part of the team and having low visibility in the organization. Two new hires left because they did not want to conduct home visiting.

To address these challenges, Ms. Guillory engaged the new hires in site meetings to promote their visibility and voice. She asked them to conduct presentations on PrEP and provide opportunities to role play scenarios that could be sensitive or embarrassing for the patient. She also discussed performance standards as a requirement of their PrEP grant. Going forward, Unity has developed training and guidance for new community health workers to address a mix of knowledge and experience. They refined job positions to be clear and upfront about home visiting. And they created a standard interview protocol to include more questions about home visiting and community outreach. They also included scenario questions and a conversation about what outreach means to the applicant.

BHW Community Health Worker Training Program

Tara D. Spencer, MS, RN, Chief, Nursing Education and Practice Branch, Health Resources and Services Administration

Ms. Tara Spencer provided an overview of HRSA's BHW, which supports community-based training and programs that encourage clinicians to work in rural and underserved communities. BHW provides training grants to health professionals to support innovative and flexible responses to emerging health care challenges. BHW's role in delivering health care to underserved communities is more important than ever, in light of the disparities highlighted by the COVID-19 pandemic and a shifting health care landscape. This shift prompted BHW to consider different approaches to serve the community.

Authorized by Title 7, Section 765 of the Public Health Service Act and the American Rescue Plan of 2021, BHW's new Community Health Worker Training program aims to increase the number of individuals in public health workforce and enhance the quality and ability of the workforce to meet national, state, and local health care needs. Eligible applicants include health profession schools; academic health centers; state or local governments; or any other public, private, or nonprofit entity.

The Community Health Worker Training Program has four "buckets" or objectives: 1) expansion (i.e., recruiting, training, and retaining new community health workers); 2) extension/upskilling (i.e., training for current community health workers); 3) employment (i.e., field placement in underserved areas) and 4) health equity (ensuring critical gaps are filled by community health workers). BHW has awarded $225 million through 83 three-year grants to support the training

and apprenticeship of an estimated 13,000 community health workers through this new program. Nearly half of the grants were awarded to nonprofit community-based organizations. The grant includes tracks for expansion, extension/upskilling, and employment with a number of requirements under each to ensure that trainees receive training on the core competencies, specialized upskilling training, and access to an apprenticeship program that provides training on health equity and social determinants of health.

Award recipients were able to select the populations they wanted to support, and 12 recipients chose to focus on HIV/AIDS. Some of the areas that these recipients have chosen to focus on include recruitment of individuals with HIV or AIDS, employment training to work with high-risk individuals, incorporating HIV/AIDS topics into upskills training, and partnering with community-based organizations that focus on HIV/AIDS as registered apprenticeship sites.

CHAC Member Discussion on Panel 3

- Mr. Driffin asked Ms. Guillory whether Unity had talked to applicants about the salary range they were interested in and for clarification about the new hires who felt like they were not part of the team. Ms. Guillory said that they did ask about salary range. Some applicants asked for bilingual pay and others had significant experience that Unity wanted to reward. They would refer to their budget and talk to human resources to determine how to shift money around to meet those needs. She added that individuals in the PrEP team were hired around the same time and had separate PrEP meetings. Therefore, they bonded with each other but did not feel a part of the larger agency. There was also monthly community health worker meetings and giving the PrEP team permission to engage and present was helpful for them.
- Dr. Greene acknowledged the challenges of conducting home visits during the pandemic. She asked Ms. Guillory if her team had identified a way to balance the knowledge of HIV and PrEP with experience in the community during recruitment. Ms. Guillory answered that they based hiring decisions on responses to their interview questions. It is important to understand that the position is about community engagement and involvement. A person may have a lot of experience but could express some reluctance during questions about home visits. The team uses the answers to determine if the applicant would really be effective in engaging the community.
- Dr. Greene talked about the idea of siloes in different community health programs. There is an unmet need for people who are virally suppressed but are dealing with a lot of comorbid conditions and are trying to navigate a complex health care system. She asked the panelists about what could be done to break down these siloes and whether community health workers could support people with navigating through all the different appointments and medications. Ms. Brazeel said that ASTHO is currently discussing this topic. There is an opportunity to standardize how to recruit the community health worker public health workforce and intentionally cross train them to serve this role. Whether they would be state employees or community-based organization employees depends on each state and region. It is a matter of having the right operational processes in place. Community health workers have challenges as employees in a clinical space, as Ms. Guillory described, in part because patients have complex comorbid conditions. ASTHO sees their role as helping state health agencies cultivate and train the workforce to meet these needs, but it will obviously be a multi-year effort.
- Ms. Seiler added that some of the ways that states are thinking about reimbursing community health workers would allow them to coordinate care for people across both health issues and unmet social needs that are impacting multiple health issues. For

example, one Medicaid managed care plan will have community health workers on staff to serve enrollees across any unmet health or social service need. Another novel Medicaid model reimburses care teams with per member, per month payments to coordinate health and social services for all patients in addition to the pay they receive for clinical care. Those payments could allow or require community health workers to be part of the team to serve as a coordinating role across health conditions.

- Mr. Fitzsimmons said that Ryan White programs have always had a culture of providing support services and activities that are not directly linked to clinical care, but the issue is whether there is funding for other conditions. He talked about a state innovation model in Maryland in which providers would pay a monthly fee to fund things that did not have widespread reimbursement mechanisms, such as community health workers.
- Ms. Brazeel agreed that it is critical at the federal level to ensure there is sustainable reimbursement for community health workers. However, ASTHO emphasizes the need to shore up state health agencies with more flexible funding streams, similar to that which came out of CDC for infrastructure and workforce, to allow states to hire individuals and train them in cross-cutting ways. The Medicaid component is critical, in tandem with a continued examination of grant funding.
- Dr. Dionne commented that it is much easier to provide HIV knowledge through a tool such as the National HIV Curriculum than it is to teach someone who knows a lot about HIV but does not want to be in the community.
- Ms. Parkinson suggested that the lived experience component will resonate with people with HIV 100 percent of the time. It would be helpful to be intentional with job application language to reach trans women, Black women, cisgender women, and non-conforming and non-binary individuals so that there can be someone from the community to resonate authentically to those identities.
- Dr. Anderson said that a lot of community health workers want to have a pathway to gain greater skills for promotion. She asked the panelists about their experience or thoughts on this. Ms. Guillory answered that her team had considered having a Lead Community Health Worker position. Some positions require a specific degree or level of education based on grant language. Most community health workers have a high school diploma or GED. Having a Lead Community Health Care Worker position would not require advanced education but rather experience. It would allow them to develop their skill set or move to a different team. People with significant experience are people who should be rewarded and retained.
- Dr. Anderson asked the panelists what one wish they would have to better integrate community health workers into the health care workforce. Mr. Fitzsimmons answered that the ability to bill and have a reimbursement mechanism is the most frequent wish. Revenue is generated in other places and currently community health care workers are viewed as an expense. The money has to come from somewhere. If there was a way to bill for the services, then program managers could sell it to leadership. Ms. Seiler added that having a coverage approach that extends beyond a fee-for-service billing and would support community health workers who are situated in community settings would ensure they are not left out of the system. Ms. Spencer agreed and said that BHW is training a workforce of 13,000 community health workers, but there is a need to sustain them after the grant funding ends. Ms. Brazeel agreed that both Medicaid reimbursement and current grant and funding mechanisms need attention as core components of sustaining the workforce.

- Dr. Dionne suggested that extending the reach of disease intervention specialists with community health workers in the midst of the STI epidemic should be a recommendation that moves forward.
- Mr. Riester reiterated Mr. Misrok's public comment on the need for employment opportunities. He also commended the new BHW training program as critical for the post-COVID-19 workforce shift.
- Dr. Anderson asked Ms. Spencer if it was time to develop a national community health worker training program. Ms. Spencer said that BHW is trying to go in this direction and that it is necessary, but that it will have to be done with small steps. There could be a standardized core curriculum of components that every community health worker should know. But there are many different factors involved. For instance, some states have reimbursement and others do not, and this could change standards. The field is not yet on the same page for what community health workers can and cannot do. Ms. Guillory agreed that there should be fundamental baseline training for all community health workers on the functions they need to perform. Mr. Fitzsimmons highlighted an implementation guide project that he worked on that included what an agency would need to start a program, as well as curriculum for both the community health worker and the frontline supervisor. He mentioned the Core Consensus Project at C3.org that provides an agreed upon list of community health worker skills and competencies. Ms. Seiler cautioned that every state community health worker certification program currently in place is voluntary. There is a strong sentiment that certification should remain voluntary so as not to create a barrier for entry. There could be level setting in terms of a national curriculum, but perhaps tied to Medicaid reimbursement. Otherwise, there could be an exclusion of very effective people from the field.

Business Session Part 3
Member Discussion, and Suggestions for Future Agenda Items

Dr. Anderson said that there were three items for CHAC members to address. The first was a request from the Self-Testing and Self-Collection Workgroup.

