Presidential Advisory Council on HIV/AIDS (PACHA)

80th Meeting

March 27–28, 2024

Council Members—Present
Marlene McNeese, PACHA Co-Chair, Assistant Director, Houston Health Department, Houston, TX
Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, Co-Chair, Executive Director, Institute for Policy Solutions; Professor, Johns Hopkins University School of Nursing, Washington, DC
Guillermo Chacón, President, Latino Commission on AIDS; Founder, Hispanic Health Network, New York City, NY
Philip Chan, M.D., M.S., Associate Professor of Medicine, Brown University, Providence, RI (virtual)
Tori Cooper, M.P.H., Director of Community Engagement for the Transgender Justice Initiative, Human Rights Campaign, College Park, GA
Raniyah Copeland, M.P.H., Principal, Equity & Impact Solutions, Los Angeles, CA
Mackenzie Copley, Co-Founder and CEO, One Tent Health, Washington, DC
Alicia Diggs, M.P.H., Manager, Office of Community Engagement, Center for AIDS Research, The University of North Carolina at Chapel Hill, Greensboro, NC
Jennifer Kates, Ph.D., Senior Vice President and Director of Global Health & HIV Policy, KFF, Washington, DC (virtual)
Paul Kawata, M.A., Executive Director, NMAC, Washington, DC
Duvia Lozano, LMSW, Program Director, Chicanos Por La Causa, Inc., Phoenix, AZ
Tiommi Luckett, National Organizer, Transgender Law Center, Little Rock, AR
Jesse Milan Jr., J.D., President and CEO, AIDS United, Washington, DC
Deondre Moore, Ambassador, The Elizabeth Taylor AIDS Foundation, Beaumont, TX
Leo Moore, M.D., M.S.H.P.M., Medical Director for Clinic Services, Los Angeles County Department of Public Health, Los Angeles, CA
Natalie Sanchez, M.P.H., Director, UCLA Family AIDS Network, Los Angeles, CA
Patrick Sullivan, D.V.M., Ph.D., Dipl. ACVPM, Charles Howard Candler Professor of Epidemiology, Rollins School of Public Health, Emory University, Atlanta, GA
Jeff Taylor, Executive Director, HIV and Aging Research Project, Palm Springs, CA
Marvell Terry II, Activist and Cultural Organizer, Founder, The Red Door Foundation and the Saving Ourselves Symposium, Memphis, TN
Hansel Tookes, M.D., Assistant Professor, Department of Medicine, University of Miami Miller School of Medicine, Miami, FL
Carole Treston, M.P.H., RN, ACRN, FAAN, Executive Director, Association of Nurses in AIDS Care, Philadelphia, PA
Darrell P. Wheeler, Ph.D., M.P.H., M.S.W., President, State University of New York at New Paltz, New Paltz, NY
Council Members—Absent
Laura Platero, J.D., Executive Director, Northwest Portland Area Indian Health Board, Portland, OR
Kayla Quimbley, National Youth HIV and AIDS Awareness Day Ambassador, Advocates for Youth, Columbus, GA
Dafina Ward, J.D., Executive Director, Southern AIDS Coalition, Bluffton, SC

Liaison: Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis, and Sexually Transmitted Disease (STD) Prevention and Treatment (CHAC)
Wendy Armstrong, M.D., FIDSA, Professor of Medicine, Emory University; Executive Medical Director, Ponce de Leon Center, Grady Health System, Atlanta, GA (virtual)

Staff
B. Kaye Hayes, M.P.A., PACHA Executive Director, Designated Federal Officer (DFO); Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP); Deputy Assistant Secretary for Infectious Disease, Office of the Assistant Secretary for Health (OASH), U.S. Department of Health and Health Services (HHS)
Caroline Talev, M.P.A., Alternate DFO for PACHA, Senior Management Analyst, OIDP, OASH, HHS

Federal Partners
Sharonda Brown, Deputy Director of Operations, OIDP, OASH, HHS
LCDR Rodrigo Chavez, Deputy Director, HIV Prevention through Active Community Engagement (PACE) Program Region 6, HHS
Laura Cheever, M.D., Sc.M., Associate Administrator for HIV/AIDS Bureau, HRSA (virtual)
Mary Glenshaw, Ph.D., M.P.H., Acting Director, Office of AIDS Research, National Institutes of Health (NIH) (virtual)
Timothy Harrison, Ph.D., Principal Deputy Director, OIDP, OASH, HHS
Ernia P. Hughes, M.B.A., Director, Office of Health Center Investment Oversight, Bureau of Primary Health Care, HRSA
Andrea Jackson, Dr.P.H., Senior Advisor, HIV/AIDS Bureau, HRSA
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CAPT John Oguntomilade, Ph.D., M.P.H., B.D.S., Regional Director, PACE Program Region 4, HHS
Kristin Roha, M.S., M.P.H., Public Health Advisor for HIV, Substance Abuse and Mental Health Services Administration (SAMHSA)
Day 1

Opening Remarks

Marlene McNeese and Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, PACHA Co-Chairs; and Eric Boerwinkle, Ph.D., Dean, University of Texas Health Houston School of Public Health

Ms. McNeese called the meeting to order at 9 a.m. CT and welcomed the participants. Dr. Boerwinkle welcomed the group, thanking PACHA for its significant impact on patients, families, communities, and the country.

Ms. McNeese described PACHA’s charge, charter, and membership, explaining that PACHA advises the HHS Secretary and the White House (via the Office of National AIDS Policy) but does not have any regulatory or funding authority. (See HIV.gov for more information.) She noted that Federal HIV programs have incredible support from lawmakers, who ensured continued funding in the most recent round of budget negotiations, but PACHA and others must continue to press for full funding that meets the urgent needs of these programs. Ms. McNeese said that the discussion among PACHA members, Federal partners, and community members contributes to thoughtful advice and recommendations that reflect the challenges and successes in the field.

Before this meeting, PACHA members visited three sites in Houston that serve people with HIV: Fundación Latinoamericana de Accion Social (FLAS), Inc., Avenue 360, and the Normal Anomaly. Each site demonstrated that the community has answers and should be empowered to respond to its own needs. In another nod to community empowerment, Ms. McNeese pointed out that the artwork in the meeting space was the result of a long-term local project celebrating World AIDS Day in collaboration with local school districts and Houston’s Art on the Streets program. Finally, Ms. McNeese noted that March is Women’s History Month and also includes National Women and Girls HIV/AIDS Awareness Day and National Native HIV/AIDS Awareness Day.

Dr. Guillamo-Ramos added his welcome to the attendees. He said PACHA’s site visits showcased each organization’s deep commitment to the work and clarity of purpose, leaving him feeling recharged. The visits also brought to light issues unique to the city. To achieve the goals of the Ending the HIV Epidemic in the U.S. (EHE) initiative and the National HIV/AIDS Strategy (NHAS), there should be more discussion about challenges at the local level. Dr. Guillamo-Ramos gave an overview of the agenda. (This meeting was broadcast live online; the recorded broadcast is available online.)

Roll Call

B. Kaye Hayes, M.P.A., PACHA Executive Director; Director, OIDP; Deputy Assistant Secretary for Infectious Disease, OASH, HHS

Ms. Hayes thanked Ms. McNeese and her team for their thoughtfulness and engagement in hosting this meeting. She then called the roll.
National Syphilis and Congenital Syphilis Syndemic Federal Task Force Update

Timothy Harrison, Ph.D., Principal Deputy Director, OIDP, HHS

At its June 2023 public meeting in Arizona, PACHA heard testimony describing problems in care and access contributing to a resurgence of syphilis. PACHA immediately passed a resolution calling for immediate HHS action, and the Task Force was created shortly afterward. Dr. Harrison summarized the data demonstrating increasing rates of syphilis that disproportionately affect gay, bisexual, and other men who have sex with men. Half of this population who have primary or secondary syphilis also have HIV. The rates of syphilis are also increasing among racial and ethnic minorities, especially Indigenous people.

The Task Force is chaired by the Assistant Secretary for Health, ADM Rachel Levine, M.D.; it has more than 200 members across the Federal government representing every sector of the U.S. government needed to move strategically and urgently. The Task Force created a framework that centers health equity, supported by three pillars: data and surveillance; prevention, screening, and diagnosis; and treatment. Multiple subcommittees address issues within the pillars. Using CDC data, the Task Force identified 14 jurisdictions that together account for 57 percent of primary and secondary syphilis and 74 percent of congenital syphilis. The Task Force prioritizes these jurisdictions but continues to address syphilis across the nation. Texas is among those priority jurisdictions, with a 76 percent increase in primary and secondary syphilis and a 151 percent increase in congenital syphilis from 2018 to 2022. Hispanic/Latino and Black/African American Texans carry a disproportionate burden of disease. Texas is one of only four States that require testing at all three stages of prenatal care and delivery, yet congenital syphilis has skyrocketed in recent years, primarily because of inadequate treatment.

The Task Force has triggered various actions, including raising awareness about the issue and available resources, providing treatment guidelines, addressing drug shortages, initiating research, and convening providers around prevention. Regional outreach efforts include meetings and webinars around the country that focus on providers and subpopulations. The Task Force is particularly concerned with addressing missed opportunities, such as treatment shortages and high costs, and is advocating for more point-of-care testing, harmonization of testing recommendations for pregnant people, and attention to the syndemic-related issues of substance use and stigma as a barrier to prevention and treatment. It also aims to raise public and provider awareness and share best practices more broadly across jurisdictions.

Discussion

Dr. Harrison said the Task Force is looking closely at syphilis rates in people of color. It has not yet focused on young people specifically but will likely do so in partnership with jurisdictions facing high rates of syphilis among that population.

Ms. Hayes pointed out that ADM Levine took immediate action in response to PACHA’s resolution on syphilis; she also thanked the community partners who highlighted the urgency of the issue.

Other discussions raised the role of the CHAC in relation to the Task Force and highlighted that the country faces not just an HIV epidemic but a synergistic epidemic of sexually transmitted
infections (STIs). Dr. Harrison said the Task Force included “syndemic” in its name to highlight the interaction of various conditions.

**PACHA Subcommittee Reports**

**Aging with HIV, Long-Term and Lifetime Survivors**

*Alicia Diggs, M.P.H., and Jesse Milan Jr., J.D., Co-Chairs*

Ms. Diggs said the newly formed Subcommittee finalized its charge to provide advice on enhancing the Federal response to medical, social, and mental health needs of people aging with HIV, including long-term and lifetime survivors. It will also propose recommendations for increasing access to comprehensive and integrated health care and funding HIV and aging research, support and social services, benefits, and resources that promote the health and well-being of people aging with HIV.

At the December 2023 PACHA public meeting, Ms. Diggs and Mr. Milan facilitated a session on this population that included experts in biomedical issues and policy challenges. The Subcommittee has met with a representative of the Department of Housing and Urban Development, who highlighted resources outside of the Housing Opportunities for Persons with AIDS (HOPWA) program for people aging with HIV. Laura Cheever, M.D., Sc.M., of HRSA’s HIV/AIDS Bureau described her agency’s work specific to people aging with HIV. She also shared her personal experience helping a family member transition from private insurance to Medicare. That transition is a huge concern for people with HIV, who are concerned about adequate coverage of HIV medications under Medicare. Ms. Diggs said the Subcommittee hopes to provide recommendations for PACHA’s consideration by the end of the year.

**Ending the HIV Epidemic**

*Guillermo Chacón and Tori Cooper, Co-Chairs*

Ms. Cooper said the Subcommittee frequently discusses what “ending HIV” means. To reach the goal of equitable health outcomes, the Subcommittee maintains that some redistribution of wealth and power is needed to ensure that all people at risk for HIV have access to preventive care, including preexposure prophylaxis (PrEP). The Subcommittee also seeks to prioritize marginalized populations, such as transgender people; women; Black, Indigenous, and people of color; people who use substances; people experiencing houselessness; and people with mental health conditions (including those undiagnosed). A comprehensive approach should address the social determinants of health (SDH) for all people with HIV and at risk for HIV. Mr. Chacón added that the Subcommittee is the largest of PACHA’s subcommittees, demonstrating the intense interest in the topic. The Subcommittee is working with the CHAC around workforce development issues and seeks to collaborate with the other PACHA subcommittees. In 2025, the Subcommittee will lead the way in evaluating progress toward the EHE initiative’s 2030 goals.

