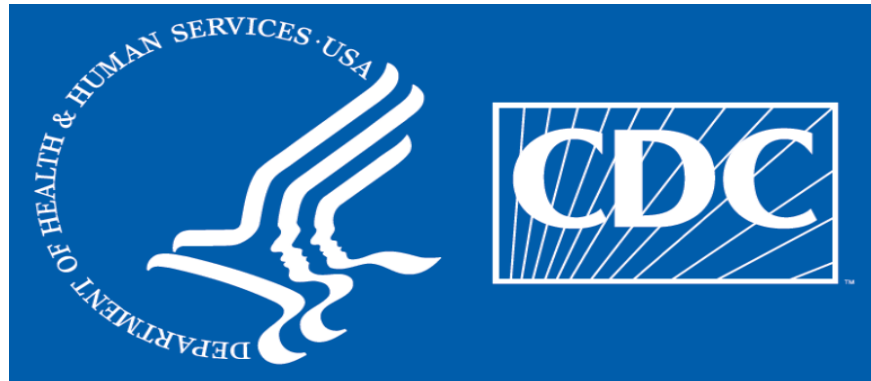


**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
HEALTH RESOURCES AND SERVICES ADMINISTRATION**



**Virtual Meeting of the
CDC/HRSA Advisory Committee on
HIV, Viral Hepatitis, and STD Prevention and Treatment
July 21, 2020**

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**CDC/HRSA ADVISORY COMMITTEE ON
HIV, VIRAL HEPATITIS, AND STD PREVENTION AND TREATMENT
VIRTUAL MEETING
July 21, 2020**

Minutes of the Meeting - DRAFT

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, Sexually Transmitted Disease (STDs) and Tuberculosis (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 July 21, 2020, beginning at 2:00 P.M. EDT.

The CHAC is a committee that is 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.

The meeting was open to the public (*Attachment 1: Participant List*). Information for the public to attend the CHAC meeting remotely via teleconference was published in the *Federal Register* in accordance with FACA rules and regulations.

Opening of Meeting and Roll Call

Jonathan Mermin, MD, MPH (RADM, USPHS)

Director, CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCCHHSTP)

Dr. Mermin opened the meeting by reminding everyone that the meeting is public, and all comments made during this meeting are a matter of public record. Members should be mindful of potential conflicts of interest (COI) identified by the CDC Committee Management Office and recuse themselves from voting and participating in these discussions. Members will state if there is a conflict of interest at the first roll call so that they may be noted for the record.

Conflict of Interest Disclosures

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Jean Anderson, MD (Johns Hopkins Medical Institutions)	Recipient of funding from NIH and HRSA and has stock in Merck and Abbvie
Wendy Armstrong (Emory University School of Medicine)	Recipient of HRSA/RWHAP funding
Marvin Belzer, MD, FACP, FSAM (University of Southern California, Keck School of Medicine)	Recipient of funding from CDC, HRSA/RWHAP, Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health (NIH) and is medical editor for the American Board of Pediatrics.
Demetre Daskalakis (New York City Department of Health and Mental Hygiene)	Recipient of CDC and HRSA funding
Jodie Dionne-Odom, MD (University of Alabama Birmingham)	Recipient of NICHD funding
Debra Hauser, MPH (Advocates for Youth)	Recipient of DASH and Gilead funding
Venton Hill-Jones (Southern Black Policy and Advocacy Network)	Organization receives Gilead funding
Devin Hursey (U.S. People Living with HIV Caucus)	Recipient of funding from HRSA/RWHAP
Jennifer Kates, PhD (Kaiser Family Foundation)	No conflicts disclosed
Greg Millet, MPH (amfAR)	No conflicts disclosed
Johanne Morne, MS ED (New York State Department of Health)	Recipient of HRSA and CDC funding
Kneeshe Parkinson (Washington University)	No conflicts
Michael Saag, PhD (University of Alabama at Birmingham, School of Medicine, UAB Center for AIDS Research)	Recipient of funding from HRSA/RWHAP and CDC and a consultant for BMS, Merck, Gilead, and VIVE

CHAC Voting Member (Institution/Organization)	Potential Conflict of Interest
Bradley Stoner, MD, PhD (Washington University School of Medicine)	Recipient of funding from CDC and HRSA
Lynn E. Taylor, MD, FAASLD (University of Rhode Island)	Recipient of funding from CDC

Ex-officio members in attendance included: Pradip N. Akolkar, PhD; Paul Gaist, PhD, MPH; Kaye Hayes, MPA; Richard Haverkate, MPH. Carl Schmid, Presidential Advisory Committee on HIV/AIDS Liaison, and Richard Wild, MD, JD, MBA, FACEP, alternate for CMS, were also in attendance. Dr. Mermin confirmed that over 14 voting members and ex-officio members (or their alternates) were in attendance and constituted a quorum for CHAC to conduct its business on July 21, 2020. Following the roll call, Dr. Mermin confirmed that they submitted the 2020 CHAC Draft Nomination package to HHS on February 12th, 2020 for replacements for Dr. Gayles, Dr. Taylor, and Dr. Stoner who are rotating off on November 30, 2020 and will hopefully get information back from HHS about package approval.

CHAC Action

Dr. Bradley Stoner made a motion to approve the March 2020 meeting minutes, seconded by Dr. Jennifer Kates. The minutes were accepted unanimously.

CDC Update

Jonathan Mermin, MD, MPH (RADM, USPHS)

Director, CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCCHHSTP)

Dr. Mermin started off with an overview of his presentation. He began with updates on COVID-19 and shared they have 190 employees currently deployed to the COVID-19 response and have had over 500 people deployed since the beginning of the response (625 total). He mentioned this is a long-term chronic activity to help with the response to COVID both in Atlanta and in the field. He acknowledged that it disrupts a fair amount of their ability to get their job done as well as their partners.

He stated they have attempted to mitigate some of the impacts of COVID-19 both internally and with grantees and partners. With staffing, they have staggered and rotated deployments in order to make sure no particular CDC unit is overwhelmed with deployments and are trying to streamline hiring and onboarding, but he acknowledged that the human resources functions of the agency are stretched from the response itself. With strategy, they are assessing challenges and opportunities about how they can get some of their core capacities with testing, treatment, and linking people to care. They are also reassigning people and assessing gaps in services and impacts and are planning for disruptions in surveillance and data analysis. He mentioned the agency itself is postponing planned events and activities in order to concentrate on the COVID-19 response. They are

also sharing knowledge and resources where possible and trying to write guidance and provide recommendations that could make dealing with the public health aspects of these infections easier in this time. He stated that some ways in which they have been doing this is allowing flexible grants management/reporting. This means extending some deadlines and reassessing expectations for some performance targets and measures. They are also providing guidance and sharing lessons from the field and have released a variety of cross-cutting or specific recommendations including guidance for syringe service programs (SSP) and are supporting/expanding telehealth and telepre-exposure prophylaxis (PrEP), setting surveillance program priorities, delaying more labor intensive priorities, and limiting some of the reporting to some of the core elements they need to know about to make sure grantees are performing.

