

**Presidential Advisory Council on HIV/AIDS (PACHA)
66th Meeting**

**Grand Hyatt Washington
Washington, DC
February 10–11, 2020**

Council Members—Present

Carl Schmid, M.B.A., Co-Chair, Executive Director, HIV & Hepatitis Policy Institute

Gregg H. Alton, J.D., San Francisco, CA

Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, ACRN, ANP-BC, Professor and Director,
Center for Latino Adolescent and Family Health; Pilot and Mentoring Core Director, Center
for Drug Use and HIV Research, New York University; Adolescent AIDS Program
Montefiore Medical Center

Wendy Holman, CEO and Co-Founder, Ridgeback Biotherapeutics

Marc Meachem, M.B.A., Head, External Affairs, ViiV Healthcare

Rafaelé Roberto Narváez, Co-Founder and Director of Health Programs, Latinos Salud

Michael Saag, M.D., Associate Dean, Global Health School of Medicine, Professor of Medicine,
Division of Infectious Disease, The University of Alabama at Birmingham (UAB); Director,
UAB Center for AIDS Research

John Saperro, Director, Ending the HIV Epidemic, Collaborative Research, LLC

Robert A. Schwartz, M.D., M.P.H., D.Sc. (Hon.), Professor and Head, Dermatology, Rutgers
New Jersey Medical School, The State University of New Jersey

Justin C. Smith, M.S., M.P.H., Director, Campaign to End AIDS, Positive Impact Health
Centers; Behavioral Scientist, Rollins School of Public Health, Emory University

Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, Lead Provider and HIV Specialist,
Cooperative Health

Staff

B. Kaye Hayes, M.P.A., PACHA Executive Director, Designated Federal Officer; Principal
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Assistant Secretary for Health (OASH), U.S. Department of Health and Human Services
(HHS)

Caroline Talev, M.P.A., Public Health Analyst and PACHA Committee Manager, OIDP, OASH,
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Federal Partners

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Neeraj Gandotra, M.D., Chief Medical Officer, Substance Abuse and Mental Health Services Administration (SAMHSA)
ADM Brett P. Giroir, M.D., U.S. Public Health Service (USPHS), Assistant Secretary for Health (ASH), HHS
Maureen M. Goodenow, Ph.D., Associate Director, AIDS Research, Director, Office of AIDS Research, National Institutes for Health (NIH)
Rita Harcrow, Director, Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development (HUD)
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Rick Haverkate, M.P.H., National HIV/AIDS & Hepatitis C Program Coordinator, Indian Health Service (IHS)
Harold J. Philips, Senior HIV Advisor and Chief Operating Officer, *Ending the HIV Epidemic: A Plan for America*, OASH, HHS
Crystal Simpson, M.D., Medical Officer, Office of Medicare, Centers for Medicare and Medicaid Services (CMS), HHS
Judith Steinberg, M.D., M.P.H., Chief Medical Officer, OIDP (*day one*)
Paul Weidle, Pharm.D., M.P.H., Deputy, Program Operations, Ending the HIV Epidemic, National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC)
CAPT Samuel Wu, Pharm.D., Public Health Advisor, Office of Minority Health, HHS
Sara Ziegler, Associate Director for Planning and Policy, NCHHSTP, CDC

Presenters and Panelists

Sequoia Ayala, J.D., M.A., Director, Policy and Advocacy, SisterLove, Inc.
Genevieve Barrow, M.S., Assistant Director, HIV/STD Prevention, Baltimore City (MD) Health Department
Tammy R. Beckham, D.V.M., Ph.D., Director, OIDP, OASH, HHS
Jacquelyn Naomi Bickham, M.P.A., Prevention Program Manager, STD/HIV/Hepatitis Program, Louisiana Department of Health
Deborah L. Birx, M.D., U.S. Global AIDS Coordinator & U.S. Special Representative for Global Health Diplomacy, U.S. President's Emergency Plan for AIDS Relief (PEPFAR)
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Colleen Edwards, Client, Family and Medical Counseling Service
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Corrie Franks, Outreach and Addiction Counselor, Family and Medical Counseling Service
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DeMarc Hickson, Ph.D., Executive Director, US Helping US
Kathryn "Kathie" Hiers, Chief Executive Officer, AIDS Alabama
George "Mizrahi" Jackson, Team Lead, APEB (formally AIDS Project of the East Bay)
Diana Jordan, RN, M.S., Director, Division of Disease Prevention, Virginia Department of Health
Michael Kharfen, Senior Deputy Director, HIV/AIDS, Hepatitis, STD & TB Administration, District of Columbia (DC) Department of Health
L. William Lyons, Director, Office of HIV/AIDS, Georgia Department of Public Health
Jorge Mera, M.D., FACP, Director, Infectious Diseases, Cherokee Nation Health Services
Bisola Ojikutu, M.D., M.P.H., Assistant Professor of Medicine, Division of Global Health Equity, Brigham and Women's Hospital, Divisions of Infectious Diseases, Brigham and Women's Hospital and Massachusetts General Hospital, Harvard Medical School
Queen Victoria Ortega, Chair, Flux (a national division of AIDS Healthcare Foundation)
James Perry, Peer Recovery Specialist, Family and Medical Counseling Service
Michael Serlin, M.D., Medical Director, Family and Medical Counseling Service
Ronald Shannon, Nonmedical Case Manager, Us Helping Us, People Into Living, Inc.
Anandi Sheth, M.D., M.Sc., Associate Professor, Department of Medicine, Division of Infectious Disease, Emory University School of Medicine, Grady Infectious Diseases Program
Dawn Smith, M.D., M.P.H., M.S., Medical Officer, Division of HIV/AIDS Prevention, NCHHSTP, CDC
A. Toni Young, Chief Executive Officer, Community Education Group

Day 1

Welcome and Remarks from the Co-Chair

Carl Schmid, M.B.A., PACHA Co-Chair, called the meeting to order at 1:05 p.m. (This meeting was broadcast live online; the recorded broadcast is available online, (<https://www.youtube.com/watch?v=9brnDo2WH3k&t=1384s>)). PACHA advises the HHS Secretary through the ASH. This meeting was scheduled to continue into the early evening to allow members of the public to provide comment in person outside of regular working hours. Mr. Schmid outlined the agenda for the meeting. He said he believes that ending the HIV epidemic in the United States is a priority for this administration, noting that *Ending the HIV Epidemic: A Plan for America* (EHE) was mentioned in the President's State of the Union address. PACHA's charter was renewed through September 2021, and two new members have joined the Council. Congress approved appropriations for 2020 that include almost \$330 million for EHE. However, Mr. Schmid noted that funding did not include any money for IHS.

Welcome, 2020–2021 Budget Update, and Swearing-In of New Members

ADM Brett P. Giroir, M.D., USPHS, ASH, HHS

ADM Giroir introduced two new PACHA members: Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, ACRN, ANP-BC; and Alicia Diggs, M.P.H. Dr. Guillamo-Ramos is Professor and

Director, Center for Latino Adolescent and Family Health; Pilot and Mentoring Core Director, Center for Drug Use and HIV Research, New York University; he maintains an active clinical practice at the Adolescent AIDS Program Montefiore Medical Center; Bronx, New York. Ms. Diggs is a Medical Case Manager at the Positive Wellness Alliance in Lexington, NC. ADM Giroir administered the oath of office to Dr. Guillermo-Ramos. (Ms. Diggs was unable to attend.)

ADM Giroir reiterated the goals of EHE. Since the initiative was announced in February 2019, the heads of the agencies involved have visited almost all jurisdictions targeted by EHE and all states with a high rural burden of HIV. The themes identified during those visits have been integrated into the notices of funding opportunities (NOFOs).

HHS directed \$33 million from the Minority HIV/AIDS Fund to support planning. In June 2019, HHS provided grants to jumpstart HIV efforts in Dekalb County, GA; Baltimore City, MD; and East Baton Rouge, LA. In addition, IHS initiated a pilot program in the Cherokee Nation in Oklahoma. Lessons learned from these early initiatives will inform EHE.

HHS awarded funding to raise awareness about preexposure prophylaxis (PrEP). It provided \$12 million to local health departments to create community health plans that address the unique needs of each community. HHS also is supporting planning grants to enable the geographic areas targeted by EHE to craft community-wide plans for implementing EHE. The National Alliance of State and Territorial AIDS Directors (NASTAD) is assisting HHS with community-level support. HHS is leveraging the Prevention through Active Community Engagement program to assign six USPHS officers to act as liaisons in key regions.

HHS launched the Ready, Set, PrEP program, through which PrEP medications will be provided at no cost to people without insurance, thanks to a substantial donation from Gilead Sciences. HHS also provided funding to affected communities to assist with the costs of associated testing and office visits. HHS has partnered with CVS, Rite Aid, Walgreens, and RxHealthMart to distribute medication. The agency is further promoting the program through printed materials and social media.

EHE progress will be tracked by measures reported on a public dashboard to ensure transparency. HHS expects the static version of the dashboard will be online in the second quarter of 2020, and the interactive version will be available in the third quarter.

The President's proposed budget for fiscal year (FY) 2021 includes \$716 million for EHE, a substantial funding increase over the previous year. In addition to increases for HRSA, CDC, and the NIH Centers for AIDS Research (CFAR), IHS would receive \$27 million (it received no EHE funding for FY 2019). ADM Giroir noted that the President's budget proposes cuts elsewhere.