**Stigma and Disparities**

*Raniyah Copeland, M.P.H., and Leo Moore, M.D., M.S.H.P.M., Co-Chairs*

Dr. Moore described the Subcommittee’s in-person strategic planning meeting in February to map out goals for the year. The group narrowed its many areas of interest down to three high-priority topics, each represented by a working group:
• HIV Criminalization and Discrimination Working Group, led by Marvell Terry II, is planning a document on best practices used by States to eliminate HIV criminalization.
• The PrEP and Postexposure Prophylaxis (PEP) Working Group, led by Natalie Sanchez, M.P.H., will focus on raising awareness and plans to leverage HIV.gov as a communication platform.
• The Stigma Disruption Working Group, led by Dafina Ward, J.D., will address steps for tangible impact, including measuring and responding to stigma.

The Subcommittee discussed CDC’s funding opportunity announcement on surveillance and its recent guidance to health departments. It also heard from Mario Perez, M.P.H., of the Los Angeles County Department of Public Health, on strategies to reduce stigma.

Ms. Copeland added that the working group leads are newer PACHA members who will use the opportunity to build their leadership skills. The Subcommittee is seeking avenues for collaboration with the other PACHA subcommittees.

**The Global Agenda**
*Jen Kates, Ph.D., and Patrick Sullivan, D.V.M., Ph.D., Dipl. ACVPM, Co-Chairs*

Dr. Sullivan pointed out that a lot of the challenges to ending HIV in the United States are also global issues that will require cooperation. The Subcommittee seeks lessons from global initiatives that can be applied in the United States and to international partnerships around HIV. Subcommittee members believe that bidirectional learning means being open to sharing experiences and learning from others. Some areas of success include rapid start of treatment following an HIV diagnosis and HIV self-testing kits. The Subcommittee has talked with Federal partners and is planning more discussions with global partners to inform its work plan.

Dr. Kates pointed out that the Global Subcommittee sees itself as a conduit for sharing information about the President’s Emergency Plan for AIDS Relief (PEPFAR). The recently passed Federal budget reauthorized PEPFAR for 1 year. Dr. Kates welcomed input and questions from PACHA members, especially from those who do not regularly work on global HIV issues.

Ms. McNeese noted that the subcommittee co-chairs meet regularly with the PACHA Co-Chairs for strategic planning that takes into account input from the community and public meetings as well as subcommittee discussions.

**Ending the HIV Epidemic in Texas: Setting the Stage & County Perspectives**

*Facilitators:* Marlene McNeese, PACHA Co-Chair  
Deondre Moore, PACHA Member

*Panelists:* Thomas P. Giordano, M.D., M.P.H., Professor of Medicine; Chief, Section of Infectious Diseases; Director, Texas Developmental Center for AIDS Research; Baylor College of Medicine  
Venton Jones, M.S., Representative, District 100, Texas House of Representatives  
Lindsay Lanagan, Vice President of Government Relations and Public Affairs, Legacy Community Health Services
Sofia Sepulveda, Field Director, Equality Texas
Hope Adams, M.P.H., EHE Program Manager, Tarrant County, Texas
Miranda Grant, EHE Program Manager, Dallas County Health and Human Services
Dawn Jenkins, LCSW-S, Director, HIV Services, Harris Health Systems
Jason Black, EHE Coordinator, Harris County Public Health

Introduction
Ms. McNeese and Mr. Moore said the session was designed to bring forth challenges, successes, and opportunities from the unique perspectives of the presenters. State Representative Jolanda Jones, a longtime member of the Houston City Council and HIV advocate, presented PACHA with a certificate from the Texas House of Representatives, on behalf of the constituents of District 147, in which Rep. J. Jones commended PACHA for its dedication and commitment to the quality of life of people of color living with HIV.

Setting the Stage
Dr. Giordano explained that the care continuum for people with HIV in Texas (from diagnosis to viral suppression) is similar to that of the United States in several respects but worse than average in viral suppression, with notable disparities across familiar lines (e.g., lower rates of suppression among older people, people of color, and the transgender community). New diagnoses have increased substantially since 2019, but it is not clear whether the data reflect a true rise in incidence or the rate of diagnoses catching up with people who would have been diagnosed earlier if not for the COVID-19 pandemic.

The Texas Developmental Center for AIDS Research (D-CFAR) is a partnership among the States’ three major academic health research institutions that seeks to be a statewide HIV research resource and to draw more Federal HIV-related research funding to the State. It is specifically funded to propose and implement solutions through pilot programs. For example, the Baylor College of Medicine and Houston’s AIDS Education and Training Center (AETC) initiated a program for rapidly starting newly diagnosed people on antiretroviral therapy (ART), focusing on people outside of traditional academic centers. The program engages communities across the State, leveraging the Project Echo model, which links experts with providers in the field. Through the D-CFAR collaboration, the Harris Health System initiated the first routine universal HIV screening program, including screening in emergency departments (EDs), using an opt-out approach. The D-CFAR also hosts a popular annual community engagement program to share scientific results with the public.

Dr. Giordano said Texas has a highly engaged community, visible leadership, substantial research resources, and a collaborative environment focused on solutions. However, city, county, and State resources dedicated to ending HIV are minimal. The State has not expanded its Medicaid program and has a poor social safety net. Texas has restrictive policies on sex education, syringe exchange, and issues related to lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other (LGBTQIA+) people, as well as entrenched structural racism. There is limited philanthropy at the local level, and few formal partnerships between public health and academia. Regarding the lack of public funding, Dr. Giordano pointed out that Texas has a
higher rate of uninsured people and lower amount of Ryan White HIV/AIDS Program funding than most other States, even those that have not expanded their Medicaid programs. As a result, HIV in Texas falls affects low-income people more disproportionately. Organizations lack funding for evidence-based solutions and are sometimes denied funding because their implementation of much-needed basic services is not considered innovative enough.

Rep. V. Jones said he has seen some gains as a result of the EHE initiative, but Texas is a long way from ending HIV by 2030. Ms. Lanagan explained that Legacy organizes an annual visit to legislators at the State capitol, this year in partnership with the Positive Women’s Network’s (PWN’s) Texas Strike Force. This year, for the first time, legislation promoting HIV testing made it out of committee and passed in the House. Rep. V. Jones described the progress of two HIV bills, one of which would shift testing to an opt-out model and had bipartisan support. He explained the slow process of changing hearts and minds. Legislators continue to push forward on increasing HIV testing, allowing syringe exchange, eliminating HIV criminalization, and removing barriers to PrEP access. Other topics include adding injectable HIV therapy to the State Medicaid formulary and reinstating some important vaccines for immunocompromised people. Rep. V. Jones pointed out that 41 States purchase health insurance for people with HIV using AIDS Drug Assistance Program (ADAP) funding, including Florida and Georgia. The approach saves money, and Legacy is strongly advocating for Texas to adopt it.

Ms. Sepulveda said Equality Texas is a leading advocacy organization that has mobilized hundreds of people to visit the Capitol. In 2023, the Texas legislature introduced 141 bills targeting the LGBTQIA+ community, efforts to promote diversity, and other progressive movements—and the community managed to defeat 134 of those. Ms. Sepulveda stressed that it is impossible to end HIV when the government is openly hostile to the communities most affected: LGBTQIA+ people, Latinx and Black people, and immigrants. Even cities that are part of the global Fast-Track Cities initiative rely on local money because the State will not fund HIV research or education. Medicaid in Texas constructs a lot of barriers to HIV medications and to gender-affirming care, even for adults. Rep. V. Jones praised Equality Texas and its partners for showing up to advocate and refusing to be discouraged. Ms. Sepulveda emphatically called for Federal funding directly to organizations, cities, and counties that serve people with HIV, because Texas limits funding and the public’s capacity to advocate for itself.

Discussion

Rep. V. Jones explained that building relationships with legislators from both parties has contributed to the progress of HIV legislation in Texas. Regarding outreach and education, Dr. Giordano noted that the State is so hostile to HIV treatment that the Texas D-CFAR does not promote its success loudly because it wants to avoid negative attention; moreover, Dr. Giordano has been called to testify before a Texas House committee about the legality of D-CFAR’s programs.

Rep. V. Jones said there is a huge disconnect between the Federal perception of work to eliminate HIV and what is happening in cities. One way to address the issue is for Federal requests for funding proposals be clear about the obligations of grantees, particularly what constitutes “community engagement.”
County Perspectives and Discussion

Panelists briefly summarized the work of their organizations in the counties that encompass Fort Worth, Dallas, and Houston. They were asked to describe the top three points that they would like PACHA to communicate to those at the Federal level for the national agenda. The following issues emerged:

- What is innovative in counties with limited State support is not considered innovative enough at the Federal level for funding.
- Federal entities should make it easier for people to stay on Medicaid and Ryan White programs.
- Federal entities should make it harder to kick people off of Medicaid.
- Federal entities should send more funding to places that have higher needs (i.e., apply equity in funding).
- More cost data are needed to support the case for routine HIV testing, Medicaid expansion, and increased access to care at the State level.

The discussion surfaced skepticism about meeting the goals of the EHE initiative and whether entities are committed to ending HIV. For example, Rep. V. Jones said, there is little evidence that EHE jurisdictions are monitoring programs closely to demonstrate success. The EHE initiative does not seem to consider the need to address disparities in HIV care and prevention or the impact of COVID-19 on disruption of care. Rep. V. Jones called for re-envisioning the EHE initiative’s goals, centering efforts to end HIV, and better promoting coordination within and across jurisdictions.

Panelists reported that EHE funding goes to the State rather than counties or cities (with the exception of Houston), which limits the amount of money that reaches people who need it. Federal support for convenings is valuable, enabling organizations to learn from and partner with other EHE jurisdictions. Stigma remains strong in Texas, as evidenced by legislation targeting the LGBTQIA+ community, HIV criminalization laws, abortion restrictions, and barriers to sex education and syringe exchange programs. Panelists suggested that advocacy organizations work to engage more voters and advocate at the State level for change.

Ending the HIV Epidemic in Texas: Addressing the Needs of Black and Latina Cisgender Women and Efforts to Increase PrEP Access and Utilization

Facilitators: Raniyah Copeland, M.P.H., PACHA Stigma and Disparities Subcommittee Co-Chair
Natalie Sanchez, M.P.H., PACHA Member

Panelists: Adriana Avila-DiBello, ICPS, CHW, Senior Program Manager, Association of the Advancement of Mexican Americans
Ashley Cobb, Community Ambassador, Let’s Stop HIV Together
Charlene Flash, M.D., M.P.H., President and CEO, Avenue 360 Health and Wellness
Introduction

Ms. Copeland and Ms. Sanchez pointed out that despite the availability of PrEP for a decade, women have remained at the fringes of the HIV community. The panel was convened to center cisgender women at high risk. Panelists introduced themselves, outlined their work, and described their thoughts on why PrEP is critical for Black and Latina cisgender women.

Dr. Flash said the primary challenge is that cisgender women do not see themselves at risk for HIV. More investment must be made in studying PrEP in women. Additionally, Dr. Flash said funding should set money aside for capacity building, so that community organizations can build a track record and compete for their own funding. Ms. Cobb highlighted that cisgender Black women in particular should recognize that they are all “HIV-possible.” Ms. Avila-DiBello said she focuses on educating young people, so they do not make the mistakes of previous generations. Ms. Ray said PrEP is one tool, but the Black community needs fundamental system change to thrive. Ms. Williams drew attention to those born with HIV or diagnosed very young (a.k.a. dandelions), who face unique challenges.

Panel Questions and Answers

**What specific factors contribute to the increased need for PrEP among Black and Latina cisgender women?**

Dr. Hill said that despite prevention efforts, new cases persist, and there are clear inequities. From 2017 to 2021, Black women were 10 times more likely to be diagnosed with HIV than white women and four times more likely than Latina women. Ms. Avila-DiBello said rates do not appear to be improving nationally, and attitudes about safer sex practices and intimate partner violence have not progressed. In addition, organizations do not have the support they need to fulfill the obligations of Federal requests for proposals.

**Which SDH most impact access to Black women’s use of PrEP?**

Dr. Robinson said efforts should focus on where women work, play, and worship, and they should address the structural determinants—governance, policy, social and cultural values—that affect access. People with lived experience must have a voice to bring to light needs that vary according to geography, age, and other factors. Ms. Johnson suggested partnering with others to tap into systems that address housing, employment, education, food insecurity, and other SDH to build better systems that support PrEP. When systems fail to address the urgent, daily needs of living, an individual is unlikely to prioritize adherence to a preventive medication.
What has the Ryan White program done to provide culturally appropriate services for Black women with HIV?

