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 March 30, 2017

Record of the Proceedings

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CDC/HRSA ADVISORY COMMITTEE ON HIV, VIRAL HEPATITIS AND STD PREVENTION AND TREATMENT
March 30, 2017

Minutes of the Virtual Meeting

The U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP), and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) convened a virtual meeting of the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC). The proceedings were held on March 30, 2017.

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

Information for the public to attend the virtual CHAC meeting via teleconference was published in the *Federal Register* in accordance with Federal Advisory Committee Act regulations. All sessions of the meeting were open to the public (*Attachment 1: Participants' Directory*).

Opening Session

Opening of Meeting and Roll Call

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

Dr. Cheever conducted a roll call to determine the CHAC voting members, ex-officio members (or their alternates) and liaison representatives who were in attendance. She announced that CHAC meetings are open to the public and all comments made during the proceedings are a matter of public record. She reminded the CHAC voting members of their responsibility to disclose any potential individual and/or institutional conflicts of interest for the public record and recuse themselves from voting or participating in these matters. She also announced that since this was a short business meeting as follow-up to the November 2016 meeting, there would be no public comment period.

CONFLICT OF INTEREST DISCLOSURES

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Richard Aleshire, MSW, ACSW (Washington State Department of Health)	Recipient of federal funding from HRSA, including Ryan White HIV/AIDS Program (RWHAP) Part B.
Jean Anderson, MD (Johns Hopkins University)	Recipient of federal funding from HRSA, including RWHAP funding.
Peter Byrd (Peer Educator and Advocate)	No conflicts disclosed.
Dawn Fukuda, ScM (Massachusetts Department of Public Health)	Recipient of federal funding from CDC and HRSA, including a RWHAP Part B grant.
Debra Hauser, MPH (Advocates for Youth)	Recipient of federal funding from CDC.
Peter Havens, MD, MS (Children's Hospital of Wisconsin)	Recipient of federal funding from HRSA and NIH, including RWHAP funding.
Amy Leonard, MPH (Legacy Community Health Services)	Recipient of federal funding from CDC and HRSA for HIV prevention and treatment activities, including an RWHAP grant.
Jorge Raul Mera, MD (Cherokee Nation, W.W. Hastings Indian Hospital)	Recipient of funding from Gilead, federal funding from Indian Health Services (IHS).

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Greg Millet, MPH (amfAR)	No conflicts disclosed.
Bradley Stoner, MD, PhD (Washington University School of Medicine)	Recipient of federal funding from CDC.
Lynn Tailor, MD, FACP (Brown University/The Miriam Hospital)	Recipient of federal funding from HRSA, including RWHAP funding.

Dr. Cheever confirmed that the 16 voting members and ex-officio members (or their alternates) in attendance constituted a quorum for CHAC to conduct its business on March 30, 2017. She called the proceedings to order at 2:15 p.m. ET and welcomed the participants to the virtual CHAC meeting.

Introductions and Welcome

Peter Byrd, CHAC Co-Chair
Peer Educator and Advocate

Dawn Fukuda, ScM, CHAC Co-Chair
Director, Office of HIV/AIDS
Massachusetts Department of Public Health

Ms. Fukuda welcomed the participants to the virtual meeting and introduced three new CDC-nominated members to the CHAC: Dr. Lynn Erica Taylor, Dr. Bradley Stoner, and Mr. Gregorio Millett.

Ms. Fukuda explained that the virtual meeting is being held in order to complete important business in advance of the in-person meeting on May 10-11, 2017, in Atlanta. This meeting will be devoted to the CHAC's discussion and formal vote on two draft resolutions. The first proposed resolution focuses on the HIV workforce. The second proposed resolution calls for expanding the focus of the CHAC's viral hepatitis workgroup. In addition, a new viral hepatitis workgroup chair must be identified.

CHAC's Formal Action on the Draft Resolutions

Proposed Resolution on HIV Workforce

Ms. Fukuda announced that the resolution was crafted by Bruce Agins, Virginia Caine, Carlos del Rio, Peter Havens, Peter Byrd, and herself, with input from CDC and HRSA. Carlos del Rio is a former member of the CHAC. The proposed resolution was provided to members in

advance of the virtual meeting. Ms. Fukuda invited members to ask questions of the authors and to discuss the proposed resolution.