Discussion

Mr. Schmid noted that PACHA passed a resolution that called for increasing EHE funding, and he was pleased with the President's proposal. ADM Giroir added that communities applying for EHE funding are encouraged to develop with solutions, within the context of the evidence base

and certain guardrails, that meet local needs. Lessons learned from the jumpstart sites and CFAR will inform future NOFOs. Mr. Schmid and ADM Giroir both emphasized that the actual budget for FY 2020 will be determined by Congress.

Roll Call

PACHA Executive Director B. Kaye Hayes, M.P.A., called the roll.

Special Acknowledgment

Carl Schmid, M.B.A., PACHA Co-Chair

Dr. Schmid presented David Mansdoerfer, M.P.P., The University of North Texas Health Science Center at Fort Worth, with a certificate of achievement recognizing his role in restarting PACHA under the current administration while he was the deputy ASH for HHS. Mr. Mansdoerfer said PACHA is instrumental to EHE, and reinvigorating the Council was among his fondest memories of his time at HHS. He stated that PACHA has an impact on people's lives that will resonate into the future and thanked PACHA members for their work.

PACHA Subcommittee Reports

EHE and the Updated National HIV/AIDS Strategy

Carl Schmid, M.B.A., and John Sapero, Co-Chairs

The Subcommittee appreciated that Federal representatives are visiting areas deeply affected by HIV and using the input from those communities to inform planning. The Subcommittee hopes that PACHA will continue to foster community discussion (as it did during PACHA meetings in Jackson, MS, and Miami, FL, in 2019) and proposed that PACHA meet next on the West coast.

Stigma and Disparities

Rafaelé Roberto Narváez and Justin C. Smith, M.S., M.P.H., Co-Chairs

The Subcommittee has heard from NIH investigators about their research on reducing stigma in the United States and internationally; it seeks to determine how evidence-based practices can be deployed. The Subcommittee discussed the power of art and culture to contribute to the “disruptive innovation” that EHE calls for. One example is *As Much As I Can*, a play about Black gay men living with or affected by HIV that spurs conversation and is sponsored by ViiV Healthcare. The Subcommittee also is discussing how to promote PrEP to those who would benefit, such as heterosexual Black Americans and those who inject illicit drugs.

In September, the Subcommittee Co-Chairs met with the director of the HHS Office for Civil Rights, Roger Severino, to express concerns about a proposed rule regarding potential discrimination against lesbian, gay, bisexual, transgender, and queer (LGBTQ) people in health care (Section 1557 of the Patient Protection and Affordable Care Act). Mr. Severino provided a written response to PACHA. The PACHA Co-Chairs and the Stigma and Disparities Subcommittee Co-Chairs replied, further emphasizing the civil rights of LGBTQ individuals ([see Appendix A](#)).

Global

Robert A. Schwartz, M.D., M.P.H., D.Sc. (Hon.), and Gregg H. Alton, J.D., Co-Chairs

The Subcommittee seeks to gather lessons from international experiences that can be applied to the United States. Dr. Schwartz met with HIV experts from Cambodia and Botswana. Dr. Alton added that knowledge gathered from PEPFAR and other organizations could inform EHE. Discussions have included addressing stigma and providing PrEP to young women and girls.

OIDP Update: EHE

Tammy R. Beckham, D.V.M., Ph.D., Director, OIDP, OASH, HHS

Dr. Beckham described key steps toward EHE implementation. All jurisdictions targeted for phase one have submitted draft plans. HHS has made funds available to enhance and expand HIV diagnosis, PrEP initiation, HIV prevention, linkage to treatment, engagement in care, and viral suppression. The agency is collaborating within and outside of HHS, including with HUD's Housing Opportunities for Persons with AIDS (HOPWA) program and the Department of Veterans Affairs, and exploring future collaborations and policy discussions with the U.S. Departments of Justice, Labor, and Treasury.

Dr. Beckham offered some highlights from the jumpstart programs, including initiatives to use mobile vans to reach people in the community, train nurses to provide HIV testing in jails, and deploy telehealth technology to prescribe PrEP. USPHS liaisons have been working in Regions 4, 6, and 9 to help communities implement EHE initiatives and raise awareness about the Ready, Set, PrEP program. Ready, Set, PrEP launched on December 3, 2019, and preliminary educational materials are available now online at [HIV.gov](https://www.hiv.gov) in English and Spanish. HHS is planning a larger campaign to develop additional materials to raise awareness about the program. Dr. Beckham explained that the campaign will take advantage of various media platforms, including social media, in-store radio networks, and dating apps.

HHS awarded Gilead Sciences a 6-month contract to quickly distribute the donated PrEP medications via Gilead's medication assistance program. HHS will use an open competition process to select contractors to handle long-term distribution. Dr. Beckham described the current process for obtaining and filling a PrEP prescription. Beginning in March 2020, donated PrEP will be distributed by CVS, Rite Aid, Walgreens, and RxHealthMart pharmacies. RxHealthMart reaches many small, independent pharmacies in rural states, Dr. Beckham noted. Individuals can enroll in the Ready, Set, PrEP program online or by telephone.

At present, CDC is finalizing the data that will be used as the baseline for measuring progress toward EHE goals under a new data analysis and visualization system. An interactive data dashboard is expected by mid-2020. HHS anticipates having a single site that houses all the relevant data, resources, and educational material for EHE.

Applications have been submitted by jurisdictions and are being reviewed; they will be returned to the applicants with feedback by the end of March. It is expected that jurisdictions will build out their EHE implementation plans throughout the year, and Federal agencies will monitor their progress. Among the agencies offering funding to support EHE, NIH is soliciting proposals for research on screening and treatment of substance use disorders at Ryan White sites, and

SAMHSA is seeking applications specific to HIV for its Prevention Navigators Program for Racial/Ethnic Minorities.

HHS intends to bring representatives from HOPWA and HUD to future listening sessions around the country to engage them in addressing the needs of jurisdictions. It also hopes to bring in representatives from the business and academic sectors. All departments and agencies involved in the National HIV/AIDS Strategy (NHAS) will join HHS in updating that document.

In the near future, OIDP will work closely with CMS to discuss how to harmonize and prioritize policies that affect EHE and the NHAS. It also is working with the Departments of Labor and Treasury to identify potential strategic collaborations and best practices. Dr. Beckham noted that there is significant overlap among the Federal representatives involved in updating national plans on HIV, sexually transmitted infections (STIs), and viral hepatitis, which she noted would ensure that the plans complement and cross-reference one another.

Discussion

Dr. Beckham agreed with the observation that social media can be particularly effective when driven at the local level by individuals or community organizations; she added, however, that Federal agencies can do more to ensure that jurisdictions have the tools they need to educate and raise awareness.

Michael Saag, M.D., noted that providing PrEP on site at clinics helps to ensure that individuals fill their prescriptions. Dispensing PrEP through outside pharmacies may pose barriers to some. Dr. Beckham replied that she would keep in mind the concerns about the extra steps required. Wendy Holman pointed out that Ready, Set, PrEP excludes young people who are covered by their parents' insurance plan. Mr. Sapero commented that Federal entities should help community health centers build capacity to conduct more outreach activities and communicate with potential clients rather than wait for community members to come to them. Marc Meachem, M.B.A., wondered whether there are enough providers in rural areas who know about PrEP and the Ready, Set, PrEP program. In response to Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, Dr. Beckham explained that individuals who received PrEP through Gilead's medication assistance program but were no longer deemed eligible would be eligible for the Ready, Set, PrEP. William Chang, J.D., Office of the General Counsel, added that Gilead's medication assistance program exists for those who are insured but cannot afford PrEP.

Mr. Schmid appreciated HHS' efforts to engage HUD, but noted that the proposed budget for FY 2020 would cut \$80 million from HOPWA. During site visits to HIV service providers in Washington, DC, for example, PACHA heard about the critical role of housing for maintaining health among people with HIV (PWH). He added that much work remains to be done to make people aware of PrEP and to increase its use.

ADM Giroir noted that CMS has a new data system that will eventually provide detailed information about utilization that will factor into EHE data measurement. Antigone Dempsey, M.Ed., HIV/AIDS Bureau, HRSA added that HRSA collects data on people eligible for the Ryan White HIV/AIDS Program (Ryan White) and other programs that use Ryan White or Section 340B dollars, which provides insight into the impact of Ryan White dollars.

Dr. Beckham acknowledged concerns raised by many about how to ensure that EHE dollars go where they are needed to meet the goals of the initiative. She said that reaching the goals of EHE requires the development of structures to support the community at every level and involvement across the whole community, including families and faith-based organizations, as well as community-based organizations (CBOs) and advocates. It is up to the communities to identify the solutions and support they need. Other Federal representatives broadly outlined the ways in which funding and education are intended to reach small organizations and individual providers in the target communities. Dr. Beckham noted that her office can work with states to identify gaps (e.g., in Medicaid formularies) and encourage states to fill those gaps.

HIV in the DMV (District of Columbia, Maryland, and Virginia): Regional Voices, Challenges, and Best Practices

Perspectives from People Living with HIV

Facilitator: John Saperro, PACHA Member

Panelists: Colleen Edwards, Client, Family and Medical Counseling Service

Corrie Franks, Outreach and Addiction Counselor, Family and Medical Counseling Service

Ronald Shannon, Nonmedical Case Manager, Us Helping Us, People Into Living, Inc.

Mr. Saperro and other PACHA members posed a series of questions, and each panelist responded. Highlights are noted below.

What is needed to reduce the impact of HIV in your community?

- Address stigma by normalizing the conversation around HIV.
- Communicate a clear and consistent message about effective HIV prevention and treatment.

What is the perception of PrEP in your community?