- Dr. Dionne provided more detail about the request, which aims to extend the time to focus on self-testing outside of the clinical care setting for STI, specifically chlamydia, gonorrhea, and syphilis, with the expectation of a letter to the HHS Secretary with recommendations to improve access and reduce barriers from FDA requirements to improve testing rates.

CHAC Action
Dr. Jodie Dionne called for a motion to approve the request to extend time to the Self-Testing and Self-Collection Workgroup to focus on STIs. CHAC members unanimously approved the request with no changes or further discussion.

Dr. Anderson said that the second item for CHAC review was the request from Dr. Mermin for feedback and advice on the CDC response to mpox. She reviewed four draft recommendations:

1. CDC and HRSA should host listening sessions or focus groups with a community of MSM, LGBTQ, and persons with HIV to discuss communication issues and public-facing messages with the current mpox outbreak.

2. CDC and HRSA should develop an equity plan to proactively address issues related to both current and future epidemics/pandemics to include non-stigmatizing communication and attention to risk perception; inclusion of affected communities in developing a response; and access barriers to care and treatment/vaccines, including maldistribution. CDC should encourage state and local jurisdictions to develop or adopt similar equity plans, recognizing that mpox and other emerging infections disproportionately affect populations with the greatest disparities in access and outcomes.
3. CDC should use epidemiological data to identify emerging populations affected or at-risk and strategically use these data to give a full picture of the epidemic and to determine where communication strategies and vaccine delivery will have the greatest impact, as well as to develop innovative strategies to accomplish this.
4. Recognizing that vaccine allocation and distribution are limited, CDC should continue to leverage its efforts and influence to encourage vaccine manufacturers to ramp up production to the extent possible.

- Dr. Markham talked about using lessons learned from the COVID-19 pandemic during the rapid development and testing of vaccines to ensure that diverse populations, as well as pregnant women, are included in clinical trials to the extent possible. Dr. Anderson suggested that this could be added to the equity recommendation. Dr. Greene added that it should be extended to clinical trials for treatment.
- Ms. Morne suggested the addition of a recommendation calling for appropriate resource allocation to address mpox.
- Dr. Dionne added that there will be future pandemics and that the recommendation might be to have a separate allocation that is just for pandemics.
- Dr. Cheever clarified that CHAC provides recommendations to the HHS Secretary, but that Congress is responsible for allocation of funds. The recommendation might be for the Secretary to utilize existing funding in that direction.
- Dr. Markham suggested adding language for the rapid development of community health worker training to be on the frontline response to emerging diseases and infections.

The additional recommendations discussed were:

5. Recommend that the HHS Secretary request new emergency funding to support additional flexibility in emergency pandemic funding, earmarked to develop an effective and efficient public health response that would not divert from currently funded public health programs.
6. Recommend that the HHS Secretary allocate funding for the development and implementation of community health worker training related to emerging diseases and infections.

CHAC Action

Dr. Greene called for a motion to approve the recommendations to CDC on their response to mpox. CHAC members unanimously approved the recommendations with the amendment of the language and two additional recommendations that were discussed.

Dr. Anderson said that the third request for CHAC was to review the workforce recommendations. There is a wide range of issues related to workforce and there is a need to ensure that the recommendations fall under the purview of CDC and HRSA. She reviewed three options for reviewing the recommendations: 1) continue the Workgroup, but narrow its topics,

scope, and deliverables to what can be addressed in the April 2023 meeting. 2) develop a joint letter with PACHA and recommend a standing committee for workforce issues, and 3) make a CHAC resolution to recommend that CDC and HRSA continue to explore workforce development with HBCUs or other organizations.

- Dr. Stewart said that a joint letter with PACHA would amplify the need to address workforce and that her colleagues at PACHA would agree to it.
- Dr. Dionne endorsed the idea of continuing the Workgroup but with more focus. It can take a lot of discussion to develop concrete recommendations, but CHAC members have the expertise to build meaningful ideas.
- Dr. Greene agreed there is a need to continue the Workforce Workgroup, but that it is such a large issue that there may be a need to have subgroups. The solution might be to both continue the Workgroup and develop a letter with PACHA.
- Ms. Parkinson asked what the time constraints would be for the three options. Dr. Anderson answered that the joint letter with PACHA could be resolved immediately. The Workgroup continuation would need a limit for its scope with the expectation that there would be a deliverable by the April 2023 meeting. The joint letter with PACHA could also be developed by then.
- Dr. Stewart agreed that both the letter with PACHA and the continuation of the Workgroup should go forward.

Recap and Meeting Summary

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.

<Name>, Co-Chair CDC/HRSA Advisory Committee on HIV, Viral Hepatitis, and STD Prevention and Treatment	Date

<Name>, 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 (Chair)
Dr. Travis Gayles (Chair)
Dr. Wendy Armstrong
Dr. Jodie Dionne
Mr. Daniel Driffin
Dr. Meredith Greene
Mr. Kali Lindsey
Dr. Christine Markham
Dr. Shruti Mehta
Dr. Johanne Morne
Ms. Kneeshe Parkinson
Mr. Robert Riester
Mr. Leandro Rodriquez
Dr. Samuel So
Mr. Venton Hill-Jones
Ms. Gloria Searson

CHAC Members Absent

Dr. Shannon Dowler
Dr. Vincent Guilamo Ramos

CHAC Ex-Officio Members Present

Dr. Pradip N. Akolkar
US Food and Drug Administration

Dr. Neeraj Gandotra
Substance Abuse and Mental Health Services Administration

Dr. Maureen Goodenow
National Institutes of Health

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

Mr. Richard Haverkate
Indian Health Service

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

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

CHAC *Ex-Officio* Members Absent

No *Ex-Officio* members were absent.

CHAC Liaison Representative

Dr. Ada Stewart
Presidential Advisory Council on HIV/AIDS

CHAC Designated Federal Officers

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

CAPT Deron Cornell Burton
Centers for Disease Control and Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention

Federal Agency Attendees

Dr. Theresa Jumento
Senior Advisor
HIV/AIDS Bureau
Division of Policy and Data

Ms. Marah Condit
Public Health Analyst
Centers for Disease Control and Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention

Ms. Lauren Barna
Public Health Analyst
Centers for Disease Control and Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention

Ms. Rebeccann Pope Alley
Public Health Analyst
Centers for Disease Control and Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention

Public Attendees
Mr. Mark Misrok
US People Living with HIV Caucus
National Working Positive Coalition

Mr. Richard MacKinnon
Music City PrEP Clinic

Me. Mariah Wilberg
US Strategy & Ending the Epidemic

Attachment B: List of Acronyms

AETC	AIDS Education & Training Centers
AHRQ	Agency for Healthcare Research and Quality
ACOG	American College of Obstetricians and Gynecologists
ASTHO	Association of State and Territorial Health Officials
BHW	Bureau of Health Workforce
BPHC	Bureau of Primary Health Care
CATCH	Changing Actions to Change Habits (Court)
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
CSELS	Center for Surveillance, Epidemiology, and Laboratory Services
CSP	Clinician Scholars Program
DASH	Division of Adolescent and School Health
DHP	Division of HIV Prevention
DSTP	Division of STD Prevention
DTBE	Division of Tuberculosis Elimination
DVH	Division of Viral Hepatitis
EHE	Ending the HIV Epidemic
FACA	Federal Advisory Committee Act
FDA	Food and Drug Administration
HAB	HIV/AIDS Bureau
HBCU	Historically Black Colleges and Universities
HRSA	Health Resources and Services Administration
HHS	Department of Health and Human Services
HOPWA	Housing Opportunities for Persons with AIDS
HUD	Housing and Urban Development
IDEA	Infectious Diseases Education and Assessment (University of Washington)
IHS	Indian Health Service
JYNNEOS	Smallpox/mpox vaccine
LGTBQI	Lesbian, Gay, Bisexual, Transgender/Transsexual, Queer/Questioning, Intersex
MAETC	Midwest AIDS Education & Training Center
Mpox	Monkeypox
MSM	Men who have sex with men
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases (STDs), and Tuberculosis (TB) Prevention
NHSC	National Health Service Corps
NIH	National Institutes of Health
OIDP	Office of Infectious Disease and HIV/AIDS Policy
PACHA	Presidential Advisory on HIV/AIDS
PrEP	Pre-exposure prophylaxis
SAMHSA	Substance Abuse and Mental Health Services Administration
STOMP	Study of tecovirimat for human monkeypox virus (NIH)
STEAM	Science, technology, engineering, arts and mathematic
U=U	Undetectable=Untransmittable

Attachment C: Public Comments

Northeast Caribbean AIDS Education and Training Center, Francine Cournos, M.D.

This is Francine Cournos, M.D. I'm writing in my role as Co-Principal Investigator of the Northeast Caribbean AIDS Education and Training Center (NECA AETC). I listened to the November 2 presentation and panel discussion of the AETC programs at the Fall 2022 CHAC meeting. I'm writing to help clarify the full range of Regional AETCs activities.