Dr. Jackson responded that grantees are encouraged to leverage the Ryan White program infrastructure for whole-person care, including prevention. Among Black and Latina women receiving care in the Ryan White program in 2022, 89 percent and 91 percent, respectively, achieved viral suppression. Ryan White program efforts to address Black women specifically include funding for the Black Women First initiative. It sought to improve health outcomes for Black women with HIV within a culturally sensitive and responsive manner through the delivery of bundled interventions that included, for example, trauma-informed care and behavioral health.

How does PrEP fit into the world of women living with HIV?

Ms. Williams said that as a person born with HIV, PrEP was never an option, although she advocates for PrEP use. As a peer counselor, she sees recently diagnosed clients who do not know what PrEP is. Providers are not asking the right questions and not giving answers. Ms. Ray said PrEP fits into her role as an educator and community leader. She would like to see PrEP and HIV testing become prominent components of well-woman care to reduce the stigma.

Ms. Ray highlighted the need for more Black women in leadership and decision-making roles, where they can address the political determinants of health. What is now called the status-neutral approach is what clinics should have been providing all along—so that everyone gets the care and services they need. At the same time, Ms. Ray said, organizations like Black South Rising are fighting to preserve the Ryan White program resources and infrastructure to treat Black women with HIV, rather than adding PrEP and diluting the resources available for those with HIV. Organizations should not be fighting over money; resources should be available for everyone. Ms. Ray added that PrEP is not a magic tool, but it is one stop on the journey to liberation for Black women.

What are the main barriers preventing Black and Latina cisgender women from access PrEP?

Ms. Cobb said PrEP marketing excludes Black women, and many women do not see themselves as being at risk. Dr. Flash agreed, adding that women often avoid preventive care, as demonstrated by a lack of uptake of blood pressure and breast cancer screening, because they are too busy caring for others. Clinicians contribute to the problem when they are uncomfortable asking patients about their sexual history, especially patients from different races or cultures. Dr. Flash added that some young people equate sexuality with freedom—without thinking about risk; the same messaging does not work in the face of different cultural, social, and sexual norms.

In addition, structural barriers persist, said Dr. Flash. In Texas, Medicaid is only available to low-income women who are or have recently been pregnant. Even for those who can access patient assistance programs, the perceived costs of medications are itself a barrier, as patients may see it as a luxury they cannot afford. Education about PrEP must be more widespread among professionals, including primary care providers and clinicians in community health centers but also in the justice system and in schools, among other settings.
What are the capacity building needs for getting PrEP to Black and Latina women, and what efforts have worked?

Ms. Williams said the Black AIDS Institute’s ambassadorship program prepared people to educate their communities about PrEP, providing crucial knowledge to people well positioned to get the word out. Ms. Johnson added that the Black AIDS Institute’s PrEP learning collaborative, PrEP town hall meetings, and Black Treatment Advocacy Network were also very helpful. More capacity building efforts should focus on what is happening around PrEP right now, she said.

In what ways can we address cultural sensitivities and myths surrounding PrEP in Black and Latina communities?

Ms. Avila-DiBello stressed that cultural sensitivity begins at the clinic door and extends to every interaction. Moreover, providers must refrain from judgement, recognize that every individual is in a unique situation, and take whatever steps are available given the circumstances. She emphasized the need to meet people where they are and be supportive.

Ms. Johnson added that Black women do not see themselves reflected in marketing around PrEP. In addition, sexual health education is a very sensitive topic in Black and Latinx communities, and even health providers are reluctant to talk with women about HIV testing and PrEP. Parents need more education so they can teach their children about sexual health. Medical mistrust persists in the Black community and must be addressed. Cost is another barrier, as people perceive the cost of PrEP as very high, and the work required to secure discounted medication can be overwhelming.

What are the research gaps, particularly around implementation, and who is funding meaningful research?

Dr. Hill responded that Black and Latina women must be seen and valued. Much discussion centers around the failures of systems, but she believes the systems are working as designed—the health inequities are intentional, and Black and Latina women are not prioritized. Solutions must combat structural racism, medical mistrust, and stigma. Dr. Hill also noted that the funders of science and reviewers of grants appear to be the same people who created the current system. Ms. Ray agreed, noting that political will is absent, and the current decision makers fund their research priorities. Dr. Hill said the decision makers must prioritize research on implementation science around HIV incidence and prevalence among Black and Latina cisgender women.

How does the current political environment affect HIV medication access for Black and Latina cisgender women?

Ms. Ray said Black people and the LGBTQIA+ community are being targeted by the current political environment. Black and Latina women live at the intersection of race and gender discrimination and inequity. The systems are not improving. Ms. Ray said Black South Rising is working upstream to encourage voting and get more transgender and cisgender women into elected office. She added that despite the attention to women of color, resources do not follow, raising questions about the level of commitment. She called for building foundations and infrastructure where women take the lead, claiming political power by elevating Black and Latina women.
What strategies have been effective in increasing awareness and knowledge about PrEP among Black and Latina cisgender women?

Dr. Robinson said that change starts with reshaping the dialogue and providing the forum for honest, open conversations—beginning with sexual health and progressing to whole-person health. All people are HIV-possible and all are experts of their own health with lived experience to share. Bringing more people to the table is key, including young people and others who have been left out of the conversation.

Dr. Hill said her university conducted a pilot trial to link cisgender Black women who visited the ED with local PrEP clinics. Of 40 women enrolled, one visit to a community provider was confirmed. That woman had a mother and grandmother with HIV and went on to engage in more research. Dr. Hill emphasized that change is slow and takes time. Funders and study organizers must begin supporting implementation research that recognizes the pace of change. Ms. Avila-DiBello added that fear is a big part of decision making and is not easily reversed.

Dr. Flash noted that the Black AIDS Institute’s learning collaborative succeeded, as some of the small, grassroots organizations involved went on to become among the largest PrEP providers. She added that educating clinicians means including physicians, nurses, medical assistants, and community health workers (CHWs), among others, to talk with patients and promote PrEP. Social media is effective; Dr. Flash called for more investment in health communication that aims to send the right message through the right messenger for the intended audience.

Ms. Williams said more providers should be talking with women about PrEP and the risk of HIV. She also recommended more research on the use of PrEP among pregnant women.

Discussion

Ms. Ray explained that women represent a quarter of the HIV epidemic in the United States, and Black women make up 60 percent of that. If resources were proportional, there would be no problem. Decision making and funding must continue to consider the impact of HIV on Black women; resources will increase when more Black women are making decisions.

Ms. Sanchez noted that in her entire career, no forum has focused on HIV prevention for Latina women, and certainly no such space has ever been dedicated to the topic among Latina women in the United States who only speak Spanish. Latina women must be prioritized. Dr. Jackson agreed, adding that the Ryan White program assesses whether women are represented on planning councils, community advisory boards, and other spaces where they have an opportunity to have a direct impact on the quality and types of care being delivered to people with HIV. Ms. Williams hoped that dandelions would also be included. Several panelists expressed appreciation to PACHA for sponsoring this dialogue.

To address medical mistrust, Dr. Flash suggested looking more closely at the context to understand whether an individual mistrusts the institution, the medication itself, or the provider, and whether interventions are accurately targeting the source of the mistrust. Employing people from within the community served helps to break down some barriers, so workforce development should be more intentional. Dr. Flash said her research shows that respectful, humane treatment is critical to the health care experience. Interventions must build better bridges...
between providers and patients, because both are waiting for the other to broach the subjects of sexual health and PrEP.

Meeting participants were encouraged to seek out opportunities to give input into NIH’s strategic planning. Also, Robyn Neblett-Fanfair, M.D., M.P.H., said that CDC recognizes that Black women do not see themselves in social marketing around PrEP, so it sponsored #ShesWell, created by and for Black women. It also sponsored Sister to Sister to support clinicians with tools for having conversations with patients about sexual health. Dr. Neblett-Fanfair noted that the American Academy of HIV Medicine, in association with ViiV, recently announced the Dr. Dawn K. Smith HIV Prevention Clinical Fellowship to provide HIV training to 10 fellows who are not specializing in infectious disease in an effort to boost the HIV workforce.

**Ending the HIV Epidemic in Texas: Addressing the Needs of Hispanic/Latinx Communities, Including New Immigrants: Setting the Stage and Local Perspectives**

**Setting the Stage**

*Facilitator: Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, Co-Chair*

*Panelist: Andrew Selee, Ph.D., President, Migration Policy Institute*

Dr. Guillamo-Ramos invited Dr. Selee to give an overview of the relationship between Mexico and the United States. In addition to sharing a border with the United States, Dr. Selee said, Mexico is its largest trading partner, and more than one tenth of the U.S. population has Mexican heritage. The economic disparity between the two countries contributes to the complexity of the relationship. In terms of public health, there is a significant exchange of information across the countries that affects messaging and public policy. Dr. Selee observed that the rise in anti-immigrant, anti-Latino sentiment in the United States is likely related to the fact that every State in America has a significant Latino community, and the shifting nature of jobs means immigrants are everywhere. However, anti-immigration incidents tend to occur at the gateways (the border) and in places where people are feeling newly threatened by immigrants in the workforce.

Dr. Guillamo-Ramos asked how to entice large Latino organizations into partnerships around ending HIV and addressing health inequities. Dr. Selee responded that some Latino organizations in the United States represent broad swaths of Latino cultures, while others are narrowly focused around hometowns and shared languages. He recommended taking the message beyond the large nationally known organizations to the smaller ones that have credibility within their communities to deliver key messages. Dr. Selee anticipated that over time, Latino immigrants and U.S.-born Latinos will eventually move toward a more cohesive Latino identity, and that identity will likely be formed around English-language information. He concluded that organizations serving people with HIV should keep in mind people in Mexico, Central America, and South America. With so many people moving back and forth across the border, there may be opportunities to work transnationally, through government agencies.
Local Perspectives

Facilitators: Guillermo Chacón, PACHA Member, Ending the HIV Epidemic Subcommittee Co-Chair
Duvia Lozano, LMSW, PACHA Member

Panelists: Daniel Castellanos, Dr.P.H., Director of the Institute for Hispanic/Latinx Health Equity; Vice President of Research & Innovation, Latino Commission on AIDS
Elia Chinó, CEO and Executive Director, FLAS, Inc.
Pedro Coronado, Deputy Chief of Organizational Development & Training, Valley AIDS Council
Steven Vargas, Advocate

Introduction

By way of context, Mr. Chacón said that the number of Latinx people in the United States make up a disproportionate share of people with HIV, and the figure is rising. He observed that without more focus on prevention, the country will never achieve the 2030 goals of the EHE initiative. Ms. Lozano noted that Texas bears a high burden of HIV, and Houston, its largest city, has the highest rate of transmission among Latinx people. In Texas, one in six residents is an immigrant.

HIV Among Hispanic Texans: The Need for Micro and Macro Responses

Dr. Castellanos stressed the need for context and the importance of taking both a micro and a macro view of the challenges. He suggested recalibrating the four pillars of EHE by looking at the public health infrastructure and demographics in target areas and tailored the goals to local realities. Similarly, the same strategies will not work for every State and U.S. Territory. Understanding the local context is critical.

With a nod to the earlier discussion about the systems in place that perpetuate SDH, Dr. Castellanos described systems of exposure, which contribute to the fundamental causes of disease, SDH, and syndemics. For example, tuberculosis and HIV are linked to each other by homelessness, further fueled by substance use, and exacerbated in Texas’ border counties with Mexico. Those same counties have the highest rates of uninsured people and people living below the Federal poverty level. This data points to the influence of structures and systems on individual health.

The health professional workforce shortage across Texas poses significant challenges. Texas has one CHW for every 4,900 Texans, one psychologist for every 6,000 Texans, and one social worker for every 6,600 students. Workforce development is key to addressing HIV and the syndemics. Although 40 percent of Texans are Hispanic, only 15 percent have doctorates from Texas health-related public institutions, and those with higher skills tend to seek out higher-paying jobs in urban hospital systems, draining the workforce in smaller cities and rural areas.

Leading the next public health revolution requires addressing the mechanisms of inequity (e.g., unequal service location, restricted eligibility, and lack of Medicaid expansion) that lead to health disparities across Texas. It means providing flexible funding to meet counties’ sociocultural and economic needs. It requires rebalancing the role and funding of health and community-based organizations (CBOs) across Texas to provide culturally and linguistically
appropriate services, address medical mistrust, and increase community-driven health promotion. Efforts must support training and also ensure retention across the workforce pipeline. Finally, current national public health programs must be integrated and use a syndemic perspective to address the needs of a changing epidemic, not just in Texas but across the country.