- Mistrust of medical research and the medical establishment persists in the Black community, especially among those who do not have HIV.
- More information is needed about the side effects of PrEP and its effects on pregnancy and conception.
- More discussion is needed about postexposure prophylaxis (PEP).
- People who inject illicit drugs need more education and help.

How has the HIV epidemic changed in your community over time?

- With the message that undetectable equals untransmittable (U=U), people stopped using condoms. Some PWH stopped taking their medication and relapsed. Many PWH are having unprotected sex.
- There is more education about HIV, more support for people diagnosed with HIV, and more links to care than in the past.
- There is more education and training for health care providers on giving results, counseling patients, and connecting them to care.

- The demographics of the infection are changing.
- More resources are needed for those who are not in the target demographic, such as heterosexual Black men and women. Those who do not fall into the expected demographic categories need to see themselves represented in treatment and outreach efforts.

What are the barriers you faced to accessing and staying in care?

- People need wraparound services that address mental health, homelessness, affordable transportation, and substance abuse.
- Getting back into care is difficult.
- Mental health services should recognize generational trauma, and mental health providers should look like the communities they serve.

What impacts do you see of EHE and other national efforts to address HIV?

- Outside of public health, EHE is not tangible or visible.
- It is not clear when the money promised will trickle down or whether it will reach the right people.
- Nothing has changed yet in the Black community.
- Some PWH are dropping out of care, so it is not clear how they will benefit.

How would you advise people who are afraid to disclose their HIV status?

- Seeking out mental health services and building self-esteem helped me disclose my status and deal with stigma. I stand up for friends who do not stand up for themselves.
- Take your time and work through your own mental process until you can stand in your truth.
- U=U helped me deal with some of the stigma.
- I know there is purpose in my pain.
- Disclosing my status in the context of support groups for alcohol and drug abuse allowed me to come to terms with it and let others see that they could, too.

How can programs engage young people at risk?

- Scare them with data that include them so they see themselves in the data.
- Involve young PWH in communications—people who embody the data.
- Let them know you care about them.
- Provide a technology-based solution, such as an app for scheduling appointments or connecting with peers who have HIV.

Perspectives from Local Government Officials

Facilitator: Marc Meachem, M.B.A., PACHA Member

Panelists: Peter DeMartino, Ph.D., Center Chief, HIV Prevention and Health Services, Maryland Department of Health
Travis Gayles, M.D., Ph.D., County Health Officer and Chief of Public Health Service, Montgomery County Department of Health and Human Services
Ravinia Hayes-Cozier, M.H.A., Senior Manager, Family Health Services Division, Prince George's County Health Department
Diana Jordan, RN, M.S., Director, Division of Disease Prevention, Virginia Department of Health
Michael Kharfen, Senior Deputy Director, HIV/AIDS, Hepatitis, STD & TB Administration, DC Department of Health

Mr. Meachem and other PACHA members posed a series of questions. Highlights of panelist responses are noted below.

How has cooperation across jurisdictions in the DMV worked to increase access?

- Recognizing how mobile the population is and bringing suburban Maryland and Baltimore City to the table have helped.
- Collaboration around data collection allows entities to ask and answer data-driven questions and determine what drives the epidemic so they can work with other jurisdictions and mobilize local government to act.
- Working together has opened the door for discussion about the standards of care for PWH in different jurisdictions.
- State data have helped identify other social determinants of health (SDH) to address, such as food deserts.
- Finding an academic partner to collate data from across the region allows entities to get a more realistic picture of the continuum of care for PWH who might live, work, and receive care in multiple areas. All the entities involved have used the data to identify thousands of people who appeared to have dropped out of care.
- Sharing data enables better coordination and allocation of resources.

How close to ideal is your data integration process?

- It would be helpful to be able to look at the impact of HIV services regardless of who pays for it.
- If a person chooses not to begin PrEP, that contact is counted as a failure for the PrEP program, even if the individual takes advantage of available mental health, substance abuse, or transportation services as a result of the contact.
- More work is needed to allow entities to ask deeper questions about how SDH are driving outcomes, down to the ZIP-code level.
- Health departments should be able to operationalize data for multiple health conditions, not just HIV.
- The data still do not tell the story about what works, what does not work, and why.
- A pilot program across the region aims to promote early intervention and will collect and integrate broad data from PWH and people who do not have HIV.

How has EHE affected your organization?

- The initiative has improved collaboration across jurisdictions in multiple ways, including merging advisory and planning groups so they can join forces. It has elevated the conversation around all the aspects that must be addressed to end HIV. It has facilitated existing community engagement efforts.
- Lowering the Federal barrier to cooperation provides flexibility, which is very important.
- Funding has given Prince George's County a voice that it had not had before and a forum for sharing information. Being involved in regional discussions has shed light on the epidemic in the DMV.
- HIV was not seen by policymakers as a problem in Montgomery County until the initiative identified the county as a target jurisdiction. The initiative catalyzed meaningful conversations within the county and partnerships with other stakeholders about how to drive public health interventions around HIV. Having real examples helps demonstrate the relationship between HIV and SDH.
- Maryland's Department of Health has been able to draw attention to ending the syndemic (which includes hepatitis and other STIs). The State aims to give local jurisdictions the resources they need and then step out of the way.

How are standards of care enforced or encouraged across jurisdictions?

- With CFAR funding, DC piloted a rapid treatment initiation program and shared it with Virginia.
- Efforts are still needed to educate providers, especially those who are not up to date on HIV practices.
- Health departments are doing a good job achieving viral suppression, but those rates are much lower among other providers. Some mechanism is needed to ensure that the whole community has the same high-quality, comprehensive care as Ryan White recipients.
- More flexibility in Federal funding would help public health providers work across jurisdictions.
- Patient empowerment enables individuals to understand what resources are available and what they should be asking their providers.
- Providers should be talking with adolescents about sex in a healthier way that is not solely focused on disease risk.

Advanced, shared data collection would identify clusters of HIV but not the sources of exposure, given the mobility of people in the DMV area. How can that be addressed?

- Public health entities could respond to the clusters and inform the broader public health community about them. Social media campaigns and social networks could work to spread information across borders.
- Federal data are not released quickly enough to inform intervention; jurisdictions can work together to gather and disseminate data much faster.
- The DC Health Department has a Maryland-based investigator so that instances of HIV and other STIs can be identified more quickly.
- Because residency data do not identify where people socialize, the region has to lower the barriers to testing and treatment.

- The next step is to use the cluster data to learn more about the systems of care outside of publicly funded systems.
- More efforts are needed to engage private providers and build their capacity to address PWH.
- Through community outreach, entities are finding ways to increase community engagement and build the HIV workforce at the same time.

What data collection barriers do you face?

- Jurisdictions are working to overcome legal barriers and create data-sharing agreements, which they can then share with other States.

What works to reach people in the communities?

- Prince George's County asked CBOs to work directly with target populations, such as young Black men who have sex with men, women, transgender people, homeless people, or people in ZIP codes with high rates of HIV. The County will create an advisory committee to incorporate the gathered information into its efforts.
- Rather than rely on the existing provider organizations, the DC Department of Health tapped into different social networks, without regard for HIV status, by asking staff to bring in their friends and leveraging those relationships to get the word out.

What works in terms of school outreach and education?

- Prince George's County had some success in community colleges and historically Black colleges and universities by incorporating experiential activities around HIV into education programs. For example, students in a theater program had to create a piece around HIV/AIDS.
- The DC school-based sexual health program is a good example of a program that raises awareness about STIs, HIV, and access to PrEP.

Perspectives from Health Providers

Facilitator: Marc Meachem, M.B.A., PACHA Member

Panelists: DeMarc Hickson, Ph.D., Executive Director, US Helping US

James Perry, Peer Recovery Specialist, Family and Medical Counseling Service

Michael Serlin, M.D., Medical Director, Family and Medical Counseling Service

A. Toni Young, Chief Executive Officer, Community Education Group

Mr. Meachem and other PACHA members posed a series of questions. Highlights of panelist responses are noted below.

What has been the biggest change in the HIV epidemic during your time in the field?

- More young and elderly people are being diagnosed with HIV.
- Little has changed among the Black community, but as a result of urban redevelopment, the epidemic is migrating to suburban Maryland.
- Many CBOs have had to start providing wraparound services.
- Increasing rates of hepatitis and the opioid crisis are now intertwined with the HIV epidemic.

How has EHE affected your organization?

- The initiative has increased the focus on prevention, testing in the community, and linkage to care.
- DC offers a syringe services program (SSP) that includes HIV and hepatitis testing. Many patients have been able to manage their HIV after receiving buprenorphine therapy for opioid addiction.
- The initiative has helped to bring people back into care because it addresses SDH, such as homelessness.
- The initiative has revolutionized the focus on how to end the epidemic. One organization is revising its strategic plan to provide wraparound services, expand the target treatment population, and initiate comprehensive health screening.
- The initiative has encouraged some CBOs in jurisdictions not included in phase one to begin thinking about what they can do when phase two begins.

Do the people you serve believe that the HIV epidemic can be ended, and what is your role in that or the role of the national response?

- Addressing the SDH is a significant part of ending the epidemic, and housing is a particularly difficult issue to address in the DMV.
- There is a sense that individuals, including those who have fallen out of care, buy into the medical model for treating HIV. Sharing information across providers remains difficult.
- Awareness about PrEP remains low; more education in community settings is needed, especially for people coming out of incarceration.
- One mathematical model indicates that it is possible to end the epidemic, but the lack of awareness, lack of trust, or both in the medical model suggests that might not be true. Some communities believe PrEP is a government conspiracy to kill Black people. It will take a significant, continued presence to establish trust in communities that have been oppressed and marginalized.
- In West Virginia, most people do not perceive the risk of HIV as high, despite clusters of high HIV rates. Poor infrastructure contributes to poor SDH, which contribute to HIV.
- There has not been a significant investment in educating Black women about HIV or PrEP.