Introduction

(CHAC will create when the resolution is finalized.)

Background

Predicted shortages in the supply of physicians and other advanced practice medical providers[1] in the United States are slated to reach over 30,000 by 2025. Shortages in the HIV workforce are likely to be more severe, with projections estimating that the supply of HIV clinicians will only be able to meet three-quarters of the needs for HIV care services. These forecasts are a result of success in expanding highly effective HIV treatment, and potentially exacerbated by a surge in new infections in young men who have sex with men. Thus, increased prevalence, as a result of improved survival, an increase in new infections in some populations, and a continued decline in medical care providers choosing infectious diseases as a subspecialty or pursuing HIV specialization in the context of primary care practice are the main causes of this looming problem.

It must be noted, however, that the impact of these factors is geographically variable based on both incidence and prevalence of HIV infection, as well as the distribution of physicians and other providers. Rural areas of the United States, in particular, which often do not have any HIV providers, or in the best of circumstances rely on one experienced HIV provider, are vulnerable to shortages without innovative strategies to address this critical need. In addition, the disparities prominent in HIV infection in the United States demand specific steps to ensure that a competent workforce is available to address HIV among racial and ethnic minorities. To reduce new infections and HIV-related deaths, and end the HIV epidemic in the United States, a sufficient and expertly prepared medical workforce is essential.

Among factors contributing to a diminishing HIV workforce are the natural aging of clinicians who entered HIV care during the early years of the epidemic and a declining interest in infectious diseases as a specialty for both internal medicine and pediatric residents. In addition, as previously stated, successes in treatment have increased the number of patients who need care. HIV care requires specialized training and can be performed by infectious diseases medical care providers, primary care medical care providers, and advanced practice providers such as physician assistants and nurse practitioners who have received additional HIV care training. However, it cannot simply be turned over to general primary care practices. Care by an experienced HIV provider has clearly been shown to improve outcomes. Workforce

[1] The term “provider” is used throughout the document to refer to authorized medication prescribers broadly, including physician assistants, nurse practitioners, and other advanced practice and licensed independent practitioners.

development initiatives, therefore, need to be multifaceted in order to increase the supply of expert infectious disease medical care providers and capable internal medicine and family practice medical care providers. Members of the CHAC recognize that:

Major Issues of Concern

1) There is already an acute shortage, and there will be, in the future, a more severe shortage of competent, prepared HIV clinical practitioners that must be addressed. Sixty-eight percent of HIV clinicians in the county are over 45 years of age; 16.5 percent are 65 years and older. The country is already facing a shortage of over 500 full-time equivalent HIV clinicians and the problem will worsen without immediate action.[2],[3]
2) To address the shortage, the Department of Health and Human Services and the federal agencies responsible for health services for the country must ensure that there is a steady corps of experienced HIV medical care providers and advanced practice providers, and a process to ensure that there is a pipeline to continue it. Since experienced HIV medical care providers need not be infectious diseases specialists, the evolving HIV workforce must also include internists and family practitioners, if not also OB/GYN providers and others. Comprehensive, high-quality HIV care includes preparation not only in clinical HIV medicine (and general primary care), but also mental health and substance use.
3) To achieve high quality care for people living with HIV (PLWH) and address the public health challenges associated with this persistent national epidemic, supply issues relative to the medical workforce and distribution of experienced HIV providers need to be addressed, and models of care to address provider supply, distribution, and health disparities. Ideally, the United States will have both centers of excellence/experience/specialty for HIV medicine and experienced providers within integrated models of care in community-based hospitals and health centers. This model is likely to maximize health outcomes at the patient level, accomplish cost-effectiveness, and fulfill the aims of communicable disease control and public health.
4) Care models and responses to workforce supply issues must specifically address medical shortage areas that are reflected by data about workforce distribution for HIV and, importantly, where health disparities are most prominent.