**Challenges Facing Spanish-Speaking Residents**

Ms. Chinó described her experience, from witnessing the toll of HIV and AIDS on her friends in the 1990s to becoming a volunteer with the AIDS Foundation of Houston to eventually opening FLAS. FLAS is committed to enhancing behavioral health and wellness services for the Latino community and seeks to create a positive impact in the Latino community for a better quality of life. It offers comprehensive health, wellness, and social services. Some of its programs reach out to youth, the LGBTQIA+ community, and the transgender community in particular, with a focus on training people to advocate for themselves. In recent years, FLAS’ collaboration with the Consulate General of Mexico has helped link thousands of people to primary care services. The organization has reached hundreds of people locally and millions through Spanish-language media.

FLAS is located in the area of Houston with the highest incidence of HIV. Clients face the challenges of poor public transportation, lack of housing for undocumented people, unemployment, lack of health insurance, and poor medical care for Spanish-speaking people. They mistrust the health system and are scared of knowing their HIV status, because there is no support for the HIV community from local officials. Ms. Chinó called for more health care providers who speak Spanish and more education generally about HIV and immigration, as people with HIV face stigma and poor community support.

Ms. Chinó said the single most important recommendation is more funding. She proposed creating requirements in funding mechanisms that for every 100 people an organization serves, it should have at least two fully bilingual staff members. Ms. Chinó suggested more funding to small agencies that provide sustainable housing and food; allocating funds for public transportation so that people can get to testing, follow-up appointments, and services; funding for incentives for HIV testing; and increasing access to health care for everyone. She echoed the need to address SDH as well as immigration, pointing out that organizations may train CHWs, but without documentation, they are limited in where they can work. Ms.’ Chinó urged more attention to health equity for underserved minority communities and to HIV stigma and discrimination in the community and the workplace.

**Challenges at the Texas-Mexico Border**

Mr. Coronado described starting out as a part-time street outreach worker for Valley AIDS Council, where he still works today. The organization is located in Cameron County, TX, which borders Mexico and has high poverty and little health insurance. Valley AIDS Council provides status-neutral services similar to that of an EHE jurisdiction. As Dr. Castellanos noted, the four pillars of EHE do not work everywhere. Some counties are offering rapid start on ART but not PrEP because they lack the capacity. The University of Texas Rio Grande Valley School of Medicine provides training, but as Dr. Castellanos pointed out, most graduates move on to higher paying jobs elsewhere.
Mr. Coronado explained that working at the border poses unique challenges. The geographic area is vast; it takes 14 hours to drive from one end to the other of the Texas border. Valley AIDS Council provides training to communities that are hours away, and staff must pass through border checkpoints along the way. At those checkpoints, border patrol agents have the authority to stop individuals, ask about citizenship, and request documentation. Mr. Coronado said a number of advocates are unable to attend an upcoming conference in El Paso because they cannot risk being stopped at a checkpoint.

Valley AIDS Council collaborates with other AETCs, including the U.S.-Mexico Border AETC Steering Team that developed information sheets about insurance for people with HIV traveling to their home countries in Latin America. The effort involved working with U.S. Immigration and Customs Enforcement staff. Through that collaboration, the team has met with Mexican counterparts who disseminate the information sheets and exchange information. Mr. Coronado reported that many border towns in Mexico are offering PrEP for asylum seekers, and it is the job of community organizations to link migrants to the services they need in the United States. He described persistent efforts over 8 months to help one client who migrated to Utah get into HIV care, because so few providers there speak Spanish. Mr. Coronado said that addressing the health workforce is key, particularly training more CHWs, because they know their communities and can help defeat stigma through education and raising awareness.

**Challenges to Ending HIV in Texas**

Mr. Vargas hoped to sound an alarm, saying that the situation in Texas is even worse than presenters have depicted. People with HIV in Texas cannot count on the State to provide accurate information to end the epidemic. In fact, the State is actively working to counter efforts to end the epidemic and passing laws that promote stigma. The border checkpoints described by Mr. Coronado promote racial and ethnic profiling and target those who might be leaving the State to access reproductive health care.

Mr. Vargas noted that without addressing poverty, there will never be real progress against any syndemic. Other barriers include the excessive paperwork associated with funding, which kills the spirit of people working in the field to care for others. Mr. Vargas said CDC put a lot of money into helping hospitals develop electronic medical records systems; to finish the job, more funding is needed to make those systems interoperable to more easily keep people in care.

Mr. Vargas expressed pride in Houston’s Project Learning, Empowerment, Advocacy, and Participation (LEAP) is a 17-week HIV training program to prepare participants to sit on Ryan White planning councils. However, he noted, the city puts none of its own money into HIV services and has long refused to include a line item in its budget to address HIV. Discrepancies persist in services for long-term survivors of HIV, highlighting the need for Federal intervention. The lack of Spanish-speaking health care providers means Latinx people wait longer than others for care; Mr. Vargas supported Ms. Chinó’s recommendation that funding require organizations to have bilingual providers.

Texas has not expanded Medicaid, and the State prohibits citizens from creating ballot measures that could address such issues, again underscoring the need for Federal intervention. Medical mistrust goes back generations.
Mr. Vargas pointed out that the Texas Legislature is pushing laws to drastically limit women’s and the LGBTQIA+ community’s access to health care, so it is not the environment in which to implement molecular health surveillance (MHS). Mr. Vargas called for a full moratorium on MHS, because years of promised conversations around the issue have not materialized. Situations have changed, and it is no longer acceptable to assume that consent provided in the past applies to the current environment.

Discussion

Mr. Coronado said that the Valley AIDS Council will meet with the U.S.-Mexico Border AETC Steering Team at an upcoming conference to talk about issues such as the changing face of immigration and how to provide information tailored to various immigrant populations. In addition to binational meetings, representatives from all the Southern border States should meet and discuss strategies. Mr. Coronado noted that binational work is time-consuming and would be easier with more support from Federal partners.

Dr. Castellanos said flexibility in funding is key to changing grantmaking. PACHA and others should look more closely at where Minority AIDS Initiative and Ryan White program funding goes. Addressing endemic disease requires enhancing the workforce on the ground; providers who are part of the community can work to counter medical mistrust. A lot of funding goes to organizations that the community does not trust, Dr. Castellanos observed. More funding must go to prevention, early intervention, and support for HIV and AIDS services, balancing those needs against funding for biomedical intervention and treatment.

Mr. Vargas said people with HIV need help expanding Medicaid. The Texas HIV Medication Advisory Board recommended that the State use ADAP funds to purchase health insurance for people with HIV, yet the State’s health commissioner refused to do so. The Federal government should mandate that States that have not expanded their Medicaid programs use ADAP funds to purchase insurance for people with HIV, especially aging people with HIV. Mr. Vargas said advocates recently succeeded in gaining some Medicaid access for women with newborns, demonstrating that the piecemeal approach to policymaking can be effective in Texas.

Ms. Chinó urged more support for the transgender community. She said members of the transgender community are living in poverty because they cannot find work. Transgender immigrants leave Texas to apply for documentation for legal status. Transgender people have been used as research subjects, receiving only token amounts of cash in return. They are living without food and housing and are the most marginalized community of all.

Mr. Moore stated that Texas legislators have created what amounts to bounties by creating economic incentives for people to report women seeking abortion, illegal immigrants, and drag performers. He hoped his PACHA colleagues and Federal partners have clearly heard the needs of Texans.

Dr. Castellanos pointed out that more than half of U.S. States have some sort of HIV criminalization laws on the books. Although there are few prosecutions under those laws, the message they send is clear, and the result is an epidemic that hits people of color particularly hard. He suggested PACHA look at HIV criminalization in the larger context of inequality and discrimination.
Paul Kawata, M.A., acknowledged how eye-opening the presentations and site visits around this meeting have been in revealing the significant challenges Texans face. He urged Federal partners to fight harder than ever to respond to those challenges through the following steps:

- Rewrite funding opportunities to channel support to organizations with meaningful community ties.
- Select grant reviewers who are not beholden to the status quo.
- Level the playing field for CBOs.

Public Comment

**Michael Bailey of the Compass Housing Alliance** in Seattle, WA, which operates affordable housing across 20 sites, said there are certain fundamental rights that no person should have to fight for. These include access to quality and culturally appropriate health care and access to housing. He asked that in its deliberations, PACHA remember the unsheltered population and those struggling with housing insecurity. Compass’ facilities are instrumental in providing much-needed support and resources to both those populations, which tend to include individuals living with HIV and AIDS. People who are homeless or unstably housed tend to have a harder time attaining or sustaining care than those with more stable housing. They also tend to be less trusting of traditional structures, such as government-led social and health care programs. There is a timely opportunity to empower and leverage front-line employees as trusted messengers. They can help someone through the process of not just getting housed, but also getting health insurance, pursuing care, and following up with their care plan.

Mr. Bailey asked that PACHA allow housing advocates a voice in its work. He noted that the workforce supporting unsheltered and housing-insecure populations are concerned about the effects on funding under a new administration. Mr. Bailey said that the way to provide critique without offending key players is by requiring community to be a part of the process. He asked that PACHA include the housing community in its conversations and thanked the Council for taking the time to fight the battles of others.

**Mario Harper from the U.S. Business Action to End HIV and the Health Action Alliance** said PACHA’s vision inspired the creation of a coalition of private-sector companies united by a common commitment to end HIV epidemic. PACHA’s call to action resonated with ViiV Healthcare, which reached out to the Health Action Alliance to turn this vision into a reality. The mission of the coalition is aligned with the NHAS and seeks to accelerate progress in ending the U.S. HIV epidemic and improving health equity across the country. The success of the coalition is rooted in collective action, ranging from hosting HIV education events and strengthening HIV health benefits for employees to launching new innovative partnerships and connecting customers in vulnerable communities with HIV services. The coalition also plans to offer programs that deepen business engagement and is developing local chapters in priority regions to better engage businesses in the local public health response.

The U.S. Business Action to End HIV launched its first local chapter in Atlanta and is developing its second chapter in Houston, working closely with local leaders to identify the unique needs of this community and how Houston businesses can be a force-multiplier of public
sector efforts. It is working closely with the Houston LGBTQ+ Chamber of Commerce, Mercer, and Chevron, with a goal of launching in Houston later this summer.

In February 2024, the coalition spearheaded the submission of a letter to Congress, signed by influential private-sector leaders, calling on Congress to fully fund domestic HIV programs in the final 2024 appropriations packages. Mr. Harper said the private sector can be a catalyst for achieving the ambitious goals outlined in the NHAS. The coalition does not replace any existing efforts, but rather aims to collaborate. It stands ready to work alongside PACHA and others to create healthier workforces and community.

**Carl Schmid of the HIV+Hepatitis Institute** drew attention to substandard HIV drug coverage by a Houston-based insurer, Community Health Choice of Texas. The importance and value of modern-day HIV treatment, including single-tablet regimens, is well known, as is the importance of using the most current drugs that do not cause serious side effects or drug resistance, the value of NIH’s treatment guidelines, and the importance of adherence, which all lead to viral suppression. It is also well known that high cost-sharing leads to patients not taking their drugs. Patient protections enshrined in the Affordable Care Act (ACA) include important nondiscrimination provisions in implementing regulations. Plans cannot place all or a majority of the drugs to treat a specific condition on the highest cost-sharing tier. Drug formularies must be clinically based and follow acceptable treatment guidelines. A plan is potentially discriminatory if it does not cover single-tablet regimens.

The HIV+Hepatitis Institute found troubling results from its assessment of Community Health Choice and filed a complaint with the Center for Consumer Information and Insurance Oversight (CCIIO), the Federal agency that regulates ACA plans. Some of the drugs on its formulary are no longer used and were phased out due to their high toxicity levels. One of its plans does not cover a single drug recommended to initiate therapy according to NIH’s HIV treatment guidelines. Another plan just covers three, but two of them have to be taken as three separate pills. Very few single-tablet regimens are covered. One plan puts all HIV drugs on the highest tier, while another one puts 68 percent of them on the highest tier, which can translate into a 50-percent coinsurance payment. The HIV+Hepatitis Institute included the plan data, treatment guidelines, analysis, and the government’s own regulations in its formal complaint.