What can be done to increase PrEP uptake? Should PrEP counseling be integrated into other programs, such as SSPs and substance abuse treatment?

- Despite broad testing and counseling about PrEP, uptake remains low. Heterosexual men and women are less likely to feel they are at risk.
- More collaboration is needed across programs to coordinate care at the individual level.
- Educating people about PEP can be a gateway to PrEP uptake.
- For people who only perceive themselves to be at risk periodically, consideration should be given to prescribing on-demand or event-based PrEP.
- College students can benefit from more education about STIs.
- Workarounds are needed to provide PrEP in a confidential manner—for example, to young people who are on their parents' insurance plans.
- West Virginia is focusing its PrEP awareness campaign on Whites with substance abuse disorders, which is an appropriate target. More education about PrEP should target

women and girls. Organizations should increase HIV screening. Financial burdens prevent organizations from recommending PrEP.

What concrete steps can be taken to improve education and awareness about HIV and PrEP among people of color?

- People of color (and women in general) should be adequately represented in clinical trials to provide evidence that the medical interventions are appropriate for them.
- Messaging should strive to be inclusive.

Public Comments

Giffin Daughtridge, M.D., CEO, UR Sure, explained that his company makes urine and blood tests that measure adherence to PrEP. The initiatives to drive PrEP uptake are exciting, but there has been no mention of adherence. Evidence shows that PrEP works, but the ability to support adherence to medication regimens remains an issue of concern. Using the UR Sure system, providers can determine whether patients are struggling with adherence and get them back on track. More than 20 clinics and health departments have used the system; they are seeing improved adherence and have been able to predict which patients will drop out of care. Mr. Daughtry said that a provider told him the only way to know that a patient is not adhering to PrEP is if that patient seroconverts. He hoped providers would use UR Sure to make sure PrEP works for those who use it.

Rachel Klein, Deputy Executive Director, The AIDS Institute, observed that today's testimony offered a lot of information about both barriers and successes of EHE. It is clear that coordination across Federal, State, and local agencies is important for the success of the initiative. She added that CMS seems to be missing from the conversation. Ms. Klein appreciated the President's proposed FY 2020 budget and the commitment it represents to EHE, but the budget also includes policy proposals that run counter to that commitment. Although Ready, Set, PrEP provides medication for the uninsured, many barriers to access to PrEP and other drugs remain for the insured, and some of the proposals in the President's budget would make it harder for insured people to get prescribed drugs. Ms. Klein asked that HHS work harder to bring CMS into the discussions about EHE. Also, she asked that PACHA emphasize the importance of ensuring that Federal policies are not working at cross-purposes or creating additional barriers on top of the intransigent issues already at play in the effort to end HIV.

Ramin Bastani, CEO, Healthvana, explained that his company works daily to address mistrust around PrEP. The Healthvana platform empowers people at high risk who are taking PrEP or HIV medications to manage their health using their mobile phones, leveraging the expertise of staff who know how to communicate with people in their own communities. Healthvana has more than 300,000 users, of whom 150,000 are people of color. Mr. Bastani asked that PACHA consider the important role of technology in every aspect of ending the HIV epidemic. He hoped that there would be as much attention to adherence to and persistence of PrEP as there has been to access to PrEP.

Carole Treston, M.P.H., RN, ACRN, FAAN, Chief Nursing Officer, Association of Nurses in AIDS Care, recalled that nurses were the backbone of the response to AIDS when there was

no effective treatment. Then, nurses' holistic, compassionate care and coordination of support and other services were paramount. Despite advances in the medical model, age and disparities along racial, economic, and geographic lines define the outcomes. The road ahead will not be easy, and medicine will not be enough for treatment or prevention. The importance of addressing social issues is critical, including through investments in intensive nurse case management and care coordination, alternative treatment sites, and holistic care that includes support groups, mental health services, food and nutrition, and housing support. Ms. Treston said that an effective response to maintain those in care and engage and sustain those out of care includes supporting a health care workforce that reflects the populations served. Providers who build relationships with the whole person—not just their viral load success—will help. Reducing bureaucracies and other institutional hurdles also will help. Nurses can often identify and implement these necessary person-centered solutions. Ms. Treston added that her organization is thrilled that Mr. Guillamo-Ramos has joined PACHA as a member. The many roles and experiences of nurses are important for perspective. Often, nurses are not at the table despite their contributions and significant size in the workforce—even in 2020, designated the Year of the Nurse by the World Health Organization.

See [Appendix B](#) for additional public comments submitted.

Closing Remarks and Potential Resolutions

Mr. Schmid thanked all those who participated. He noted that the full funding for EHE had not been awarded, so it is understandable that many in the community are not aware of the initiative. Great strides have been made, as evidenced by the panelists who took part in the meeting, but much work remains.

Mr. Schmid suggested that PACHA put forth a resolution to the HHS Secretary expressing its appreciation for the increased funding for EHE proposed in the President's FY 2020 budget but also raising concerns about proposed cuts to HOPWA and Medicaid. Members agreed, and Mr. Schmid promised to draft a resolution for consideration on day 2.

Mr. Smith suggested that PACHA refrain from describing people or communities as “hard to reach” and acknowledge that the systems and services are hard to access. The onus is on the architects of the system to improve, he noted, and members agreed.

Mr. Guillamo-Ramos acknowledged the public comments and agreed that more attention is needed on the role of nurses in ending the epidemic. The meeting recessed for the day at approximately 6:30 p.m.

Day 2

Welcome and Roll Call

Mr. Schmid reconvened the meeting at 9:05 a.m. and welcomed the participants. Ms. Hayes called the roll.

Discussion of EHE: Lessons Learned from Jumpstart Jurisdictions

Facilitator: Justin Smith, M.S., M.P.H., PACHA Member

Baltimore, MD

Adena Greenbaum, M.D., M.P.H., Assistant Commissioner, Bureau of Clinical Services; and Genevieve Barrow, M.S., Assistant Director, HIV/STD Prevention, Baltimore City Health Department

Dr. Greenbaum described the challenges Baltimore faces, pointing out that the success of EHE depends on efforts to address stigma, mistrust, SDH, and syndemics, and providers must offer status-neutral care. Baltimore used its jumpstart funding to launch 14 initiatives, mostly through partner contracts, such as the following, which are described according to their alignment with the four pillars of EHE but often include activities across multiple categories:

- Diagnosis: Rapid HIV diagnosis in emergency departments (EDs) and home self-testing for HIV and other STIs
- Treatment: Provider response “warm” line, enhanced case management, and links to care
- Prevention: PrEP navigation at two Federally Qualified Health Centers (FQHCs); engagement, empowerment, and training for and about transgender people; U=U campaign
- Response: Collaboration with the State health department

Ms. Barrow noted that the most successful efforts were those that addressed SDH and individuals’ needs outside of the clinic setting. The department is addressing workforce needs by providing trauma-informed training and HIV and STI training for staff across the department. For all of these initiatives, the department is expanding community engagement and awareness through listening sessions, social innovation and design, media campaigns, and storytelling.

Dr. Greenbaum emphasized the department’s innovative solutions:

- Build trust through meaningful community engagement that delivers on promises.
- Facilitate collaboration that results in better communication across jurisdictions, enhanced integration of funding streams and services, and more investment in data integration.
- Provide training to local health departments to report HIV diagnoses as sentinel events so education and resources can be mobilized.
- Allow time to build trust, combat stigma, and address privacy and safety issues in the effort to increase PrEP uptake, especially among young, healthy people.

Among the next steps are incorporating treatment for other STIs and substance abuse into the HIV work, increasing integration with Ryan White services, and increasing reporting about marginalized and underserved populations. Dr. Greenbaum presented the video “[People Who Look Like Me](#)” as an example of the department’s outreach work.

Discussion

ADM Giroir commented that Ryan White programs are the best hope for integrating services, and he hopes to move forward via these programs. More work is needed to incorporate HIV testing into federally funded substance abuse programs, including opioid programs. ADM Giroir asked what HHS could do to help local health departments better integrate services.

Dr. Greenbaum replied that the operational challenges—such as tracking payment to staff, programs, and partners that receive funding through various Federal and State contracts—are significant. ADM Giroir agreed on the need to find ways to streamline reporting, for example, and he called for concrete recommendations from the field on how to minimize the operational burdens.

East Baton Rouge, LA

DeAnn Gruber, Ph.D., LCSW, Director, Bureau of Infectious Diseases; and Jacquelyn Naomi Bickham, M.P.A., Prevention Program Manager, STD/HIV/Hepatitis Program, Louisiana Department of Health

Dr. Gruber summarized the racial/ethnic, gender, and economic disparities in the region in the context of new HIV diagnoses. Ms. Bickham described successful initiatives across the four pillars, including the following:

- **Diagnosis:** Expanded HIV testing in CBOs and EDs; use of mobile phlebotomists to conduct screening at prisons
- **Treatment:** Expanded incentive programs that reward clients who achieve clinical milestones; employment of a rapid-start navigator to expedite links to care
- **Prevention:** Increased number of “telePrEP” navigators; expanded SSP capacity

Public health officials in East Baton Rouge also are bolstering the HIV workforce through a robust social marketing campaign, employment of community health workers, and creation of an EHE coordinator position to assist its EHE Task Force. The city launched a standalone STI clinic at a partner FQHC. Ms. Bickham provided data on early successes across the initiatives. In addition, the city’s team of community health workers was featured in an area newspaper, highlighting the public programs and workforce opportunities.

Dr. Gruber noted that the data reporting required by the jumpstart projects has been challenging and requires significant time and coordination, but she believed it would ultimately strengthen accountability and enable the health department to examine outcome measures. Conducting the required site visits for EHE led to increased coordination and communication with the community, funders, and other stakeholders. More work remains to navigate the State bureaucracy, including the need to amend existing contracts.

Ms. Bickham commented that establishing contracts with trusted personnel allowed the health department to staff programs quickly and coordinate office space and equipment. Involving the

community from the outset helped shape the program. She recommended that community engagement efforts be mindful of the distinction between “gathering input” for a plan or program yet to be created and “getting feedback” on an initiative that has already been developed. Holding monthly EHE meetings has contributed to transparency within the community. Hiring, training, and retaining the right people in the right positions is key to success.

DeKalb County, GA

L. William Lyons, Director, Office of HIV/AIDS, Georgia Department of Public Health

Mr. Lyons outlined the nature of the HIV epidemic in DeKalb County and highlighted some of the jumpstart initiatives underway:

- **Diagnosis:** Marketing campaign that included a public service announcement about HIV testing that was shown in movie theaters; expanded routine clinical testing in county jails and a local hospital
- **Treatment:** Expanded HIV/STI information line; increased efforts to engage and reengage PWH in care
- **Prevention:** Expanded SSP; support for Atlanta Harm Reduction Coalition in building the capacity of CBOs, local police departments, and others through training on SSPs, overdose response, and other topics

Successes to date include expanded testing and access to PrEP, increased community awareness, routinization of testing in jails, and retention support through appointment-reminder calls.

Mr. Lyons noted that flexibility has been key to meeting an aggressive timeline for planning and implementation. Other challenges include the lack of mechanisms for contract execution, the burden of reporting (which predates EHE), and the overlap of city and county activities. Expanding routine, opt-out HIV testing in EDs has been challenging but should help identify more PWH so they can be linked to care.

Among the innovative steps taken, Mr. Lyons highlighted improving outreach to people in jails, focusing on reengaging PWH in care, increasing condom distribution on college campuses, expanding PrEP access and availability, using mobile testing units, and collaborating with FQHCs. Discussion is underway about how to increase the HIV workforce. He added that the county is exploring home HIV testing and the initiation of SSPs, which requires State legislation.

Cherokee Nation of Oklahoma

Jorge Mera, M.D., FACP, Director, Infectious Diseases, and Whitney Essex, M.S.N., FNP-BC, Nurse Practitioner Specialist, HIV/HCV Program, Cherokee Nation Health Services

Dr. Mera laid out the HIV burden in Oklahoma and among American Indians, and he noted the lack of State data for a number of HIV measures across the continuum of care. The area’s biggest hurdle is identifying PWH, so Cherokee Nation Health Services is focusing on diagnosis and prevention. Ms. Essex outlined some of the approaches under the jumpstart program:

- **Diagnosis:** Electronic health record prompts for HIV screening; HIV screening at community events and in EDs, dental clinics, behavioral health programs, substance abuse treatment programs, homeless shelters, schools, and jails

- Prevention: Increased education of providers on sexual health, HIV screening, and the link between STI screening results and the need for HIV screening and prevention; expanded outreach to vulnerable populations; increased condom distribution
- Treatment: Same-day initiation of treatment for PWH

Among the specific interventions underway are a public campaign (using advertising and social media) to raise awareness about HIV testing, planning for an upcoming event in 13 states across IHS sites to highlight HIV efforts, and educational workshops for providers on identifying and counseling candidates for PrEP. Oklahoma's legislature is considering a bill to allow SSPs and other harm-reduction strategies.

Ms. Essex noted that stigma is the primary barrier her organization faces. Establishing an LGBTQ-friendly clinic has been more challenging than anticipated. The organization also faces the same operational challenges mentioned by other presenters, including the complexity and time involved with contracting services and the difficulty of hiring high-quality staff for relatively short-term job opportunities. Dr. Mera added that the 1-year timeline for the jumpstart project is unlikely to yield impressive results, but it might reveal promising practices. He added that Tribal sites vary but face similar barriers. For example, most Tribal clinics are located far from pharmacies, so efforts are underway to make Ready, Set, PrEP medications available through IHS clinics.

Discussion

The jumpstart programs approach the role of CBOs differently. In DeKalb County, CBOs receive significant public health dollars and do great work testing and linking people to care, and the State could benefit from more CBOs. In Louisiana, New Orleans and Baton Rouge health departments do not support HIV prevention, so the State funds CBOs directly; the State lacks the infrastructure required by the Federal NOFOs to rely primarily on local health departments and their CBO networks. In Baltimore, the logistic and operational challenges of working with CBOs can be a barrier to ongoing work.

Some of the jumpstart programs have started home HIV testing efforts. They have not encountered resistance to such programs, but overall response data are not yet available. The concept is being explored in Oklahoma but must be approved by the Cherokee Nation, so it cannot be implemented within the jumpstart program timeframe.

When asked to elaborate on the client incentives for care in Louisiana, Ms. Bickham explained that the program began in 2013 and emphasized the ongoing nature of care. Results are evaluated in terms of behavior change over time. Even small incentives are effective. Cherokee Nation Health Services also is starting an incentive program to help keep people in care and to encourage PWH to refer others for PrEP.

The presenters described challenges associated with the burden of reporting but recognized that data are needed to evaluate programs. Dr. Greenbaum thought attention should be paid to more effectively organizing and coordinating reporting requirements so that they are useful to the programs and are HIV-status neutral. More work is needed to identify how to measure individual engagement and how services contribute to overall health. Dr. Greenbaum also echoed the

concern that programs do not receive credit for counseling people about PrEP unless those counseled choose to initiate PrEP.

Women and HIV

Facilitator: Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, PACHA Member

Epidemiology of HIV in Women

Dawn Smith, M.D., M.P.H., M.S., Medical Officer, Division of HIV/AIDS Prevention, NCHHSTP, CDC

Dr. Smith presented the epidemiologic data of HIV in women, underscoring disparities. The second-highest percentage of new HIV diagnoses occurs in women, primarily Black women. The lifetime risk for Black women (1 in 54) is dramatically higher than that of all other races/ethnicities. Women have higher rates of HIV testing than men, partly because they are likely to be tested as part of reproductive care and pregnancy, and they are more likely than men to know their HIV status. Nearly 89 percent of women with HIV are diagnosed, yet only 53 percent have achieved viral suppression. Consistent viral suppression is key to preventing transmission. Lack of suppression contributes to the higher death rate for Black women (and men) when compared with other races and ethnicities. Women ages 25 to 44 years are the only age group for whom HIV remains one of the top 10 causes of death.

Prescriptions for PrEP are increasing steadily for men, but not for women. White women are more likely to be prescribed PrEP and to use PrEP than Black or Hispanic women, revealing a combination of racial/ethnic and gender disparity.

Half of the new diagnoses among transgender women were in Black transgender women, and 20 percent were in Hispanic transgender women. Although transgender women have a very high prevalence of HIV, many more cisgender women have HIV than do transgender women. Many jurisdictions do not report these data separately or do not measure HIV in transgender women. Dr. Smith observed that there is much more discussion about the needs of transgender women who have or are at risk for HIV than there is about the needs of cisgender women, especially cisgender women who are not pregnant.

HIV Prevention and Treatment for Women

Anandi Sheth, M.D., M.Sc., Associate Professor, Department of Medicine, Division of Infectious Disease, Emory University School of Medicine, Grady Infectious Diseases Program

Dr. Sheth stressed that the disparities between women and men in PrEP prescriptions and uptake, if not addressed, could worsen existing inequities. Women are underrepresented in PrEP research. PrEP awareness is low among women. In general, messaging has not been inclusive, nor has it focused on women. PrEP guideline criteria miss women who would benefit from PrEP. To increase demand, better tools and indicators are needed to promote routine education about and offering of PrEP. Dr. Sheth described a standardized tool that effectively promoted provider-patient conversations about HIV and PrEP in Atlanta. The study subjects commented that everyone should know about PrEP, for which more community outreach and education are needed.

Access to PrEP is especially low in the South, where HIV rates are highest. Family planning clinics were not prioritized during the introduction of PrEP, yet women are far more likely to use such clinics for sexual health services than STI clinics or their primary care providers. In States that have not expanded Medicaid, family planning clinics may be a woman's only source of health care. There is little understanding of how to integrate PrEP into women's health services in resource-constrained settings. In family planning clinics in the South that do not provide PrEP, the barriers were perceived to be the lack of resources and lack of leadership engagement rather than lack of knowledge about PrEP.

Dr. Sheth and her colleagues are piloting a project to assess HIV testing, prevention practices, and training needs across family planning clinics in Atlanta, with the aim of using the findings for training, building capacity, and increasing community awareness. Women with HIV face unique challenges, including having limited data on the safety of HIV treatment during pregnancy. Better integration of services requires partnerships between HIV prevention programs and women's health providers, as well as a shared advocacy approach and recognition of the need to maintain access to sexual and reproductive health services for women.

Ending the HIV Epidemic Among Diverse Populations of Women

Bisola Ojikutu, M.D., M.P.H., Assistant Professor of Medicine, Division of Global Health Equity, Brigham and Women's Hospital, Divisions of Infectious Diseases, Brigham and Women's Hospital and Massachusetts General Hospital, Harvard Medical School

Dr. Ojikutu focused attention on barriers at the community and individual levels that contribute to low PrEP uptake among women, particularly women of color. Many women at high risk do not perceive HIV as an imminent health threat, and providers fail to screen women to determine their risk. Research confirms these observations, but studies have mixed results about how much educating women about their risk and PrEP contributes to PrEP uptake. Dr. Ojikutu pointed out that how the message is delivered and by whom likely affects willingness to begin PrEP.