I think it's important to know that our regional AETC (the NECA AETC) trains all health care providers, not just those with advanced professional degrees. The workforce has changed dramatically, and we reach out to the entire care system and team, including, for example, receptionists, peers, community health workers, patient navigators, social workers, etc. We know that every health care worker in every role matters.

Our regional AETC does in fact provide extensive training about managing mental illness and substance use among people with or at risk of HIV. We teach about harm reduction and do our best to address the social determinants of health of vulnerable populations. Our agility to do this work allowed us, for example, to mount immediate extensive training efforts in response the distress of HIV care providers and their patients during the COVID-19 pandemic.
One of the panelists asked: "If you build it, will they come?" Regional AETCs reach out to local providers to ensure that yes, they will come. We are powerful implementers at the local level. We see "the elephant in the room", and we try to help programs find the best possible workarounds.

I was impressed that your panelists were very aware of just how much work is involved in implementation and just how many barriers can get in the way. I want to make sure CHAC knows how much Regional AETCs strive to improve what happens on the ground.

Francine Cournos, M.D.
Professor of Clinical Psychiatry, Columbia University
Co-Principal Investigator, Northeast Caribbean AETC
fc15@cumc.columbia.edu
Cell: 917-232-8902

Northeast/Caribbean AIDS Education & Training Center, Daria Boccher-Lattimore, DrPH MPH

I appreciate the opportunity to provide a written comment to CHAC. I was unable to attend the final day when there was an opportunity for oral public comment.

My colleagues presented on some of the specific programs within the larger AETC program. In light of the questions and workforce concerns expressed by the CHAC members, I wanted to expand on the role the Regional AETCs play in addressing those concerns. I am the Director and PI of the Northeast/Caribbean AETC.

The successes of the Regional AETC program can be, at least in part, attributed to its unique infrastructure, bringing leading experts across the country to community providers, health profession schools and HIV and primary care settings. Each Regional AETC partners with regional performance sites who have expertise in HIV, as well as HIV comorbidities, social determinants of health and knowledge of the local communities they serve. We partner with leading academic medical centers, peer networks, HSIs, HBCU, departments of health, professional associations/organizations, implementation science researchers, and other federally funded training centers. Our work includes translating the latest in scientific advances in HV prevention, treatment and care, as well as that which impacts the HIV care continuum, morbidity, mortality and quality of life into care, which includes those concerns raised by the CHAC membership --behavioral health, stigma and aging, to name a few. While we work with health profession schools to integrate HIV into their curriculum to address pipeline issues, there is a large and continuous need for ongoing training and support of the existing workforce and health care settings due to everchanging clinical and behavioral science, challenges in HIV management, emerging best practices, turnover, etc.

Because of the unique infrastructure of the program, a presence in our communities and access to diverse expertise, we are able to identify needs of the HIV workforce and care settings as they evolve and rapidly mobilize to address them. Such was evident in our robust responses to both COVID 19 and MPox. In the Northeast/Caribbean region alone we conducted 225 training and technical assistance programs reaching 8,506 participants between March 1, 2020, and March 30, 2022, addressing COVID-19 diagnosis, testing, treatment, vaccines, behavioral health and workforce challenges, health care disparities and best practices in telehealth.

This role of the AETCs as disseminators and implementers has been recognized by others and called upon time and time again. Such as in our partnerships with the following to aide them in their TA and/or program implementation: SAMHSA's Opioid Response TA Network; CDC's CBA for HIV Prevention program and Prevention Training Centers; HRSA HABs national TA centers, e.g., TAP-IN, Midwest Integration of the National HIV Curriculum program, and SPNs programs; NIMH's AIDS Research Centers, NIH's CFARs. They have reached out to us for collaboration due to our presence and reach in highly impacted communities and the recognition that national programs need to be implemented locally.

The members of CHAC also expressed interest in training and support for the non-clinical workforce. The AETC program no longer focuses solely on clinical providers. We train nonclinical providers in a variety of formats, by training the health care team as a whole but also by working directly with our Departments of Health on specific programs for case managers, community health workers, etc. In addition, we work to ensure the peer perspective is integrated into our trainings.

Finally, I did want to reiterate that the AETC program trains on all four pillars of EHE. I particularly want to highlight for CHAC the work we are doing on PrEP. Our training and TA include training providers on the science behind PrEP and on implementation and outreach best practices. As the larger community is discussing national PrEP initiatives it is important to recognize the workforce needed to implement any national PrEP program. The AETCs are in a unique position to assist in that. There is a history of partnership of the AETCs with CDC, as we have in the past successfully collaborated and received CDC funding to assist in the dissemination and implementation of HIV testing guidelines. The workforce needs to be in the forefront of any national PrEP program.

Thank you for the opportunity to comment.

Daria Boccher-Lattimore, DrPH MPH
Director and Principal Investigator
Northeast/Caribbean AIDS Education & Training Center
Associate Professor of Sociomedical Sciences (in Psychiatry) at Columbia University Medial Center
President, National Alliance for HIV Education and Workforce Development

Kentucky Primary Care Association, Chera Mattox

I want to thank you for this opportunity to attend the meeting today. I apologize for contacting you in this manner but like many of us, I was multi-tasking during the sessions and missed my opportunity to ask a question. I am in KY, and we are a priority state. I was wondering if there are any conversations on the federal level regarding starting treatment within the local jails for HCV/HIV/MOUD? In KY we have the barrier of not being allowed to test because treatment isn't allowable. The same with home testing. It is a wonderful tool, but it is not allowed in my state. I managed a region of SSPs and when I spoke to administrators and wrote my state representatives about individual's rights being violated under the ADA for not being able to continue Suboxone while in custody, it was met with silence. Often, people who previously were linked to care would get out and start injecting substances leading to overdose deaths. I am hopeful that these conversations have been initiated as we are looking at the syndemics that we are experiencing and actively developing programing to improve SDoH that people experience.

Thank you in advance for your response. Enjoy your day.

Chera H. Mattox, MPH
Kentucky Primary Care Association
Supported by funding from Gilead Sciences, Inc.
Program Manager
EHE Initiative
651 Comanche Trail
Frankfort, KY 40601

Undetectable = Untransmittable (U=U), Mariah Wilberg

Transcript of oral public comments at the November 3, 2022, CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHACHSPT) meeting

Thank you for the opportunity to speak. I will start by celebrating recent progress. This year, our federal government has started using clear, plain language to describe U=U across federal agencies and affirmed national support for U=U.

I'm here today to respectfully that CHAC helps continue this momentum by advocating for the following.

Meaningfully include U=U in future notice of funding opportunities developed by HRSA and CDC, including prevention, EHE, RWHAP, and the AETCs.

This inclusion should not be limited to U=U as a primary prevention method. U=U awareness has been shown to increase HIV testing uptake and reduce internal and perceived stigma.

It is also related to better quality of life and health outcomes, particularly improved mental health and viral suppression, among others.

Therefore, U=U should be included not only in testing and early identification of status, but also in care linkage and engagement and treatment adherence support.

Research shows stronger relationships with improved outcomes when U=U is discussed in clinical settings; the AETCs can play a critical role in supporting providers to have these conversations.

We also ask that the HIV/AIDS Bureau issue a new “Dear Colleague” letter and also share it with colleagues in the Bureau of Primary Health Care for dissemination.

The most recent letter from 2018 uses language that has since been phased out and urges education only to people living with HIV, which doesn’t capture the larger role U=U can play in stigma reduction and early identification of status, for example.

It also refers only to treatment as prevention. The positive outcomes I have described are related specifically to the concept of U=U, so I therefore ask that U=U be specifically referenced in the NOFOs, Dear Colleague letter and in applicable planned future policy clarifications.

We also ask that CDC and HRSA ensure that the workforce is supported by providing adequate capacity building and technical assistance specifically related to U=U.

Implementing these recommendations can reduce stigma, mitigate existing knowledge inequities, and improve lives while making progress towards the goals of the national HIV strategy and Ending the Epidemic initiative.

We are here to support these efforts and are eager to provide feedback on draft language or provide suggested draft language upon request. Thank you for your time and your service.