Dr. Mermin shared that they have learned of major disruptions in providing services by their partners and are examining surveillance data to interpret what has been happening to our diseases. He stated it is already clear that community-based organizations and others have been profoundly affected both because of their inability to do what they normally do and because people have been moved to other activities. In addition, resources they receive from outside the federal government have been reduced or stopped, having short- and long-term implications for these organizations. He added that emergency room visits have gone down 42%, which has also resulted in a decrease in people receiving HIV, STD, and viral hepatitis screenings. He also mentioned that, as far as they know right now, the routine screening as people come to clinical settings continues, but there has been a reduction in the absolute number of people. Schools have been profoundly disrupted and STD clinics have been impacted like community-based organizations. SSP operations have reduced by about 50% either by reducing hours or closing. TB programs have also been affected, in some ways because the first place you look to get assistance for a pulmonary infection that is highly transmittable would be TB programs, and a lot of people have been shifted to help with COVID-19.

To try to respond to this, Dr. Mermin stated they have provided guidance for HIV self-testing, implemented SSPs during COVID-19, provided PrEP when it is really hard to do in-person services, recommended the use of tests that may have limited sensitivity, but important during this time when in-person testing is less available, and addressed some of the difficulties of conducting STD testing for initiating or continuing PrEP. As previously mentioned, they have also provided guidance to schools, the STD program provided new recommendations about treatment and telehealth during the time of COVID-19 including all oral treatment, and the TB programs have also provided guidance for how to adapt during this time.

Dr. Mermin stated that some of the support for schools has come from guidance issued by DASH itself. He stated that they have been thinking about ways to support youth, updating Youth Risk Behavioral Surveillance (YRBS) structure, some research projects to better understand and meet student and parent needs, working with NGOs to build tools for schools to support students and parents and the mental health needs of students, and provided TA to COVID-19 response including deployments. He restated there is a profound disruption in the normal way schools are functioning and do not yet know how this will

impact students, but it is certainly not going to stop over the next year. As such, we must think about how we can keep programs functioning in supporting healthy behaviors.

Dr. Mermin shared many NCHHSTP-supported staff in health departments have provided training for, or conducted, contact tracing for COVID-19 because, in many ways, they have the most background and experience in this area. They have developed some advertisements related to HIV and COVID-19, both print and digital for both clinicians and consumers, and are trying to continually update this information.

For specific HIV updates, Dr. Mermin shared that they produced three new surveillance reports this Spring. He highlighted that from 2014 - 2018 there has been a statistically non-significant decline in new HIV infections. In sub-analyses, there has been a 31% decrease of HIV infections among MSM aged 13-24 years, which was previously one of the highest groups for HIV incidence. They are now seeing the highest incidence among people 25-34 years. They continue to see disparities among MSM and transgender persons and noted multiple outbreaks of HIV among people who inject drugs (PWID).

They produced a report that shows HIV infection risks for PWID. About 32% of those interviewed used a syringe after someone else had used it and 28% of PWID tried but were unable to receive medication assisted treatment for substance use, which shows limitations. He added that last year there was also an increase in people who died of overdoses in the US. It is presumed that some of the services that were previously available in the beginning of this year are limited. For example, people may have a harder time accessing naloxone if SSPs are closed or if they continue to have reductions in access to medication assisted substance abuse treatment there may be people who are unable to stop using drugs. As such, risks for HIV and viral hepatitis and STDs among PWID may worsen over the next year. He reassured that they will be looking closely at their data to see whether this is happening and will do everything they can to prevent these complications.

Dr. Mermin continued with ending the HIV epidemic jurisdictional planning efforts including the revised EHE plans now due on December 31st and there is a no cost extension provided for grantees. The three pilot jumpstart sites of Baltimore, Dekalb County (GA), and East Baton Rouge had been able to accomplish quite a bit during the time that they got their initial funding. For all the jurisdictions, CDC anticipates awarding its resources to start implementing the funds this fiscal year on August 1st.

Dr. Mermin then discussed the recently released vital signs on Hepatitis C (HCV). It highlighted that HCV incidence is increasing in the US particularly among adults younger than 40 years. What they are getting is a large increase in reports of HCV among people aged 20-40 and continue to have diagnoses among people older than 50 years. He shared that this reflects the increase in transmission among younger people but continued in middle aged and older as well. They are still seeing that 4 in 10 people with HCV do not know they have the infection, and their recommendations take this into account by recommending testing at least once for all adults, during every pregnancy for pregnant women, and regularly for everyone with ongoing risk factors.

Dr. Mermin shared updates on the *Know More Hepatitis* public education campaign with new updated areas related to the guidelines and with new materials and resources designed to encourage all adults to get tested. This continues to be a cost-effective public service campaign. Dr. Mermin proceeded to share updates for DASH, which have implemented some new resources including the new DASH strategic plan which looks to strengthen efforts to support schools to address overall health risk behaviors among students that contribute to HIV, STDs, and unintended pregnancy. The Healthy Youth Board launched on CDC's Pinterest account which provides resources to educators to promote healthy behaviors and connect youth to health services. They also have a new webpage published on how schools can lead effective staff professional development and aims to positively impact the health and well-being of young people.

Regarding STDs, Dr. Mermin shared they have provided continuing education credits (CE) for new STD guidance. It is focused on STD clinical services in primary care and STD specialty care and Medscape is offering these CE credits for the new recommendations. In addition, they have continued to see increases in congenital syphilis cases. They published a MMWR highlighting 1 in 2 newborn syphilis cases occur because of missed testing and treatment opportunities during prenatal care. Even with increased attention and efforts, they are seeing this increase in number of newborns with congenital syphilis, where close to 100 newborns died in 2018 alone. Dr. Mermin acknowledged that this is a preventable, serious infection. They are finding themselves with the challenge of trying to do a better job of screening pregnant women for syphilis and providing resources for treatment and prevention. It is an area of continued focus for CDC and hope that 2020 will be a better year in this respect.