Dr. Ojikutu compared recent survey results with comparable results from 2002–2003; they found that substantially more people harbor mistrust of medicine, medical systems, and the government's role in health care, particularly around HIV, than in the past. Younger people have higher levels of mistrust around HIV than others. Notably, Black and Latino people have higher levels of medical mistrust, but women in those groups also have higher rates of HIV testing. Women who report medical mistrust are three times more likely to use PrEP than others. Dr. Ojikutu commented that she thinks that those who mistrust the medical system feel that no one is protecting them, so they must protect themselves. These findings could inform targeted messaging about HIV testing and PrEP.

Intimate partner violence can be a barrier to PrEP use and adherence. Dr. Ojikutu suggested incorporating intimate partner violence screening into the guidelines for PrEP screening. Other data indicate that people who inject illicit drugs report a willingness to use PrEP, but health care providers report that it is difficult to get them started on PrEP. Dr. Ojikutu described the issue of HIV diagnoses among immigrants, noting that the difficulty of distinguishing whether HIV was acquired before or after immigration results in a missed opportunity to prescribe PrEP to those at high risk. More research is needed on all of these populations.

Dr. Ojikutu stated her colleagues believe that women with HIV are being left out of the conversation. She concluded that more women should be included in HIV prevention and treatment research. Studies should assess what works for women and what women want, including new drugs in the pipeline (e.g., long-acting injectables and implants). Guidelines for PrEP should cast a wider net to better identify women who are candidates for PrEP.

Discussion

Dr. Smith reported that CDC is asking jurisdictions to address in their EHE plans ways to leverage public health resources to provide PrEP in clinics, such as detailing public health officers to assist with services. She noted that even family planning clinics that do provide PrEP often focus on men who have sex with men and overlook women, and the Office of Population Affairs aims to address the problem. Dr. Sheth pointed out that states differ in how they distribute Title X funds, which affects whether PrEP is prescribed. Judith Steinberg, M.D., M.P.H., of ODP said the Office of Population Affairs created a [toolkit](#) last year to assist family planning clinics with counseling about PrEP.

Dr. Sheth commented that health providers report frustration when applying the PrEP guidelines because they do not have much time for screening, and the conversation can be difficult, even for those who provide sexual health services. At the same time, women would prefer that screening be universal, not targeted. Dr. Ojikutu said educating women so that they accurately perceive their risk will drive demand, and more women will initiate the conversation about PrEP with their providers. Dr. Smith added that providers should have a sense of responsibility for missed opportunities because they are letting their patients down by not offering PrEP.

An International Perspective: Global Update

Deborah L. Birx, M.D., U.S. Global AIDS Coordinator and U.S. Special Representative for Global Health Diplomacy, PEPFAR

Dr. Birx stated that if she were working on HIV domestically, she would focus on getting local and state governments to use their resources in a synergistic way with Federal agencies. PEPFAR works by aligning public policy at all levels. Efforts started by prioritizing the sickest patients, but with the availability of new therapies, PEPFAR aims to ensure that everyone is treated. Notably, PWH are highly motivated to seek treatment despite barriers. Healthy people who would benefit from PrEP are less willing to make sacrifices, so that PEPFAR needs to reevaluate all aspects of its work. Dr. Birx summarized some key lessons that could be applied domestically:

- Political will matters; it changes policy, and it is needed to ensure that policies are implemented.
- Data matters because it motivates policymakers.
- Community involvement in planning is vital to the implementation of effective programs.
- Decision making should consider what care should cost, not how much is being spent. Spending should be aligned with the burden of disease.
- Programs benefit from accountability, transparency, and continuous impact assessment at the community level.

- Funders should identify other outside sources of money that could be used to address structural barriers.
- Programs should evaluate the impact of investments frequently and reallocate funds as needed.

PEPFAR has reached full implementation of Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS), a structural intervention for comprehensive HIV prevention for adolescent girls and young women that integrates PrEP and incorporates all aspects of the family and community. Dr. Birx described positive results from this and other interventions, particularly in Africa, because of long-term, continued investment. However, HIV infection and mortality rates are rising in politically unstable countries and those in the midst of conflict.

Dr. Birx explained that detailed PEPFAR and other data help countries uncover the challenges unique to their citizenry and focus investments accordingly. For example, in Uganda, most new diagnoses are found in women; men rarely seek health care. Evidence indicates that Ugandan men are strongly influenced by their mothers, so a new campaign encourages mothers to bring their sons of any age to health care clinics for screening.

Dr. Birx explained that PEPFAR is determining how to translate the speed and magnitude of gains in HIV treatment in sub-Saharan Africa to other countries where progress has stalled. Some countries—such as Indonesia, the Philippines, Guatemala, and Jamaica—have structural barriers to services that can be addressed only through policy. PEPFAR has collected data that open the door to direct talks with governments, and the data reveal the real epidemic, rather than the situation that policymakers want to believe. Having data at the local level has been key to transcending personal perceptions. Triangulating the data with other sources and validating them have allowed PEPFAR to root out fraud and corruption.

Discussion

When asked for advice on how to overcome State, local, and regional barriers to implementing Federal initiatives, Dr. Birx emphatically stated that Federal funds should have strings attached. PEPFAR has minimum program requirements, and they transcend HIV. For example, funded programs must ensure that clients have access to services. PEPFAR insisted that Nigeria and other countries address the formal and informal fees that prevent poor women from accessing health care (not just HIV care).

Last year, PEPFAR required programs to establish unique personal identifiers so they could track patients across programs. As a result, one million more people were counted in treatment programs. Dr. Birx said she thinks data must be used more quickly; PEPFAR gathers comprehensive data quarterly and acts on those data quarterly.

PEPFAR began reframing the role of communities in planning 5 years ago. Bringing community members in as equal partners was difficult at first, because government officials were unaccustomed to public criticism, but they got used to it, explained Dr. Birx. PEPFAR also relies on external watchdogs to monitor its processes.

From its participation in the MenStar Coalition, which sought to learn more about barriers to retention in care, PEPFAR learned that the men interviewed expect pregnant women and children to suffer from illness but not young men. Their self-perception is not consistent with vulnerability or illness. The men did not want to receive services from women in clinics because they believed the women were talking about the men among themselves and in the community. As a result, PEPFAR has established some men-only clinics, with male and female staff, and with early hours so men can access services before work and before other clients arrive. Dr. Birx noted that some local governments have been very helpful in facilitating such efforts. Still, current programs for men under age 30 are not ideal. Dr. Birx hoped to spark a global dialogue with politicians about local, State, and Federal efforts at the upcoming International AIDS Conference.

Dr. Birx noted that how programs are rolled out has a long-term impact on community perceptions. In countries where PEPFAR had been restricted to treating only young female sex workers, the general population is now reluctant to accept HIV treatment and PrEP.

Stigma as a Barrier: Shared Experiences and Challenges from a Domestic Lens

Facilitator: Gregg Alton, J.D., PACHA Member

Panelists: Sequoia Ayala, J.D., M.A., Director, Policy and Advocacy, SisterLove, Inc.

Kathryn “Kathie” Hiers, Chief Executive Officer, AIDS Alabama

George “Mizrahi” Jackson, Team Lead, APEB (formally AIDS Project of the East Bay)

Queen Victoria Ortega, Chair, Flux (a national division of AIDS Healthcare Foundation)

Panelists described their organizations and offered some observations. Ms. Ayala pointed out that stigma manifests as discrimination against PWH, and it does not affect just the poor or uninsured. Ms. Hiers suggested combating stigma by listening to those with real-life experiences, eliminating funding that supports structural barriers, taking advantage of existing expertise, and promoting employment opportunities for PWH. Mr. Jackson called for empowering PWH to make their own health decisions, and he noted that many health care providers remain underinformed and harbor bias. Ms. Ortega described stigma in the transgender community and commented that access to treatment and prevention would improve by tackling the underlying institutional barriers rather than targeting subpopulations. She also recommended that PACHA include a transgender member.

Mr. Alton and other PACHA members posed a series of questions. Highlights of panelist responses are noted below.

What local policies or practices can help overcome stigma?

- Legislative advocacy against stigma can be effective. PWH should recognize that it is part of their civic responsibility to vote and be involved in civic affairs.
- Legislation can do only so much; families and communities remain a major source of stigma.

- Entities should collaborate and share best practices.
- Generational differences contribute to stigma; the involvement of more young and disenfranchised people will help.
- Economic empowerment is a lynchpin to undoing stigma. Higher wages are key to stable housing, which, in turn, is essential for health.
- Providers need more education about stigma, bias, and how PrEP benefits the broader community, particularly in the South. Technology offers a lot of promise for integrating sexual and reproductive health services, but the stigma that patients face and providers' discomfort remain substantial barriers.
- Even within the HIV workforce, power is concentrated among people who are not the face of the epidemic; the most successful programs involve care navigators and peer counselors, which are the lowest-paid positions.
- Organizations must actively go into communities to seek input and engagement.

How can individual, internalized stigma be addressed, and how can efforts go beyond those at risk for broader impact?

- Publicizing U=U can help reduce internalized stigma.
- PWH need to be able to talk to peers and leaders who look like them. Access to information and care from well-paid, relatable peers makes a difference.
- PWH should feel emboldened to call out stigma among friends and family and hold them accountable.