Delivered by:

Mariah Wilberg
Senior Director, U.S. Strategy & Ending the Epidemic
Undetectable = Untransmittable (U=U) in the U.S.
In case you missed it: Prevention Access Campaign Evolves into Separate Global and U.S. Organizations

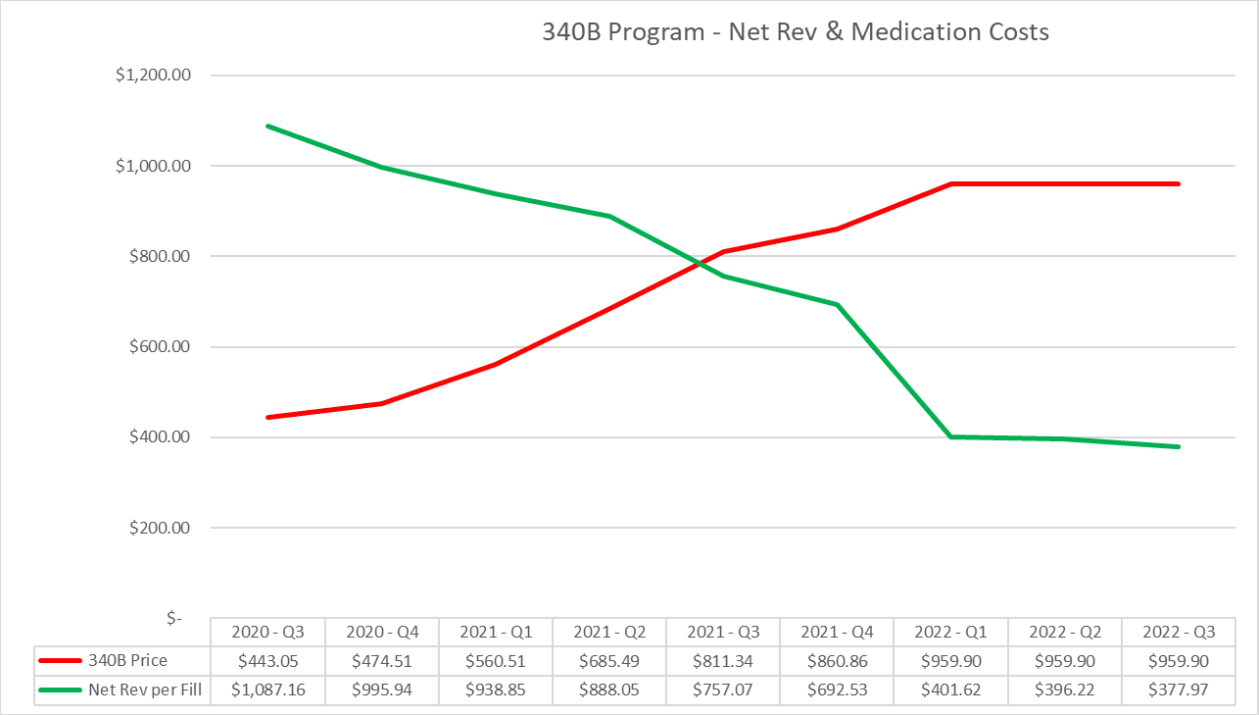
Nashville/Davidson County Local Response Plan

Last updated 10/24/22 2:27pm CT

Problem

Gilead's unilateral decision to modify its payment assistance program for uninsured patients diverted 340b revenue back to Gilead and away from 340b STD clinics. Many of these clinics are non-profit or government-based entities and depend on this revenue to provide service to uninsured patients. Mission dictates that these clinics serve a significant number of uninsured patients since they tend to be disproportionately affected by HIV. The Music City PrEP Clinic

MCPC's expected revenue. By effectively reducing the net revenue per fill by 50%, it required MCPC to provide services to all of its patients with just half the planned budget if it continued to serve uninsured patients at the same proportion.



	2020 - Q3	2020 - Q4	2021 - Q1	2021 - Q2	2021 - Q3	2021 - Q4	2022 - Q1	2022 - Q2	2022 - Q3
340B Price	$443.05	$474.51	$560.51	$685.49	$811.34	$860.86	$959.90	$959.90	$959.90
Net Rev per Fill	$1,087.16	$995.94	$938.85	$888.05	$757.07	$692.53	$401.62	$396.22	$377.97

Source: MCPC

This devastating budgetary blow is compounded by Gilead unilaterally regularly increasing the price that 340b clinics must pay for Descovy Finally, the situation is further compounded by insurance companies unilaterally disallowing the coverage of Descovy, instead pushing generic PrEP. This convergence of unregulated profit-seeking is crippling the concept of using the 340b Drug Pricing Program as a funding source for the national HIV prevention strategy.

National Crisis

It is expected that the crippling of the 340b model will result in the cessation of HIV prevention services nationwide as 340b entities struggle to operate in a downward spiral of escalating costs and decreased revenue while Gilead reaps record profits from PrEP.

"'This will shut us down': HIV prevention clinics brace for Gilead reimbursement cuts: HIV Prevention Clinics Brace for Gilead Reimbursement Cuts" (*Benjamin Ryan, NBC News, 7/7/21*)

> *"An expected funding loss of at least $100 million annually will soon drain .front-line clinics, threatening the federal government's pledge to end the HIV/AIDS epidemic by 2030." (NBC News analysis)*

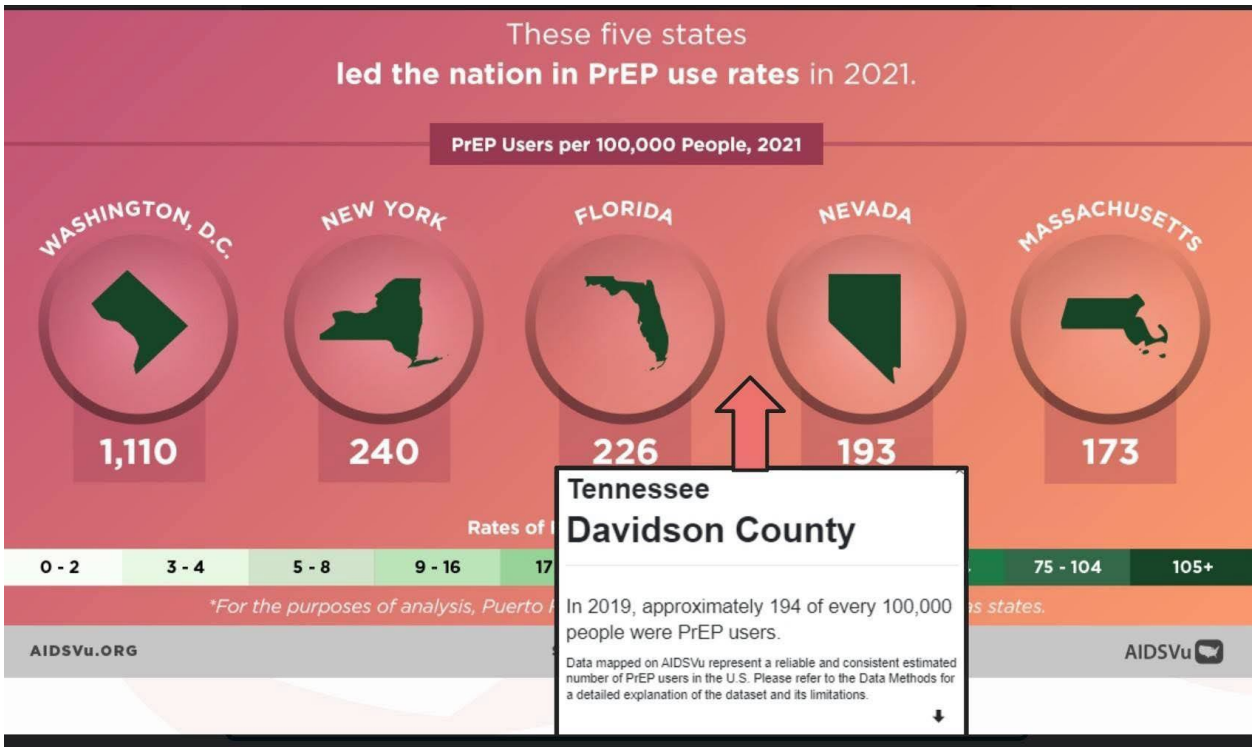
- **Fear of retaliation:** NBC News asked nearly 120 HIV prevention-focused 340B clinics for their PrEP-patient figures. "The vast majority were unresponsive or refused to share their data. Many said they were wary of alienating Gilead, given the clinics' further dependency on charitable grants from the company, which is the dominant manufacturer of HIV-treatment pharmaceuticals."
- "An expected funding loss of at least $100 million annually will soon drain front-line clinics, threatening the federal government's pledge to end the HIV/AIDS epidemic by 2030."
- **Memphis:** During an April 8 call between HIV advocates and Gilead to discuss the impending financial changes, Eric Leue, vice president of prevention services at the HIV-prevention clinic Friends for Life in Memphis, Tennessee, was clearly distraught as he pleaded with company representatives to reconsider their change in policy. Noting that Memphis has one of the nation's highest HIV diagnosis rates, Leue said, Gilead's "unconscionable" impending reimbursement cut will force his clinic to close, and that overall, it "will set this county and our population back by at least another decade."
- **Alabama:** "This will shut us down," said Christon-Walker, of how Gilead's policy change will affect AIDS Alabama's PrEP clinic. Losing the funds, he said, will "destroy our program and totally inhibit our ability to see uninsured clients, which make up the bulk of our business."
- **Chicago:** "It's going to put a lot of our programs in serious harm's way at best," Jim Pickett, senior director of prevention advocacy and gay men's health at AIDS Foundation Chicago said. "Some of them will be decimated and destroyed."
- **Austin/San Antonio:** "HIV has a disproportionate impact on Black and brown communities, especially here in Texas. I really fear that we will have more Black and Latinx people acquiring HIV if other funding sources aren't in place," Christopher Hamilton, CEO of Texas Health Action, an HIV- and LGBTQ-focused nonprofit health care provider, said as he echoed a concern shared among his colleagues across the country.