Dr. Mermin shared highlights of 2019 TB provisional data, showing slight decreases from 2018. There were still about 9000 new cases of active TB disease. He stated that they are looking at this closely to see the impact of COVID-19. Dr. Mermin also provided some resources for guidance related to HIV, STD, TB, viral hepatitis, and adolescent school health. These resources are also available on the COVID-19 website. Dr. Mermin welcomed input from CHAC on additional areas where guidance from CDC would be helpful. He opened for questions or comments.

Dr. Stoner thanked Dr. Mermin for his presentation and leadership and recognized that it must be difficult to hold this focus during COVID-19.

Dr. Michael Saag echoed Dr. Stoner's comments and shared a quote from the play *Hamilton*: "the world has turned upside down."

Dr. Jean Anderson had two questions. The first related to the fact that there is a fair amount of data that intimate partner violence, depression, other mental health issues, and substance abuse has increased with a lot of the stay at home orders. These may have particular relevance for some of the more vulnerable populations, such as women and men with HIV. What are your thoughts about that? The second relates to the opportunity to move along certain self-testing regimens for HPV and others that are available but not currently FDA approved. What are your thoughts on that? Dr. Mermin responded that, like

the injury center, NCHHSTP is concerned about the increases in overdose deaths and violence. He acknowledged that thinking about what they can do is a major question. He would think that Dr. Cheever may have some thoughts about that given that HRSA reaches such a high proportion of people with HIV around the country. It would be interesting to know what they are seeing and what they are able to do through the Ryan White HIV/AIDS Program. In terms of self-testing, he mentioned these crises, like COVID-19, give us these opportunities as well as challenges and allow us to learn about how we can do things differently. He used this meeting as an example of how some things change yet can still be productive. He acknowledged that the question about testing is one of the most important for them. CDC's obligation is to get as many people tested as possible. For HIV, a third of all diagnoses in the nation are funded by CDC. For STDs and viral hepatitis, it is less but for a lot of the testing CDC helps the underserved get access to testing in ways they may not have otherwise. It is also a challenge for what it means to get tested and how we make sure people get care. They are very interested in ideas like distance testing and mailing tests if they can receive tests, and consequently ensuring they get linked. CDC is trying to expand both self-testing for HIV, where an FDA approved test already exists, as well as getting self-sample collection at home or a convenient place which could be beneficial and there are a lot of opportunities to do that. It varies in cost and type of sample necessary, but he thinks there will be a flurry of scientific interest in new technologies that can be used for self-testing. Lastly, he concluded by stating that they are very supportive of scientific innovation and programmatic change.

Dr. Mermin passed it on to Dr. Laura Cheever for her presentation.

HRSA Update

Dr. Laura Cheever, MD, ScM

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

Dr. Cheever started by sharing the vision and mission of HRSA, which are to provide optimal HIV/AIDS care and treatment for all and to provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people with HIV and their families. She stated that these have not changed at all due to COVID-19. They were able to fund their Ending the HIV Epidemic (EHE) awards, which started on March 1. The EHE awards included funding for the Ryan White HIV/AIDS Program (RWHAP) parts A and B. Through EHE, they also funded the technical assistance provider, systems coordination provider, and provided supplements to the AIDS Education and Training Centers. She reiterated that jurisdictions have been significantly impacted by COVID-19, which has slowed their abilities to start new and different things related to EHE. She stated that for EHE they are focused on 3 populations. They have 87% viral suppression rate among people in care, which means that there are 13% who are not viral suppressed, so they need to focus on those people and find how to decrease disparities. The RWHAP also needs to focus on the people who are going to be newly diagnosed with HIV, and lastly focus on the people who are out of care. She stated that they must think

about what needs to be done to get those people engaged in care, and clearly, they need to do things differently than they have done in the past. In this time of COVID-19 there have been many opportunities to do things differently. She has heard anecdotally that some people's retention rates have improved tremendously, as people can be called over the phone and engaged in this way.

Dr. Cheever stated that HAB received Minority AIDS Initiative funding for 2020. The Bureau was able to develop initiative in 3 areas and release Notice of Funding Opportunities (NOFOs) to fully compete these opportunities. All three reflect areas highlighted by communities as needs during the community engagements that HRSA and CDC conducted last year as part of the Ending the Epidemic Initiative Community Outreach. The first NOFO focuses on addressing stigma at systems, organizational, and individual client levels in the RWHAP. They have heard clearly from the community that they needed to better address stigma in order to achieve the goals of EHE. The second initiative funds sites for rapid implementation of ART. The third initiative focuses on building the capacity of organizations to better serve African American women with HIV by testing bundled interventions.

Through responding to the COVID-19 pandemic, there have been important lessons learned that may have relevance for accelerating jurisdictional responses to the Ending the Epidemic initiative. The first is the adoption of telehealth. Dr. Cheever commented on the lack of best practices for telemedicine for patients with HIV, given the new flexibilities in format. She noted that although many patients have appreciated not having to come to the clinic during the pandemic, many also noted that they missed the social interactions the clinics afforded. Anecdotally, RWHAP clinicians are reporting improved adherence with telemedicine visits. The Centers for Medicare and Medicaid Services (CMS) was able to waive many telehealth regulations, but Dr. Cheever expressed concern that these would not continue indefinitely.

A second lesson is the extension of medication refill. Previously, often insurance/Medicaid only permitted 30-day refills, but many have extended this to allow 90-day refills under COVID. She also mentioned that home delivery became easier to do because people were home more often.

Third, she mentioned the expansion of self-testing issue has been a significant advance. HRSA has heard from many PrEP providers, that are also RWHAP providers, that telemedicine and self-testing were ideally suited for PrEP, and they have been able to expand programs during this time because of the increased flexibility. She stated that there is a bright lining there, but we need to be careful about how we move forward and are deliberate to make these advances persist beyond the pandemic.

Dr. Cheever stated that HRSA received \$90 million in CARES Act Funding, which was COVID-19 funding. HRSA funded RWHAP parts A, B, C, D, and AETCs to meet the evolving needs that they had for people living with HIV related to COVID-19. She mentioned that there is some reporting burden in this in the sense that people are having

to report in a monthly basis in the aggregate about how they are spending their funds. In terms of reporting, Dr. Cheever added that the program works hard to keep the reporting as simple and streamlined as possible. HRSA overall has received more than \$100 billion to respond to the COVID-19 epidemic, and a lot of it goes to community health centers who are on the frontlines. HRSA also has the claims reimbursement portal, which was the provider funding that Congress had appropriated for individual providers and hospitals. She echoed that CDC has certainly been hugely impacted. HRSA has had people deployed, but they also have so many new COVID-related funding and programs that they have been managing that has taken up a lot of their time and efforts. However, she stated that HRSA stands in support of the federal government and the White House in providing any resources and assets they can help deploy.