How can the influence of the ballroom community be leveraged to address stigma?

- Established members of the ballroom community can recognize and encourage potential social justice advocates and future leaders, especially among those who feel powerless and disenfranchised.
- It is good business to invest in the communities that are disproportionately affected by HIV and that have the income and influence to create change.
- The affected communities need to know that they matter.

PACHA Member Discussion and Action Steps

Resolution in Support of FY 2021 Budget for EHE

The resolution drafted by Mr. Schmid congratulated the Secretary for securing significant increases for the second year of EHE in the President's proposed budget and asked that proposed cuts to HOPWA and other safety net programs not be implemented. It also asked that the \$3-billion cut to NIH not be enacted, because it could affect HIV/AIDS research outside of the CFAR.

Ms. Holman expressed concern that the resolution goes beyond PACHA's charter and mission. She suggested that the language on proposed cuts should focus solely on Medicare and Medicaid, which are directly related to the treatment of PWH. Mr. Schmid stated it is clear that focusing only on direct services for HIV is not enough to end the epidemic—addressing housing, nutrition, and other SDH is key. Ultimately, the Council agreed to eliminate references to safety net programs while maintaining the language about cuts to HOPWA and NIH. Members also agreed to soften the language by asking that the proposed cuts be “revisited.”

Vote

The Council voted unanimously in favor of finalizing the resolution, as amended, and sending it to the ASH.

See [Appendix C](#) for the finalized PACHA resolution.

Next Steps and Closing Remarks from the PACHA Co-Chair

For future meetings, Mr. Schmid expressed hope that PACHA staff and members would enhance their efforts to inform the community regarding the opportunity for public comments. He also pointed out that the number of speakers and presentations should be limited so that there is enough time for questions and discussions; several PACHA members agreed. Mr. Narváez urged PACHA to be mindful of its responsibility to invite guests who represent the diverse face of the epidemic. Mr. Saperó added that more PWH should be represented on the Council.

Some potential topics for the next meeting were suggested:

- Syndemics and interactions among Federally funded programs on hepatitis, substance abuse, and other STIs
- HIV and aging
- Overview of the EHE jurisdiction plans from Federal partners
- Areas of concern to Federal partners that they would like PACHA to explore
- Issues of interest to communities in the EHE jurisdictions (on the basis of local input)
- Barriers to PrEP uptake
- Early signals from jurisdictions that have EHE funding

Council members proposed holding a future PACHA meeting in the West or Northeast as part of the PACHA to the People effort. The International AIDS Conference will take place in San Francisco in July. It was noted that San Francisco and Oakland already receive significant attention, so Los Angeles, which has a significant Native American population, might be an appealing alternative. The U.S. Conference on AIDS takes place in Puerto Rico in October 2020, and PACHA could meet around that event. Ms. Hayes reminded the Council that its charter states that it will meet at least three times per fiscal year (October 1 through September 30).

The meeting adjourned at approximately 4:00 p.m.

Appendix A: Letter to the Director of the Office of Civil Rights



December 17, 2019

Roger Severino, JD
Director, Office of Civil Rights
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Severino:

We very much appreciated meeting with you on September 24, 2019 and your correspondence to us dated October 8, 2019.

Clearly, the Office of Civil Rights (OCR) works hard to ensure that the civil rights of those persons living with HIV are being protected. We very much appreciate OCR's participation on the various HIV/AIDS and hepatitis interagency work groups and the work you all do to educate, train, provide technical assistance, and investigate complaints as it relates to HIV-related discrimination.

We agree that "discrimination has no place in our Nation's health care system." We believe strongly that to achieve the goals of the President's initiative "Ending the HIV Epidemic: A Plan for America," HHS must state this loudly and clearly as it implements the initiative and conducts ongoing HIV activities so that people most impacted by HIV, such as gay men and transgender individuals, are comfortable in accessing HIV prevention and treatment programs. Additionally, HHS and other parts of the Administration must avoid actions that repel LGBT+ individuals from seeking proper health care.

Civil rights protections must extend beyond HIV status to include status or perceived status as gay, bisexual, or transgender. Civil rights protections are critically important for ensuring that LGBT+ persons can access health care and for creating stigma-free environments where all LGBT+ persons can receive quality health care services.

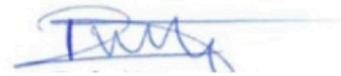
As we work towards an end to the HIV epidemic in the United States, it is vital that LGBT+ persons receive the same kind of protections as persons living with, or perceived to have, HIV/AIDS. We welcome any opportunities to work with the Trump administration and Congress to achieve this.

Sincerely,

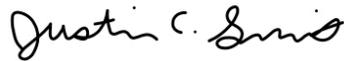


Carl Schmid, MBA
Co-Chair, Presidential Advisory Council on HIV/AIDS

John Wiesman, DrPH
Co-Chair, Presidential Advisory Council on HIV/AIDS



Rafaelé Narváez
Co-Chair, Stigma and Disparities Subcommittee, Presidential Advisory Council on HIV AIDS



Justin C. Smith, MS, MPH
Co-Chair, Stigma and Disparities Subcommittee, Presidential Advisory Council on HIV AIDS

Appendix B: Written Public Comments for the Presidential Advisory Council on HIV/AIDS



February 10, 2020

To member of PACHA,

The Well Project, on behalf of a diverse group of HIV thoughtleaders representing all aspects of the HIV response who are committed to women living with and vulnerable to HIV, is working with the administration to ensure that the *Ending the HIV Epidemic: A Plan for America* (EHE) adequately addresses the needs of women, inclusive of trans women.

While we applaud the decision to undertake the effort to end HIV as an epidemic in the United States, we believe that it is crucial to the plan's success that women's unique needs are prioritized, particularly those of cis and trans women of color.

Despite the fact that federal policies exist to ensure the inclusion of women in clinical research and other programming, women continue to be excluded from HIV efforts than 30 years into the epidemic. Just last fall, the U.S. Food and Drug Administration (FDA) approved what is only the second drug for HIV pre-exposure prophylaxis (PrEP) with zero studies having been conducted in cis women. The recent FDA approval means that we now have a two-tiered prevention approach entitling cis women to fewer options than men.

In order to sufficiently integrate women into the EHE, The Well Project is working with the administration to ensure that they consider the needs and experiences of women living with and vulnerable to HIV across all programming, from prevention and testing campaigns, to research development, to mental health and social support, to clinical care. Ultimately, it is vital that the EHE explicitly retains a commitment to and is held accountable for the survival and well-being of women living with HIV during its implementation.

Women represent 23 percent of all people living with HIV in the United States. African-American women, while only representing 13 percent of the female population, make up more than 59 percent of new HIV infections among women. Trans women are 49 times more likely to get HIV than the general population. Yet, somehow, the notion persists that women do not deserve focus in the HIV sphere, which has effectively rendered them and their experiences invisible. When women are left out of HIV research and programming efforts, it has a detrimental effect on everyone living with HIV. As researchers, policymakers, advocates, providers, and women living with HIV, we know that only by addressing all populations, including women, will we succeed in ending HIV as an epidemic.

With input from relevant stakeholders, we believe that EHE has the potential to be the framework that ends the battle we have fought for more than three decades.

Sincerely,
The Well Project

Cc: Krista Martel, Executive Director, The Well Project (kmartel@thewellproject.org)



PACHA Public Comment

February 10/11, 2020

Washington, DC

Hello, my name is Giffin Daughtridge. I am a medical doctor and the cofounder of an HIV prevention venture called UrSure. UrSure is focused on improving PrEP and ART adherence and retention.

At UrSure, we think of PrEP as a three-legged stool. In order for PrEP to be optimally effective, we need:

- **Uptake** – the individuals at highest risk need access to the drug.
- **Adherence** – once on the drug, compliant dosing is key.
- **Retention** – those who have started on PrEP need to stay on it.

As EHE scales up, we are at a crucial inflection point. “Ready, Set, PrEP” and the new funding are driving unprecedented resources to HIV prevention. To date, the focus has largely been on the uptake leg of the PrEP stool, which is obviously critical, but we want to ensure we don’t forget about the adherence and retention legs of our stool.

Without a focus on adherence and retention, we know PrEP will not work for those individuals who need it most – the people the EHE initiative is rightfully attempting to reach. This has been demonstrated in two important publications:

- Eaton et al showed that among over 4,000 black MSM nationwide, HIV prevalence was actually higher in those on PrEP than in those not on PrEP due to problems with adherence and retention.
- Marcus et al showed that HIV incidence is almost 20% higher among those who have been on PrEP and were not retained in care vs those who were never on PrEP.

We know PrEP is almost perfectly effective at preventing HIV when taken consistently, but these studies show how critical a comprehensive approach to PrEP care is. Driving uptake without supporting adherence and retention undermines the utility of PrEP and keeps us from ending the epidemic in exactly the populations who most need it.

Today, I want to talk about objective adherence monitoring as a tool to effectively support the adherence and retention legs of the stool. Imagine trying to treat HIV if we didn’t have viral load. Viral load is the marker that tells us whether our patients are taking the drug as prescribed. PrEP should be similar. Without a biomarker of adherence, the only way we truly know if someone is not adherent is if they seroconvert, and that is obviously unacceptable.

So let’s walk through the 3 reasons why adherence monitoring is such a critical tool:

1. **Need:** Our clinical data shows that 4 in 5 non-adherent patients are currently self-reporting consistent adherence. This means tens to hundreds of thousands of missed opportunities to intervene as PrEP scales up. Self-report is insufficient; we need an objective measure.
2. **Feasibility:** Implementing adherence monitoring is now feasible and affordable. We have run over 6,000 of our lab tests in over 20 Departments of Health and Federally Qualified Health Centers across 14 of the hotspot jurisdictions. Our clinics have been able to seamlessly integrate the test and get it reimbursed through an established CPT code. Further, we developed a point of care version of our test which delivers results in minutes, and we are working with FDA to bring this test to market this year.
3. **Effectiveness:** Adherence monitoring can play a crucial role in improving PrEP adherence and retention.
 - a. 82% of patients who test non-adherent demonstrated recent adherence at their next visit.
 - b. Those who test non-adherent are almost twice as likely to drop out of care in the next 6 months.

We can only manage what we can measure, and as we have seen, we must manage adherence and retention for PrEP to be effective. Today, I ask for two key actions to ensure we address all three legs of the PrEP stool:

1. **Strengthen clinical recommendations around tools shown to increase adherence and retention** - Clinical recommendations from guidelines bodies like the CDC and USPSTF are the fastest way to drive the adoption and payer coverage needed to make adherence tools widely available.
2. **Incorporate objective adherence monitoring into the SOPs for jurisdictions receiving EHE funding** – These are the communities that most need innovation to ensure PrEP works for traditionally marginalized individuals.

Thank you for your time. I look forward to working with you to make PrEP work for our populations who need it most.

Sincerely,

Giffin Daughtridge, MD MPA



Healthvana

Presidential Advisory Council on HIV/AIDS
February 10, 2020 - Washington D.C.
Public Comment

"I know this seems crazy, but can I get HIV from taking PrEP? Other vaccines infect you with a bit of the virus, right? So how is this different?" - Patient of color via Healthvana.

Medical Mistrust

In a 2016 national survey about HIV in the black community, **"40% believed there is a cure for HIV, but the government is withholding it from the poor."** Medical mistrust among communities of color is one of the largest impediments to ending the HIV epidemic and it can be best addressed with the use of technology - and we're seeing it successfully done, every day, by way of our platform.

My name is Ramin Bastani and I'm the CEO of Healthvana. Our mission is to help end HIV with our innovative, technology platform that both empowers patients on their mobile phones and amplifies the incredible front-line staff who know how to communicate with **their** communities best.

150,000+ patients of color on Healthvana

This isn't just an idea. We are already working with over 300,000 patients across the U.S. who are at-risk of HIV, on PrEP or HIV positive. **Over 150,000 of those patients are from communities of color, and they are asking questions exactly like the one above.** They are doing so at a time of **their** choosing, at a place of **their** choosing, in the way of **their** choosing, and through the most intimate thing the world has ever seen - **their** mobile phone.

Our team respectfully asks you to consider the importance of technology in all aspects of ending the HIV epidemic, especially when it comes to helping communities of color start and stay on PrEP. I made similar comments at the last PACHA meeting in Miami (next page) and hope there will be just as much attention devoted to adherence and persistence of PrEP as there is to access to PrEP.

I appreciate the opportunity to address the council. Thank you for the work you do and please know that I am here to help any stakeholders looking to use technology to help end HIV.



Healthvana

Presidential Advisory Council on HIV/AIDS
October 22, 2019 - Miami
Public Comment

Hello, my name is Ramin Bastani, CEO of Healthvana. Our mission is to help end HIV with innovation and technology.

You may not have heard of us, but we're empowering over 300,000 patients who are at high-risk of HIV, already on PrEP or HIV+ manage their health on their mobile phones. And we're doing so by working with clinics in 17 states today - helping them deliver better care at a lower cost. If you go to our website, there is a 1 min video that will show you exactly what we do.

Our recent focus has been on PrEP and by the end of this year we'll have about 5% of all patients on PrEP using Healthvana - and by this time next year we anticipate it to be about ~15%. These patients will receive automated reminders and educational messages such as:

- "You may experience nausea the first few days on PrEP - don't worry, it's normal. If it persists, please click here to send a message to your care team" or
- "It's time to come back in for get your next prescription for PrEP, please click here to schedule an appointment"

The idea is to help build relationships with patients where they spend most of their time - on their phones. And now that you know a bit about our company, I'd like to share a growing problem we're seeing - and it's around adherence and retention to PrEP. No doubt PrEP works amazingly well, when taken as prescribed. And access is increasing through incredible initiatives shared such as:

1. 200,000 patients getting free PrEP from Gilead
2. Pharmacies enabling patients to get PrEP without a prescription or pre-authorization (starting in California)
3. Work by PACHA increasing access to PrEP through support of the Ending the HIV Epidemic Plan

But I respectfully request the council, and all stakeholders, consider making PrEP adherence and retention just as big of an initiative as access. Dr. Lisa Eaton published a paper late last year, highlighting what we're seeing on the ground. And she interviewed 4,000 black men who have sex with men at black pride events, and found that HIV prevalence in the population on PrEP was actually 60% higher than in those not on PrEP. We know that technology can help.

I appreciate the opportunity to address the council. Thank you for the work you do and please know that I am here to help any stakeholders looking to use technology to help end HIV.

My name is Carole Treston. I am a nurse with the Association of Nurses in AIDS Care. Nurses were the backbone of the response to AIDS when there was no effective treatment-nursing care. Holistic, compassionate care and the judgment-free nurse coordination of support & other services were paramount. Advances have ushered in the medical model, for which we are grateful because hundreds of thousands lived, and many became undetectable. But we are at a crossroads now, where the experiences & outcomes of people living with and at risk for HIV are divided.

Disparities along racial, economic, geographical lines, and age define the outcomes. The road ahead – ensuring that the 400,000 people not in care will receive the same care & sustained healthy outcomes as those already receiving care will not be easy. We can't treat our way to the end of the HIV epidemic. For many, it's so much more than pills, either for treatment or prevention. The importance of addressing social issues, including via methods like investments in intensive nurse case management & care coordination; alternative treatment sites; and other measures such as a focus on holistic care that includes support groups, mental health services, food & nutrition, and housing support are critical.

I want to share a story with you of a woman living with HIV for 25 years, working, engaged in care, an advocate- the epitome of successful living with HIV, UDVL & U=U. But due to IPV, she left her home to start fresh, became housing unstable (living here & there), and dealt with understandable depression. Her medical care slipped, & her viral load climbed. She was ashamed and embarrassed. Support groups are helping her get back on track, but housing assistance is still a challenge because she doesn't have her name on a lease. Yes, our own bureaucracies aren't getting her the services she needs to return to a healthy place.

Part of an effective response to maintain those in care and engage and sustain those out of care includes supporting a healthcare workforce that is reflective of the populations being served. Investing in interprofessional teams that reflect the racial, ethnic, and sexual orientation identities of the community served will help. Providers who build relationships with the whole person – not just their viral load success – will help. Reducing bureaucracies and other institutional hurdles will help. This takes time- more than a 15-min scheduled visit. Nurses can often identify & implement these necessary person-centered solutions.

The Association of Nurses in AIDS Care (ANAC) is thrilled that PACHA has seated Vincent Ramos- ANAC member, nurse, & social worker. Having the voice of Vincent- and I hope others like him- will broaden the discussions. The many roles & experiences of nurses are important perspectives, and we applaud HHS & PACHA for this inclusion. We often aren't at the table despite our size in the workforce & contributions- even in 2020- the WHO-designated Year of the Nurse.

Appendix C: Resolution

Presidential Advisory Council on AIDS (PACHA) Resolution in Support of FY2021 Budget for “Ending the HIV Epidemic: A Plan for America”

Whereas, as part of the Administration’s implementation and scale up of the *Ending the HIV Epidemic* (EHE) initiative, the President’s Fiscal Year 2021 budget includes increased funding for programs that will support efforts to end HIV in the U.S. within 10 years by increasing HIV testing, treatment and prevention services, initially focused in those geographic areas most impacted by HIV;

Whereas, building on the increased funding that the President proposed and Congress approved for Fiscal Year 2020, the President is recommending a further increase of \$450 million for the second year of the EHE. Specifically, the budget proposes a \$231 million increase for the Centers for Disease Control and Prevention (CDC), \$95 million for the Ryan White HIV/AIDS Program; \$87 million for Community Health Centers, \$27 million for the Indian Health Service, and \$10 million for the National Institutes of Health (NIH) Centers for AIDS Research;

Whereas, at the same time the President is proposing a \$80 million cut to the U.S. Department of Housing and Urban Development’s (HUD) Housing Opportunities for Persons with AIDS (HOPWA) program, a \$263 million cut to AIDS Research at the NIH, and reforms to critically important programs such as Medicaid and Medicare that could reduce services to people living with and at risk of HIV;

Whereas, PACHA passed a resolution on October 22, 2019 urging the Secretary of the U.S. Department of Health and Human Services “to work with the Office of Management and Budget to ensure that the President’s budget for Fiscal Year 2021 contains the necessary resources to implement year two of the *Ending the HIV Epidemic* initiative by providing substantial increased resources to each of the agencies, programs, and communities implementing the initiative” while at the same time ensuring “there are no proposed cuts to programs such as the Housing and Urban Development’s Housing Opportunities for People with AIDS and other federal government programs that impact the success of meeting the goals of the *Ending the HIV Epidemic*”;

Therefore, be it resolved that PACHA commends the President and the Secretary for proposing the historic, substantial funding increases for year two of the EHE in order to scale up activities, while at the same time expresses concern regarding the proposed funding cuts;

Be it further resolved that we urge the Secretary to work with the Congress in a bipartisan manner to ensure that the proposed funding increases are realized, and the proposed cuts revisited.

February 10, 2020