Local Crisis

MCPC had projected in March 2022 that it would be experiencing cash flow issues by June 2023. It adopted a “sinking Titanic " strategy to mitigate and prolong the inevitable capsizing of Tennessee’s largest PrEP clinic and one of the titans in the national fleet of super large, successful HIV prevention programs. At $50MM in revenues, 15,000 patients growing at a rate of 500-600 per month, it was indeed a sinking ship because of a structural flaw in the funding design of the national HIV prevention strategy--the lack of sufficient federal oversight and regulation of Gilead and the insurance carriers whose collaboration is necessary for the strategy to be buoyant. With Gilead and the carriers acting in their self-interest and no watchdog to supervise the crippling effects of their unilateral moves, the 340b funding strategy is doomed to fail.

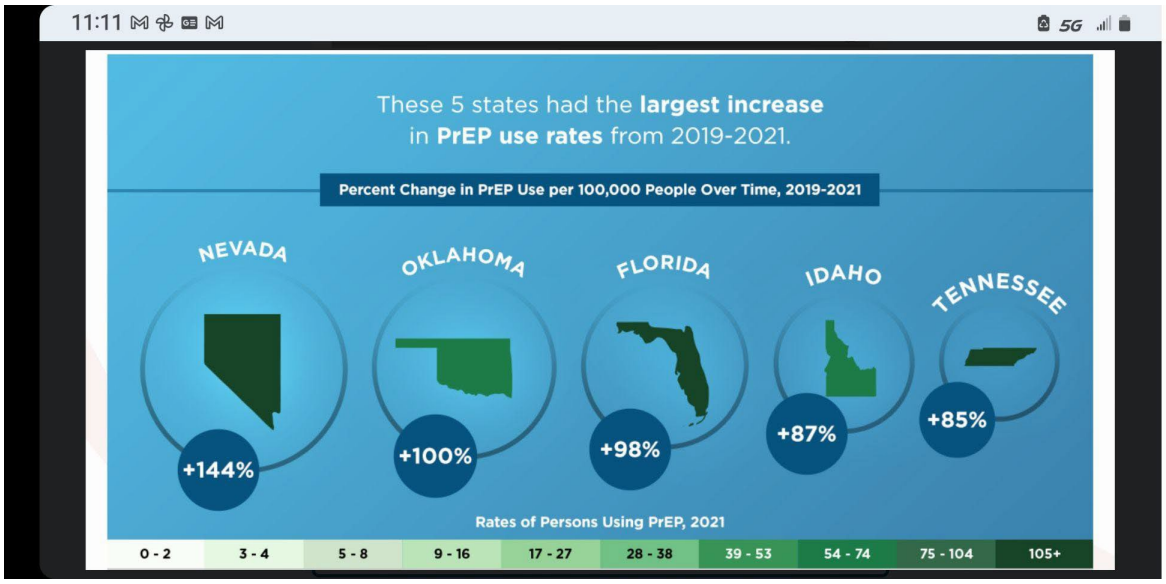
While it was not possible for MCPC to prevent itself from sinking indefinitely, its strategy was intended to keep it afloat for as long as possible, buying time for the federal government to receive its S.O.S. and send out a rescue party. As of now, the call for help has been heard, but no immediate rescue plan is in place to save MCPC or the rest of the clinics still treading water. Unfortunately, Gilead’s continued unilateral price hikes paired with insurance companies refusing to cover Descovy has increased at a rate beyond the doomsday predictions of MCPC, and the clinic is now projecting cash flow issues in January 2023, not June.

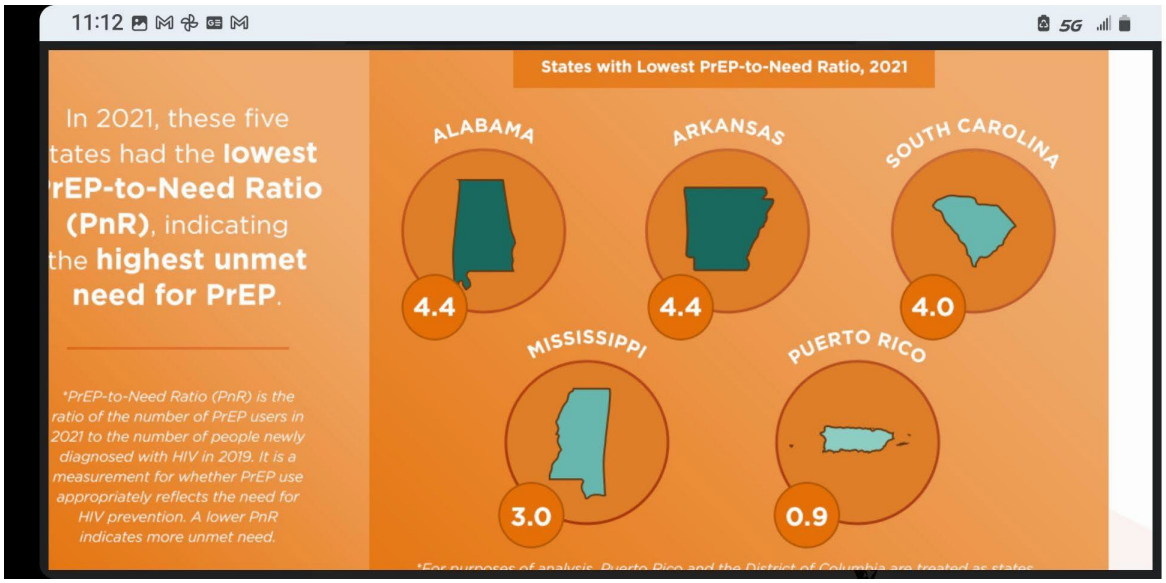
What’s at risk for Nashville/Davidson County and Tennessee?



Source: SEATC

MCPC played a significant role in Tennessee's meteoric rise from the bottom tier of the country to the Top 5 states leading the nation in PrEP use rates in 2021. It's worthwhile noting that it is not the state of Tennessee that actually appears in the #4 spot, but Nashville/Davidson County punching above its weight as if it were a state in its own right--besting the states of Nevada and Massachusetts in the Top 5 and the other 48 states ranked below them. As nearly a third of new HIV infections in TN are diagnosed in Davidson County, this feat clearly has substantial impacts in reducing new infections in the state. Where the state of Tennessee does appear is in the Top 5 rankings of most improved--again powered by MCPC.





Source: SEATC

MCPC's specific mission to end the HIV epidemic in Nashville and middle Tennessee enabled it to focus its passion and 340b-derived resources in a way that no other organizations, with

broader missions, in the city, county, and state could match. Indeed, Nashville became a health care destination for out-of-state patients seeking PrEP, most of them driving in from neighboring Kentucky. Note that four of the states in the Bottom 5 are members of Tennessee's neighborhood and present a clearer picture of where Tennessee and its regional partners were before MCPC's push to end the HIV epidemic. Without a concerted effort to address this local crisis, the State of Tennessee will lose its newly gained and hard-fought leadership position purchased with a significant investment in the health of its residents. The consequence of this loss is dire, as a return to the bottom will be measured in the uptick of HIV cases that had been prevented as a result of the overwhelmingly successful execution of the national HIV prevention strategy within its borders. Furthermore, the price to treat the newly diagnosed (and preventable) HIV cases will exceed the costs to prevent them, and will pale in comparison to the cost in terms of dollars and quality of life years lost to treat the complications arising from the inevitable new undiagnosed HIV cases. Given that new infections occur most frequently in young adults (ages 25-34) in TN, and the frequency of new infections among those ages 15-24 is close behind (and growing), the cost to treat spans many decades and the potential for quality-of-life years lost is massive (cit: tn.gov).

Analysis: Cost to Prevent versus Cost to Treat

"The lifetime treatment cost of an HIV infection can be used as a conservative threshold value for the cost of averting one infection. Currently, the lifetime treatment cost of an HIV infection is estimated at $379,668 (in 2010 dollars)." (CDC, "HIV Cost-Effectiveness"). Adjusted for 2022 dollars, the cost is $516,349.

The 2019 State of TN Surveillance Report noted that in 2018, there were 156 newly diagnosed cases of HIV in Nashville/Davidson county and 147 and 134 in the years before. Based on these 3 years alone, the community responsibility to provide care for 437 HIV patients for the rest of their lives is $225,644,513 in 2020 dollars. It must be remembered that the HIV prevention strategy is designed to reduce or eliminate new cases of HIV. Without an adequately funded strategy, the number of new cases each year, and the associated lifetime costs, will increase. While these costs alone are breathtaking, they fail to fully capture the impact on the quality of life for the affected patients, and certainly don't include the costs in dollars and suffering of patients who are undiagnosed, untreated, and suffering from diseases and complications arising from HIV cases developing into AIDS.

