Presidential Advisory Council on HIV/AIDS (PACHA)
69th Meeting (Virtual)
December 2–3, 2020

Council Members—Present

Carl Schmid, M.B.A., PACHA Co-Chair, Executive Director, HIV + Hepatitis Policy Institute, Washington, DC

John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chair, Secretary of Health, Washington State Department of Health, Olympia, WA

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

Alicia Diggs, M.P.H., Medical Case Manager, Positive Wellness Alliance, Lexington, NC

Vincent Guillamo-Ramos, Ph.D., M.P.H., LCSW, ACRN, ANP-BC, AAHIVS, Professor and Director, Center for Latino Adolescent and Family Health, New York University (NYU); Pilot and Mentoring Core Director, Center for Drug Use and HIV Research, NYU; Nurse Practitioner, Adolescent AIDS Program, Montefiore Medical Center, Bronx, NY (*Day 2 only*)

Marc Meachem, M.B.A., Head, External Affairs, ViiV Healthcare North America, Washington, DC (*Day 2 only*)

Rafaelé Narváez, Co-Founder and Director of Health Programs, Latinos Salud, Wilton Manors, FL

Laura Platero, J.D., Executive Director, Northwest Portland Area Indian Health Board, Portland, OR

Michael Saag, M.D., Associate Dean, Global Health, School of Medicine, and Professor of Medicine, Division of Infectious Disease, The University of Alabama at Birmingham (UAB); Director, UAB Center for AIDS Research, Birmingham, AL (*Day 1 only*)

John Sapero, Director, Ending the HIV Epidemic, Collaborative Research LLC, Phoenix, AZ

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

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, Atlanta, GA

Ada Stewart, M.D., RPh, FAAFP, AAHIVS, HMDC, Lead Provider and HIV Specialist, Eau Claire Cooperative Health Centers (Now Cooperative Health), Columbia, SC

Council Members—Absent

Wendy Holman, CEO and Co-Founder, Ridgeback Biotherapeutics, Miami, FL

Liaison: Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis, and Sexually Transmitted Disease (STD) Prevention and Treatment (CHAC)

Jennifer Kates, Ph.D., Senior Vice President and Director, Global Health and HIV Policy, Kaiser Family Foundation

Staff

B. Kaye Hayes, M.P.A., Acting Director, Office of Infectious Disease and HIV/AIDS Policy (OIDP); PACHA Executive Director, Designated Federal Officer; Office of the 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, HHS

Federal Partners

Laura Cheever, M.D., Sc.M., Associate Administrator, HIV/AIDS Bureau, HRSA
Neeraj Gandotra, M.D., Chief Medical Officer, Substance Abuse and Mental Health Services Administration
LT Neelam "Nelly" Gazarian, Prevention through Active Community Engagement (PACE) Deputy Director, Region 4
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 for AIDS Research, Director, Office of AIDS Research, National Institutes of Health (NIH)
Irene Hall, Ph.D., M.P.H., Acting Director, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and Tuberculosis Prevention (NCHHSTP), CDC
Rita Harcrow, Director, Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development (HUD) (Day 2 only)
Norma Harris, Ph.D., M.S.P.H., Division of HIV/AIDS Prevention, NCHHSTP, CDC
Rick Haverkate, M.P.H., National HIV/AIDS & Hepatitis C Program Coordinator, Indian Health Service (IHS)
David Johnson, Deputy ASH, OASH, HHS
RADM Jonathan Mermin, M.D., M.P.H., USPHS, Director, NCHHSTP, CDC
Douglas Olson, M.D., Chief Medical Officer, Medicaid/Children's Health Insurance Program, Centers for Medicare & Medicaid Services (CMS)
Harold J. Phillips, Senior HIV Advisor and Chief Operating Officer, Ending the HIV Epidemic: A Plan for America (EHE), OASH, HHS
CAPT Paul Reed, M.D., Deputy ASH, Office of Disease Prevention and Health Promotion, HHS
Crystal Simpson, M.D., Medical Officer, Office of Medicare, CMS, HHS
Judith Steinberg, M.D., M.P.H., Chief Medical Officer, OIDP
Tigisty Zerilassie, Bureau of Primary Health Care, HRSA
Sara Ziegler, Associate Director for Planning and Policy, NCHHSTP, CDC

Day 1

Opening Remarks from the PACHA Co-Chairs

John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chair, called the meeting to order at 1:00 p.m. (This meeting was broadcast live online; the recorded broadcast is available online.) He commented that World AIDS Day (December 1, 2020) offered an opportunity to reflect on the HIV epidemic, honor those who have passed, and acknowledge those who continue to fight the epidemic. Dr. Wiesman summarized the agenda for the meeting.

Carl Schmid, M.B.A., PACHA Co-Chair, emphasized that the drive to end the HIV epidemic continues and is now complicated by a second pandemic—COVID-19. He outlined competing proposals currently under consideration by Congress to fund EHE for 2021.

Welcome

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

Via recorded remarks, ADM Giroir welcomed the meeting participants, noting that they are essential to the whole-of-society approach required by the EHE initiative. He thanked Kaye Hayes, M.P.A., in particular, for her outstanding work and commitment as PACHA's executive director and the acting director of OIDP. ADM Giroir also thanked the clinicians, public health experts, community-based organizations (CBOs), and others in the HIV community for their continued efforts to address HIV while also working at the forefront of the COVID-19 pandemic.

ADM Giroir said when he started his tenure as ASH, he asked why the United States continued to see 40,000 new HIV infections every year and learned that the lack of leadership on the issue prevented progress. He made HIV a top priority of the OASH, re-established PACHA, and worked with leaders at HHS, CDC, and NIH and the President to implement EHE. ADM Giroir commended PACHA members' extraordinary commitment to ending HIV, as well as their collegiality and professionalism, even when they disagreed with the administration's policies.

ADM Giroir outlined the OASH's recent accomplishments and current priorities around EHE:

- Continued efforts to increase uptake of preexposure prophylaxis (PrEP) by ensuring communities have access to medication and raising awareness through the I'm Ready promotional campaign
- Continued work to increase enrollment in the Ready, Set, PrEP (RSP) program, which provides PrEP at no cost to people without prescription drug coverage
- Formalized involvement of the PACE program's public health professionals in EHE to improve coordination and collaborations in EHE jurisdictions
- Rolled out America's HIV Epidemic Analysis Dashboard (AHEAD)

COVID-19 has presented new challenges, and providers of care for people with HIV (PWH), sexually transmitted infections (STIs), and hepatitis have been working to ensure continuity of care during the pandemic. The situation has forced HHS leadership and others to embrace disruptive innovation. It also underscores the importance of an integrated approach to care, which is reflected in new national plans for addressing HIV, STIs, and viral hepatitis and developing vaccines, all of which are nearing finalization. ADM Giroir emphasized the need to address all the components of this syndemic (i.e., a set of interrelated health problems) to reverse the trajectory of each component, taking a whole-of-society approach.

On behalf of HHS, ADM Giroir thanked the PACHA members for their commitment to the fight against HIV/AIDS. He appreciated the unique perspective that each member brings and the work they do in their communities.

Roll Call

Ms. Hayes, PACHA executive director, called the roll.

PACHA Subcommittee Reports

EHE and the Updated National HIV/AIDS Strategy

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

Mr. Sapero reported that this Subcommittee was asked to provide insights on improving public awareness of and enrollment in the RSP program. The Subcommittee also received updates on the new HIV National Strategic Plan: A Roadmap to End the Epidemic, AHEAD, the RSP program, and other EHE work. Additionally, the Subcommittee contributed to the agenda for this meeting and crafted a proposed resolution expressing appreciation to HHS leadership for initiating EHE, to be addressed at this meeting.

Stigma and Disparities

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

Mr. Smith said the Stigma and Disparities Subcommittee works with its PACHA counterparts to ensure that concepts of equity are infused in all of PACHA's work. He thanked Maureen M. Goodenow, Ph.D., for including him and Mr. Narváez in an NIH workshop on HIV-related intersectional stigma research. During the workshop, leading scientists from around the country discussed advancing the science of HIV-related stigma, with the goal of translating the findings into policies and programs. The outcomes of the workshop will be published in the coming year.

Global

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

Dr. Schwartz observed that PACHA and the Global Subcommittee have heard from leaders of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), including Ambassador Deborah L. Birx, M.D. The Subcommittee organized the panel discussion on international perspectives for this meeting, facilitated by Cornelius Baker, PEPFAR liaison. Mr. Alton added that the virtual meeting format provides an opportunity to hear from people on the ground around the world and learn from their experience.