A multi-pronged approach to addressing this growing problem is required. In addition to developing a motivated and prepared workforce that is currently practicing in areas of need, pre-service education is needed to ensure that young medical care providers are well trained to recognize, treat, and manage HIV infection throughout its course. Evolving science that requires changes in practice strategies requires ongoing programs for continuing practitioner education,

[2] Gilman, B. et al., The HIV Clinician Workforce in the United States: Supply and Demand Projections from 2010 to 2015, *HIV Specialist*, The American Academy of HIV Medicine, v. 8, No. 3 (August 2016)

[3] Weiser, J. et al. Qualifications, Demographics, Satisfaction, and Future Capacity of the HIV Care Provider Workforce in the United States, 2013–2014, *Clinical Infectious Diseases*, v. 63, Issue #7 (June 2016)

along with innovative practice models for shared management between specialist and community practice settings. Harnessing technological solutions to support distance education and clinical mentoring, telemedicine for remote patient care, and robust information systems for shared information management are crucial for ensuring quality of care for PLWH across the country.

Recommendations

In an effort to increase the number and diversity of available HIV care providers, to strengthen the current provider workforce to ensure access to and quality of care, and in light of the needs noted above, the CHAC recommends a set of actions that will address both long-term workforce capacity concerns, and the immediate need to implement service models that will meet medical care needs of PLWH while strengthening the nation's public health response.

Respond to the HIV workforce capacity shortage.

1) Ongoing systems for monitoring the HIV workforce should be established with platforms for associating workforce supply with quality of care. A technical working group should be established to focus on HIV workforce development to monitor the progress and effectiveness of planning and implementation of workforce programs.
2) Federal programs should support adequate pre-service clinical training to prepare providers-in-training to deliver HIV care. There also needs to be support for the development of fellowships for advanced practice practitioners (APPs) or support for clinics to hire APPs into an apprenticeship-training program. Alignment with professional societies to facilitate and sustain credentialing or other methods for identifying qualified HIV providers should be continued. Specific recommendations to address workforce shortages and HIV human resources need to be integrated into relevant national strategies and initiatives.
3) Federal funding should be expanded to provide grants or loans for startup costs associated with development of HIV training programs to target underserved communities or integrated into current training programs. Examples such as the *Nursing Workforce Diversity Program* from the HRSA Bureau of Health Workforce, could serve as an example for HIV workforce development funding opportunities.
4) The Centers for Medicare and Medicaid Services should re-evaluate reimbursement methodologies for cognitive services to address significant payment disparities across medical specialists.

Ensure access to HIV medical care, particularly in the most impacted parts of the country and where disparities are most pronounced.

1) Technology platforms should be promoted to provide telemedicine in hard-to-reach areas, along with video-mentoring programs that are continuously available to clinicians who treat HIV patients in areas where experienced providers are unavailable or limited.
2) Loan repayment programs similar to the one that the state of New Hampshire has implemented to incentivize physicians and other advanced practice providers to pursue HIV medicine in their professional careers, particularly in underserved areas of the country should be considered, or facilitating designation of Ryan HIV/AIDS Program sites as eligible National Health Service Corps sites as was considered by HRSA's 2010 to 2011 Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas. This approach has been successful in the past and has the potential to be a highly effective recruitment strategy.
3) Consider federal funding to promote innovative practice models through demonstration grants and other initiatives.
4) Targeted federal funding should be available for areas of need, especially in rural health communities and for minority health care professionals to receive specialized training in infectious disease medicine, and support to integrate HIV care into primary care medical practices.

Discussion

CHAC members discussed the proposed resolution. The following issues were raised:

- **HIV Providers Versus Other Providers**. Members expressed the need to maintain the focus of the resolution on the HIV workforce since severe shortages are projected in the coming years. In particular, few residents are choosing to specialize in infectious disease (which also has implications for hepatitis treatment). There has been a major effort to shift the care of PLWH to non-specialty providers. Additional training is required for these providers, but there also must be a focus on ensuring sufficient numbers of HIV specialty providers to meet demand. It was noted that the federal government does not play a role in certification.
- **Biomedical HIV Prevention Services**. Demand for biomedical HIV prevention services (e.g., pre-exposure prophylaxis [PrEP]) is increasing. However, there is limited capacity to provide these services. While HIV providers are well positioned to provide PrEP, RWHAP funds cannot be used for these services. Other providers have been reluctant to take on biomedical HIV prevention services, often claiming that they lack the necessary expertise. In particular, providers at sexually transmitted infections (STI) clinics, primary care providers, and pediatricians will be critical in the provision of PrEP

and other biomedical prevention strategies. Allied health professionals, such as pharmacists, can also play a role. The need to build provider capacity in terms of biomedical HIV prevention should be discussed in the resolution, but it should be emphasized that many providers can play a role in the provision of these services, not just HIV providers.

- **Diversity of Workforce**. While the proposed resolution discusses increasing the diversity of the HIV workforce in terms of the types of providers with HIV expertise, it does not call for increasing the racial/ethnic diversity of the HIV workforce. Members called for adding language on increasing the racial/ethnic diversity of the HIV workforce.

Action	Description
Co-Chair's call for a vote on the proposed resolution with the addition of language focused on: provision of biomedical HIV prevention; the need for training/capacity building for non-specialty providers; and increasing the racial/ethnic diversity of the HIV workforce.	Motion properly made by Dr. Jean Anderson to approve the resolution with the specified additions. Motion seconded by Dr. Jorge Raul Mera.
Outcome of vote:	**Motion unanimously passed by 11 CHAC voting members.**
Next steps:	The resolution will be revised based on the input provided by members during the meeting.

Proposed Resolution to Expand the Existing CHAC Viral Hepatitis Workgroup to Focus on Perinatal Hepatitis C Virus Transmission and Infection

Ms. Fukuda stated that the proposal was submitted by CDC to expand the focus of the viral hepatitis workgroup to address issues related to perinatal hepatitis C virus (HCV) testing and surveillance. Members received a copy for review prior to the virtual meeting. The workgroup currently has two members. It also needs a new Co-Chair.

Ms. Fukuda introduced Dr. John Ward, CDC/Office of Infectious Diseases (OID)/NCHHSTP, to provide information on the proposed resolution and answer questions. Dr. Ward stated that the workgroup has been in existence for several years. The expansion will allow the workgroup to address the rise of perinatal HCV transmission and HCV in pregnant women. The expansion will bring in other stakeholders and outside experts to help guide the decision-making process and identify research questions. CDC has used a similar process with its immunization workgroup.

Rationale

Eliminating mother-to-child transmission of hepatitis B virus and HCV is one of the strategies to prevent new viral hepatitis infections included in the National Viral Hepatitis Action Plan 2017-2020. The rate of vertical HCV transmission in the United States has been difficult to determine because reports of mother-to-child HCV transmission are based on small numbers of patients, and there is no formal definition for perinatal HCV infection. Risk factors that promote vertical transmission and lead to chronic infection of the infant are also unclear, including the extent to which this may be modified by maternal substance use status. To identify current gaps in knowledge of HCV prevalence among pregnant women and perinatal transmission of the virus, it is proposed that the existing CHAC HCV workgroup expand its focus to include perinatal HCV transmission. The expanded focus would fit within the existing charge of the CHAC Viral Hepatitis workgroup under epidemiologic research on viral hepatitis, and will advise CHAC on issues related to women of childbearing age, pregnant women infected with HCV, and exposed infants.

Goal

To provide a sounding board for CHAC on issues relevant to perinatal HCV transmission and infection and, specifically, to help CDC develop guidance to address testing and surveillance issues for perinatal HCV transmission.

Objectives

To help develop feasible guidance related to perinatal HCV prevention on the following priorities:

1) How can CDC best provide national leadership in regard to preventing perinatal HCV?
2) What actions should CDC suggest others take to decrease vertical transmission of HCV?
3) What indicators should CDC monitor to assess progress in preventing vertical transmission of HCV over time?
4) What partnerships should CDC initiate or strengthen to better understand perinatal HCV transmission and infection as well as its prevention?

Activities

It is proposed that the workgroup include additional CHAC members, pediatricians, pediatric infectious disease consultants, obstetricians/gynecologists, gastroenterologists, addiction specialists, CDC staff from the Division of Viral Hepatitis, HRSA staff, and other external experts as needed. The workgroup will review and provide feedback on draft guidance documents (i.e., CDC perinatal HCV guidance for testing of pregnant women and/or exposed infants) and

conduct meetings to discuss such guidance.

Timeline

The workgroup focus on perinatal HCV transmission and infection would entail a 12- to 24-month timeframe. The need for additional time will be assessed toward the end of the identified timeframe.

Discussion

- **Partners.** Members encouraged CDC to work with the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians. Guidelines are driven by these organizations.
- **Beyond Perinatal Transmission.** Consider pregnant women and women before and after they get pregnant. Since treatment cannot be provided during pregnancy, the periods both before and after pregnancy are critical.
- **Testing.** HIV testing can serve as a model. CDC needs to decide whether to recommend testing based on risk or prevalence or universal testing.

Action	Description
Co-Chair's call for a vote to expand the scope of the Viral Hepatitis Workgroup to include perinatal transmission and surveillance.	Motion properly made by Dr. Jorge Raul Mera to formally approve the spirit of the resolution. Motion seconded by Ms. Amy Leonard.
Outcome of vote:	**Motion unanimously passed by 11 CHAC voting members.**
Next steps:	Members were asked to volunteer for the workgroup. Dr. Jean Anderson, Dr. Peter Havens, Mr. Greg Millett, and Dr. Lynn Taylor volunteered to serve on the workgroup. Dr. Jean Anderson and Dr. Peter Havens will chair this project for the workgroup. Dr. John Ward asked that the workgroup convene a call as soon as possible. CDC will coordinate the logistics.

Closing Session

Ms. Fukuda reminded the participants that the next CHAC meeting will be CDC-focused and convened in person on May 10-11, 2017, in Atlanta, Georgia.

With no further discussion or business brought before the CHAC, Ms. Fukuda adjourned the virtual meeting at 2:47 p.m. ET on March 30, 2017.

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

_____
Date

_____
Peter Byrd, Co-Chair
CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment

_____
Date

_____
Dawn Fukuda, ScM, Co-Chair
CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment

Attachment 1: Participants' Directory

CHAC Members Present

Mr. Peter Byrd, Co-Chair
Ms. Dawn Fukuda, Co-Chair
Mr. Richard Aleshire
Dr. Jean Anderson
Ms. Debra Hauser
Dr. Peter Havens
Ms. Amy Leonard
Dr. Jorge Raul Mera
Mr. Greg Millett
Dr. Bradley Stoner
Dr. Lynn Taylor

CHAC Members Absent

Dr. Susan Philip
Ms. Linda Scruggs

CHAC Ex-Officio Members Present

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

Dr. Melinda Campopiano
Substance Abuse and Mental Health Services Administration

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

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

Dr. Jessica Leston
(For Richard Haverkate)
Indian Health Service

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

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

Dr. Lisa Kaplowitz
(Alternate Ex-Officio)
Substance Abuse and Mental Health Services Administration

CHAC Ex-Officio Members Absent

Dr. Andrey Ostrovsky
Centers for Medicare and Medicaid Services

CHAC Liaison Representative Present

Dr. Mildred Williamson
Presidential Advisory Council on HIV/AIDS

CHAC Designated Federal Officers

Dr. Laura Cheever
HRSA/HAB Associate Administrator

Dr. Jonathan Mermin
CDC/NCHHSTP Director

Federal Agency Representatives

Dr. Gail Bolan
Ms. Antigone Dempsey
Ms. Nadine Doyle
Dr. Monique Foster
Ms. Shelley Gordon
Ms. Heather Hauck, MSW
Ms. Theresa Jumento
Ms. Niki Kaiser
CAPT Tracy Matthews
Ms. Amanda McWhorter
LCDR Alyson Rose-Wood
Dr. Sarah Schillie
Ms. Margie Scott-Cseh
Dr. John Ward
Dr. Richard Wild

Members of the Public

Ms. Julianne Aldous
Brownstein Hyatt, Children's Hospital of Los Angeles, University of Southern California

Dr. Marvin Belzer
Children's Hospital of Los Angeles

Dr. Carlos del Rio
Emory University

Mr. David Fluker
Northrup Grumman

Mr. Devin Hursey
Student and Peer Advocate

Dr. Jennifer Kates
Kaiser Foundation

Ms. Natalie Keen
The AIDS Institute

Ms. Emily McCloskey
National Alliance of State and Territorial AIDS Directors

Mr. Daniel Pleasant
Start at Westminster

Mr. Andrew Reynolds
Project Inform

Ms. Andrea Weddle
HIV Medicine Association

Mr. Joey Wynn
Empower Your Community Health Center

Attachment 2: Glossary of Acronyms

Acronym	Full Name
CDC	Centers for Disease Control and Prevention
CHAC	CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment
DFOs	Designated Federal Officers
HAB	HIV/AIDS Bureau
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention
PLWH	Persons Living with HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
RWHAP	Ryan White HIV/AIDS Program
STI	Sexually Transmitted Infections