Unfortunately, the response was disappointing. CCIIO acknowledged the concerns but gave a pass to the insurer and did not seem interested in enforcing its own regulations. Exposing the plan must have had some impact, because this week Community Health Choice shifted some drugs away from the high-cost specialty tier of its formulary. However, there was no change in which drugs were covered. The HIV+Hepatitis Institute is working on scheduling a meeting with CCIIO and advocates and providers from Houston to further discuss the agency’s response and lack of enforcement. Mr. Schmid said he hoped that PACHA shares his organization’s concern that if the Federal government allows this plan to get away with these policies, other insurers will follow suit, jeopardizing HIV treatment around the country.

**Jason Farley, Ph.D., of the Center for Infectious Disease and Nursing Innovation (CIDNI) at the Johns Hopkins University School of Nursing** said CIDNI receives funding through all four pillars of EHE to support the people of Baltimore City. Under the diagnosis pillar, CIDNI’s testing efforts offer status-neutral approaches for HIV testing, linkage, and navigation services
for PrEP or HIV care for every client, in English and Spanish. Recently, the Baltimore City Health Department learned that the funding would end in early July of 2024. New CDC funding opportunities are delayed due to Congress’ slow action on budget appropriations, posing a clear threat to public health and EHE progress. Although a new budget is moving forward, it must be recognized that flat funding equates to a reduction in HIV funding.

Under the treatment pillar, CIDNI’s HRSA-funded, nurse-led CHW model seeks to support the approximately 10 to 15 percent of Ryan White clients who are unable to achieve or maintain viral suppression, often because of mental health issues, substance use, and social and structural determinants of health. Under CIDNI’s program targeting those 10 to 15 percent, 70 percent of clients have achieved viral suppression, and 43 percent of those have sustained viral suppression for 6 months or more.

Despite this remarkable achievement, because of the delayed budget agreement, the program received funding covering only 6 months of this year’s budget. Congress’ inaction threatens delicate progress. Dr. Farley asked PACHA to prepare a resolution to HHS Secretary Becerra outlining the successes of the EHE program and the harmful national impact of reducing or withdrawing current funding, emphasizing that flat funding translates into a reduction of programmatically available funding. To effectively end HIV in the United States, EHE should not only continue, but its funding should be increased. In a resolution, PACHA should utilize EHE programmatic successes to justify increased funding.

**Jester Jersey**, a vaccine advocate and CHW in California, said the pandemic exposed inequalities for many disadvantaged and stigmatized groups, such as newly arrived immigrants, minorities, the elderly, those from low economic backgrounds, and members of the LGBTQIA+ community. When COVID vaccines first became available, some counties in Southern California made access difficult for individuals with HIV/AIDS, prioritizing people with HIV who were already using a treatment program like PrEP. When mpox later emerged, guidelines and information about where to get vaccines and who was eligible were often confusing. In both cases, the response could have been better.

Mr. Jersey said that as a vaccine advocate and member of the LGBTQIA+ community, he found the disparities very disappointing. When health resources were stretched to their breaking points and trust in science was waning, the last thing the country needed were confusing guidelines. The nation’s health leaders should do better. People with HIV/AIDS are already very susceptible to other illnesses. Vaccine rates remain low for many vaccine-preventable diseases, and the incidence of measles, tuberculosis, and other illnesses are on the rise. Solutions are needed that inform and empower rather than guidelines that confuse people at best or ostracize them at worst. Continuing down this path will not only drive down vaccine rates, but also the trust in the science that is supposed to keep people safe. Mr. Jersey called for more investment in trusted messaging around vaccine advocacy and disease prevention. He also urged a more proactive approach, treating problems at the source rather than waiting for an issue to develop.

Ending the HIV epidemic in the United States will require more inclusion of those at risk and avoiding a one-size-fits-all approach. People in the LGBTQIA+ community are unique individuals who deserve care based on their unique circumstances. Mr. Jersey implored PACHA, HHS, and the Biden Administration to invest more in trusted messaging, collaborate more with
health advocates in LGBTQIA+ community spaces, and provide better care for LGBTQIA+ community members across the country.

Selena Harbor of PWN addressed surveillance of transgender and gender-diverse Texans and MHS of Texans living with HIV. When health care is criminalized, surveillance puts people in harm’s way, especially those who are already oversurveilled by police. Texas recently enacted a law banning transgender youth from accessing gender-affirming care, such as puberty blockers and hormone therapy. Since then, Texas Attorney General Ken Paxton has been requesting medical records on Texas youth from out-of-State care facilities that may have provided telehealth services, including in Georgia and Washington. Gender-affirming care has been proven to be lifesaving for transgender youth, as they face higher rates of suicide and suicide attempts than their cisgender counterparts. The surveillance of young transgender bodies is a violation of patient privacy and human rights, and it must end, said Ms. Harbor. Moreover, surveillance and criminalization of abortion in Texas is a violation of human rights. Lastly, the more than 100,000 people living with HIV in Texas are under surveillance.

In 2018, CDC began requiring that all entities accepting HIV prevention funds must implement MHS, in which State and local health departments identify HIV transmission networks by mapping the social and sexual networks of people living with HIV without requiring their knowledge or consent. PWN is concerned about this lack of consent. It is also concerned about the possibility that private health information could be used in criminal prosecutions. This risk is even higher for communities most impacted by HIV and communities most overpoliced, including people of color, queer and transgender people, sex workers, low-income housed folks, and people who use drugs. The practice of MHS is dangerous. Medical mistrust continues to affect relationships between the health care system and patients most in need of access to care. Sharing information without consent or knowledge only further deepens medical mistrust and alienates folks from the lifesaving medical care they need.

On a personal level, Ms. Harbor said that surveillance persists for people living with HIV in many different areas of their lives. As a person living with HIV for 20 years, she has felt unsafe for the past 5 years regarding how her medical information might affect her housing through the HOPWA program. The program requires annual recertification that includes proof of CD4 count and viral load. Ms. Harbor does not know who else may access her private health information without her permission and cannot trust that the information would not be used against her in a criminal or civil proceeding. This type of mistrust in HIV service programs sustains HIV stigma, which leads to folks not feeling safe enough to access care and services they need to thrive with HIV. Ms. Harbor demanded robust health data privacy protections, transparency, and informed consent when it comes to the needs of people living with HIV.

See the appendix for written submissions.

Next Steps and Closing Remarks

Marlene McNeese and Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, PACHA Co-Chairs

Ms. McNeese urged all Council members to serve on at least one subcommittee. She and Dr. Guillamo-Ramos will each serve on two subcommittees so that Council leadership has a
Day 2

Opening Remarks and Roll Call

Marlene McNeese and Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, PACHA Co-Chairs; and B. Kaye Hayes, M.P.A., PACHA Executive Director; Director, OIDP; Deputy Assistant Secretary for Infectious Disease, OASH, HHS

Dr. McNeese called the meeting to order at 9:01 a.m., CT. Dr. Guillamo-Ramos said that among the topics resonating with him are Texas’ uninsured population, the potential to incentivize States to use best practices in governing formularies and regimens for people with HIV, better positioning Medicare to support people with HIV, and the persistence of biased laws that are not based in science and criminalize people with HIV. Ms. Hayes called the roll.

Ending the HIV Epidemic in Texas: Addressing the Unique Rural and Urban Needs

Facilitators: Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, PACHA Co-Chair
Marvell Terry II, PACHA Member

Panelists: Samuel Hebbe Goings, M.P.H., HIV and Hepatitis Prevention Director, Texas Department of State Health Services
Anayensi Almaraz, HIV Prevention Program Manager, CAN Community Health
Dena Hughes, Executive Director, Triangle Area Network
Cordella Lyon, M.A., HIV Program Coordinator, Baptist Hospitals of Southeast Texas
Martese Prince, Chief Program Officer, Abounding Prosperity
J. P. Cano, Director of Prevention, HELP Center for LGBT Health & Wellness
Nathaniel Holley, CEO, The FreeLux Project
Cherise Rohr-Allegrini, Ph.D., M.P.H., CEO, San Antonio AIDS Foundation (SAAF)

Rural Perspectives

What are the core issues for people who are vulnerable to or living with HIV in rural areas?

Ms. Lyon responded that communities face a lack of expertise in HIV care, which could be addressed by providing student loan relief for graduates who practice in rural communities. Ma. Almaraz added that stigma exists everywhere but is pervasive in rural communities where privacy cannot be guaranteed. One way to counter stigma is to pair HIV testing with routine health screenings and provide health services in a neutral approach. Mr. Goings pointed out that
171 of Texas’ 254 counties have fewer than 50,000 residents, so infrastructure and stigma are driving forces. In addition, focusing resources in areas where the numbers of people with HIV are highest results in a lack of visibility for rural communities.

Ms. Hughes pointed out that the Triangle Area Network was well known in the community for providing STI testing and care before it became a Federally Qualified Health Center. Its greatest challenge is HIV prevention, particularly among young adults who travel to the cities where their risk of exposure is higher. In addition, Ms. Hughes said, while there remains a clear need to get the prevention message out to people of color, low-income white people in rural areas are also at high risk, and organizations must overcome barriers imposed by policies and beliefs that make it hard to get the message out to those vulnerable people.

**What are the infrastructure challenges in rural areas?**

Ms. Hughes said the challenges go beyond organizations partnering to better use their limited resources. Data from rural areas are not being adequately considered in decision making, and rural communities are left out of conversations in Houston and elsewhere about their need for services and resources. Counties have different political structures than cities and require more coordination across entities. Ms. Hughes said local service providers need more funding to support participation and collaboration. Ms. Lyon added that the South is at high risk for natural disasters, which takes a mental toll on communities on top of long-term structural damage. The high cost and limited availability of housing affects access to health care, and people in rural areas live farther from their resources. Ms. Lyon said housing must be seen as a crucial tool for health care prevention.

**How should hospital systems be better used in rural areas?**

Ms. Lyon observed that hospitals in many rural areas are closing down or limiting services. In rural communities, hospitals often are health care hubs that provide services to all and are seen as neutral ground. Hospitals have access to pharmacy and other specialty services. Partnering with hospitals and health departments in rural areas can be very effective, although concerns persist about who funds such work.

**In rural areas, what is the relationship between hospitals and CBOs that are fighting HIV?**

Ms. Lyon said that in Beaumont, TX, the relationship is respectful, and she gave several examples of cooperation. For example, Baptist Hospital worked with the health department to inform policies around first responders’ exposure to bloodborne pathogens. Ultimately, the city saved money by enacting evidence-based policies. Hospitals can prescribe PEP in their EDs, and they can help people with HIV who are inpatients reengage in HIV care, neither of which costs the hospital anything. Mr. Goings added that hospitals are often teaching environments. Many hospitals have expansive networks and can recruit providers to practice periodically at a rural location. Exposing providers in training to models of HIV screening, linkage, and services is beneficial. Ms. Lyon also noted that rural hospitals can participate in clinical studies, increasing the likelihood that study findings are relevant to rural communities. Rural clinical studies could offer insights on medication adherence, for example.
How has technology impacted the work of your organization?
Ms. Hughes noted that after years of minimal progress, the COVID-19 pandemic forced providers to offer telehealth, which is expected to be very helpful for rural residents. Organizations also have had to invest in technology to support integrated networks. Providers have invested in mobile units to provide in-person services within communities. So, technology has helped with sharing information and providing telehealth and has also expanded the capacity to see clients in person.

How has your organization worked through harsh weather and the COVID-19 pandemic, and how do such disruptions affect staff and community morale?
Ms. Almaraz said that CAN Community Health launched in October 2020, mid-pandemic, and remained open to serve people in person, taking every precaution to protect patients and staff. It supplemented telehealth with home-testing kits. Its risk management staff and other leadership keep an eye out for dangerous weather conditions that might affect the safety of people receiving care or traveling for appointments. Ms. Hughes pointed out that being in a smaller community can be a positive in times of disaster, because organizations and people are already closely related. Her organization strives to provide staff with flexibility so they can balance their own needs with the needs of clients and the community.

What recommendations could PACHA pursue to make work in rural areas easier?
Ms. Almaraz emphasized that limitations on funding are at the root of the problem, such as restrictions that prevent an organization from serving the neighboring community or clients who commute across jurisdictions. More flexible funding would help. Mr. Goings said the State has revised its funding mechanisms to allow organizations more flexibility across city and county lines. He called for more prevention strategies and interventions designed specifically for rural communities. Ms. Lyon suggested funding technology platforms that privately connect clinical and social services (e.g., Unite Us), which can help rural communities refer clients to services and follow up on the referral. Ms. Hughes recommended creating an accurate definition of “rural” that reflects the reality on the ground. Federal agencies can not only make more resources available to rural areas but also help establish collaborations and public-private partnerships to maximize available resources.