Dr. Cheever stated that the National RWHAP conference will be virtual. She is excited about the event. The content is highly curated with many new innovations in practice across the country. Workshop presenters are prerecording in advance but plan to have live sessions as well.

Dr. Cheever thanked everyone and opened for questions and discussion.

CHAC DISCUSSION

Ms. Johanne Morne thanked both Dr. Mermin and Dr. Cheever for their presentations. She commented on telehealth that she certainly recognizes telehealth has been something they have finally had the chance to show can be very effective. At the same time, she acknowledged that there is a balance for those who need the in-person component. However, she underscored the point that the one thing they say about COVID-19 is that things that were once impossible suddenly now seem possible in times of COVID-19. She hopes that the opportunity or the option for telehealth will remain on the table. The only other comment she shared was related to congenital syphilis. She mentioned that it is an ongoing issue and concern for them, and she hopes for the continued opportunity to talk about best practices that can be worked on and potentially have additional resource support, which would be appreciated. Dr. Cheever responded to these comments that they have allowed telehealth in the RWHAP program prior to COVID and has it explicitly stated in the Policy Clarification Notice on Use of Funds,

Mr. Venton Hill-Jones added that another thing that has been extremely helpful during COVID-19 is at the RWHAP planning council level. These councils have always insisted on face-to-face meetings and that has now changed. He is excited that this change is happening and hopes it continues moving forward. Dr. Cheever agreed that it was a good example.

Mr. Devin Hersey pushed back slightly, stating that meeting virtually requires access to technology and Wi-Fi., which are not accessible to all. It is evident in education, but he is wondering what kind of data is possible for us to collect when it comes to people accessing technology and how they can track that. Dr. Cheever thinks that the digital divide is an important issue. She acknowledged that sometimes it is assumed people have unlimited

data plans, which is not the case. She stated that they should continue to focus on that and is concerned how we might drive new disparities because of the rise of telehealth. She said HRSA has allowed purchase of devices and minutes as needed. Dr. Jodie Dionne-Odom echoed this statement and added that there are many patients who do well with telehealth and others that do not. It is not a one-size fits all solution. Mr. Hersey adds that even before COVID-19, he had elderly clients asking for help setting an alarm on their phone so they could take their medications. Mr. Hill-Jones responded that this should be an “and” approach and not an “or” approach. Dr. Cheever added that giving the patients options and knowing what their preferences are is very important. She said that another piece is the possibility of a provider to visit patients in their homes to setup the technology that would allow them to take advantage of telehealth. During this time of COVID-19 it may be complicated, but it is something that they could come back to. Dr. Stoner added that, along those lines, in terms of pushing health systems, he asked if they had had any luck moving towards a “menu approach” and meeting people where they are with regards to these new flexible options. Dr. Cheever responded that it makes a lot of sense and describes they are funding a big project with Rutgers about getting more places for self-testing and self-sampling.

Ms. Kneeshe Parkinson had a question regarding technology barriers related to COVID-19 and women’s issues. She commented that a lot of times women need to go in to see their physicians to build relationships around breast mammograms, for example. What does this look like for women or have you all dialogued around women’s issues? Dr. Cheever responded that that particular funding is specifically to look at what evidence/interventions best meet the needs of women. They are letting the recipients define what they think those interventions would be working with their communities, and then to test them so they can evaluate those outcomes for women. They want them to be evidence-based interventions. The other piece around telehealth that she has heard is that sometimes patients do not have privacy on their end. For example, when providing IPV services virtually, you do not know who is off camera, which presents a confidentiality issue.

Dr. Armstrong stated that she was grateful for the statement from HRSA encouraging flexibility in March. However, she commented that there are many states that tend to add additional layers of bureaucracy for RWHAP enrollment. She wondered if there was an opportunity to set a minimum standard of access and flexibility that states are required to meet and allowing them to customize in ways that do not restrict patients’ access. Dr. Cheever responded that they are really excited how people were willing to be flexible because they had quite a bit of latitude that they had not fully utilized. HRSA will work to continue to encourage jurisdictions to be focused on flexibility and the safety of patients and staff. She added that the Ryan White statute gives great authority to jurisdictions to decide how to run their program. She will work with staff to look more closely at this.

Dr. Anderson commented that some of the things that were mentioned about IPV they have thought a lot about and think there are some potential things that could be supported in terms of either interfaces for those who have access to electronic medical records, which many people do, being able to have some sort of confidential communication if they are in

potential danger or having a safe word. Dr. Cheever agreed that HRSA has worked through the Office of Women's Health on IPV strategy and how to address this issue. She thinks they can add it to the agenda for this year.

Dr. Lynn Taylor thanked them for the CDC 2020 recommendations and STI clinic services. Regarding congenital syphilis, she commented that she understands it is easier to access women with syphilis who are coming into care because of pregnancy, but is hoping that CDC could be more explicit in supporting earlier preconception care, planned pregnancies, understanding it is important to target diagnosis of syphilis in pregnancy, but even recommending and ideally incentivizing contraceptive care and preconception care in STI clinics, supporting/incentivizing/funding STI clinics to offer intrauterine device (IUD) placement, long-acting contraceptives, and engaging people of child-bearing potential in STI prevention and care prior to pregnancy as a very specific goal. She is worried that it is coming too late. However, she thanked them for the 2020 publication. Dr. Mermin addressed this saying that they are certainly interested in that and that the comment is appreciated. Dr. Gail Bolan added her thanks to Dr. Taylor and said it is something they have incorporated in all their messaging around congenital syphilis prevention that one way to prevent congenital syphilis is to prevent an unintended pregnancy. She added that the challenge they have is that most STD clinics are funded by local or state dollars and their federal dollars are not truly service delivery dollars as they are more public health dollars. They also had been looking at training their disease intervention specialists in preconception care and make sure that they are referring people to contraceptive care if interested. There are some clinics that incorporate family planning services, but it is not something they can usually support at the federal level, so it must be worked locally.

Dr. Mermin restated the questions posed earlier about how to reach people who need to be reached when normal methods are not as effective as they could be in the time of COVID-19. One of the advantages of thinking about reaching people in their homes is that, as long as it is a place where they can be reached, care and distribution can be centralized. People in rural areas who may have to drive to get care, and even that care may not be welcoming, may be reached through telehealth. He acknowledged that it is not a one-stop shop and he appreciated everybody's comments about having different approaches for different people, but to be able to do this effectively could change how we approach a variety of public health issues.