The CDC recognizes that testing and prevention saves lives, improves quality of life, and saves money (CDC, "CDC's HIV Works Saves Lives and Money"; CDC, "High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States"; Flackman, B.R., Fleishman, J.A., Su, A.E., et. al. "The Lifetime Medical Cost Savings from Preventing HIV in the United States", CDC, "Evolution of HIV/AIDS Prevention Programs--United States, 1981-2006")

MCPC's success in Nashville/Davidson County can be quantified by calculating the number of HIV cases averted through its efforts to educate, inform, and treat. Using the methodology described in "Estimated Impact of Targeted Pre-Exposure Prophylaxis: Strategies for Men Who

Have Sex with Men in the United States" (Elion, RA, Kabir, M,2, Kenneth H. Mayer, KH, et. al., Int J Environ Res Public Health. 2019 May; 16(9): 1592), we are able to combine treatment data from MCPC with the "number needed to treat" to determine how many cases of HIV, and the associated costs for HIV treatment, were averted.

Source: SEATC

Treated with PrEP by MCPC 2018-Present				
MSM-10+	BMSM-10+	YBMSM-10+	HMSM-10+	YHMSM-10+
6235	985	342	776	331

HIV Cases Averted by MCPC 2018-Present				
MSM-10+	BMSM-10+	YBMSM-10+	HMSM-10+	YHMSM-10+
89.07	29.85	34.2	12.32	9.46

HIV Treatment Costs Averted by MCPC
$45,991,205.43

Solution Paths

Definitions:

NASTAD: A leading non-partisan non-profit association that represents public health officials who administer HIV and hepatitis programs in the U.S. We work to advance the health and dignity of people living with and impacted by HIV/AIDS, viral hepatitis, and intersecting epidemics by strengthening governmental public health through advocacy, capacity building, and social justice.

CHAC: The purpose of the CHAC is to advise the Secretary, HHS; the Director, CDC; and the Administrator, HRSA, regarding objectives, strategies, policies, and priorities for HIV, viral hepatitis, and other STDs. During the November meeting, CHAC members will discuss issues related to HIV and workforce including non-traditional partnerships to address out of care people with HIV, what's next for the AIDS Education and Training Center (AETC) program, integrating innovative programs to address HIV workforce challenges into the Ryan White HIV/AIDS Program, and how to more effectively use community health workers and disease intervention specialists in HIV and STI prevention, care, and treatment.

SEATC: The Southeast AIDS Education and Training Center (SE AETC) is one of eight regional AETCs across the country. Encompassing Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee, the SE AETC offers comprehensive, collaborative educational opportunities designed to increase the size and strength of the HIV clinical workforce, improve outcomes along the HIV Care Continuum, and reduce the number of new HIV infections. This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30535, AIDS Education and Training Centers Program.

Fast Track Cities: The Fast-Track Cities initiative is a global partnership between cities and municipalities around the world and four core partners – the International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat), and the City of Paris.

Mayors and other city/municipal officials designate their cities as Fast-Track Cities by signing the Paris Declaration on Fast-Track Cities, which outlines a set of commitments to achieve the initiative's objectives. Initially heavily focused on the 90-90-90 targets, the Paris Declaration was recently updated to establish attainment of the three 90 targets as the starting point on a trajectory towards getting to zero new HIV infections and zero AIDS-related deaths. Click here to access the Paris Declaration 4.0

Grounded in the principle of data transparency, the initiative includes a Fast-Track Cities Global Web Portal that allows cities to report on their progress against the fast-track and other targets.

As the initiative's primary technical partner, IAPAC supports Fast-Track Cities with: technical assistance to local health departments on data generation, monitoring, and reporting. implementation planning among key local stakeholders, capacity-building support for clinical and service providers, community-based organizations, and affected communities. eliminating HIV-related stigma in healthcare settings and assessing quality of life among communities of people living with HIV.

Nashville became a Fast Track-City in 2022.

Clare Bolds (SEATC) writes:
I did mention the 340B concerns to our Fast Track Cities rep since he has a broader perspective on how this is playing out nationally, and this is what he said:

Without a change or update from Gilead, there will have to be something to advocate for a at other levels like a city/county fund (Tampa/Hillsborough County has developed a fund to provide health insurance coverage for individuals who need it, more than happy to make a connection for how they set it up), or at the state or federal level! This coming year we do plan on a White House meeting to discuss directly with HHS administrators about necessary changes needed to update the national HIV response, but for Nashville it seems leveraging Tennessee would be the key.

Three Identified Solution Paths
1. Change from Gilead
2. Fund for health care coverage or uninsured financial assistance at city/county/state level
3. Change at HHS

Local Response Plan
Create a team to pursue each of the three identified solution paths. Each team should have working volunteer members committed to working the problem and delivering a solution. Each team should be

supported by a group of advisors who can facilitate networking and the recruitment of additional working volunteers.

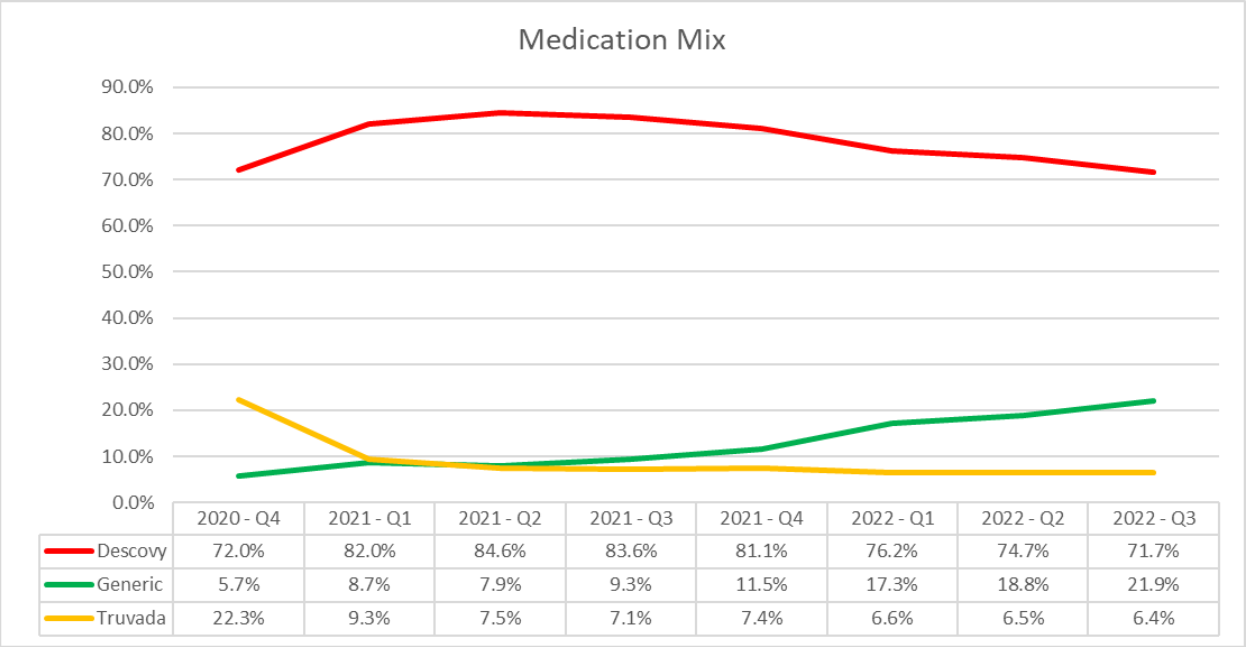
Solution Path 1: Change at Gilead

Team members: Rich MacKinnon, Exec. Dir, MCPC
Advisors: Lauren Gaffney, Bass, Berry & Sims

10/2122 Rich: Dwight Watson is under the impression that Gilead is not increasing Descovy and Truvada prices monthly. He suspects it may be McKesson. Rich invited Dwight to view the price increase chart in the LRP. He sent an invite to Jerry Purcell, Founder of Avita Pharmacy. Avita is the MCPC's 340b contract pharmacy that processes most of the eligible prescriptions. Avita manages the McKesson relationship on behalf of MCPC.

10/11/22 Rich: Communicated unsustainable price increases to Dwight Watson, Gilead SE Regional Director (404-391-6785 / Dwight.watson@gilead.com). Watson believed that MCPC's Descovy med mix could be much better than 70% and as high as 86%, based on peer performance in Florida. Watson believed that PAs could be more effective. Rich said he would utilize Gilead recommendations to improve PA and appeal success rate. He also noted that any gains from improved med mix would be wiped out by Gilead's continued, unpredictable price increases for Descovy. Rich said that business planning was nearly impossible without any visibility into Gilead's price hikes. Business planning requires predictable costs of goods sold and predictable revenue from the sale. With insurance companies increasingly disallowing coverage of Descovy and Gilead continually raising the price of Descovy, the only knowable business trend is that the 340b PrEP prevention strategy is unsustainable.

It should be noted that MCPC had already reached Gilead's so-called high efficiency rate of 84.6% in 2Q21; however, 1Q22 showed a dramatic increase in denied prior authorizations by insurance companies.