What should PACHA understand about advancing EHE work in rural areas?
Ms. Lyon said EHE is not visible in rural communities. She asked for an evaluation of progress to date, with an eye toward expanding EHE to rural communities by leveraging partnerships and technology. Mr. Goings added the need to lay the groundwork for extending EHE by gathering lessons learned from States like South Carolina, where HIV is most prevalent in rural communities. Rural communities can start applying those lessons now, with more funding to support steps such as peer networks and workforce development. Ms. Hughes said rural communities should have the same access to resources as people in urban areas, and communities should have sufficient resources to support people with HIV over the long term.

Discussion
Ms. Hughes explained that her organization is known for providing STI services but also screens patients who are seeking routine care, so people have access to HIV and other services regardless of how they approach the organization. All staff are educated and trained in care management,
insurance, navigation, and medication assistance, and staff work hard to ensure that clients have a seamless experience.

Ms. Lyon said her hospital is currently supporting a clinical study of an approved medication for people newly diagnosed with HIV. The hospital does not promote the study but recruits patients as appropriate through a one-on-one meeting, allowing time and space to respond to questions. Frank discussions are key to building trust, Ms. Lyon added.

Asked about the process of submitting patient-level data to HRSA, Ms. Hughes said she hoped HRSA gets a full, comprehensive picture of the patient population. Triangle Area Network is implementing new technology to gather more real-time data to better understand what patients are facing. Managing patients with HIV is complicated by the impact of SDH and stigma. Ms. Hughes said she is learning how to tell the story better, but she needs more help interpreting and communicating what is happening in her rural patient population and how that compares with other, non-urban settings.

To reach immigrants and non-English-speaking people, Ms. Lyon said Baptist Hospital forges relationships with people who teach English as a second language. She suggested that grants allow some funds to go to English language learning, which is key to building confidence and advocating for oneself.

Urban Perspectives
What are the unique challenges facing urban areas?

Mr. Wiley responded that lack of housing, food deserts, and insufficient infrastructure are major challenges in urban areas. Another is complacency around HIV; advocates must go back to the basics of educating people about HIV, because so many people do not believe an epidemic of HIV still exists. Mr. Wiley called for more discussion about what ending HIV means and an assessment of progress toward EHE goals.

Dr. Rohr-Allegrini said San Antonio feels like a small town, especially for those in the LGBTQIA+ community, so stigma persists. Questions come up often around privacy protection, and some people are reluctant to get tested or take PrEP because their families or roommates will notice. Dr. Rohr-Allegrini added that San Antonio is paradoxical: there is a lot of stigma but also great acceptance. In addition, San Antonio offers a lot of ways to access HIV care, but the city remains divided, and a substantial portion of its poorest residents have very limited access to health care and transportation. Despite robust education efforts and information available online, many people are unaware of where they can get services and how the process works.

Dr. Rohr-Allegrini said that offering testing for gonorrhea and chlamydia brought a lot of people in who then agreed to HIV and syphilis testing. As a result, the city saw an increase in HIV and syphilis diagnoses among young women. Dr. Rohr-Allegrini noted that funding is targeted to address priority populations, not cisgender women or heterosexual men, making it financially challenging to provide services to everyone.

Mr. Holley added that Dallas lacks culturally competent providers. Also, Dallas lacks continuity in health services for people with HIV recently released from incarceration. They may be given a week’s worth of medication but no link to services, housing, or other needs.
Mr. Cano emphasized that the cost of housing is increasing, especially in cities, pushing low-income LGBTQIA+ people out of the city. Fort Worth and other cities also receive a lot of Spanish-speaking immigrants who need housing and services but do not speak English. Mr. Cano said more education is needed, as well as more communication, despite the prevalence of social media messaging, and particularly for people who do not speak English. Mr. Cano also noted that focusing only on “urban” and “rural” leaves a lot of ground uncovered. Moreover, clients are individuals with unique needs and perspectives, and they do not just live or work in one place.

Mr. Prince pointed out that many of Abounding Prosperity’s clients face barriers to accessing services because they do not have an up-to-date driver’s license, birth certificate, or proof of residence or bills paid. For people who are unhoused, it is difficult to hold on to such documents; without transportation, it may be impossible to get to the government buildings that provide such documents. More consideration is needed of what access really means in context.

**Is competition among service providers unique to urban settings?**

Mr. Holley said competition over limited funding streams is inevitable. The result is a disincentive for community organizations to collaborate, because each aims to boost its own numbers to maintain funding. Mr. Holley said FreeLux was created with Federal funding, which enabled it to avoid competition for local level funding and open up avenues for cooperation. The issue of competition raises questions about whether the goal of EHE funding is to end HIV or to maintain businesses that provide services. Mr. Holley added that without collaboration, EHE’s 2030 goals will not be met. Mr. Holley suggested that PACHA recommend more Federal grant funding go directly to local organizations rather than being funneled through the State.

Dr. Rohr-Allegrini acknowledged that organizations in San Antonio are all vying for the same pot of money, but they have worked together as a community, thanks to strong leadership and personal relationships. For example, San Antonio set up a task force that brings HIV testing providers together monthly to talk about what is available and the challenges they face. There is now interest in doing the same for those who provide housing and case management. Dr. Rohr-Allegrini said the community works collaboratively to serve people in need.

Mr. Wiley emphasized that the goal is to provide high-quality health care and services, not to advance the organization through competition, and he makes that message clear to all the organizations in his area. He maintains notes about clients’ experiences with organizations to which they are referred, and he follows up with those organizations if necessary. Mr. Wiley called for using creative approaches to draw more funding, such as revising the mission statement to focus on a broader population.

**Discussion**

Mr. Holley noted that FreeLux trains health professionals and others to organize and advocate around HIV, building the next generation of leaders. There are many mechanisms to build capacity, with the understanding that one’s own story has a lot of power, he added. FreeLux amplifies stories to reach a broader audience. The main barrier Mr. Holley sees to ending the epidemic is that people do not perceive HIV as an epidemic. Mr. Wiley added that mentorship is critical. More organizations, especially national organizations, should recommit to leadership training, which not only builds capacity but also boosts collaboration. Mr. Cano highlighted that
representation matters, and the conversation changes when people of color are in leadership positions, so training and mentoring are vital.

Dr. Rohr-Allegrini said SAAF started an early intervention program to help people with HIV newly released from incarceration make the transition into a community. The effort has been successful locally and is expanding across the State.

Mr. Wiley reiterated the proposal that grants include funding for capacity building, because small organizations can sometimes meet peoples’ needs better than larger ones.

Dr. Rohr-Allegrini said more money is always needed to advance toward ending HIV. However, rather than wait for the problem to get worse, Federal funding should broaden the definition of priority populations or eliminate the requirements around priority populations altogether. As a previous session discussed, women need more awareness of and access to PrEP now.

Darrell P. Wheeler, Ph.D., M.P.H., M.S.W., asked for opinions on how the field can move forward rather than reinventing the wheel with every generation and how to put systems in place in a concrete way so the field is not losing ground. Mr. Cano said the field continues to use the same mechanisms to do the same work, and the government’s approach is always about 10 years behind. Bureaucracy is slow, and the population of people at risk for HIV is changing rapidly. Dr. Wheeler observed that the current system perpetuates an illness-based approach rather than a mindset of wellness. Mr. Moore added that the field must make room for new voices and new perspectives.

Dr. Wheeler noted the absence of community-academic partnerships. Dr. Rohr-Allegrini said SAAF has several such efforts underway. The organization is frequently approached about participating in projects—but without any funding to support the extra work. Dr. Rohr-Allegrini suggested that academic researchers include community partners in their grant proposals.

**PACHA to the People: Community Engagement Session**

PACHA invited all those participating to speak. Key comments are summarized here according to the main themes.

### Training and Workforce Issues

- Increase funding for nursing and medical students to get training in HIV care. Academics are volunteering their time to offer interprofessional training around HIV, but HIV is not on the curriculum, and there is no funding to put it on to the curriculum.
- Health care professionals in training would benefit from learning how to provide care in a kind, compassionate, and respectful manner.
- Train the HIV workforce to broaden their vision rather than focusing narrowly on the steps needed to secure a grant.
- More funding is needed for academic grants that boost the pipeline of academic researchers, particularly those from underrepresented groups.
- HRSA’s training stipend for people pursuing a master’s degree in social work is a good model for supporting training.
• Build the workforce through more funding for training, including more fellowships and postdoctoral fellowships.
• Workforce development efforts should also address dissatisfaction, pay, and administrative barriers for current providers of HIV care.
• HRSA and CDC should align funding to increase the number of CHWs, which could fill workforce gaps in rural communities in particular.

Leadership Training and Capacity Building
• Invest in leadership training and building capacity in communities. The persistence of young leaders in small CBOs with minimal investment has contributed to some important gains, such as the election of State representatives who represent the LGBTQIA+ community. Local activists have pushed back against the State with some success.
• People with HIV must be meaningfully involved in all aspects, including decision making around funding.
• People need a sense of ownership and autonomy to advance the field.

Role of Nursing
• Increase support for nurses in the field, who are leaving the profession because of burnout.
• The shortage of health care professionals with HIV training threatens the continuity and quality of care for people with HIV, especially in rural and high-need areas. Nurse practitioners provide comprehensive care and a patient-centered approach that can fill the gaps, so their roles should be strengthened and barriers to practice reduced.
• PACHA should include more nurses. Nurses play a vital role in providing direct patient care, education, support, and advocacy. They serve in roles across the spectrum of care, from intake to prescriber to researcher to administrator, and they spend more time with patients than physicians do.

Systems Change
• Point-of-care HIV testing should be standard for all people aged 13 and older seeking care in an ED. Nurses should be able to order and perform the testing. To support this plan, nurses and EDs need resources for and education on routine testing. All staff should be trained to provide posttest counseling and to link patients to care outside of the ED.
• The health care system and its reimbursement models must change: a 15-minute patient encounter is not enough time to address any patient’s concerns in a comprehensive way and particularly not the comorbidities of an aging person with HIV. There is little economic incentive for providers to practice primary care. Some Federal funding or regulations can influence insurers and help gain more time for patient encounters.
• There should be a coordinated effort between the public health sector and clinicians around syphilis. Routine, opt-out screening for syphilis in the ED is crucial to detect syphilis early and thus reduce congenital syphilis cases.
Federal Steps

- Using ADAP funds to purchase health insurance saves the State money, yet Texas refused to do so, just as the State has refused Medicaid expansion. The Federal government should mandate that States without Medicaid expansion use ADAP funds to pay for health insurance for aging people with HIV.
- Requiring individuals to demonstrate eligibility for ADAP twice a year is a barrier to medication access. HRSA clarified that annual review is acceptable but left the decision about the interval up to States.
- How can the Federal government better address HIV in small towns where there are few cases?
- The Federal government should borrow from the tactics of the previous administration by using executive orders to enact change and withholding funding from States that do not treat their Black, Latinx, and LGBTQIA+ communities with dignity and respect. It should also uphold existing laws more strictly to protect these communities.
- The cost of insurance is too high, even with ADAP, and President Biden has not honored his campaign commitment to create a public insurance option.
- PACHA should advocate for a fully funded response to HIV.
- The Texas border with Mexico should be designated an EHE jurisdiction, which would provide the area with more leverage in dealing with local governments.
- The 340B program is America’s health safety net and must be protected.
- Address the differences across States in formularies and medication eligibility.

Grantmaking

- Federal grants should require at least annual monitoring, with corrective actions as needed, and allow for automatic renewal when grantees succeed. Increase technical assistance for grantees.
- Grants to academic institutions should address the issue of out-of-control indirect costs.
- To achieve good geographic balance, communities should review the service delivery grants targeting their areas.
- To increase collaboration between academics and CBOs, researchers need more time to set up those relationships, so that CBOs can be included in grant applications.

Special Populations

- Keep in mind the needs of people who acquired HIV at birth and are now well into adulthood.
- Aging people with HIV need comprehensive health care services and access to health insurance.
- Solidarity across genders, race, ethnicity, sexual orientation and gender identity, and other distinctions is critical for the HIV community.
- PACHA should advocate for full sexual and reproductive rights of people with HIV. Reproductive rights are under attack, especially for Black women in the South. Reproductive rights are a human right.
• PACHA should organize a youth council to hear the perspectives of young people and give them opportunities to develop leadership skills.

HIV Criminalization
• PACHA should continue to speak up against MHS.
• There should be a moratorium on MHS, especially in States like Texas that are criminalizing people seeking health care. A moratorium would help build trust within the HIV community.

Other Topics
• Increase the visibility of available resources and communicate that availability better to CBOs, academic centers, and health care providers.
• PACHA should address the issue of huge for-profit conglomerates like Health Care of America buying rural hospital systems and then closing them down or dramatically cutting services.
• PACHA should address rural infrastructure issues.

Remarks from the Assistant Secretary for Health

ADM Rachel L. Levine, M.D., Assistant Secretary for Health, HHS
ADM Levine thanked the PACHA Co-Chairs for their work and Ms. Hayes for her exceptional leadership. The observance of Women’s History Month celebrates the outstanding progress women have led in improving health. ADM Levine pointed out that the NHAS highlights ways to accelerate HIV-related research, prevention, care, and treatment for women and girls by including Black and transgender women as priority populations, highlighting research needs, and recognizing the need to scale up interventions for girls and women with HIV. Across the Federal government, agencies are prioritizing projects such as the Ryan White program’s Black Women First initiative; CDC’s #ShesWell PrEP for women campaign; and OIDP’s Work of ART campaign. OIDP recently launched an initiative centering the well-being of Black cisgender and transgender women.

ADM Levine shared her excitement about President Biden’s recent Executive Order to prioritize women’s health across the Federal research portfolio and budget. The President’s proposed fiscal year (FY) 2025 budget calls for investment in all aspects of health, supports the most vulnerable, and shifts focus from illness to promoting wellness. The proposed budget invests in treatment and prevention of HIV and other infectious diseases as well as vaccine-preventable diseases. It would continue funding for the EHE initiative, with increases for the Ryan White program and the Indian Health Service and would sustain funding for HIV programs and services under other Federal health agencies. Notably, the budget proposes $9.8 billion over 10 years for a mandatory PrEP delivery program. It also requires States to cover PrEP and associated laboratory services with no cost sharing for Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries. Such programs would save lives and money. The FY 2025 budget also invests in syndemic conditions that affect HIV, including viral hepatitis, STIs, substance use disorder prevention and treatment, and mental health services.
Notable progress has been made around the availability of donor organs for people with HIV with the advancement of the HIV Organ Policy Equity Act, which facilitates research. HHS intends to propose new rulemaking standards for HIV-positive kidney and liver transplants to help increase access and reduce administrative burdens. ADM Levine pointed out that every successful transplant shortens the wait list for all patients.

Taking a syndemic approach to understand and address the interactions of HIV, STIs, viral hepatitis, substance use, and other conditions can identify new opportunities to intervene. This approach is reflected in the redesigned America’s HIV Epidemic Analysis Dashboard (AHEAD), which now includes SDH data alongside data on EHE HIV indicators to provide more context and increase the usefulness of AHEAD. The approach is also highlighted in the name of the National Syphilis and Congenital Syphilis Syndemic Federal Task Force, which is making significant progress. The Task Force has met with State health officials in all of its 14 priority jurisdictions and is dedicated to reducing primary, secondary, and congenital syphilis cases.

ADM Levine thanked PACHA for its thoughtful engagement, recognizing that the perspectives and challenges surfaced at this meeting will inform recommendations to the Secretary. She appreciated all the participants for the work they do every day to end the HIV epidemic.

**PACHA Discussion and Reflections**

Marlene McNeese and Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, Co-Chairs

Members expressed appreciation to all the participants for their candor and passion, and many indicated that they were deeply moved by the presentations and site visits. A number of Council members urged participants to stand up for their interests by voting. Several identified areas for PACHA and its subcommittees to consider, organized here according to topics of interest.

**Federal Guidance, Funding, and Policies**

- PACHA should consider recommending that Federal funding notices and guidance be more directive—for example, mandating use of ADAP or other Federal funds to purchase insurance for people with HIV in States that have not expanded Medicaid, limiting review of eligibility for the Ryan White program to once a year, and requiring that U=U (i.e., undetectable = untransmittable, meaning that a person with HIV who has an undetectable viral load cannot transmit HIV) be part of grantees’ strategic approach. Using ADAP funds to purchase health insurance saves money.
- Presenters made three clear requests to PACHA’s Federal partners:
  - Make it easier for people to stay on Medicaid and Ryan White programs.
  - Make it harder to kick people off of Medicaid.
  - Send more funding to places that have higher needs (i.e., equity in funding)
- Investigate the tools available to HHS right now, through regulations, contracts, and cooperative agreements, and other mechanisms, to advance the goals of EHE, by, for example:
  - Declaring a public health emergency in States that have not expanded Medicaid on the basis that they have failed to achieve the levels of viral suppression that the Ryan White program has achieved nationally;
mandating that States that have not expanded Medicaid provide access to insurance for people with HIV;
- requiring formularies in every State to include all approved HIV treatments; and
- requiring States to repeal HIV criminalization and limit MHS.

- Consider how Federal grant requirements around financial infrastructure can be revised to give new and small organizations a better chance at receiving funding, because they may have innovative and more effective solutions for their communities.
- Redefine “rural” to include areas that are not urban and lack access to care and resources.
- Fund the development and implementation of interventions specifically for rural communities.
- Revisit the commitment to end the epidemic as outlined by the EHE initiative and ensure that accountability is built into the metrics that communities are required to capture.
- Expand the definition of “innovation” in Federal grants to enable grantees to enact the interventions that would best fit their communities.
- Consider transnational cooperation around HIV, especially in border States.

Special Populations and Representation
- Address HIV prevention among cisgender women who do not see themselves at risk for HIV.
- Prioritize people with HIV; the Federal government seems to be more focused on PrEP, and there is little attention to U=U.
- Increase long-term HIV survivors’ access to Medicare and address the transition to Medicare of aging people with HIV.
- The South has the majority of HIV infections in the United States, so the South must take the lead in efforts to end HIV.
- Consider the needs of seasonal farmworkers.
- Include more nurses of all types in PACHA and among its presenters.
- Infrastructure is more than brick-and-mortar buildings; it also encompasses representation.
- Recognizing the Latinx community and its diversity is essential to the future of the nation’s work around HIV.

Building Capacity
- Figure out how to build the capacity of undocumented people who are passionate and want to contribute to their communities.
- Promote capacity building for people with HIV to act as mentors and be part of the workforce.

Increasing Trust
- A moratorium on MHS would increase trust among communities of color.
- Stigma continues to pose barriers to people in every State and Territory.

Workforce Issues
- Increase the role of nurses in the workforce.
• Restrictions that were removed at the outset of the COVID-19 pandemic to make it easier for providers to practice should not be reinstated, as they limit the capacity of providers to work together using the full extent of their skills and training.

Next Steps and Announcements

Marlene McNeese and Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, RN, ANP-BC, PMHNP-BC, AAHIVS, FAAN, PACHA Co-Chairs; and B. Kaye Hayes, M.P.A., PACHA Executive Director; Director, OIDP; Deputy Assistant Secretary for Infectious Disease, OASH, HHS

Ms. McNeese explained that PACHA members consider all of the information presented at meetings (with the aid of detailed notes provided by staff and contractors) in their deliberations publicly and in subcommittee meetings. Following this public meeting, the co-chairs of all the PACHA subcommittees will meet with the PACHA Co-Chairs to develop a strategic plan for the Council. PACHA recognizes the importance of acting quickly in this election year, as a change in administration could delay progress.

Ms. Hayes announced that Caroline Talev, M.P.A., would take over as PACHA’s executive director and DFO, with Dr. Harrison serving as alternate DFO. As the Director of OIDP, Ms. Hayes will continue to serve on PACHA as a Federal partner. Ms. Hayes pointed out that mentorship is an important component of leadership, and she is proud to be handing the reins over to Ms. Talev.

Ms. Talev thanked Ms. Hayes for the opportunity to learn from her and said it has been a privilege working with PACHA for more than a decade. She outlined some of PACHA’s outstanding accomplishments in that time, such as co-hosting the first Safe and Voluntary HIV Disclosure Summit with the CHAC, supporting ACA passage, developing PACHA’s Achieving an AIDS-Free Generation report, creating PACHA to the People, and hosting the HIV-Related Stigma Reduction Summit. Dr. Harrison added that he was honored to work as an alternate DFO, and he thanked Ms. Hayes for her years of leadership.

Ms. McNeese adjourned the meeting at 3:19 p.m., CT.
Appendix: Written Public Comments

Planning for Testimony

General Information
Date: 3/27/2024 - Public Comment at 5:15pm
Location: UT Health Houston School of Public Health, 1200 Pressler Street Houston, TX, 77030
Committee name: Presidential Advisory Council on HIV/AIDS (PACHA) Chair/Members of the Committee
Time limit: 3-4 minutes

Written Comment: If you decide you would like to provide public comment, you may submit your written statement by emailing PACHA@hhs.gov by close of business Thursday, April 4, 2024.

Preparing your testimony

Thank you, Chair and members of PACHA for this opportunity to provide public comment. My name is Selena Harbor. I am the Community Outreach Coordinator for Positive Women’s Network - Greater Houston Area.

Today I would like to talk about the issue of surveillance: surveillance of trans and gender diverse Texans and of course, molecular HIV surveillance of Texans living with HIV. The thread connecting all of my concerns is that when health and health care are criminalized - whether it is gender affirming care or HIV - surveillance practices can put us in harm’s way, especially for already over-surveilled and -policed communities.

Over the summer, a law went into effect that bans transgender youth from accessing gender-affirming care such as puberty blockers and hormone therapy. Since then, Texas Attorney General Ken Paxton has been requesting medical records on Texas youth from out-of-state care facilities they may have received telehealth services from, including in Georgia and Washington. Gender affirming care has been proven to be lifesaving for transgender youth as they face higher rates of suicide and suicide attempts than their cisgender counterparts. The surveillance of young trans bodies is a violation of patient privacy, human rights, and it must end.

While I don’t have time to discuss abortion, I do want to bring it up to state that the surveillance and criminalization involved with abortion in TX is a violation of our human rights.

Lastly, people living with HIV in Texas are under surveillance. There are currently over 100,000 people living with HIV in the state of Texas making Texas the state with the fourth highest prevalence of HIV in the U.S. We are being surveilled through a practice called Molecular HIV Surveillance or MHS. In 2018, the CDC began requiring that all states accepting HIV prevention funds must implement MHS which is the practice that the state and local health departments, like the Texas Department of Health & Human Services and the CDC use to identify HIV transmission networks by mapping the social and sexual networks of people living with HIV without requiring their knowledge or consent.
We are concerned about the lack of consent for people living with HIV. We are also concerned about HIV criminalization as we are unsure about the possibility that our private health information could be used in criminal prosecutions. This risk is even higher for communities most impacted by HIV and communities most overpoliced including Black and brown people, queer and trans people, sex workers, low-income and houseless folks, and people who use drugs. The practice of MHS is dangerous. Medical mistrust continues to fracture relationships between our healthcare system and patients most in need of access to care. Sharing folks’ information without their consent or knowledge only further deepens medical mistrust and alienates folks from the life-saving medical care they need.

On a personal level, I feel that surveillance persists for people living with HIV in many different areas of our lives. I have been living with HIV for 20 years and for the past five years I have felt unsafe with my medical information in regard to my housing. I utilize the HOPWA program for housing and every year I must recertify. When I recertify, I am asked to turn in proof of my CD4 Count and viral load. This is concerning because I’m not sure who else is accessing my private health information without my permission. I cannot trust that my information would not be used against me in a criminal or civil proceeding. This type of mistrust in HIV service programs sustains HIV stigma which leads to folks not feeling safe to access the care and services they’d need to thrive with HIV. I am demanding robust health data privacy protections, transparency and informed consent when it comes to the needs of people living with HIV.

Thank you, PACHA, for allowing me to be here today to provide public comment on the issues that are important to me.
We are facing a critical juncture in its battle against the HIV epidemic, not due to a lack of medical advancements but because of a dwindling number of healthcare providers specialized in HIV care. As the pioneers of HIV care approach retirement, the influx of new physicians entering this specialty is alarmingly low. This shortage poses a significant threat to the continuity and quality of care for people with HIV, especially in rural and high-need areas. In this context, the role of nurse practitioners in both specialty clinics and primary care settings is becoming increasingly vital.

With their comprehensive training and patient-centered approach, nurse practitioners are well-positioned to fill this growing gap in the HIV care workforce. Studies have shown that they can provide HIV care that is similar to or even better than that provided by physicians, particularly in rural, underserved, or resource-constrained settings where access to physician providers is limited. Other studies show greater patient-provider trust in the care provided by nurse practitioners. This is crucial for maintaining the strides made in HIV prevention, diagnosis, and management, which have significantly improved the lives of people with HIV.