Ms. Parkinson commented that she keeps hearing that the funding distribution of what the organizations that receive funding from HRSA can and cannot purchase has been relaxed a bit. Could that money be used to purchase, for example, a cellphone with a small package plan to enable priority patients to utilize telehealth services? Dr. Cheever said that in the spirit of Ryan White, the part A's, B's, C's, and D's who received funding were given the authority of how to prioritize their spending. Most of the part A's tried to get community input, although it was tough as this was at the beginning of April and it was all happening so fast. She added that there are FAQs on their website about the general rules about how the funding can be spent.

Mr. Hill-Jones had some pushback to the comment about health departments and doing

their best to engage the community which he wholeheartedly disagrees. He feels that with HRSA funding, a lot of the planning was done in a silo and reported back to communities what was decided. In speaking on behalf of the state of Texas and Dallas County and other southern states, but he feels that when COVID-19 hit and those resources hit, it even became more siloed. Dr. Cheever agrees that it has been very uneven, with differing experiences among jurisdictions. She shared that some places had more success than others and there were multiple part A's that were trying to figure out how to do conference calls to try to bring people together. Mr. Hill-Jones then added that it would be amazing to find how to start packaging these best practices so they can be communicated to jurisdictions. What makes it dangerous is that some groups do not know what they are doing and do not share what they are doing. He thinks that there are so many best practices that could be pulled in and the south could greatly benefit from some of those. Dr. Cheever thanked him for the recommendation and mentioned that they have been talking to CDC about this and have added this specific request to the agenda of the work that HRSA is coordinating with CDC in this area. Ms. Antigone Dempsey thanked Mr. Hill-Jones and added that they are trying to figure out how to create more materials for folks to be able to know who they should be able to contact in their jurisdictions, especially because CDC and HRSA funding are funding different places. They are trying to make it more accessible for people. Mr. Hill-Jones shared one more recommendation to give people on the ground the ability to communicate past their local jurisdictions if something is not happening appropriately as many people do not know who to contact outside of their local jurisdiction. Dr. Mermin commented that they must think about how they could do that but noted they were past the agenda and turned it over to next topic.

Recommendations for HIV and Youth

Debra Hauser, MPH
Workgroup Chair

Dr. Mermin introduced Ms. Hauser, who presented a revised draft of the Youth and HIV Plan letter addressed to Secretary Azar (Attachment 2). Dr. Bradley Stoner added that the recommendation letter was an action item from the last in-person CHAC meeting in November 2019. Ms. Hauser explained that the letter details that young people have not been prioritized in the Ending the Epidemic Plan and asks HHS to prioritize young people and in particular, the activities that are known to be linked to prevention of HIV in young people. She added that the letter was written a while ago and there might be newer statistics, but she felt the included statistics would suffice. The first part of the letter speaks to the science and research, addresses what is going on with young people, and touches on the political nature of what is happening within HHS and the administration. Ms. Hauser highlighted the evaluation data showing that for less than \$10 per student, which is both effective and cost-efficient, CDC/DASH was able to provide school districts with funding and technical assistance that resulted in a reduction in risk behaviors between 2014 and 2018.

The letter calls for DASH to increase the number of young people it can reach through its programs. Ms. Hauser added that DASH has about 32 million dollars for use in the area of

school health and including what was distributed to communities and within DASH, but she was not sure what DASH was allocated specifically in response to COVID-19. The letter recommends that DASH receive increased funding to:

- Improve the sex education provided to young people, particularly related to things relevant to HIV prevention and mental health, such as more information about PrEP and PEP.
- Routinize STI/HIV testing
- Provide GSAs in every school, as that alone reduces risk behaviors. Additionally, having a GSA in a school has an impact even for LGBTQ youth who do not participate in the GSA's programming.
- Better access to confidential, youth-friendly, and LGBTQ affirming sexual health services through schools
- Fund professional development for educators and other youth-serving professionals. Research has shown that when teachers get good professional development around HIV and sex education, they are able to implement quality sex education and create safe and affirming school environments. They are also often the teachers who start the GSAs.

Finally, the letter points out that the plan is heavily reliant on PrEP and testing, but in many states, about 30, PrEP is not available to young people confidentially. Instead, they need parental permission. If young people are not going to get PrEP and they are struggling to get tested, this leg of the plan falls apart.

In response to a question from Dr. Stoner asking what is different in the letter as compared to when it was last reviewed by CHAC in March 2020, Ms. Hauser noted that the modifications made to the letter included removing any irrelevant information due to changes in public policy. Additionally, this version of the letter did not call on HHS to do anything related to some of the other departments in the administration, but instead pointed out that there are things happening in the administration that are contradictory at best and damaging at worst. Ms. Hauser commented that when there are policies through other departments that affect or are unjust to LGBTQ people, men who have sex with men, or to people of color and they don't improve access to services or may increase stigma, they are in complete contradiction to the Ending the Epidemic Plan. The first version of the letter called on HHS to address these contradictions, whereas the revised version of the letter simply points out the contradictions.

Dr. Stoner asked if there were other comments on the letter, but none were raised. He stated it was a strong letter, and he did not see any downsides to CHAC sending the letter. He was happy to move forward with the letter as is. He asked if CHAC members needed to vote on the letter. Dr. Marvin Belzer indicated they did, as did Ms. Hauser.

CHAC Action

Dr. Stoner issued a motion for CHAC to adopt and approve the letter with its modifications. Dr. Michael Saag and Dr. Belzer seconded his motion. The motion was carried unanimously with no abstentions or oppositions.

Dr. Stoner stated they would work with the administrative staff to send the letter as written. He

thanked Ms. Hauser for her hard work and persistence on the letter.

Dr. Stoner pointed out that all CHAC members received copies of the letters Dr. Mermin wrote in response to CHAC's motion on recency testing (*Attachment 3 and 4*). Dr. Stoner mentioned that more information will be available at the next CHAC meeting. Dr. Mermin is continuing to investigate and will get back to CHAC with more information.

CHAC members did not raise any additional discussion items related to the Youth and HIV Plan letter or provide any additional recommendations for CHAC on youth.

New Business

Dr. Anderson asked for members to raise any new business to be discussed. Dr. Stoner did not have any additional business.

Mr. Hursey raised some questions that he and his organization, the U.S. People Living with HIV Caucus have had about EHE. They are in the process of reaching out to HRSA and CDC, but they are concerned about timelines and how the timelines may have been impacted by recent events. Mr. Hursey's personal concern was about community engagement. He suggested that new polls have come out from HRSA and CDC, which both include creating plans for community engagement. His hope is that these are not separate, disjointed plans. Further, he hopes that the HRSA plan is building on the foundation CDC is building. He wants to see continuity and a plan that is easy for community members to plug into and not feel like they are being pulled in different directions. He wants a continuation and a simple and streamlined plan.