Updates from OIDP

EHE, RSP, and the HIV National Strategic Plan

Harold J. Phillips, M.R.P., Senior HIV Advisor and Chief Operating Officer, EHE, OASH, HHS

Mr. Phillips emphasized that EHE draws on expertise from across OIDP and from PACHA to work toward its goals. In response to stakeholder suggestions, Mr. Phillips ensured that information about HUD's Housing Opportunities for Persons with AIDS (HOPWA) program is linked with EHE and represented in AHEAD data. Discussions with stakeholders also have addressed how to put a whole-of-society approach into practice to achieve EHE goals. In October, PACE officers in three regions targeted by EHE officially joined OIDP staff, facilitating better communication and coordination of Federal resources within those regions. Current stakeholder engagement efforts seek to increase the role of pharmacists and schools of pharmacy in HIV prevention, medication compliance, and messaging.

AHEAD aims to provide accurate, accessible, usable data by EHE jurisdiction so users can track progress and target services to communities in need. Mr. Phillips said work is underway to make AHEAD interactive sometime in January 2021. In response to stakeholder input, AHEAD includes success stories and a HOPWA resource tool.

The RSP program launched in October, followed by the I'm Ready public awareness campaign to promote enrollment and PrEP uptake. HHS re-launched the program with a new vendor, Trialcard, which is assisting with enrollment and will offer a mail-order option. More than 32,000 pharmacies are taking part. As of December 1, 2020, approximately 1,300 people were enrolled. More promotional materials and additional communications tactics are planned for 2021, including efforts to reach more American Indians and Alaska Natives (AI/AN).

The draft HIV National Strategic Plan was released on December 1, 2020. The 5-year plan aligns with other OIDP strategic plans and with Healthy People 2030. The plan builds on the previous two National HIV/AIDS Strategy plans from HHS and represents input from numerous community stakeholders and Federal partners. Mr. Phillips clarified that whereas EHE is a focused, 10-year plan, operationalized by HHS, to diagnose, treat, and prevent HIV, the HIV National Strategic Plan is roadmap for the country to move toward ending HIV.

Mr. Phillips described the vision, goals, objectives, and strategies of the draft HIV National Strategic Plan, which is open for public comment through 5:00 p.m. ET on December 14, 2020. Specific activities are not prescribed, because it is hoped that stakeholders will determine how best to achieve the goals in their communities. The plan describes priority populations and indicators to assess progress. New indicators measure stigma and homelessness using data from CDC's Medical Monitoring Project. HHS aims to finalize and release the plan in mid-January 2021. Mr. Phillips stressed that Federal partners will be responsible for developing implementation strategies to achieve the goals of the new plan.

STI and Viral Hepatitis National Strategic Plans

Carol Jimenez, J.D., Deputy Director for Strategic Initiatives, HHS

Ms. Jimenez noted that addressing STIs and viral hepatitis is critical to ending HIV. The two new plans employ the same structure as the HIV National Strategic Plan and were similarly developed through Federal steering committees, stakeholder input, and public comment processes. Together, the three plans address the syndemic of STIs, viral hepatitis, and HIV, with attention to combating stigma and discrimination and recognizing the role of social determinants of health (SDH).

The goals of the draft STI National Strategic Plan include accelerating progress on STI research, technology, and innovation by expanding research on vaccines, diagnostics, and therapeutics; investigating PrEP and postexposure prophylaxis (PEP) for STIs; and advancing principles of stewardship to prevent antimicrobial resistance, among other approaches. Ms. Jimenez said the plan recognizes the disproportionate impact of STIs on sexual and gender minorities but does not identify them as a priority population because national data are insufficient to do so. Therefore, the plan also calls for improved data collection to support future efforts. Ms. Jimenez pointed out

that STI rates have been increasing for the past 6 years, so indicators target first slowing the pace of STIs and then reducing the rates.

The draft Viral Hepatitis National Strategic Plan: A Roadmap to Elimination represents the United States' first commitment to eliminate viral hepatitis, recognizing that hepatitis A and B are vaccine preventable and hepatitis C can be cured with a single course of treatment. Notably, the plan proposes to improve viral hepatitis surveillance and use data to support a more focused approach to elimination. The list of priority populations does not distinguish U.S.-born from foreign-born people, but the plan recognizes the disproportionate impact of viral hepatitis on the latter group. The plan's indicators align with World Health Organization (WHO) viral hepatitis elimination targets.

Ms. Jimenez said implementation is key to realizing the goals of both plans. The Federal government and its partners must determine the actions needed and commit to them. The plans call for a whole-of-society approach, and all stakeholders play a role in reaching the goals.

Discussion

Mr. Phillips clarified the mechanisms for determining the baseline for the indicators on stigma and disparity in the HIV plan. Regarding existing barriers to PrEP uptake, Mr. Phillips said HHS relies on CDC guidance about the frequency of laboratory assessments required for PrEP during the COVID-19 pandemic, and HHS aims to make sure that health care providers, pharmacists, and pharmacy networks are aware of current CDC guidance. He added that the health centers that received funding to support laboratory testing for HIV and STI have been very effective in enrolling people in PrEP, despite the pandemic.

Laura Platero, J.D., pointed out that since the EHE initiative was put forward, no new funding has been provided to IHS or tribal health centers to implement it. She asked what plans are in place to ensure that AI/AN individuals with HIV are not left out again as Congress determines future funding. Mr. Phillips said he believes the lack of funding was the result of miscommunication among appropriators, and efforts are underway to gain funding for IHS to support EHE.

Addressing the Syndemic of HIV, Hepatitis, and STIs

Facilitator: *Carl Schmid, M.B.A., PACHA Co-Chair*

Panelists: *David C. Harvey, Executive Director, National Coalition of STD Directors (NCSD)*

Michael Ninburg, M.P.A., Executive Director, Hepatitis Education Project

Q: What are your views on the new national STI and viral hepatitis strategic plans?

Mr. Harvey appreciated the broad focus of the first-ever STI strategic plan and the attention to the relationship between HIV and other STIs. From 11 to 16 percent of new HIV infections in gay and bisexual men result from STIs (specifically chlamydia and gonorrhea), so STI diagnosis offers an opportunity to prevent HIV infection and link PWH to care. Mr. Harvey said Federal funding for State and local entities to address STIs is very limited, which partly explains the

out of-control STI epidemic in this country. He said the national STI strategic plan will guide the community in advocating increased funding.

Mr. Harvey observed that the plan is data driven and well organized, recognizes the role of stigma and SDH, and emphasizes the importance of seeing STI through a syndemic lens. It also does a great job focusing on priority populations. The accompanying implementation plan should include measures of accountability. In its comments on the draft plan, NCSD stressed the need to address systemic racism in public health, increase financing for implementation, discuss State-level barriers, and draw attention to STI specialty clinics and the crucial role of intervention specialists. The draft plan does not mention expedited partner therapy. Mr. Harvey said recent advances in STI vaccine research could have a profound effect. He applauded the government partners for producing the plan.

Regarding the viral hepatitis strategic plan, Mr. Ninburg pointed out that all the member states of WHO committed to targets for eliminating viral hepatitis 4 years ago, but U.S. efforts toward those targets have not been publicized until this draft plan. The accompanying implementation plan will be the first to operationalize the goals proposed by HHS. Three previous viral hepatitis action plans have not had much impact other than the advent of new curative therapy for hepatitis C, said Mr. Ninburg. He appreciated that the new plan acknowledges the role of racism, stigma, and discrimination as contributors to health disparities and recognizes the need for increased testing and knowledge of status. Mr. Ninburg said the draft plan mirrors successful approaches in the HIV community by calling for inclusion of people with viral hepatitis in strategic planning and use of treatment as prevention. He noted that the rollout of COVID-19 vaccines may be an opportunity to reach some specific populations who would benefit from hepatitis vaccination, such as homeless people.

Mr. Ninburg particularly appreciated the plan's goals around surveillance and integration. The field lacks the resources to gather data, and effective interventions are inhibited without surveillance. Integration has been a talking point at the Federal level for years but has not been evident in the leadership, Mr. Ninburg noted. The budget for CDC's viral hepatitis work is dwarfed by the funding for EHE, yet mortality from hepatitis C alone surpassed that of HIV in the United States more than 10 years ago. The integration of efforts around HIV, viral hepatitis, and STIs is encouraging, Mr. Ninburg commented. In a coordinated effort, the Hepatitis Education Project and more than 30 other organizations sent comments on the draft plan calling for inclusion of liver cancer screening for people with viral hepatitis, recognition of certain additional racial/ethnic populations as high risk, increased education on implicit bias among medical providers, and acknowledgment of the role of CBOs in tackling viral hepatitis.

Q: How is the country doing in addressing the syndemic, and how has EHE impacted the work?