Educating nurse practitioners in providing HIV care is not just about addressing the current provider shortage; it's about preparing for the future. With the aging population of people with HIV, the demand for specialized healthcare services is expected to grow. Integrating HIV-related content into nurse practitioner academic programs and offering specialized training can equip them with the necessary skills and knowledge to provide comprehensive care for people with HIV.

The satisfaction levels and work conditions of current HIV care providers highlight the need for a sustainable approach to workforce development. Addressing dissatisfaction with remuneration and administrative burdens is essential, but so is strengthening the role of nurse practitioners. By reducing barriers to their practice, we can ensure a high-quality, resilient workforce capable of reducing patient morbidity, preventing new HIV infections, and contributing to a more equitable healthcare system.

Emily A. Barr, PhD, RN, CPNP-PC, CNM, ACRN, FAAN
Good evening to the Presidential Advisory Council on HIV/AIDS,

My name is Jester Jersey & I’m a vaccine advocate, serving as a community health worker & health advocate in California & nationwide. I thank the Council for allowing me to speak.

The pandemic exposed inequalities for many disadvantaged and/or stigmatized groups, such as newly-arrived immigrants, minorities, the elderly & those from low-income backgrounds. Even more so for those who are members within several of these demographics. Members of the LGBTQI+ community are no exception.

When COVID vaccines first became available, some counties in southern California made access difficult for individuals with HIV/AIDS. HIV positive individuals who were already using a treatment program like PrEP (PreExposure Prophylaxis) were prioritized. When Mpox later emerged & guidelines became available for it, the guidelines & information were often confusing, such as where to get vaccines or who was eligible. In both cases, the response could have been better. I’ve heard similar stories across the country where such disparities happened but was surprised to hear about it in California too.

As a vaccine advocate & fellow member of the LGBTQI+ community, I find this very disappointing. Growing up in the Bay Area in California for most of my life, I couldn’t imagine the health inequities that LGBTQI+ community members face still existing today. At a time when health resources were stretched to their breaking points & trust in the science waning, the last thing we needed was to deny care or release confusing guidelines to the LGBTQI+ population. Our nation’s health leaders should do better.

Individuals with HIV/AIDS are already very susceptible to other illnesses. With vaccine rates continuing to remain low for many vaccine-preventable diseases, as well as incidences of measles, tuberculosis & other illnesses on the rise, we need solutions that inform & empower, rather than guidelines that confuse people at best or ostracize them at worst. Continuing down this path will not only drive down vaccine rates, but also the trust in the science that is supposed to be keeping us safe.

We need to invest more in trusted messaging, in vaccine advocacy & disease prevention in general. We also need to be more proactive instead of being reactive- treating problems at the source, rather than waiting for an issue to develop. An ounce of prevention is worth a pound of cure, as those in the health field say. Finally, if we’re going to be working towards ending the HIV epidemic in the U.S., we need to be more inclusive of those we’re trying to help, i.e. give those we’re helping a greater say in the efforts rather than prescribing an all-size fits approach. I’ve spoken to other government leaders about this important strategy because all of us in the LGBTQI+ community are uniquely different & deserve care based on our own unique needs.

I implore the Presidential Advisory Council on HIV/AIDS, the Department of Health & Human Services & President Joe Biden’s administration to invest more in trusted messaging, to collaborate more with health advocates in LGBTQI+ community spaces & to provide better care for our LGBTQI+ members across the country. Thank you.
Sources

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   https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10038746/#:%3A:text=Race%20and%20ethnic%20backgrounds%20were,Islanders%2C%20and%20other%20vulnerable%20populations.

2. Excerpt from the National Vaccine Advisory Committee meeting, Feb 3, 2023: Kristin Flickinger of the Pacific Pride Foundation discusses CBO Coordination and MPOX vaccination in LGBTQ+ Communities (presentation begins here)
   https://www.youtube.com/watch?v=nXUg82C7es&t=1838s

3. “CDC director discusses efforts to reform the agency amid COVID, monkeypox criticisms”

4. “Living with HIV – Dying of TB: CDC Accelerates TB Prevention for People Living with HIV”
   https://www.cdc.gov/globalhivtb/who-we-are/features/tbpreventivetherapy.html

5. Excerpt from the Food & Drug Administration’s 181st Meeting of the Vaccines and Related Biological Products Advisory Committee: Public comment
   https://www.youtube.com/watch?v=NXVMILYvocM&t=17812s
Good afternoon. Today, we would like to focus on something that Co-chair Marlene McNeese actually first raised at a past PACHA meeting and referenced this morning, and that is the substandard HIV drug coverage by one of the insurers in Houston-Community Health Choice of Texas.

We all know the importance and value of modern-day HIV treatment, including single tablet regimens, using the most current drugs that do not cause serious side effects or drug resistance, the value of NIH’s treatment guidelines and the importance of adherence which all leads to viral suppression. We also know that high cost sharing leads to patients not taking their drugs.

We also are all thankful to the patient protections enshrined in the Affordable Care Act. This includes important nondiscrimination provisions and implementing regulations. Plans cannot place all or a majority of drugs to treat a specific condition on the highest cost sharing tier, drug formularies must be clinically based and follow acceptable treatment guidelines. A plan is potentially discriminatory if it does not cover single tablet regimens.

So, we took a look at Community Health Choice and found some troubling results. We then filed a complaint with CCIIO, the federal agency that regulates ACA plans in Texas.

We found that some of the drugs on its formulary are no longer used and phased out due to high toxicity levels. One of their plans does not cover a single drug recommended to initiate therapy on NIH’s HIV treatment guidelines. Another plan just covers three, but two of them have to be taken as three separate pills. Very few single tablet regimens are covered.

One plan puts all HIV drugs on the highest tier, while another puts 68 percent of them on the highest tier, which can translate into 50 percent coinsurance.

We compiled all the plan data, the treatment guidelines, our analysis along with the government’s own regulations and included it in the formal complaint. Unfortunately, we received a disappointing response that while acknowledging some of our concerns, sadly gave a pass to the insurer and did not seem interested in enforcing their own regulations.

Exposing this plan must have had some impact because we found that their March formularies shifted some drugs away from the high-cost Specialty Tier, but the drugs covered hasn’t changed.

We are now working on scheduling a meeting with CCIIO with advocates and providers from Houston to further discuss their response and lack of enforcement. We hope you share our concern that if the federal government allows this plan to get away with this, other insurers will follow suit and could jeopardize HIV treatment around the country. Thank you.
Hi, I am Robin Hardwicke PhD, FNP-C, AACRN, FAANP and first of all I am a NURSE. Specifically, an HIV clinician, researcher & educator Nurse Practitioner credentialed as an HIV specialist through the HANCB of ANAC & AAHIVM.

We emphasize an urgent need and goal for ending the HIV epidemic, however, we continue to fall short. We are all sensitive to the fact that we must identify those who are unaware of their diagnosis and link them to appropriate care. We are also well aware that we can prevent future transmission with PrEP.

According to the CDC, nearly 136 million patients present to emergency departments (EDs) in the US per year. About 30% of ED visits among patients with common chronic conditions are potentially unnecessary because they have not been adequately linked to care, leading to $8.3 billion in additional healthcare costs. These individuals continue to return and frequent EDs for care. On top of EDs being overwhelmed with visits, nurses are leaving the profession due to burn out from lack of support. Seventeen percent of nurses quit their position within the first year of their careers—a whopping 56 percent left within the first five years leaving the average career length for nurses now at nine years reported in 2023.

While we are focusing efforts at advancing understanding and developing better means of preventing, diagnosing and treating HIV, we need to tremendously support nurses and provide the necessary resources to accomplish our goals.

1. **Point of Care (POC) HIV testing should be available and STANDARD of care to EVERYONE seeking care in an ED from age 13+. Nurses should not require an advanced practice order to be able to obtain the test. Nurses should be allowed to autonomously order and perform the test on patient entry as standard.**

2. **Nurses need the resources to support this plan- Education needs to be provided as routine to Ending the Epidemic and nurses need to understand the difference between opt out and opt in testing.**

3. **EDs need resources- EDs fall short on POC testing due to lack of resources- they do not have the tests available due to cost, concern that patient insurance will not cover, if the patient is not having other diagnostic testing performed at the visit, testing is ignored. Not only should testing be standard of care to all, POC tests need to be provided as standard. All staff members need to be trained in post-test counseling and linkage of care protocols and algorithms provided so that patients have an alternative site for care and can stop using the ED for visits that can easily be managed by a PCP.**
From: Noah Raper <noahshivstory@gmail.com>
Sent: Thursday, March 28, 2024 1:36 PM
To: Presidential Advisory Council on HIV/AIDS (HHS/OASH) <PACHA@hhs.gov>
Subject: Pacha comment

I feel the end of the epidemic campaign has become another funding funnel that excludes pplwh. It’s stacked with people with special interest. These people already control our lives and funding. Why not have people living with HIV that do NOT work in the industry involved in the ETE?

My local aso Nashville cares is not what it used to be. More funding than ever, less oversight in spending. People are no longer looked at as humans, we are merely funding opps. The greed is so great it disgusts me. Greed is not what we fought for in the late 80’s and early 90’s. It disrespects the memory of all those who died fighting for funding.

This gross competition between organizations fighting over funding is a huge barrier. Why not create some grants that require competing aso’s to work together towards a common goal? Why not let the people know their value to the organizations. These aso’s are supposed to work for us but they’re too blinded by greed to actually have any kind of success in their programs.

I see so much waste and feel it’s the job of pacha to get control over this new mindset and competitive nature; to force these organizations to work together or lose their funding all together.

Make annual reports visible for people living with HIV. People have a right to know how much money each individual generated in funding.

Require ASO’s to create a client advisory board. At Nashville cares clients are not allowed to attend board meetings, they won’t even tell us when and where they are. The board is stacked with so many special interest groups that have nothing to do with the clients. The board has never taken a minute just to hear from clients. They are clueless as to what life is really like. If you have to “buy” a seat on the board then you can be assured that board is stacked with people just using it as a mention on their resume.
The reassessments we do all the time for Ryan white is literally a waste of time and money. The goals we set are just words on paper, it’s not like they actually do anything to help people reach their goals. In most cases people can’t even reach their case manager. Since covid hit the amount of wasted funds and the lack of on-site staff has changed the atmosphere in HIV care.

Please make the ASO’s return to normal business and make them stop using COVID as an excuse to half ass do their job. At Nashville cares they use Covid as an excuse for everything, but they don’t actually take any steps to prevent covid like wearing masks. Some case managers don’t even live in Nashville anymore but because of covid they don’t have to. How effective can a case manager be if they are not available for their clients?

I’ve been pos since I turned 21. I just turned 53. If someone doesn’t get control over wasted funding, we’re going to see more states follow Tennessee’s lead in refusing federal funds and replacing it with state funds, just so they can ensure the funding is not being wasted. There’s so much waste and as a client I should have a place to express my feeling about the way things are going at Nashville cares. Since our new CEO started the organization has gone downhill rapidly.

It’s sad to say that I no longer trust Nashville cares to do what’s best for our community, their focus is hooking up colleagues with contracts despite it being given to for profit businesses. It’s not about the client, it’s about how much funding each client could generate. I wanted to switch to another health care facility because I’m unhappy at Vanderbilt and the amount of money they waste. Unfortunately, I couldn’t because 340B funding. The other place wouldn’t take me as a client unless I dropped out of IAP and enrolled in their program. I am somewhat ignorant of 340b funding but I’m trying to learn so I can understand why 340b is the deciding factor in where one can go for their HIV health care.

Please take a look at Nashville’s Ryan white planning council. It’s stacked with Health care professionals. They refused me a seat at the table because I didn’t have the same mindset as they did. They didn’t even meet their required minimum members of 15 but still refused me a seat. I think they are going to regret it as I’m being forced to work with the other side, the republicans. The difference between me and members of the planning council, I have no special interest group to consider, my focus is only on
what’s best for the community. Wasted funding is not the best for us, it’s actually the recipe for disaster and more loss of funding.

Hold ASO’s accountable. Stop allocating funding for the same thing over and over. Have a real conversation about funding and the amount of wasted funds. If we don’t put an end to the wasted funds, then our legislators will.

Thank you kindly for your time and your service to the HIV+ community.

Sincerely,

Noah Raper…..he/him
HIV Law & Policy Advocate
#HIVisNOTaCRIME