Dr. Cheever responded that for EHE specific planning, CDC received the funding for community planning engagement, but HRSA is working closely with them on community engagement. She added that HRSA has received the plans and they are reviewing them hand in hand with CDC. She was not sure if there was a separate process Devin was referring to.

Dr. Mermin added that this issue may need to be investigated further, as their understanding was that there is a single process that is supported by CDC funding received through EHE from Congress, but that this funding was for joint jurisdictional planning. The jurisdictional planning is going to continue and it is supposed to encompass the approach of the community itself, all of its institutions and health departments, and what they think are the essential areas they need to work in to make the biggest difference for high impact prevention and care. Then, each of the federal agencies, in this case HRSA and CDC, would use their normal mechanisms to fund activities, aligned with these plans. For instance, Ryan White has the mechanisms to support Ryan White grantees. Dr. Mermin wondered if the CDC's notice of funding awards for CDC activities have been interpreted as a new separate activity not under the overarching concepts of the jurisdictional plans.

Mr. Hursey replied he may have misinterpreted it. He also added that his organization is concerned because they have identified a lot of different deadlines for a lot of different upcoming initiatives. He also mentioned tedious review processes. He further mentioned notices for TA projects for HRSA and for CDC, both including a component on community engagement.

He is hoping they are talking about the same system, instead of CDC's system for community engagement and HRSA's system for community engagement. He wants to make sure there is continuity, so that community members can easily plug in and not get lost in the process.

Mr. Hill-Jones replied that he thinks there is a continuous system and that the intent was not for there to be separate systems. He added that some communities are dealing with at least four different overlapping planning processes and they need to learn to how to sync and understand these processes. He further mentioned that there are people who still do not acknowledge that the 191906 HRSA grant that was funded, and CDC's 202010 were related and part of the Ending the Epidemic work. He thinks that as we are talking about the Ending the Epidemic plans, efforts should not be stopped at the planning and should be more specific in making sure the health departments on the ground are making the connections with the work. He stated that what hurts community engagement is when health departments do not make the connections and think that because something is not ending the epidemic, communities do not need to be engaged. He concluded that there is not a level of clarity, even for health departments, around the three funding announcements released and the larger funding announcements related to Ending the Epidemic.

Dr. Mermin and Dr. Cheever both stated these points were helpful. Dr. Mermin added that it is also helpful because just as there are intragovernmental actions making these efforts complicated, there are also coordination efforts that are not funded by the government but are quite active and need to be aligned.

Mr. Hill-Jones noted he found the following alarming regarding the CDC's feedback on the Ending the Epidemic plans and wanted it to be added to the record. He knows he has been vocal about his work in the South and with southern health departments, especially Texas, and their progress on ending the epidemic. Based on the number of federal updates, he knew the CDC had released their feedback on the draft plans to state health departments. When he reached out in April, he was told that the state health departments were going to look at it and provide the feedback, but communities and local health departments had not seen the feedback. He made another outreach asking about it because none of his colleagues at the health departments had seen the feedback. For Dallas, he had to give them their feedback after following up with the state health department. In response to this, he wants there to be several conversations:

1. He advocated for the release of feedback in a public way to ensure that people who are advocating and want to be involved in the work can see the feedback, not just the state health departments.
2. He further mentioned the challenges in defining the primary role of state health departments in this process. He commented that the state health departments have held onto CDC's feedback for several months, but community engagement has not been addressed at the state-level. When he asked how the state is communicating its strategy around community engagement to local health departments, he was told by the state that that level of engagement was for the local community and not necessarily the state. Just as federal partners are being held accountable, Mr. Hill-Jones felt state and local health departments also need to be held accountable. He wanted to acknowledge that

since a state funding mechanism is being used, there needs to be conversations about the prominent role state health departments are playing, since not everyone has the ability to be directly funded by the CDC, like Baltimore and Houston.

Dr. Cheever said both Mr. Hursey's and Mr. Hill-Jones' points were valid and that HRSA and CDC need to go back and explore the ways people can be supported in this process and HRSA and CDC can provide better communication.

Mr. Hursey reiterated that we are all on the same side, but that there needs to be a conversation to straighten some of these issues out.

Mr. McCray commented that CDC became aware of the states not sharing the feedback with the counties and local health departments a few weeks ago. As a result, CDC followed up directly with all jurisdictions stating that they must share the reports. The correspondence went out last week. Project Officers are also following up with all of the states to remind them that the feedback must be shared with all of the counties. While the CDC was informed about this happening in Texas, they suspected it might be happening in other jurisdictions as well.

Dr. Stoner asked Dr. Mermin whether he had a sense of when things would start to go back to a version of normal, especially regarding the workforce situation and deployments due to COVID-19. Dr. Mermin shared that it is tough to say and he does not feel the need for a public health workforce and deployments is decreasing. There are ways CDC can provide large-scale technical assistance and guidance, other times where CDC goes in the field to provide direct support, and times when it is in between. He thinks that right now, CDC is stretched. He provided the context that HHS has designated that all commissioned officers can be deployed without supervisory approval, and many have done 3-4 deployments. Dr. Mermin stated there is an expectation that the public health workforce will be working extensively on COVID. For the rest of the agency, there is a lot of need for good people, but those who are good and experienced develop a lot of direct-COVID experience and are wanted more often on the COVID response. Dr. Mermin suggested it might balance out at about the current state, with a fair proportion of scientific, programmatic, and administrative staff spending time helping the nation respond to COVID-19, through outbreak investigations or by helping local health departments to respond effectively. He felt efforts with local health departments may be increasing and that things would not go back to normal until a vaccine has been administered.

Dr. Taylor thanked Dr. Mermin for all his and all of CDC's work on COVID-19. She also added a comment to the record stating it is imperative that CDC receive data on COVID-19 incidence/new cases, hospitalizations, and deaths. She felt that placing medical data collection outside of the leadership of public health experts could severely weaken the quality and availability of public health data, cause a greater burden to hospitals, and weaken the pandemic response. Dr. Taylor added that we need the administration to follow the CDC's and public health expertise. She stated she was grateful to the physicians on the call, the researchers, the people who have lived experience, the activists, and others who are standing up and stepping up as much as possible to support the CDC. She appreciated everyone who is juggling CHAC's efforts with the response and hopes that the public can continue to get the data they need through the CDC.