Mr. Harvey said the country is not doing very well, in part because of the complexity and inconsistency of the public health infrastructure. Barriers to effective integration of HIV, STI, and viral hepatitis treatments result from siloed funding streams and differences in grant requirements, lack of collaboration within health departments, and lack of integration within and among Federal public health agencies. Mr. Harvey pointed out that the Ryan White HIV/AIDS Program is critical to the response to HIV and STIs, and HRSA launched an initiative to improve

STI testing at Ryan White clinics, but challenges remain in ensuring that health departments take advantage of opportunities to address STIs and viral hepatitis within the Ryan White program.

Mr. Harvey appreciated all the coalitions that pushed for recognition of the syndemic of HIV, STIs, and viral hepatitis. EHE includes funding for STI screening and treatment, but efforts remain underfunded. Mr. Harvey looked forward to changing the funding equation to support more joint efforts, such as increasing PrEP prescription at STI clinics.

Mr. Ninburg said the country is not doing well with integrating the approach to viral hepatitis across all levels of government, although some State and local jurisdictions have done very well. Like Mr. Harvey, he hoped increased funding for EHE would yield more money to address viral hepatitis. Mr. Ninburg said that the EHE planning committee in his jurisdiction discussed how to expand hepatitis C testing and treatment in a context that goes beyond the needs of PWH.

Q: What approaches other than increased funding could help address the syndemic?

Mr. Harvey emphasized that even a small amount of money can go a long way in the STI effort. Other mechanisms include reducing administrative burden to allow greater flexibility in the use of funding—for example, in the Ryan White program and Maternal and Child Health block grants. Mr. Harvey noted that perinatal HIV transmission has been virtually eliminated, yet congenital syphilis persists, despite affecting a similar community. He said CDC's STI program should receive at least $300 million in funding, and he called for a new funding line of $500 million for STI clinics, as well as greater resource sharing with EHE programs.

Mr. Ninburg hoped that funding for infectious diseases related to the opioid epidemic would continue. Better surveillance for viral hepatitis must be funded to get a handle on the increase in hepatitis C infections. Mr. Ninburg pointed out that CDC's Program Collaboration and Service Integration was a good idea, but health departments did not receive any additional funding to take part. He proposed that funding require recipients to spend a certain percentage on integrating HIV, viral hepatitis, and STI services as a first step toward addressing the disparities in interventions. The amazing progress in addressing HIV resulted from providing resources and prioritizing surveillance, neither of which have occurred for viral hepatitis or STI. The syndemic approach offers a roadmap, but resources are needed to put it into place, along with champions to make sure that efforts on the ground take root, Mr. Ninburg concluded.

Q: How can access to viral hepatitis treatment be enhanced?

Mr. Ninburg pointed out that prices for hepatitis C curative therapy—the first-ever cure for any chronic viral infection—have declined dramatically since it was introduced, and it is available through most commercial payers. Access for Medicaid beneficiaries remains problematic because of State-level restrictions and requirements, which the Hepatitis Education Project and others are working to dismantle.

Q: How do you think implementation plans will address harm-reduction approaches (e.g., opioid substitution therapy and needle exchange programs)?

Mr. Ninburg noted that the current administration acknowledged the importance of reducing disease transmission through access to sterile injection equipment, and he hoped the next

administration would take such efforts further. He was cautiously optimistic that CDC and HHS policies would prioritize reducing viral hepatitis and HIV acquired through injection drug use.

Update from CDC

Irene Hall, Ph.D., M.P.H., Acting Director, Division of HIV/AIDS Prevention, NCHHSTP, CDC

Dr. Hall outlined CDC's funding to States and local health departments to begin implementation of EHE, including money from the HHS Minority HIV/AIDS Fund to support a national network of STI clinical prevention training centers for technical assistance around PrEP and PEP and mass mailing of HIV self-test kits.

New CDC data from 2010 through 2017 demonstrate a substantial decrease in deaths related to HIV across all major demographic groups, although some racial and ethnic disparities persist. AHEAD data were updated in October with preliminary data from 2019 and 2020. Because many CDC staff were called away from HIV data collection and analysis to respond to the COVID-19 pandemic, Dr. Hall recommended interpreting the data on HIV diagnoses with caution.

EHE is being adapted to the impact of COVID-19; new opportunities, partnerships, and innovations are being incorporated to allow EHE to remain flexible and ensure continued progress toward ending HIV. A CDC website is featuring success stories, such as efforts by Georgia's Dekalb County to connect more people to HIV prevention options. CDC also is spreading the word about PrEP through social marketing campaigns and partnerships with CBOs.

The EHE jurisdictions will submit their revised plans to CDC in December 2020. CDC developed community engagement planning guidance to assist jurisdictions. Jurisdictions must allocate at least 25 percent of implementation funds to support planning and implementation of EHE activities by community organizations. Dr. Hall pointed out that CDC expects jurisdictions to update their EHE plans periodically as they evolve.

Community Health Centers (CHCs) Update on PrEP Programing

Jim Macrae, M.A., M.P.P., Associate Administrator, Bureau of Primary Health Care, HRSA, HHS

Mr. Macrae said HRSA aims to make HIV prevention and treatment a routine part of primary care. Achieving that goal requires ensuring that CHCs are a welcoming place for people to seek HIV testing and care; increasing HIV testing capacity; helping health care providers offer care and link patients to specialty providers; ensuring that all people diagnosed with HIV are linked to care within 30 days; and expanding access to PrEP. In February, HRSA awarded $54 million to 195 CHCs for HIV outreach, testing, care coordination, prevention, and PrEP. These CHCs have strong relationships with Ryan White programs in their areas.

In spite of the COVID-19 pandemic, CHCs have made progress within the first few months of the award, including conducting nearly 250,000 HIV tests, linking 1,500 newly diagnosed people to care within 30 days, and prescribing PrEP to nearly 20,000 people. Mr. Macrae pointed out that CHCs increased the number of PrEP providers and patients at a higher rate than other care

delivery settings in the EHE priority counties. Subject to funding, HRSA plans to expand efforts to the 300 CHCs located in the targeted EHE jurisdictions that have not traditionally been involved in HIV prevention.

HRSA has strongly encouraged CHCs to increase their COVID-19 testing. To date, CHCs have conducted more than 5.6 million tests, approximately half in racial and ethnic minority people. About 700,000 people have tested positive, 59 percent of whom are racial or ethnic minorities, demonstrating the disproportionate impact of the disease. The number of CHC staff infected has been an ongoing concern. CHCs are using virtual visits and drive-up testing, among other approaches, to mitigate the risk to staff and patients. HRSA has relied on webinars to support CHCs in EHE; for example, a recent webinar described using telehealth for PrEP. Other efforts are underway to encourage HIV self-testing and using digital technology for patient follow-up, education, and registry enrollment. Mr. Macrae referred participants to two websites for CHC survey data that are updated weekly:

- Health Center COVID-19 Survey Data
- Health Center COVID-19 Testing by Race/Ethnicity

CHAC Update

Jennifer Kates, Ph.D., CHAC Liaison to PACHA; Senior Vice President and Director, Global Health and HIV Policy, Kaiser Family Foundation

Dr. Kates explained that CHAC met in early November and heard updates from several agencies and groups, including PACHA. Discussion centered on the impact of COVID-19 on the workforce, clinics, and patients. Representatives from HRSA described how the agency shifted resources during the pandemic. HRSA grantees have had fewer opportunities for face-to-face interaction between providers and clients, resulting in lower rates of HIV testing, but they have increased use of telemedicine and support for home-based testing.

Various CHAC work groups presented recommendations to standardize and improve perinatal infection screening and health outcomes; improve clinical assessment of PWH as they age; create a national strategy for developing diagnostics for hepatitis C; and draft a letter to support community engagement to gather guidance for year 2 of EHE. CHAC heard presentations on increasing community engagement and had a panel discussion on enhancing collaboration with CBOs, bringing new providers into EHE, increasing meaningful engagement among peers, and including PWH in decision making and implementation. Another panel addressed the need for strategies to recognize and care for women with HIV who experience trauma.

PACHA Resolution Introduction and Discussion

New Resolution

Mr. Schmid summarized a proposed resolution expressing PACHA's appreciation to HHS for instituting the EHE initiative. Members offered some minor changes to the wording.

Dr. Wiesman expressed that it is important for PACHA to recognize the leadership of all those involved.

Vote

The Council voted unanimously in favor of finalizing the resolution, as amended.

See Appendix A for the final resolution.