	2020 - Q4	2021 - Q1	2021 - Q2	2021 - Q3	2021 - Q4	2022 - Q1	2022 - Q2	2022 - Q3
Descovy	72.0%	82.0%	84.6%	83.6%	81.1%	76.2%	74.7%	71.7%
Generic	5.7%	8.7%	7.9%	9.3%	11.5%	17.3%	18.8%	21.9%
Truvada	22.3%	9.3%	7.5%	7.1%	7.4%	6.6%	6.5%	6.4%

Source: MCPC

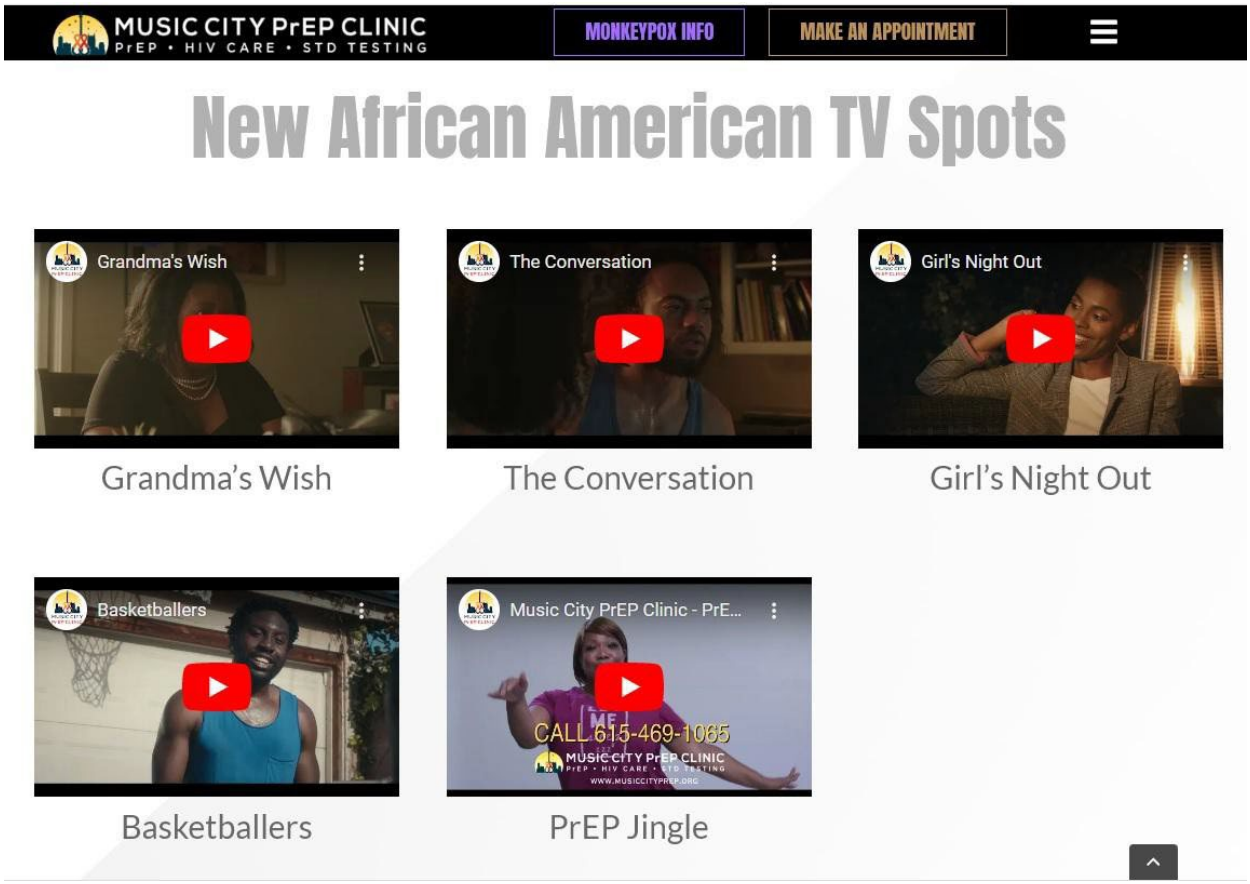
Solution Path 2: Local Fund

Team members: Rich MacKinnon, Exec. Dir, MCPC; Jenny Ford, lobbyist
Advisors: Mark Yancy, CEO, Nashville Health; Dr. Gill Wright, Assoc. Medical Director/Clinical Services, MPHD; Clare Bolds, Program Coordinator, SEATC; Dr. Sean Kelly, Medical Director, Vanderbilt CCC; Lauren Gaffney, Bass, Berry & Sims

Proposed ask: A fund and/or in-kind contributions to provide HIV prevention continuity for uninsured and under-insured patients. Could be administered as a financial assistance program or an in-kind program with a health care partner. Could be modeled after MCPC's need-based program.

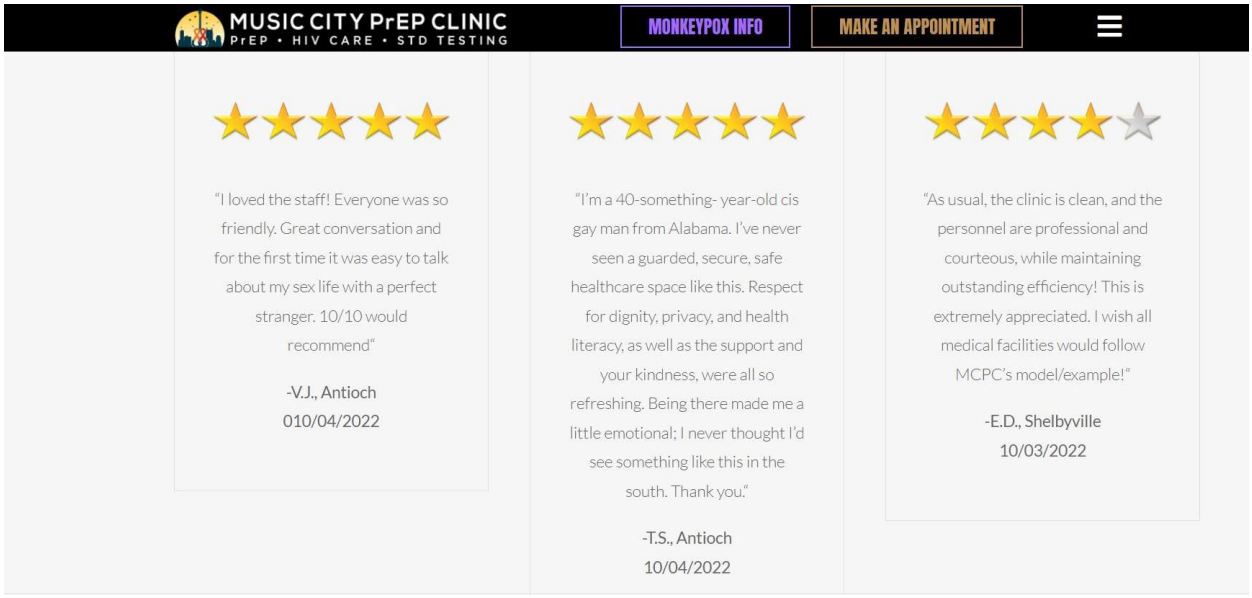
Considerations: (1) Without intervention, MCPC's uninsured patients in the Nashville Metro may seek PrEP care at MPHD. Outside the Metro, they can seek care at TDH. Currently, approximately half of MCPC's PrEP patients are uninsured. This percentage changes throughout the year. (2) The percentage of uninsured patients is highest just before the ACA open enrollment period, and drops significantly just after, then it increases again throughout the year until the next open enrollment period begins. (3) It should be noted that the MCPC financial assistance program includes paying ACA insurance premiums for patients in need. (4) The eventual insolvency of MCPC's HIV prevention program will lead to the cessation of this financial support and an increase in uninsured patients seeking PrEP. (5) While MPHD and TDH operate PrEP programs, they likely are unprepared and under-resourced for the influx of former MCPC patients. (6) If MPHD and TDH seek additional resources to add capacity to their

programs, they could consider applying those resources to the existing capacity at MCPC rather than going the slower route of hiring and training more staff and acquiring additional clinical space--MCPC already has demonstrably trained staff and world-class clinical space. (7) MCPC's extraordinary investment in research-based public outreach has enabled it to grow at 500-600 new patients per month. The patients are responding to messaging in targeted campaigns never before seen in the region. MPHD concurs that the messaging has attracted patients to STI testing and treatment who would not have otherwise participated. The messaging has been so successful with the hard-to-reach Black/African-American community, that 35% of MCPC's new patients identify with this demographic. Many more patients from this community are apparent, but declined to identify. This is, quite frankly, extraordinary. Black persons in the USA comprise 42% of new HIV infections, yet only 14% of PrEP users (cit: aidsvu.org). PrEP use equity is a critical target needed to hit to end the epidemic. At the 2022 AIDS Conference in Montreal, Patrick Sullivan, DVM, PhD said, "HIV prevention programs should be guided by PrEP use equity – the use of PrEP relative to the impact of the HIV epidemic on that group. Today's data shows that we have a long way to go." MCPC's effort to reach communities of color not only moved this needle in Tennessee, it completely rebuilt the compass. To our knowledge, no other large HIV prevention strategy in the USA has achieved such real-life progress in reducing racial/ethnic HIV risk disparities. We are at risk of losing this progress, losing our model deserving of replication across the nation, and losing the ground we have gained in dismantling systemic racism in healthcare in Tennessee.