Public Comment Period

No public comments were raised.

Adjournment

Dr. Mermin mentioned that the next CHAC meeting will be held in November 2020. Specific dates were not discussed or determined. He adjourned the meeting at 3:57 P.M. EDT.

CHAC CO-CHAIRS' CERTIFICATION

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

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

(Date)

Bradley Stoner, MD, PhD, Co-Chair
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and
Treatment

(Date)

Attachment 1: Participant List

CHAC Members Present

Dr. Jean Anderson, Co-Chair
Dr. Bradley Stoner, Co-Chair
Dr. Wendy Armstrong
Dr. Marvin Belzer
Dr. Demetre Daskalakis
Dr. Jodie Dionne-Odom
Ms. Debra Hauser
Mr. Venton Hill-Jones
Mr. Devin Hursey
Dr. Jennifer Kates
Dr. Shruti Mehta
Mr. Greg Millet
Ms. Johanne Morne
Ms. Kneeshe Parkinson
Dr. Michael Saag
Dr. Lynn Taylor

CHAC Members Absent

Dr. Travis Gayles
Ms. Gloria Searson

CHAC Ex-Officio Members Present

Dr. Pradip Akolkar
Dr. Paul Gaist

Ms. Kaye Hayes
Mr. Richard Haverkate

CHAC Ex-Officio Members Absent

Dr. Neerja Gandotra
Dr. Iris Mabry-Hernandez

CHAC Liaison Representative

Mr. Carl Schmid

Alternate for CMS

Dr. Richard Wild

CHAC Designated Federal Officers

Dr. Laura Cheever
HRSA/HAB Associate Administrator

Dr. Johnathan Mermin
CDC/NCHHSTP Director

Federal Agency Attendees

Ms. Margie Scott-Cseh, CDC
Mr. Richard McCord, CDC

Attachment 2: Recommendation Letter on HIV and Youth

CDC/HRSA ADVISORY COMMITTEE

on HIV, Viral Hepatitis and STD Prevention and Treatment

CO-CHAIRS

Jean R. Anderson, MD
Bradley Stoner, MD, PhD

MEMBERS

Wendy Armstrong, MD
Marvin E. Belzer, MD
Demetre C. Daskalakis, MD, MPH
Jodie Dionne-Odom, MD
Travis Gayles, MD, PhD
Debra Hauser, MPH
Venton Hill-Jones
Devin Hursey
Jennifer Kates, PhD
Shruti H. Mehta, PhD, MPH
Greg Millett, MPH
Johanne Morne, MD ED
Kneeshe Parkinson
Michael S. Saag, MD
Gloria Searson, MSW
Lynn Taylor, MD, FACP

DESIGNATED FEDERAL OFFICERS

Laura M. Cheever, MD, ScM
Health Resources and Services
Administration (HRSA)

Jonathan Mermin, MD, MPH
Centers for Disease Control and
Prevention (CDC)

EX-OFFICIO

Pradip N. Akolkar, PhD
Paul Gaist, PhD, MPH
Richard Haverkate, MPH
Kaye Hayes, MPA
Iris Mabry-Hernandez, MD, MPH
Neeraj Gandotra, MD
Richard Wild, MD, JD, MBA

LIAISON

Carl E. Schmid

DRAFT

Xxx xx, 2020

The Honorable Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Azar:

The Centers for Disease Control and Prevention/Health Resources and Services Administration (CDC/HRSA) Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) met on November 13-14, 2019. During this meeting, the CHAC passed a resolution and is sending a recommendation, described below, for your consideration.

Background and Rationale

Currently [*Ending the HIV Epidemic: A Plan for America*](#) does little to prioritize the needs of young people disproportionately impacted by HIV and AIDS. In addition, the Administration's actions to fund abstinence-only programming, limit young people's access to confidential care for sensitive sexual health services, and expand religious exemptions that discriminate against LGBTQ individuals, undermine public health best-practices to meet the comprehensive HIV prevention and care needs of these youth.

Some facts:

- Young people, ages 13 to 24, accounted for 21percent of new HIV diagnoses in 2017. 7,125 youth, ages 13 to 24 were newly diagnosed with HIV in 2017. Twenty-one percent of these young people were 15-19 years of age.
- In 2017, 90percent of new HIV diagnoses among young people were experienced by gay and bisexual young men.
- In 2016, 50,000 youth were living with HIV. More than half (56percent) were unaware of their HIV status.



The Advisory Committee advises the Secretary, the CDC Director and the HRSA Administrator of the U.S. Department of Health and Human Services on activities related to prevention and control of HIV/AIDS, viral hepatitis and other STDs, the support of health care services to people living with HIV/AIDS, and education of health professionals and the public about HIV/AIDS, viral hepatitis and other STDs.

- Young people, ages 13-24 who are living with HIV, are the least likely of any age group to be linked to care in a timely manner. They also are the least likely of any age group to have a suppressed viral load.

The national HIV plan should prioritize the needs of young people, particularly gay and bisexual young men and trans youth, and take into account all of the strategies and tools available to educate, empower and affirm these young people. Currently the plan focuses on four strategies: Diagnose, Treat, Prevent, and Respond. However, in many states, the barriers youth under age 18 face when seeking health care may stifle the plan's impact among this population. For example, in 2018, more than 30 states had laws requiring parental consent for minors to obtain PrEP. Condoms, which are more readily available to young people, are not prioritized within the current plan.

In addition, actions by agencies within the federal government are undermining public health efforts to end the epidemic.

Funding opportunities released by the Office of Population Affairs and its predecessor, Office of Adolescent Health propel implementation of ineffective and dangerous abstinence-only programs, rebranded as Sexual Risk Avoidance. These programs use fear and shame in an effort to control young people's behavior, stigmatize youth who are sexually active, and retraumatize survivors of sexual assault. However, fear, shame and stigma undermine young people's ability to disclose sexual health histories, obtain and use condoms and/or PrEP, seek STI/HIV testing, and obtain and remain engaged in health care services.

In addition, changes to Title X have limited minor's access to confidential services by removing federal requirements that Title X funded clinics provide young people with confidential access to sensitive health care services (contraception, drug and alcohol treatment, HIV and STI testing and treatment, and mental health care) regardless of state policy.

Significantly, in 2018, over 30 states had restrictions on minor's ability to obtain PrEP without parental consent or notification.