PACHA Next Steps

Dr. Wiesman reiterated that public comments on the draft HIV National Strategic Plan are due on December 14, which is not enough time for PACHA to put forth recommendations as a group. Mr. Schmid noted that the new plan sets more ambitious targets for every indicator. It includes more attention to stigma and acknowledges the challenges of the COVID-19 pandemic but does not examine aging PWH. Mr. Phillips explained that PWH over age 50 were not called out as a priority population, but the plan does identify the need to address the health of PWH across the life span. He added that the plan encourages communities to use their local data to identify their own priority populations.

Mr. Phillips emphasized that stakeholders can provide input to Federal agencies as they develop their implementation plans. Ms. Hayes noted that OIDP is looking forward to briefing the new administration about all of the new strategic plans. Dr. Wiesman hoped PACHA's Federal partners would address EHE in their communications with the new administration's transition teams. Mr. Schmid proposed that PACHA review the finalized plan early in 2021 and invite stakeholder comments. Mr. Smith stressed that the integration and alignment across Federal agencies envisioned by the plans must filter down to the programs on the ground to be effective. Mr. Sapero suggested inviting representatives of AIDS United to discuss how the draft HIV National Strategic Plan compares with its roadmap for Federal action to end HIV.

Action Items

Members of the EHE and the Updated National HIV/AIDS Strategy Subcommittee will meet virtually to discuss the draft HIV National Strategic Plan and may put forth comments individually (not as representatives of PACHA or the Subcommittee) by December 14.

PACHA will reconvene once the final HIV National Strategic Plan is released to discuss the plan in depth and solicit stakeholder input.

Remarks from the HHS Secretary

Alex M. Azar II, Secretary, HHS

On behalf of PACHA, Dr. Wiesman thanked Secretary Azar for championing the EHE initiative, and Mr. Schmid outlined the gratitude expressed in the PACHA resolution. Secretary Azar appreciated the resolution. He thanked the PACHA members for their many years fighting HIV

in various capacities and for continuing those efforts in the midst of the COVID-19 pandemic. The Secretary said the commitment to EHE has not wavered. Rather, its programs, as well as global efforts through PEPFAR, have adapted throughout the pandemic to continue delivering services while minimizing the risk of exposure to COVID-19, using such mechanisms as telehealth, self-testing, and drive-up testing, as well as providing access to prevention services in remote areas.

Secretary Azar said HHS continues to seek PACHA's input on increasing enrollment in the RSP program. He pointed out that progress made on the EHE initiative so far would not have been possible without the engagement of PACHA and others in the HIV community. Community engagement has been limited by the COVID-19 pandemic, however. Secretary Azar stated that such engagement is important for combating stigma, which poses even more of a challenge when it intersects with the historical marginalization of particular populations, including African Americans, Latinos, and gay men. Working hand-in-hand with those communities is an essential part of ending the HIV epidemic, he noted. He also recognized the contributions that the HIV community's advocates, infectious disease doctors and nurses, outreach workers, and researchers have made to the fight against COVID-19.

Lessons learned from combating HIV have informed community outreach and engagement around COVID-19. The HIV research infrastructure has been critical for conducting research and clinical trials on COVID-19 vaccines and therapeutics. Some of the platforms used to develop COVID-19 vaccine candidates originated in HIV vaccine research.

Secretary Azar described the initial discussions that led to creation of the EHE initiative and the leadership across HHS agencies, within the White House, and in Congress that enabled it to come to fruition. He expressed great pride in the program and confidence that it would be carried forward under the next administration. In closing, he thanked PACHA members for their friendship and partnership over the years.

Recess

Mr. Schmid recessed the meeting for the day at 5:02 p.m.

Day 2

Opening Remarks from the PACHA Co-Chairs

Mr. Schmid and Dr. Wiesman welcomed the participants at 1:02 p.m. They reviewed the proceedings of Day 1. Dr. Wiesman noted that PACHA would accept written public comments through December 10, 2020, at pacha@hhs.gov.

Roll Call

Ms. Hayes called the roll.

Assuring Equity in EHE: A Path Forward

Facilitator: *Alicia Diggs, M.P.H., PACHA Member*

Panelists: *Raniyah Copeland, M.P.H., President and CEO, Black AIDS Institute*

Allison Mathews, Ph.D., Associate Director of Integrating Special Populations, Maya Angelou Center for Health Equity, Wake Forest Baptist Health

Robert Contreras, M.B.A., President and CEO, Bienestar Human Services

Q: How does equity fit in to the current planning and implementation of EHE, and how can inclusion of vulnerable communities in EHE be strengthened?

Ms. Copeland responded that recent modeling of EHE in six cities found that in four of those cities, ending HIV among White people would be possible within 10 years, but for people of color (POC), it would take many more years, maybe even decades. The study highlights the concerns raised by those on the front lines about the importance of ending HIV for everybody. All the available tools are useless if those most affected by HIV lack access to them, Ms. Copeland stressed. It is time to look at the root cause of health inequity: structural racism. Health care systems must have the capacity and the incentives to provide high-quality care to POC. They should also consider the following:

- incorporate training in anti-racism and cultural humility;
- hire providers who represent the communities served;
- standardize best practices to ensure clinics are user-friendly; and
- invest in community-led initiatives to increase demand for and use of health care services among communities of color.

If equity is not at the center of EHE, Ms. Copeland stated, the initiative will widen the disparities—as exemplified by the current disparities in PrEP uptake by race/ethnicity.

Dr. Mathews pointed to the many barriers that prevent POC from participating in clinical trials that could lead to more and better treatments, such as lack of transportation, employment, and internet access and the paucity of POC among those providers and researchers who offer care, design clinical studies, and conduct community engagement. She called for more diverse leadership at all levels of government and throughout the research community. Dr. Mathews also

noted that the process for an individual to access treatment and stay in care is cumbersome and inefficient. She proposed looking closely at each step from the user's perspective to find solutions and move toward equity in HIV treatment.

Mr. Contreras said SDH have not been fully addressed. Latinx people, for example, face discrimination in employment and housing, stigma, and homophobia. Many are reluctant to seek care because they fear drawing attention to their immigration status or being seen as a public charge (i.e., dependent on public services, which can affect immigration status). People in low-paying jobs cannot afford to take time away from work, so organizations should offer evening and weekend hours for HIV services. Mr. Contreras also called for affordable housing for low-income people. Health care providers and their staff should be trained in cultural humility, and organizations should hire staff from within the communities they serve. Mr. Contreras said many small steps can be taken to move toward equity.

Q: Against the backdrop of racial uprising, systemic inequity, and COVID-19, what can be done to build trust between public health providers and communities around HIV care and the COVID-19 vaccine?

Dr. Mathews outlined the rationale for distrust among POC in vaccines and research. She said the burden rests on the institutions to demonstrate their trustworthiness—for example, by establishing mechanisms for community members to take part in decision making around research and governance. Institutions should leverage community feedback mechanisms, such as social media and town hall meetings, and partner with CBOs and historically Black colleges and universities. Institutions should contribute resources and information to address SDH in the community and should support local and minority-owned businesses.

Ms. Copeland stressed the need to listen to the community. She pointed out that a group of Black CDC employees published a letter about the racist culture at CDC but still has received no public response. The employees called for naming racism as a public health threat on the basis of an enormous amount of data, yet their voices have been ignored. The lack of response from the Federal government contributes to the increasing disparities in COVID-19 infections. Unless the Federal government acknowledges that structural racism is real, POC will not accept the COVID-19 vaccine. Ms. Copeland also urged investment in building the capacity and motivation of affected communities to advocate for their own health. Because HIV and COVID-19 are widespread among communities of color, response requires a broad coalition. Leadership must be representative of the community it serves and must listen to the people within the community.

Mr. Contreras also stressed the importance of engaging providers who represent the community they serve, but he acknowledged that not enough providers from marginalized communities are available to shoulder that burden. He added that health care providers must be aware of and sensitive to the needs and priorities of their clients, which might go beyond medical services. They must listen to clients, build trust over time, and communicate with them effectively. The peer model used by many CBOs is effective at overcoming medical mistrust among POC. Mr. Contreras expressed that collaboration among CBOs is difficult when organizations are forced to compete for limited funding, and many CBOs have closed because of the lack of funding, leaving fewer organizations to provide HIV and COVID-19 care.

Q: How do SDH affect the ability of vulnerable communities to access treatment and prevention, and how can EHE address the root causes of SDH?

Dr. Mathews described the difficulty of navigating the health care system and the many barriers that prevent people from continuing treatment. She again called for an assessment of the whole process from a user's perspective. Dr. Mathews called out the inefficiency of requiring paperwork to be completed manually and submitted in person as an example. The behavior that leads people to avoid or drop out of care is a reaction to the processes created by the system.

Ms. Copeland said health care and services should be comprehensive, integrated, holistic, and person-centered. Consideration should be given to mandating trauma-informed care, requiring harm-reduction approaches, and incorporating peer support, to name a few methods. Ms. Copeland stated that services and policies must mitigate the major barriers, such as mass incarceration and poverty, and promote links to housing, immigration services, and violence prevention. Reducing deaths from HIV requires substantial new investments in training and employment. Poverty should not be a crime, so policies should eliminate the option of incarceration for court debt or homelessness. Ending HIV among POC requires thinking differently about the circumstances, Ms. Copeland concluded.

Mr. Contreras said addressing SDH requires a national movement. COVID-19 has caused economic instability among the lowest-paid workers, and day-to-day economic survival is a higher priority than HIV treatment or prevention. Mr. Contreras said providing access to technology would enable more people to use telehealth services. He also proposed integrating immigration services into programs like Ryan White. The need clearly exists to address the intersection of SDH to provide comprehensive care. Mr. Contreras again noted that small steps can be taken now toward the big goals of equity and inclusion.

Q: What can HIV service organizations—many of which were founded by gay White men to serve gay White men—do to address racism and social justice more broadly?

Ms. Copeland observed that White supremacy has been embedded in systems over hundreds of years and cannot be erased in a half-day training. She urged organizations to invest in consultants who would work with them over many months to frame the questions and facilitate meaningful conversation. Dr. Mathews appreciated the contributions of many long-time advocates but said it is time for some leaders to give up their seats and allow new perspectives and voices to come to the table. Organizations should provide training and opportunities for emerging leaders to develop and hone their expertise. Community representatives should be compensated for their time and insight, Dr. Mathews added.

Q: Are there innovative approaches to increasing PrEP uptake beyond telehealth?

Mr. Contreras said individuals are more likely to trust providers who look like them and listen to them. A typical 15-minute health care visit is not enough time to build a relationship, especially if the provider focuses on issues that are not of pressing concern to the client. Mr. Contreras added that the benefits of PrEP can be difficult to appreciate because they are not tangible.

Q: What should be the immediate next step toward equity within EHE?

Ms. Copeland called for acknowledging the inequity of a plan that will likely end HIV among White populations long before communities of color. She suggested pausing to refocus the EHE strategy toward ending HIV for all people at the same time.

Q: What methods are working now at the local level to provide comprehensive, integrated, holistic, and person-centered services?

Dr. Mathews said her organization hired community health workers and embedded them within their communities, where they have been transformative in helping individuals navigate the system and connect to services through close, one-on-one interaction.

Q: Are there data available to support advocacy around extended office hours and other innovative approaches?

Mr. Contreras offered anecdotal data of success with extended office hours at his organization, noting that collecting data would require funding. He added that his organization recognizes the whole person, which includes staying in touch with clients and inviting them to be part of social activities. Ms. Copeland said her organization is working with NIH's HIV Prevention and Treatment Network to identify services within communities of color.

Dr. Wiesman observed that PACHA could recommend the following to the Federal government:

- commit to ending HIV for all people in the United States at the same time by allocating EHE resources according to need and disparities;
- prioritize addressing systemic and structural elements of racism as part of EHE plans; and
- declare racism a public health issue.

RADM Jonathan Mermin, M.D., M.P.H., said some aspects of EHE awards already sought to target resources to reduce disparities, but CDC did not include explicit indicators to monitor progress over time or require action if dramatic reductions are not achieved. He proposed recommending the development of such indicators and adding specific language about collecting and responding to the data. Dr. Mathews proposed directing resources creatively to generate economic opportunities within the community and avoid funding only those organizations that have done the same thing over and over.

COVID-19 and HIV from an International Perspective

Facilitator: *Cornelius Baker, Special Advisor and PEPFAR Liaison, Office of AIDS Research, NIH*

Panelists: *Simon Agolory, M.D., Country Director, CDC—Zambia, U.S. Embassy Lusaka, Zambia*

Solange L. Baptiste, M.P.H., Executive Director, International Treatment Preparedness Coalition (ITPC)—Global Team, Johannesburg, South Africa

Ivan Cruickshank, Executive Director, Caribbean Vulnerable Communities (CVC) Coalition, Kingston, Jamaica

Maria Phelan, M.A., Interim Fund Director, Robert Carr Fund (RCF), Amsterdam, Netherlands

Q: How has COVID-19 affected work on HIV in Zambia?

Dr. Agolory said Zambia's economy is in poor shape, and the country relies heavily on donations from PEPFAR and the Global Fund for its HIV response. Recognizing the threat of COVID-19, CBOs, faith-based organizations, and the government worked together on common messaging in clear language to empower PWH to protect themselves. Zambia's health care system was overcrowded even before COVID-19. CDC worked with the government to revise policies so that PWH would not have to risk exposure to COVID-19 in crowded facilities. New policies allowed PWH to receive 6 months' worth of antiretroviral medication, and within 6 months of the policy, 60 percent of PWH had received a 6-month supply of medication. For those who were unable to come to a health facility to get their medications, CBOs arranged to provide the medication in secure, private settings. Other messaging promoted HIV self-testing to reach those not in treatment. Dr. Agolory reported that Zambia achieved the United Nations goal of 90-90-90 in 2020. He also noted that Zambia has a lower death rate from COVID-19 than other countries, although the reason is not clear.

Q: How does RCF work?

Ms. Phelan explained that RCF was established to ensure that vulnerable populations are part of the solutions to end HIV. COVID-19 has had a disproportionate impact on communities that are already vulnerable. For example, in South Africa, during COVID-19 lockdown, police targeted PWH who were seeking access to care. Lockdowns in Mexico and Greece, among other areas, prevented access to essential services, such as harm-reduction programs. In Asia, undocumented migrant workers were excluded from services. RCF heard reports of rising gender-based violence. It recognized the need to increase funding to organizations and to allow them more flexibility so they could pivot from their usual operations to provide basic support, such as food and housing. RCF also supported translation of materials so that people would have accurate, accessible information about COVID-19 and HIV. The organization aimed to coordinate with other funders to support its networks on the ground.

Q: How has the Caribbean focused on stigma and discrimination among PWH?

As a result of COVID-19, Mr. Cruickshank explained, the Caribbean has faced health, economic, and social challenges. The Caribbean hospitality and tourism industries suffered significantly. Persistent stigma in the region influences access to HIV services, and the pandemic eliminated

the facilities that were seen by many as safe havens. Lockdowns prevented people from seeking services. Mobile health facilities that visited quarantined communities provided general health care, but not HIV-related services. To increase access, CVC worked with pharmacies and organized couriers to get prescriptions filled and delivered to people in need. It leveraged the success of one island's telehealth mental services by making the program accessible across the region. Mr. Cruickshank said migrants had been used to moving freely throughout the region, but new curfews and lockdowns posed challenges, and CVC had to intervene to get vulnerable individuals out of detention centers where they were subject to gender-based violence. The region discussed offering multi-month prescription dispensing (MMD), but supply chain issues posed significant problems. The region also had difficulty getting reagents to laboratories. Some countries that relied on laboratories across borders found that COVID-19 slowed down testing.

Q: How has the ITPC addressed issues such as access to treatment?

Ms. Baptiste noted that the HIV community was at the forefront of the COVID-19 response, which relied on structures built to address HIV. Despite sufficient supplies, people at the local level were unable to get medications. ITPC had to address the supply problem, as well as respond to COVID-19. There was a lot of disinformation and confusion about where to get medications and what symptoms were concerning, among other issues. To address medication adherence on the ground, ITPC supported local community efforts. For example, it provided money for gas so that individuals could pick up prescriptions for their communities, and it worked to get permission for these people to travel during the lockdown. Ms. Baptiste pointed out that PrEP took a back seat to more pressing issues, such as the need for food and jobs, and now HIV prevention services must ramp up again.

Q: What major innovations or policy changes were made in response to COVID-19 that were inspired by HIV policies, and has the COVID-19 response brought forth innovative approaches that could be applied to HIV?

Dr. Agolory explained that Zambians get prescription drugs from health care facilities rather than pharmacies, so facilitating a 6-month supply of medication was an innovative step that helped free up health care facilities. Also, as the country faced shortages of personal protective equipment, providers relied on their experience with HIV and tuberculosis to minimize exposure to disease by separating potentially infectious patients and isolating those who screened positive. The effort required community buy-in as well as clear communication. Working collaboratively with CBOs made a big difference, Dr. Agolory observed.

Ms. Baptiste said that community-led monitoring—in which communities define a research question, monitor trends over time in a systematic way, and collate the findings—gained traction just as the COVID-19 pandemic hit. Such approaches are an important companion to traditional academic research. Ms. Baptiste added that including those most affected by a disease in discussion and decision making about vaccine development and trial design and providing timely information about trial results are concepts pioneered by the HIV community that have informed the COVID-19 response. Furthermore, HIV and COVID-19 both require clear, effective communication about risks and treatment.

Mr. Cruickshank noted that COVID-19 sped up the pace of change and use of technology. Telemedicine services, including psychosocial support, rapidly emerged. Contact tracing has

been problematic for the HIV community, but with COVID-19, there has been rapid movement to develop new applications for contact tracing, some of which are being translated into use for HIV. Others have relied on novel COVID-19 technology platforms to promote HIV self-testing and linkages to care.

Ms. Phelan said RCF learned that providing flexibility for community organizations was key to ensuring that they could quickly respond to the needs of their communities. The pandemic has also highlighted the importance of the social safety net. When people lack basic necessities, such as food and housing, health care needs become secondary.

Q: What can PACHA recommend to support the global response to HIV?

Mr. Cruickshank called for greater investment in community-led responses, putting communities at the heart of design and implementation of policies and interventions. Ms. Phelan proposed scaling up social safety net protections to meet basic needs and increasing the urgency of ending the HIV epidemic. She added that any response should be fully funded. Ms. Baptiste observed the need to look at interconnectedness over individual country interests. She noted that the pandemic demonstrated the danger of overreliance on a single country or producer. Dr. Agolory said that resources are critical to success, but even with limited resources, success can be achieved by listening to clients and prioritizing what they believe to be best for them.

Q: Has COVID-19 revealed any practices or programs that may not be as important as once thought?

Dr. Agolory said the pandemic has shown that switching to virtual training where appropriate could save a lot of resources. Ms. Baptiste agreed but believed that travel and in-person training should continue when necessary and effective. She said organizations should continue to seek ways to be more efficient—for example, by creating hybrid training opportunities where appropriate. Mr. Cruickshank recognized the need to decentralize some interventions, which can save administrative costs. He added that the pandemic showed that more work can be accomplished online, which can conserve resources while expanding access. Ms. Phelan said that such innovations as telemedicine and MMD are cost-effective and applicable to many conditions. She noted that take-home opioid substitution therapy was unthinkable before COVID-19 but is cost-effective. She hoped for continued attention to practical approaches to services.

Q: What lessons from human T-lymphotropic virus types 1 and 2 (HTLV-1 and HTLV-2) have been learned in the Caribbean?

Mr. Cruickshank said the partnerships established between communities and academia have been essential in tackling the disease. Lessons learned from such collaboration can be applied to the HIV response.

Public Comments

Ace Robinson of the National Minority AIDS Council (NMAC) said he was very encouraged to hear a PACHA member acknowledge that HIV service organizations were created by White gay men to support White gay men, as well as the discussion calling for equity in health departments to ensure that they reflect the priority populations. Targeted investment in treating

HIV among the White gay community in the 1980s and 1990s resulted in success. The same results can be achieved in communities of color, which face similar issues now of medical mistrust and lack of access to culturally competent health care. Mr. Robinson praised the concepts that the people most affected by the epidemic must be heard and that those who have held positions of influence for a long time should make way for new voices.

Mr. Robinson commended Mr. Phillips for his work on EHE, observing that Mr. Phillips came to the position with a strong understanding of how government works and what the community in need looks like. He said the HIV community was initially disheartened because EHE leadership lacked experience and did not reflect the community, but under Mr. Phillips' guidance, EHE has begun to gain traction.

NMAC recommends that the White House Office of National AIDS Policy be reinstated. Its staff should have not only the critical skills necessary to navigate the political environment but also should represent the communities that are disproportionately impacted by HIV. Mr. Robinson said learning on the job is not acceptable, as demonstrated by previous efforts around HIV. NMAC recommends full funding of EHE leadership. Mr. Robinson pointed out that EHE should be fully funded through a distinct line item on the HHS budget. It is not acceptable to take money away from the work that needs to be done in minority populations (i.e., the HHS Minority HIV/AIDS Fund) to support other work in minority populations, he stressed.

NMAC also calls for a streamlined approach to addressing HIV, STIs, COVID-19, and viral hepatitis programming across all of HHS, such that those working across the communities served all report to the health equity directors to ensure continued focus on equity. Finally, NMAC recommends that EHE include indicators of health outcomes related to the highly impacted populations within the jurisdictions. HHS should not continue to fund organizations that have historically failed their communities. Mr. Robinson said the community can no longer be led by people who do not look like the communities they serve and have not done the hard work of engaging with those communities.

Jax Kelly, president of Let's Kick ASS (AIDS Survivor Syndrome) Palm Springs, said his community has one of the largest populations of aging PWH. AIDS survivor syndrome is marked by loneliness and isolation and affects PWH over age 50. As an African American who has HIV and has been living with AIDS since 2006, Mr. Kelly said he experiences significant intersectionality. Now, he is approaching a system that is rife with ageism. The United States has a problem with people who are aging, and this is the first time the country has ever dealt with aging PWH, so these people are facing stigma and ageism. Mr. Kelly called for standards of care in the Ryan White program for aging PWH. He called for more mental health professionals, noting that current funding for such professionals does not encourage people to serve in those positions in the Ryan White program. He said the Ryan White planning councils in which he is involved in California and other States set aside money for mental health care workers, but the money often goes unspent, because programs cannot find the people who will take those positions at the salaries offered.

Mr. Kelly encouraged people to focus on the easy requests. Much legislation and activism related to aging has been underway for decades, even though the issues are new to PWH. Proposed

legislation, such as the Older Americans Act, could be amended to include language that benefits aging PWH. Mr. Kelly encouraged PACHA members and others to consider such approaches.

See Appendix B for additional public comments submitted.

Looking to the Future of EHE

Co-Facilitators: Carl Schmid, M.B.A., and John Wiesman, Dr.P.H., M.P.H., PACHA Co-Chairs

Panelists: *Edric Figueroa, ACT NOW: END AIDS Coalition Coordinator*

Stephen Lee, M.D., M.B.A., DHSM, Executive Director, National Alliance of State and Territorial AIDS Directors (NASTAD)

Linda Villarosa, M.J., Journalist and Contributing Writer, New York Times Magazine

Q: How can attention to EHE be sustained?

Mr. Figueroa replied that sustaining any program requires specific guidelines on implementation and distribution of funding. It also requires ongoing input from communities of PWH and those disproportionately affected by HIV because of disparities, racism, economic injustice, stigma, and other factors that contribute to HIV across the country. Community voices and community leadership are key. Building leadership involves repairing the broken trust between communities of color, public health institutions, and researchers. Mr. Figueroa said efforts require political will that goes beyond goodwill gestures. The next administration must put forth comprehensive plans that take into consideration what has been accomplished so far and bring community voices to the table. HIV community activists have been trying to bring attention to disparities for decades. It is critical to elevate plans like ACT NOW: END AIDS' updated executive summary for the Community Roadmap for EHE and resources from the Black AIDS Institute, the Latino Commission on AIDS, and the Positive Women's Network, to name a few.

Dr. Lee said the next administration should reinforce its political commitment and increase funding for that commitment in a sustainable way. He reiterated the call to reinstate the Office of National AIDS Policy with leadership that reflects the communities most affected by HIV now. More attention should be given to using data to identify gaps in services, such as for aging PWH, and identifying strategies to fill those gaps.

Ms. Villarosa described the evolution of her story, "America's Hidden HIV Epidemic," published in the *New York Times Magazine* in 2017, explaining that she first sought to shed light on a problem not widely recognized and was then encouraged by her editor to look more deeply at the root causes of disparities in HIV services in the South. Ms. Villarosa said the HIV community can sustain media attention by continuing to bring forward new stories of those hardest hit, such as the transgender community, and highlighting influential leaders and researchers in the field.

Q: What is the status of EHE in light of the COVID-19 pandemic?

Dr. Lee noted that the COVID-19 response facilitated use of telehealth services, self-testing, and MMD, and he hoped EHE could build on those mechanisms. He pointed out that CDC and

HRSA have afforded grantees more flexibility in implementing programs during the pandemic, some of which can translate into long-term changes. Dr. Lee hoped that EHE would build on efforts undertaken during COVID-19 to put patients at the center of care and to make processes and procedures more streamlined and effective.

Dr. Lee said that COVID-19 showed that the public health infrastructure was woefully unprepared for a pandemic. The country has an opportunity to think about the infrastructure gaps, such as inadequate surveillance and challenges to the capacity of the public health workforce. The pandemic illustrated the significant impact that health disparities have on people's lives. Addressing the workforce issues includes ensuring that leaders at all levels reflect the communities they serve, from the front-line staff to the people designing and evaluating programs to those disseminating funding.

In terms of the status of EHE, Mr. Figueroa supported the concept of slowing down to reflect on whether EHE is adequately poised to end HIV in all communities. At the local level, organizations should consider whether programs are accessible and responsive to the communities they serve. He called on leaders to ask why it took a pandemic to allow for the technological innovations to expand access to care, such as telehealth services. Dr. Wiesman appreciated the insight, adding that the pandemic disrupted "business as usual." It paved the way for questioning the necessity of certain regulations and asking whether some restrictions reflect an entrenched imbalance of power.

Mr. Figueroa agreed that leadership should reflect the community served. He emphasized that growing a pool of leaders requires training people in advocacy and public health issues so they have the tools to make good decisions.

Dr. Lee said the conversations held by this and previous panels reminded him that everyone in the field should take time to reflect on their role in perpetuating some of the systemic and ingrained processes and policies that perpetuate racism, health inequities, and disparities.

Q: How has COVID-19 affected the public's understanding of infectious disease?

Ms. Villarosa said the pandemic has clarified how racial health disparities and inequities affect people. Less than a year ago, even among public health professionals, there was reluctance to call out racism as a public health threat, but since the pandemic, the concept has become widely accepted and discussed. The racial reckoning sparked by the death of George Floyd at the hands of police officers coincided with the spread of the pandemic, drawing attention to the intersection of race and health. In addition, Ms. Villarosa pointed out that journalists have been forced to become better at reporting on public health because of the pandemic.

Mr. Figueroa observed that people have become better at identifying the problem of health disparities and inequity and now have the language to address it. However, with so much time spent on addressing the public health crisis and correcting false information about COVID-19, the opportunity to talk about how the country should address health disparities has been overlooked. The conversation about how to fix the root causes will be long and difficult and goes beyond naming the problem.

Mr. Figueroa stated that the pandemic has provided opportunities to increase HIV health literacy and decrease some of the stigma around HIV. He would like to see more efforts to combine HIV and COVID-19 testing and to develop messaging to increase the public's knowledge about both HIV and COVID-19. In his experience with COVID-19 testing, recipients receive little information about the testing or about preventing the spread of disease.

Dr. Lee observed that timely and effective communication is a pillar of public health. The COVID-19 pandemic has exposed marked distrust. Many people, especially Black people, have a long history of legitimate reasons for mistrusting the medical community. Discussion about health disparities and inequities should acknowledge and address that history as part of efforts to build trust.

Dr. Lee recalled earlier discussion about the need for integration at the highest levels of leadership. He suggested thinking more broadly about the government agencies that should participate in the discussion. For example, the Department of Justice should be engaged to respond to issues around criminalization and the Department of Labor should provide input on employment and poverty.

Q: How can efforts to end HIV move forward without succumbing to partisan, political, and geographic divisions?

Ms. Villarosa said the media has not covered rural stories very well, but the pandemic has brought health disparities to the forefront, and stories from rural communities are becoming more prominent. She emphasized that the media seeks stories that seem novel or fresh. Health care disparities in rural areas highlight the intersection of problems around transportation, employment, and the environment. In West Virginia, for example, COVID-19 is exposing the impact of disparities on a predominately White, conservative population.

Dr. Lee said COVID-19 affects everyone, and communities can respond by focusing on what is happening at the local level. Similarly, for HIV, local entities should assess the epidemic in their own communities and use their findings to build commitment and buy-in for solutions. The EHE initiative encourages each community to develop its own policies and procedures for using the tools available to eliminate HIV. Identifying barriers at the local level, such as transportation or health care access, can help communities come together around solutions.

Mr. Figueroa said HIV will always be political because of the people it affects. Queer rights, human rights, and the dignity and value of Black lives and those of migrants are always going to be central to ending HIV. The effort needs leaders who recognize and value diversity as a tool for change. Mr. Figueroa pointed out that many of the worst HIV outbreaks are occurring in the most politically conservative areas of the country. He noted that the COVID-19 pandemic has brought attention to the tradeoffs many Americans make to access health care. Mr. Figueroa stressed that no one should have to choose between putting food on the table or seeing a doctor, and no one should be afraid to go to a doctor out of fear of deportation. He said efforts are needed to maximize the tools available and minimize the tradeoffs for all Americans, focusing on places where HIV is widespread. Leaders must be willing to acknowledge that the lives of queer people, Black people, and others matter and must help communities work toward shifting their values to alleviate the impacts of health disparities.

Dr. Wiesman pointed out the challenge of acknowledging all the different communities affected by HIV, including rural residents, as well as the impact of structural and institutional racism. He called for leaders to reflect on all those who have been left behind and how to move forward to correct the mistakes of the past. Ms. Villarosa noted that public health professionals recognize that epidemics exacerbate patterns of marginalization, exclusion, and discrimination.

Q: How can the HIV community better partner with the media to tell the stories of PWH?

Ms. Villarosa said young journalists are showing increasing interest in investigative journalism, social issues, and public health. She pointed to a number of programs supporting young journalists, such as the Reveal Investigative Fellowship based in San Francisco, the University of Southern California's Center for Health Reporting, and the Knight-Wallace Foundation. The Black Lives Matter movement has sparked interest in politics and activism among many youth.

Ms. Villarosa recommended providing journalists with specific information and sources that can help them develop a story. Journalists appreciate stories that offer a fresh angle or illustrate an emerging trend. Ms. Villarosa suggested working with individual journalists and offering exclusive access when possible.

Q: AI/AN have been disproportionately impacted by COVID-19 because of underlying health disparities. The Federal government has not met its obligations to provide health care to AI/AN, and with competing health care priorities, native PWH are not getting the services they need. What is being done to ensure that AI/AN are included?

Dr. Lee recognized the gaps and said efforts must be made to ensure that the incoming administration takes into account the need for funding and resources for AI/AN.

Q: How can PACHA help Latinx youth fight HIV and COVID-19?

Mr. Figueroa praised youth leadership development opportunities—such as those offered by the Latino Commission, NMAC, and ViiV—but said there is no central source for learning about such opportunities. A range of tactics are needed to reach out to youth who represent various communities. Mr. Figueroa said it is important to explicitly seek out people whose identities are central to the goals. For example, transgender Latinx women and youth experience disproportionately high rates of HIV, so efforts should be made to reach out to them and raise awareness about PACHA and other organizations.

Dr. Lee pointed out that the Latinx community is not monolithic. Strategies and approaches should be tailored to address the needs of specific populations in specific communities. Mr. Figueroa agreed and proposed seeking out experts from within communities to guide such work.

Closing Remarks from the PACHA Co-Chairs

Dr. Wiesman said the meeting offered a great overview of the plans in place around HIV, STIs, and viral hepatitis, which will serve as roadmaps for the Federal government and those working on the ground. He thanked the current administration for initiating the plans. Dr. Wiesman said the meeting provided PACHA's subcommittees with much information to fuel discussions about

how to advise the incoming administration. He expressed appreciation to the PACHA staff and all those who supported this meeting and PACHA's ongoing work.

Mr. Schmid anticipated that PACHA would meet in early 2021 to gather input on the HIV National Strategic Plan and discuss how to fine-tune EHE. Mr. Schmid and Dr. Wiesman thanked the PACHA members, presenters, participants, and organizers. The meeting adjourned at 4:49 p.m.

Appendix A: Resolution

Resolution in Appreciation for Beginning Ending the HIV Epidemic Initiative

Whereas, in the State of the Union Address on February 5, 2019, President Donald J. Trump announced the Administration's goal to end the HIV epidemic in the United States within 10 years;

Whereas, Ending the HIV Epidemic (EHE) initiative is the operational plan developed by agencies across the U.S. Department of Health and Human Services (HHS) to pursue that goal. With its initial focus on the 48 counties, plus Washington, DC, and San Juan, PR, where greater than 50 percent of HIV diagnoses occur, and on seven states with a substantial number of HIV diagnoses in rural areas, EHE seeks to reduce new HIV infections by 75 percent by 2025 and 90 percent by 2030 through ramping up HIV testing, increasing viral suppression through treatment, and improving access to HIV prevention services, including PrEP;

Whereas, the HHS Office of the Assistant Secretary for Health, led by the Assistant Secretary for Health (ASH), quickly embarked on laying the foundation to begin the effort and organized federal agencies and their leaders to begin implementation of this monumental effort. In order to pilot EHE, HHS dedicated existing resources to four jumpstart jurisdictions;

Whereas, in December 2019, with bipartisan support, the U.S Congress passed, and the President signed into law, a spending package for Fiscal Year (FY) 2020 that included $267 million for EHE activities across federal agencies to be distributed to EHE priority jurisdictions;

Whereas, the ASH, federal agencies, and PACHA initiated listening engagements in Phase 1 jurisdictions to hear from people living with and affected by HIV, community-based and serving organizations, along with state and local governments on how to best implement the EHE initiative to meet their needs and achieve the goals of the EHE.

Whereas, prioritized jurisdictions were provided resources to develop community plans to implement EHE efforts in their localities;

Whereas, agencies such as the CDC, HRSA, and NIH developed multiyear funding announcements to carry out increased testing, treatment, and PrEP programs which was later distributed to state and local governments, along with community-based organizations;

Whereas, HHS partnered with Gilead Sciences, Inc. and a network of pharmacies to set up the "Ready, Set, PrEP" (RSP) program to provide PrEP medications for free to uninsured individuals throughout the United States;

Whereas, on February 10, 2020, the White House released the President's Fiscal Year 2021 Federal Budget proposal, which includes $716 million for the second year of the multiyear EHE initiative in order to ramp up EHE activities;

Passed unanimously on December 2, 2020

Whereas, the ASH and the implementing agencies, have launched America's HIV Epidemic Analysis Dashboard (AHEAD), an online HIV data visualization tool to track national progress in eliminating the HIV epidemic by 2030;

Whereas, the broad HIV community along with state and local governments are committed and focused on achieving the goals outlined in the EHE initiative;

Whereas, the ASH has released a draft of the HIV National Strategic Plan for the United States: A Roadmap to End the HIV Epidemic, that includes ambitious targets and indicators for the entire country;

Whereas, PACHA has provided advice to the Secretary over the past two years on ways in which the EHE can be implemented and improved and have stated when the Council has disagreed with certain administration policies and actions;

Whereas, the foundation developed in EHE is based on sound science advanced by HIV community leaders and is exactly what is needed to end HIV and should be continued in future years, and improved upon, as appropriate;

Therefore, be it resolved that the PACHA extends its great appreciation to HHS Secretary Alex Azar; ADM Brett P. Giroir, MD, Assistant Secretary for Health; Anthony Fauci, MD, Director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health; Robert R. Redfield, MD, Director of the Centers for Disease Control and Prevention; Thomas J. Engels, Administrator of the Health Resources and Services Administration; Elinore F. McCance-Katz, MD, PhD, Assistant Secretary of Mental Health and Substance Use at the Substance Abuse and Mental Health Services Administration; RADM Michael D. Weahkee, Director of the Indian Health Service, for their roles in conceptualizing the EHE initiative and extends warm gratitude for their leadership with this historic effort;

Be it further resolved that PACHA extends the same level of appreciation and gratitude to all the staff of the federal agencies who have dedicated their time, expertise, energy, and enthusiasm to developing and implementing EHE. Without their steadfast commitment, the foundation that has been laid and the progress that has occurred to date would not have been possible.

Passed unanimously on December 2, 2020

Appendix B: Written Public Comments

69th Presidential Advisory Council on HIV/AIDS (PACHA) Full Council Meeting
December 2 – 3, 2020
Submission of Written Public Comment

Sent: Tuesday, November 24, 2020 7:41 AM
To: Presidential Advisory Council on HIV/AIDS (HHS/OASH) <PACHA@hhs.gov>
Subject: HIV Public Comments

Dear Sir

I am from Sri Lanka and suggest to implement a program in developing countries and a step forward towards eradication of HIV.

Trust you would contact me on

dushiyant8@yahoo.com with basic information for necessary Action.

Also please contact Health Authorities of SriLanka with a copy to Hon.minister of Health for their attention.

Also I suggest to launch a project in Nutrition for poorest families in SriLanka allocating sufficient funds which seems essential

Thank you

Dushiyant Gunathilake

Missionary

dushiyant8@yahoo.com

SriLanka

Public Comment
President's Advisory Council on HIV/AIDS
Dec. 2-3, 2020

Dear Members of PACHA:

Thank you for the opportunity during this meeting to address you regarding the Ready, Set, PrEP program, the aspect of the administration's *Ending the HIV Epidemic: A Plan for America* intended to bridge a gap in PrEP uptake among uninsured individuals who did not qualify for other, manufacturer-sponsored medication assistance programs. Representing approximately 20 organizational members of AIDS United's Public Policy Council (PPC), the Prevention Committee submits the following comments for your consideration.

We would first wish to express support for PACHA's August 2020 *Resolution to Increase Uptake in the Ready, Set, PrEP (RSP) Program*. PACHA members identified a number of recommendations for improving use of the program also recognized by PPC Prevention Committee members, many of whom are PrEP providers working in the rollout of this program firsthand, and we appreciate the Advisory Council's advocacy to improve the implementation of RSP. We would like to expand on and emphasize three points significantly hampering the effectiveness of RSP: 1) non-coverage of PrEP-associated medical services, 2) limitation of pharmacies eligible for partnership in medication distribution, and 3) necessary clarifications of eligibility in public messaging – as well as offer a further consideration on patient eligibility for those *with* insurance but who may not be able to use it for PrEP services.

While coverage of medication costs is certainly necessary, RSP as structured declines to fill a long-standing, long-recognized gap in PrEP expansion: that lab and physician visit costs also create a significant barrier for people seeking PrEP. The Department of Health and Human Services (HHS) should ensure dedicated funds for covering these services through federal and grantee PrEP providers so patients may be linked at their point of service.

Additionally, the requirement within RSP to utilize only select pharmacy chains for PrEP distribution significantly limits patient access by adding, in the case of many PrEP providers with in-house or contract pharmacies, an additional step in the process for patients to access their medications. Requiring a lower-income patient utilizing the services or pharmacy of a community health center on a sliding-fee basis for other non-PrEP care to use a different pharmacy for their PrEP prescription makes the process more burdensome and decreases the likelihood and ability of that patient to actually initiate PrEP and continue to adhere. Many of our PrEP-providing members clearly see the value of being able to prescribe *and* dispense PrEP; as one member in the greater Atlanta area shares, "Having a pharmacy on-site has been a major success in retention, as many of our patients have transportation barriers. Rerouting to another pharmacy may mean having to catch an extra train or bus to get to the pharmacy between leaving the clinic and home. Our patients are able to leave with a bottle of Truvada or Descovy in hand. For individuals at higher risk of acquiring HIV, this could quite easily be several days (or more) of delay in getting PrEP and delay of protection from acquiring HIV. Worst case scenario, patients who may already be on the fence about PrEP may be dissuaded from starting with this added barrier." It is crucial that PrEP providers who participate in RSP are able to engage their clients in ways that meet their needs, including by dismantling barriers to access everywhere possible.

Further, there are omitted details regarding patient eligibility that, unless clarified, may discourage potential RSP users from pursuing PrEP through the program. As specified in PACHA's resolution, it must be made clear

in public messaging that immigration status is not a barrier to use of RSP. Given that non-US-citizens are significantly more likely than citizens to be uninsured[1] and considering the population of focus for RSP – those who are uninsured but exceed income limits of other assistance programs – immigrants must be assured that RSP is a benefit available to them and, particularly, that it is not affected by the Administration's abhorrent Public Charge rule. Additionally, on the portal for individual program enrollment, the field to enter one's social security number should be made optional, as a number is not required to utilize the program. These clarifications, both in public messaging and in the specifics of bringing individuals into the program, would show RSP as an accessible option for those with whom it aims to engage.

Finally, there are key gaps even within the niche population of interest for RSP that undermine the program's impact. The HHS Secretary administering this program should consider expanding access to RSP to insured people who can't or won't use their insurance benefits to access PrEP, encompassing people under 26 insured through their parents (as youth are a key demographic in ending the epidemic), people who might experience domestic or social harm for accessing such a health service (as people in situations of domestic or intimate violence are at heightened risk for HIV acquisition), and people who technically make too much for other assistance programs but cannot afford exorbitant co-pays and other insurance-related costs. To truly support those in a gap of manufacturer-sponsored assistance, RSP must take an expansive approach to meet potential program users where they are.

Given the forthcoming change in administration, it is unclear how RSP, and the entirety of the *Ending the HIV Epidemic: A Plan for America*, will move forward. However, the PPC Prevention Committee sincerely appreciates the opportunity to reinforce the recommendations of the members of PACHA and to outline adjustments that would maximize the program's impact.

Thank you for your time and consideration.

– *AIDS United Public Policy Council Prevention Committee*

1 – *Health Coverage of Immigrants*. Kaiser Family Foundation. March 18, 2020. Access at https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/#:~:text=In%202018%2C%20more%20than%20three,in%20ten%20(9%25)%20citizens.