Source: MCPC (https://www.musiccityprep.org/mcpc_tv/)

(8) MCPCs investment in staff training to create a judgment- and stigma-free, sex-positive health care environment enables it to create unparalleled health care experiences for its patients. The service delivery philosophy created by MCPC called “Great Experiences by Design " often provides patients with the best healthcare experience they’ve experienced of any kind.



Source: MCPC (https://www.musiccityprep.org/reviews/)

"I loved the staff! Everyone was so friendly. Great conversation and for the first time it was easy to talk about my sex life with a perfect stranger. 10/10 would recommend"

-V.J., Antioch

010/04/2022

Source: MCPC (https://www.musiccityprep.org/reviews/)

"I'm a 40-something- year-old cis gay man from Alabama. I've never seen a guarded, secure, safe healthcare space like this. Respect for dignity, privacy, and health literacy, as well as the support and your kindness, were all so refreshing. Being there made me a little emotional; I never thought I'd see something like this in the south. Thank you."

-T.S., Antioch

10/04/2022

Source: MCPC (https://www.musiccityprep.org/reviews/)

"As usual, the clinic is clean, and the personnel are professional and courteous, while maintaining outstanding efficiency! This is extremely appreciated. I wish all medical facilities would follow MCPC's model/example!"

-E.D., Shelbyville

Source: MCPC (https://www.musiccityprep.org/reviews/)

What Makes Us Special: Video training series for staff
https://youtu.be/43KrpvE65o4

Conclusion: While the minimum ask should be the continuity of care fund, it's clear that MCPC's success in the region is dependent on its unparalleled investment in public outreach, staff training, and service delivery. To-date, MCPC has relied on research to strategically market its services initially to the LGBTQ community, then in 2021, the Black/African American communities. It has not yet had the opportunity to serve the much more challenging Spanish-speaking community because of language and cultural barriers. Concurrently, through its Partner Strengthening Grant (PSG) program, it has provided an additional $1MM in support to community partners serving B/AA communities, IDU clients, as well as housing unstable LGBTQ youth. Without this sustained effort with each succeeding at-risk community, the capacity for care will be under-utilized.

<u>Action-To-Date</u>

10/20/22 Rich shared LRP with Metro Council Member Zach Young

10/19/22 Rich: Rich briefed Alie Chamber, Exec Assistant to Chief Programs Officer, Friends for Life, Corner Clinic (Memphis), who briefed Mia Cotton - Chief Programs Officer, Tshaka Chambers - Director of Supportive Services, and Terra Cousin - Director of Clinical Operations at The Corner. Rich also looped in Diane Duke, Executive Director, Friends for Life.

10/17/22 Rich briefed Mark Yancy, CEO of Nashville Health. A second meeting will be scheduled. Both noted that the community LGBTQ+ is disproportionately under- and uninsured. The 340b crisis will disproportionately affect the uninsured. Rich outlined the possibility for

restructuring MCPC to continue serving under- and uninsured patients through a locally-generated continuity fund that provides financial assistance for out-of-pocket costs. Staffing could be addressed by in-kind partnerships with incumbent organizations. Attention to proper staff training is key to maintaining the trust-building relationship that MCPC has with 15,000 patients. Also briefed Tennessean health care reporter Frank Gluck (fgluck@tennessean.com).

10/19/22 Rachel Franklin, Bureau Director for Communicable Disease and Emergency Preparedness for Metro Public Health Department, confirmed that MPHD top personnel will be responding directly to this crisis.

10/14/22 Rich briefed all hands at MCPC on the state of MCPC sinking faster than previously projected

10/13/22 Rich briefed Bass, Berry, & Sims (BBS) and they will provide at least discounted, possibly pro bono, legal advice for messaging and the structuring of arguments.

10/12/22: Clare suggests recruiting Dr. Stephen Raffanti, Founder of Vanderbilt CCC. Sean Kelly, Vanderbilt CCC medical director can recruit Pam Talley (TDH) and Rob Nash (TDH). Rob Nash introduced Rich to Mark Yancy (Nashville Health) and Rich shared this plan with him.

Solution Path 3: Change at HHS

Team members: Rich MacKinnon, Exec. Dir, MCPC
Advisors: Dashiell Sears, Fast Track Cities (dsears@ftcinstitute.org), Tim Horton, Dir. Medication Access and Pricing, NASTAD; Dr. Sascha Meinrath; Lauren Gaffney, Bass, Berry & Sims; Stephanie Taylor, Progressive Change Campaign Committee.

Proposed ask: The success of the 340b Drug Pricing Program as a funding mechanism for the national HIV strategy depends on (a) a stable "spread" or margin between the drug prices paid by PrEP clinics and the revenues they receive from insurance companies; and (b) insurance companies agreeing to cover the the PrEP medication most likely to generate revenue so that the "spread" is sufficient enough to fund the strategy. Without proper supervision of the program, Gilead has made unilateral decisions to increase the price of PrEP and reduce the spread. Further, the insurance companies are increasingly disallowing the coverage of PrEP medications most likely to produce sufficient revenue. The proposed ask is for HHS to supervise the administration of the 340b Drug Pricing Program as it relates to the funding of the national HIV prevention strategy. Supervision initiatives could include (1) returning the price of PrEP medications under patent to 2019 levels; (2) requiring public notice and hearing for any proposed price increases; (3) setting a cap on the percentage and frequency of price increases; (4) requiring insurance companies to cover any PrEP medication as prescribed; (5) allowing

patients diagnosed at-risk of HIV and prescribed PrEP the immediate ability to enroll in ACA plans.

Action-to-Date:

10/20/22 Rich: Rich added journalists from Washington Monthly to this shared doc

10/19/22 Rich: Rich briefed Alie Chamber, Exec Assistant to Chief Programs Officer, Friends for Life, Corner Clinic (Memphis), who briefed Mia Cotton - Chief Programs Officer, Tshaka Chambers - Director of Supportive Services, and Terra Cousin - Director of Clinical Operations at The Corner. Rich also looped in Diane Duke, Executive Director, Friends for Life.

10/17/22 Rich: Rich was briefed by Nicole Thibeau, PharmD , Director of Pharmacy Services at the LA LGBT Center confirming that they too have faced significant revenues losses stemming from Gilead's unilateral changes and will have to revisit their programs in the coming year.

10/17/22 Rich: Theresa Jumento, Senior Advisor Division of Policy and Data, HIV/AIDS Bureau, HRSA advised Rich on how to provide a public comment at the CHAC fall meeting and how to become a CHAC member.

10/14/22: Rich registered for the CHAC fall meeting (Nov 1-3) and requested time for oral comment (CHACAdvisoryComm@hrsa.gov). Also requested membership in CHAC. The next CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) meeting will take place on November 1, 12:30 – 5:00 pm ET, November 2, 12:30 – 5:30 pm ET, and November 3, 12:30 - 4:00 pm ET. The meetings will be held virtually with access through Zoom. While the meetings are open to the public, advance registration is required. The deadline for online registration is October 28,12:00 p.m. ET.

1013/22: Sascha believes that pricing/revenue curves may be of interest to FTC. He says filing a complaint for price gouging is step 1. Will also facilitate an introduction to FTC staff for pharma.

About the Music City PrEP Clinic

The Music City PrEP Clinic (MCPC) is a 501(c)(3) non-profit STD clinic headquartered in Nashville with the mission to end HIV in middle Tennessee. Our FY 21-22 budget is approximately $50MM and our staff numbers 80. Initiating business in 2019, we have served over 15,000 patients across 3 facilities, mobile unit, and popup clinics in TN and KY. After completing the Vanderbilt CCC's Practice Transformation and SEATC curriculum, we expanded into HIV care with antiretroviral therapy. We own and practice in two medical office buildings—one in Centennial Midtown and the other in 5 Points East Nashville. The latter is a new $10MM mixed-use development featuring clinical space, on-site pharmacy, LGBTQ community center, and gay bar/restaurant. Our third location is rented clinical space carved out of a gay bar in Louisville, KY.

The Music City Physicians Group doing business as Chosen Family Medicine (CFM) will

provide primary care medicine tailored to LGBTQ patients in 1Q23. CFM will co-locate with MCPC at the 5 Points location. Also in 2023, will be the launch of Rod Bragg Diversity Health (RBDH), a health care management service organization enabling us to bring our brand of practice to new markets.

As a single organization, we cannot end HIV on our own. We developed the Partner Strengthening Grants (PSG) initiative to buttress and develop community partners sharing our mission. To-date, we have granted over $1MM through this program to several organizations in our community including Oasis, StreetWorks, Nashville CARES, First Response Center, Vanderbilt CCC, and Fisk University.

To ensure as many people as possible can benefit from the MCPC Experience, we provide need-based financial assistance to those who are uninsured and underinsured.