Finally, many of the administration's actions further stigmatize LGBTQ individuals and undermine public health efforts to end the epidemic. While some of these actions are beyond the control of the Secretary, CHAC urges you to speak out about the negative impact of these actions on the health and well-being of young people at disproportionate risk for HIV and AIDS. For example, over the past year, among other actions:

- The Department of Health and Human Services [announced](#) it would not enforce, and planned to repeal, regulations prohibiting discrimination based on gender identity, sexual orientation, and religion in all HHS grant programs. These include programs to address the HIV, opioid, and youth homelessness epidemics, as well as hundreds of billions of dollars in other health and human service programs.

- The Department of Education [published final regulations](#) permitting religious schools to ignore nondiscrimination standards set by accrediting agencies.
- The Department of Health and Human Services cancelled a plan to explicitly prohibit hospitals from discriminating against LGBTQ patients as a requirement of Medicare and Medicaid funds.
- Department of Housing and Urban Development [removed requirements](#) that applicants for homelessness funding maintain anti-discrimination policies and demonstrate efforts to serve LGBT people and their families, who are more likely to be homeless.
- Department of Housing and Urban Development (HUD) announced a plan to gut regulations prohibiting discrimination against transgender people in HUD-funded homeless shelters.
- Department of Defense put President Trump's ban on transgender service members into effect, putting service members at risk of discharge if they come out or are found out to be transgender.

Yet, there are programs within the federal government that have proven effective in helping young people reduce risk behaviors. From 2014-2018, for less than \$10 per student, CDC/DASH provided school districts with funding and technical assistance to: implement quality sex education, create formal referral networks to community health care services, and support GSAs. As a result of these efforts, funded school districts increased implementation of quality sex education to 88percent of middle schools and 93percent of high schools, increased access to key youth friendly health services, referring over 65,000 students, and increased safe and supportive environments by expanding student-led inclusive clubs to 76percent of schools. Together, these strategies led to statistically significant declines in the percentage of students who ever had sex, were currently sexually active, and/or had more than four partners.

And still, CDC/DASH's support only reaches eight percent of the 26 million middle and high school students nationwide.

Recommendations

CHAC calls on the Secretary to prioritize young people, particularly gay, bisexual and trans youth and youth of color within the National HIV Plan. CHAC further urges HHS to return to public health principles that recognize the importance of confidentiality on the health care decisions of youth and rescind religious exemptions that discriminate against LGBTQ individuals' ability to access health care. These religious exemptions stigmatize communities disproportionately impacted by HIV and AIDS and serve as barriers to care for these communities.

In addition, we urge HHS to expand CDC/DASH programs that have proven successful at building protective factors (school connectedness) and reducing sexual risk taking among youth (sexual health education and linkages to sexual health services, such as:

- Quality sex education. Quality sex education can build young people’s ability to: communicate desires and boundaries and share sexual health histories, understand the difference between healthy and unhealthy relationships, obtain PrEP and condoms, normalize routine STI/HIV testing, and help young people to become informed consumers of health care services.
- GSAs in every school. Research shows the presence of a GSA provides a protective factor even for LGBTQ youth who do not participate in the GSA’s programming.
- Access to confidential, youth-friendly and LGBTQ affirming sexual health services.
- Professional development for educators and other youth-serving professionals that helps them interrupt bullying, affirm LGBTQ youth, dismantle their unconscious bias and develop comfort and confidence to teach quality sex education.

Finally, young people need access to condom and PrEP availability programs without age restrictions or requirements for parental consent.

Thank you for your leadership and your continued commitment to ensure that prevention efforts are directed by the most current science and in advancing shared efforts to accomplish national goals.

Respectfully,

Jean Anderson, MD
CHAC Co-chair

Bradley Stoner, MD, PhD
CHAC Co-chair

Attachment 3: Recency Testing Response – Dr. Anderson



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

June 10, 2020

Jean R. Anderson, MD
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and Treatment
Co-chair
Professor, Gynecology & Obstetrics
Johns Hopkins Medical Institutions
600 N. Wolfe Street, Phipps 247
Baltimore, Maryland 21287

Dear Dr. Anderson:

Thank you for the recent letter from the Centers for Disease Control and Prevention (CDC)/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) regarding the agency's proposed HIV recency testing pilot program. We appreciate the thoughtful and detailed comments presented by CHAC.

CDC will work to provide CHAC with an update on the proposed recency testing pilot program at the November meeting. As our country continues to battle the Coronavirus Disease 2019 (COVID-19) pandemic, CDC is working to ensure the health and safety of the communities we serve and the staff on the frontlines of our efforts to combat HIV, STDs, and viral hepatitis. COVID-19 is severely disrupting the nation's services in research, surveillance, prevention, and care. Timelines for our programs, including the recency testing pilot project will need to be adjusted to adapt to recipients' needs. In these unprecedented times, HRSA and CDC remain committed to providing ongoing support for HIV, STD, and viral hepatitis prevention, care, and treatment. We look forward to updating CHAC later this year.

We value CHAC's interest in this important public health issue as well as your ongoing support of public health.

Sincerely,

A handwritten signature in blue ink that reads "Jonathan H. Mermin".

Jonathan H. Mermin, MD, MPH
RADM and Assistant Surgeon General, USPHS
Director
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Attachment 4: Recency Testing Response – Dr. Stoner



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329-4027

June 10, 2020

Bradley Stoner, MD, PhD
CDC/HRSA Advisory Committee on HIV,
Viral Hepatitis and STD Prevention and Treatment
Co-chair Associate Professor of Medicine
Division of Infectious Diseases
Department of Internal Medicine
Washington University School of Medicine
1 Brookings Drive, Campus Box 1114
St. Louis, Missouri 63130

Dear Dr. Stoner:

Thank you for the recent letter from the Centers for Disease Control and Prevention (CDC)/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) regarding the agency's proposed HIV recency testing pilot program. We appreciate the thoughtful and detailed comments presented by CHAC.

CDC will work to provide CHAC with an update on the proposed recency testing pilot program at the November meeting. As our country continues to battle the Coronavirus Disease 2019 (COVID-19) pandemic, CDC is working to ensure the health and safety of the communities we serve and the staff on the frontlines of our efforts to combat HIV, STDs, and viral hepatitis. COVID-19 is severely disrupting the nation's services in research, surveillance, prevention, and care. Timelines for our programs, including the recency testing pilot project will need to be adjusted to adapt to recipients' needs. In these unprecedented times, HRSA and CDC remain committed to providing ongoing support for HIV, STD, and viral hepatitis prevention, care, and treatment. We look forward to updating CHAC later this year.

We value CHAC's interest in this important public health issue as well as your ongoing support of public health.

Sincerely,

Jonathan H. Mermin, MD, MPH
RADM and Assistant Surgeon General, USPHS
Director
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention